Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	A. BUILDING: ______ B. WING ______	08/14/2018

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FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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L 000	Initial Comments	L 000		

An unannounced License Survey was conducted at Forest Hills of DC August 7, 2018, through August 14, 2018, and consisted of a review of 16 resident clinical records. Based on observations, record reviews, and staff interviews, an analysis of the findings determined the facility is not in compliance with the requirements of Title 22B DCMR Chapter 32 Regualtions for Nursing Homes.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter

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L 000	Continued From page 1 Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		
L 031	3207.6 Nursing Facilities The physician shall prescribe a planned regimen of medical care which includes the following: (a)Medications and treatments; (b)Rehabilitative services; (c)Diet; (d)Special procedures and contraindications for	L 031		

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L 031	Continued From page 2 the health and safety of the resident; (e)Resident therapeutic activities; and (f)Plans for continuing care and discharge. This Statute is not met as evidenced by: Based on record review and staff interview one (1) of 16 records, the physician failed to review the resident's total program of care as evidenced by an Admission History and Physical that did not accurately reflect resident's condition on admission and all pertinent related to assessed care needs (Resident #37). Findings included ... Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation (ORIF) of the Left Hip. Review of the medical record on August 13, 2018 at 11:00 AM, the "History and Physical Exam Form" dated March 16, 2018, showed admission diagnosis of Open Reduction and Internal Fixation of Left Hip, with active medical problems as Left Wrist Fracture, Atrial Fibrillation, Hypertension, Osteoporosis, Urinary Retention, Anxiety, and past medical history of Breast Cancer. The Physical Exam showed eyes/vision- clear, ears/hearing- clear, oral/teeth- clear, neck- no nodes, chest clear, Cardiovascular- irregular/irregular, Breast- a dash mark was documented, Abdomen- benign, Genitourinary- foley in place, skin- clear, Musculoskeletal- left	L 031	**LO31: Physician Visits – Review Care, Notes, Orders** **Failure to review resident's total program of care (i.e., H&P did not accurately reflect resident's condition on admission and all related assessed care needs).** 1.The resident affected by the deficient practice expired. No corrective action was possible. 2. Compare all H&Ps of newly admitted residents to hospital Discharge Summary. Determine if H&P reflects current medical needs. Advise physician of findings and require correction, as needed. 3A. Develop policy regarding physician's documentation. Inform medical staff of new policy. 3B. Include documentation policy as addendum to medical providers' contracts. 4. Audit policy compliance quarterly during external medical record audit. Report compliance quarterly to QAPI Committee x 4 quarters to determine sustainability. Expected compliance threshold = 100%.	8.7.18 10.13.18 10.15.18 10.15.18 10.25.18

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L 031	Continued From page 3	L 031		

hip incision clear/ negative calf tenderness, Neurological- non-focal/ generalized tremor, and Mental Status- alert and oriented. The admission "History and Physical Exam Form" failed to show the physician reviewed Resident #37 hospital discharge summary, medications and treatment, to reflect the physician's decisions about the continued appropriateness of the medication and treatment regimen in the nursing home.

The hospital discharge summary dated March 15, 2018 showed Resident #37's Discharge Diagnoses- Active Problems" listed as Closed Left Hip fracture, Essential Hypertension, Anxiety, Atrial Fibrillation, Systolic Ejection Murmur, Restrictive Lung Disease due to Kyphoscoliosis, Urinary Retention, Tachy-Brady Syndrome, Non-rheumatic Aortic Valve Stenosis. Past medical history included Breast Cancer, Arthritis, and Cataract, Right Breast Lumpectomy.

Further review of the Physician Progress Notes showed that Resident #37 was seen by the Nurse Practitioner on March 20, 2018. The SOAP (an acronym for subjective, objective, assessment, and plan) progress note showed "O [Objective]" blood pressure- 132/76, pulse- 68, afebrile, Extremities- left hip- upper incision staples in place, lower hip- staples in place- clean and no drainage. "A [Assessement]"- status-post ORIF Lt. [left] hip, HTN [Hypertension], and "AF [Atrial Fibrillation]." The "P [Plan]- Repeat BMP [Basic Metabolic Panel] 7 CBC [Complete Blood Count] next lab day."

The medical record lacked documented evidence the physician reviewed Resident #37 Active

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L 031	Continued From page 4 Problems and Past Medical history to reflect the physician's decisions about the continuation or appropriateness of the resident's current medical regimen related to Left Wrist Fracture, Restrictive Lung Disease due to Kyphoscoliosis, Tacy-Brady Syndrome, Cataract, and Arthritis. During a face to face interview on August 13, 2018, at approximately 12:15 PM, Employee #4 acknowledged the findings.	L 031		
L 033	3207.8 Nursing Facilities Each physician shall adhere to the written policies and regulations that govern the health services provided in the facility. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 15 sampled residents, the physician failed to respond to a request from the pharmacist to review Resident #31's psychotropic medications. Findings included ... Resident #31 was admitted to the facility on March 30, 2014 with diagnoses which included Hypertension, Diabetes Mellitus, Anxiety Disorder and Gastro Esophageal Reflux Disease. The resident was receiving the following medications Clonazepam 0.25milligram at bedtime, Lexapro 10mg, Remeron 15mg and Gabapentin 300mg TID (three times per day).	L 033	**L033: Drug Regimen Review** **Failure to respond to a request from the pharmacist regarding resident's psychotropic meds.** 1. The deficient practice was corrected in Resident #31's chart. 2. All resident charts were reviewed to identify any outstanding pharmacy recommendations regarding psychotropic meds. None were found. 3A. Re-educate medical staff on Drug Regimen Review policy. Include policy as addendum to provider contracts. 4. Audit policy compliance quarterly during external medical record audit. Report compliance quarterly to QAPI Committee x 4 quarters to determine sustainability. Expected compliance threshold = 100%.	8/31/18 10/6/18 10.15.18 10.25.18

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L 033	Continued From page 5 The pharmacist reviewed the resident's medications on May 17, 2018 and left the following recommendation: "Recommend re-evaluate all of the medications at this time to determine if any slow reductions are possible. If not, please document clinical rationale. Of note, patient is on 2 antidepressants." The pharmacist also stated that the resident has been on several psychoactive medications and that the most recent psych note from 3/2/18 only acknowledged Celexa 10mg and Clonazepam 0.25mg. The area designated for the physician's response was blank and there was no documentation to address the recommended change in the medications in the physician's progress notes. Review of Resident #31's Medication Administration Record showed Clonazepam 0.5mg. Give ½ tab (0.25mg) by mouth every night at bed time for anxiety (2/21/2018), Gabapentin 300mg cap 1 cap by mouth three (3) times a day for anxiety (2/15/2018), Mirtazapine 7.5 mg 1 tab by mouth daily at bedtime for Depression. The physician failed to acknowledge and/or respond to the pharmacist's recommendation regarding Resident #31's psychoactive medications. During a face-to-face interview on August 9, 2018, at approximately 5:00 PM, Employee #2 acknowledged the findings.	L 033		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the	L 051		

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L 051	Continued From page 6 following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:	L 051	**L 051: Notification of Changes** **A. Failure to Notify Physician of Elevated B/P Reading in Accordance with Physician's Order.**	
	1. Based on record review and staff interview of one (1) of 16 sampled residents, the charge nurse failed notify the physician of an elevated blood pressure reading, in accordance witth the physician order (Residents #23). Findings included ... Resident #23 was admitted on 7/16/18 with diagnoses which include Essential Hypertension, Vitamin D deficiency, Muscle Weakness, Dysphagia Oral phase and Unspecified Dementia without behavioral disturbance. Review of the physician progress note on 8/9/18		1. Medical record for Resident #23 was reviewed. Deficient practice has not recurred.	8.17.18
			2. All charts and MARs of residents receiving B/P medications were reviewed. No other residents experienced the deficient practice.	10.6.18
			3. Forest Hills' Physician Notification policy and procedure was updated. Staff received training on the regulation and the policy updates.	10.15.18
			4. 10% of MARs containing B/P med changes will be audited monthly against nursing documentation to determine compliance with the Physician Notification Policy. Results will be reported monthly to the QAPI Committee x 12 months to determine sustainability. Expected compliance threshold = 100%.	10.25.18

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L 051	Continued From page 7	L 051		

at 2:00 PM showed an order "monitor blood pressure routinely twice daily for hypertension. Notify MD (medical doctor) if systolic pressure is greater than 160 mmHg (milliliters of Mercury) and or diastolic is greater than 100 mmHg."

A review of Resident# 23 Medication Administration Record (MAR) for July 2018 showed on 7/17/18 a blood pressure reading of 183/98 (sitting right arm).

During an interview on 7/10/18 with Employee# 4 stated, "I am not able to find a note that the physician was notified of the high blood pressure but she is on medication."

The medical record lacked evidence the physician was notified of elevated blood pressure reading on 7/17/18 or of interventions performed to address the elevated blood pressure.

During a face-to face interview on 7/10/18 at 3:00 PM Employee# 4 acknowledged the findings.

2. Based on record review and staff interview for one (1) of 16 sampled residents, the facility failed to develop a comprehensive person-centered care plan to include goals and preferences address falls, activities of daily living, psychotropic drug use, and left wrist fracture (Resident #37).

Findings include ...

Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip.

<u>L 051:</u> <u>Failure to Develop & Implement Comprehensive, Person-Centered Care Plan</u>

Plan of Correction	Complete Date
1. The resident affected by the deficient practice expired. No corrective action was possible.	8.7.18
2. Care plans were reviewed for all residents who require assistive devices (wheelchairs, walkers), require psychotropic drugs, and/or have fractures to ensure they are person- centered. Revisions/updates were completed where indicated.	10.8.18
3A. Interdisciplinary training will be provided for all members of the care plan team on how to develop and maintain/update person-centered care plans.	10.10.18
3B. Care plans will be audited weekly for all residents whose care plans were reviewed that week to determine if goals and interventions reflect person-centered approaches to care.	10.15.18
4. Audit results will be presented to the QAPI Committee monthly x 12 months to determine sustainability. Expected compliance threshold = 100%	10.25.18

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L 051	Continued From page 8 Review of medical record on August 13, 2018 at 11:00 AM showed a Minimum Data Set dated March 22, 2018. Resident #37 was documented as being cognitively intact with a Brief Interview for Mental Status (BIMS) Summary Score of "15" in Section C0500. Resident able to make self-understood and able to understand others. Section G Functional Status for Activities of Daily Living (ADLs) assistance showed Resident #37 required extensive assistance to self-perform bed mobility, transfers, dressing, toilet use, and personal hygiene; and the assistance of one (1) for ADL support for bed mobility, dressing, personal hygiene. Resident #37 required two (2) ADL support for transfers and toilet use. For bathing, the resident was totally dependence with the assistance of one (1) staff person. Section GG "Functional Abilities and Goals" Section GG0130 on admission was coded as independent for eating, oral hygiene, sit to lying, sit to stand, and lying to sitting on the side of the bed. However, "set-up" (resident completes activity, helper assists only prior to or following the activity) was discharge goal for transfers and toileting hygiene. Admission Physician Orders dated March 15, 2018 included the following orders: Lexapro 5 milligram one (1) tablet by mouth every night for mood stability, Alprazolam [Xanax](an antipsychotic medication used to treat anxiety) 0.25 milligrams one tablet by mouth three (3) times daily as needed, monitor blood pressure daily for antihypertensive medication- notify doctor is systolic blood pressure is greater than 160 or less than 100 millimeters of Mercury and/or diastolic blood pressure is greater than 100 and less than 60 for three (3) consecutive readings, weight bearing on left leg as tolerated,	L 051		

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left hip precautionary measures every shift, and On March 16, 2018, the telephone orders for Occupational Therapy evaluate and treat five (5) times per week for four (4) weeks and Physical Therapy evaluate and treat for five (5) times per week for four (4) weeks. Occupational Therapy and Physical Therapy evaluations.

Nursing Admission Screening/History dated March 15, 2018, at 11:58 PM showed limited range of motion due to left wrist fracture; left mid hip surgical site has 8 staples, left upper hip surgical site has 6 staples. Resident #37 had a hard cast on the left wrist with limited range of motion on left lower extremity due to fracture on left hip, "cannot bear weight at this time."

Review of care plans showed the facility staff initiated care plans for pressure ulcers, dental care, falls, ADL (Activities of Daily Living) function, psychotropic drug use, short-term rehab, and fracture to arm as follows:

"Falls" care plan initiated on March 16, 2018, the interventions were documented as "Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed; and the resident needs prompt response to all requests for assistance.

"ADL Function" care plan initiated on March 16, 2018, the interventions were documented as "document/report any changes to MD, POA, Resident, initiate rehabilitation referral. Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance."

"Psychotropic Drug Use" care plan initiated on

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March 23, 2018, the interventions were documented as "Observe for signs of behavior change and report to MD, POA, and Resident."

"Short Term Rehab" care plan initiated on April 6, 2018, the interventions documented as "assess need for any durable medical equipment, assess need for skilled home health services and assist in coordinating any needed services, assess resident's ability to return to her son's home in the community, complete all necessary discharge paperwork, empower resident to be involved in discharge planning, facilitate a home evaluation, meet with resident to discusser thoughts and feelings regarding her SW [social work] transition to her future living arrangements."

"Fracture to arm r/t [related to] fall" initiated on March 23, 2018- Interventions monitor/document/report PRN [as needed] s/sx. [signs and symptoms] of hip fracture complications; contracture formation, embolism, increased heart rate, tachypnea, difficulty breathing, infection at surgical site, impaired mobility, unrelieved pain, pneumonia/poor air exchange, incontinence."

"Potential for acute/chronic pain r/t [related to] generalized weakness" initiated on March 16, 2018, the interventions documented as "evaluate the effectiveness of pain interventions review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function."

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"Potential for impairment to skin integrity r/t [related to] fragile skin" initiated on March 16, 2018, the interventions included "educate resident/family/caregivers of causative factors and measure to prevent skin injury, keep skin clean and dry. Use lotion on dry skin."

The care plans lacked person-centered goals and approaches to address use of assistive device (walker and wheelchair), interventions to manage left wrist cast, Xanax 0.25 milligrams as needed for anxiety, staples to left hip area, hip precautions, and weight bearing status.

During a face to face interview conducted on August 13, 2018 at 5:22 PM, Employee #7, reviewed the nursing documentation and confirmed the findings.

3. Based on record review and staff interview one (1) of 16 sampled residents, the facility failed to revise the care plan for changes in treatment plan related to weight bearing status and medication changes (Resident #37).

Findings included...

Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip.

Review of the medical record on August 13, 2018 showed the following physician orders:

March 28, 2018 at 4:00 PM, physician order for full weight bearing in cast for left wrist, and full

Provider's Plan of Correction:

L 051: Failure to Develop & Implement Comprehensive, Person-Centered Care Plan

Failure to revise the care plan for changes in treatment plan for psychotropic meds, ADL performance, and insomnia.

1. The resident affected by the deficient practice expired. No corrective action was possible. — 8.7.18
2. RN Supervisor on night shift will review 24-hour report each night to identify any new orders. If changes to resident's plan of care/treatment have occurred during the preceding day or evening shifts, Supervisor will update care plan. — 10.8.18
3. Revise care plan policy to include review responsibilities of Night Shift Supervisor. — 10.7.18
4. Review 10% of all interim orders at the end of the month. Compare orders to care plan updates to determine compliance. Report to QAPI Committee monthly x12 months to determine sustainability. Expected compliance threshold = 100%. — 10.25.18

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L 051	Continued From page 12 weight bearing for left hip, follow-up in three (3) weeks on April 18, 2018 at 10:00 AM, and may remove left hip staples. On April 20, 2018, the physician order to discontinue Xanax "PRN [as needed]". May 8, 2018 (no time noted), the physician ordered a referral to the hematologist, Robitussin 5 milligram by mouth three (3) times a day for cough for five (5) days, and Melatonin 3 milligrams one tablet by mouth at bedtime for insomnia. May 9, 2018 (no time noted), telephone order for chest x-ray for persistent cough rule out upper respiratory infection. Review of the care plans failed to show the facility staff reviewed and revised the resident's care plans to address changes to the resident's plan of care for psychotropic medications, ADL performance, and insomnia. During a face to face interview conducted on August 13, 2018 at 5:22 PM, Employee #7, reviewed the nursing documentation and confirmed the findings. 4. Based on record review and staff interview for one (1) of 16 sampled residents reviewed, the charge nurse failed to ensure PRN (As Needed) psychotropic medication were not ordered longer than 14 days. Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention,	L 051	**L 051: Failure to Ensure PRN Psychotropic Med was not Ordered Longer Than 14 Days Without Documented Rationale for Continued Use** 1. Resident #37 expired. No corrective action was possible. 2. Chart reviews will be conducted for all residents receiving psychotropic meds to determine: a) presence/absence of diagnosis and clinical rationale for medication, b) duration of PRN medications, and c) justification for PRN meds that extend beyond 14 days. 3a. Audits will be conducted by the SW quarterly to determine compliance for all residents receiving psychotropic meds. 3b. Unnecessary Drug Use Policy will be included as addendum to provider contracts. 4. Compliance will be reported quarterly to the QAPI Committee. Threshold = 100%	8.7.18 10.10.18 10.10.18 10.25.18

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L 051	Continued From page 13	L 051		

Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation (ORIF) of the Left Hip.

Admission Physician Orders dated March 15, 2018 included an order for Alprazolam [Xanax] (an antipsychotic medication used to treat anxiety) 0.25 milligrams one tablet by mouth three (3) times daily as needed for anxiety. However, the order did not contain a stop date.

Physician order dated April 20, 2018 instructed to discontinue "Xanax PRN."

Review of Psychiatry Progress Notes show Resident #37 was seen on March 23, 2018 at 3:10 PM. The progress note showed no major cognitive deficits, no severe mood instability; underlying anxiety/chronic; stable on Lexapro; Diagnosis: Anxiety disorder. During a Psychiatric follow-up visit on April 20, 2018, (no time recorded, the progress note showed Resident #31 was "stable at this point; D/C [discontinue] Xanax PRN, continue to monitor her mood and behavior."

The Drug Regimen Review conducted on March 19, 2018, showed "RM-P [Recommendations made to Physician] see PRN (next handwriting illegible) with a line drawn with a notation of "D/C [discontinued] 4/20) from the April 2, 2018 Drug Regimen Review box.

The Medication Administration Record (MAR) for March and April 2018, contained the order for Xanax 0.25 milligrams give one (1) tablet by mouth three (3) times a day as needed for Anxiety. However, the April 2018 MAR contained a handwritten note "D/C 4/20/18." There was no evidence the medication had been administered.

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L 051	Continued From page 14 The medical record lacked documented evidence the charge nurse ensured PRN psychotropic medication were not ordered longer than 14 days. Xanax 0.25 milligrams was ordered for 35 days without rationale for the continued order. On August 13, 2018, Employee #3 confirmed and acknowledged the findings.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;	L 052		

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(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute is not met as evidenced by:

Based on policy review, record review and staff interview for one (1) of 16 sampled residents, the facility failed address the systolic blood pressure for one (1) resident which remained over 160 millimeters of Mercury for three (3) consecutive days, failed to assess one (1) resident that experienced a complaint of cough and an unwitnessed fall with subsequent death, for physiological and behavioral signs and symptoms of distress to facilitate prompt interventions to address changes in condition (Resident #37).

Findings included ...

Facility's policy titled "Neurological Assessments", not dated, states it is the policy of the facility to conduct neurological assessments on any resident who sustains an unwitnessed fall. As a part of the resident assessment after a fall and as

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otherwise indicated, the licensed nurse completes and documents a neurological assessment.

Facility's "Documentation" policy dated February 26, 2016, states daily clinical notes are written by a licensed nurse for residents receiving Medicare benefits. These guidelines are also applicable for other required clinical notes. Clinical notes for respiratory conditions ... lungs sounds, nature of respirations, cough, temperature, hydration, medication to include any new medication prescribed, changed, or discontinued, response to medications started, changed or discontinued, and changes in resident's condition.

Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip.
On May 9, 2018, at approximately 4:30 PM, Resident #37 experienced an unwitnessed fall with injury of unknown source and subsequently expired at 4:46 PM.

Review of medical record on August 13, 2018, at 11:00 AM showed a 30- Day Minimum Data Set (MDS) dated April 11, 2018. Resident #37 was documented as requiring extensive assistance of one (1) staff for bed mobility, transfer, locomotion on and off the unit, and personal hygiene, in Section G0110.

Nursing Admission Screening/History dated March 15, 2018 at 11:58 PM showed limited

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L 052	Continued From page 17	L 052	**L 052: Physician Notification**	
	range of motion of left upper extremity due to left wrist fracture; left mid hip surgical site has 8 staples, and left upper hip surgical site has 6 staples. Resident #37 wears a hard cast on her left wrist. Also, limited range of motion on left lower extremity due to fracture on left hip, "cannot bear weight at this time."		**A. Failure to Notify Physician of Elevated B/P Reading.** 1. Resident #37 expired. No corrective action was possible.	8. 7.18
	Admission Physician Orders dated March 15, 2018, included the following orders: Lexapro 5 milligram one (1) tablet by mouth every night for mood stability, Alprazolam [Xanax](an antipsychotic medication used to treat anxiety) 0.25 milligrams one tablet by mouth three (3) times daily as needed, monitor blood pressure daily for antihypertensive medication- notify doctor is systolic blood pressure is greater than 160 or less than 100 millimeters of Mercury and/or diastolic blood pressure is greater than 100 and less than 60 for three (3) consecutive readings, weight bearing on left leg as tolerated, left hip precautionary measures every shift, and On March 16, 2018, the telephone orders for Occupational Therapy evaluate and treat five (5) times per week for four (4) weeks and Physical Therapy evaluate and treat for five (5) times per week for four (4) weeks. Occupational Therapy and Physical Therapy evaluations.		2. All charts and MARs of residents receiving B/P medications were reviewed. No other residents experienced the deficient practice.	10.6.18
			3. Forest Hills' Physician Notification policy and procedure was updated. Staff received training on the regulation and the policy updates.	10.15.18
			4. 10% of MARs containing B/P med changes will be audited monthly against nursing documentation to determine compliance with the Physician Notification Policy. Results will be reported monthly to the QAPI Committee x 12 months. Compliance threshold = 100%.	10.25.18
	Review of the Medication Administration Record for April 1, 2018- May 1, 2018, showed Resident #37's blood pressure was recorded as 170/74 on April 9th, 184/83 on April 10th, and 195/74 on April 11th.			
	The medical record lacked documented evidence of notification of the physician or interventions when the resident's systolic blood pressure was over 160 millimeters of Mercury for three (3)			

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consecutive days.

On March 28, 2018, Resident #37 was seen in follow-up with orthopedic with recommendation for "full WB [weight bearing] in cast [left] wrist, full WB [weight bearing] L [left] hip, and follow-up in 3 weeks." In addition, the medical record contained a handwritten prescription from the Orthopedist dated March 28, 2018 with instructions as follows: "left wrist full WBAT [weight bearing as tolerated], Please add platform to walker left side."

The medical record lacked documented evidence the facility staff notified the physician of the prescription for the addition of the platform to the walker. In addition, the physician progress notes failed to provide rationale for agreement or disagreement with orthopedic recommendations.

Review of the physical therapy and occupational therapy notes from March 28, 2018 to April 2, 2018, failed to show the therapist acknowledged the recommendations for change in weight bearing status and addition of platform to left side of walker from the orthopedic consult or adjust the treatment plan to reflect platform walker.

Further review of the physical therapy notes from April 3, 2018 through May 9, 2018 (date of expiration) showed "precautions/ Contraindications: L UE [left upper extremity] 50%/PWB [partial weight bearing] and L LE [left lower extremity] WBAT [weight bearing as tolerated]."

Review of care plans showed the facility staff initiated care plans for pressure ulcers, dental care, falls, ADL (Activities of Daily Living)

L 052:

B. Failure to acknowledge orders by consulting orthopedist.

1. The resident affected by these deficient practices expired. No corrective action was possible. — 8.7.18

2. Therapy records for all rehab residents were reviewed to identify any outstanding recommendations from consulting orthopedists. No deficient practices were found. — 8.15.18

3. Policy on Transcription of Physician's Orders has been updated to require transcription of recommendations by consulting physicians to the resident's charts for review and implementation by the appropriate discipline (e.g., nursing, therapy, etc.). — 10.8.18

4. 10% of MARs and TARs containing medication or other changes to the resident's treatment plan will be audited monthly against nursing/therapy documentation to determine compliance with policies. Results will be reported monthly to the QAPI Committee x12 months to determine sustainability. Expected compliance threshold = 100%. — 10.25.18

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function, psychotropic drug use, short-term rehab, and fracture to arm.

However, the care plans lacked documented evidence of person-centered goals and approaches to address use of assistive device (walker and wheelchair), interventions to manage left wrist cast, Xanax 0.25 milligrams as needed for anxiety, staples to left hip area, hip precautions, and weight bearing status.

The nursing note dated May 8, 2018, at 4:30 PM, Resident #37 complained of intermittent non-productive cough. The physician was called and new order obtained for Robitussin (use to treat cough) 5 milliliters by mouth three (3) times a day for five (5) days, Melatonin 3 milligrams for insomnia.

Nursing note dated May 9, 2018 at 1:39 PM, showed the resident's representative came into the facility to report Resident #37 complained of generalized weakness and did not have enough strength to pick up the phone in the morning when the resident representative called. The resident was assessed and noted to be alert and arousable, and "reported not feeling tired." The lungs were auscultated, and noted to be "congested bilaterally (mild crackles) on upper lobes, lower lobes clear bilaterally, cough present, non-productive ..." The physician was notified and new telephone order obtained for chest x-ray to rule out an upper respiratory infection.

Review of The "Respiratory Therapy/ Impaired Respiratory Status" instructs the staff to describe

L 052:

C. Care Plan Lacked Evidence of Person-Centered Goals and Approaches to Address Use of Assistive Devices, Interventions to Manage Wrist Cast, Use of Xanax, Staples, Hip Precautions, and Weight Bearing Status

1. The resident affected by the deficient practice expired. No corrective action was possible. — 8.7.18

2. Care plans were reviewed for all residents who require assistive devices (wheelchairs, walkers), require psychotropic drugs, and/or have fractures or mobility precautions to ensure they are person-centered. Revisions/updates were completed where indicated. — 8.15.18

3A. Interdisciplinary training will be provided for all members of the care plan team on how to develop and maintain/update person-centered care plans.
3B. Care plans will be audited weekly for all residents whose care plans were reviewed that week to determine if goals and interventions reflect person-centered approaches to care. — 10.15.18

4. Audit results will be presented to the QAPI Committee monthly x 12 months to determine sustainability. Expected compliance threshold = 100% — 10.25.18

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L 052	Continued From page 20	L 052	**L 052:**	
	accurately breaths sounds overall lung aspects, the respiratory rate, rhythm and quality, the effectiveness of any respiratory treatments given such as oxygen, resident's comfort level as it relates to respiratory status, any changes in level of consciousness, anxiety or other mental status changes, and the resident's overall condition as related to respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status.		**D. Failure to Document Respiratory Assessment by Direct Care Nurse.**	
			1. The resident affected by the deficient practice expired. No corrective action was possible.	8.7.18
	The medical record lacked documentation of a respiratory assessment performed by the direct care nurse, in accordance with the facility's impaired respiratory status assessment standards.		2. Chart reviews were conducted and all residents receiving oxygen therapy have been identified. Required documentation regarding oxygen therapy was not available in all of the nursing notes. TARs were determined as appropriate for documentation and were updated to include necessary documentation.	10.1.18
	On May 9, 2018, at 11:41 PM, the nursing staff documented that Resident #37 was found lying on the floor by the therapy staff at approximately 4:32 PM. On assessment, the resident skin was "cold and clammy to touch, rapid respirations, cyanosis in color, non-verbal, and unresponsive but breathing." The vital signs were blood pressure 70/50, heart rate- 53, respiratory rate- 28, temperature- 95.6, blood sugar- 260 and oxygen saturation- 72% on room air. Physician notified at 4:32 PM and updated on the resident's condition. New orders were given and noted. Oxygen therapy initiated, oxygen was given at 55 liters per minutes via face mask for oxygen saturation less than 80%. Paramedics were called 4:33 PM. The son was notified at 4:35 PM and requested that his mother be transferred to [local] Hospital because it is much closer to his home. Paramedics arrived on unit at 4:37 PM and took over. The resident was pronounced at 4:46 PM by paramedics.		3a. Update oxygen policy to include requirement to document respiratory rate, rhythm and quality, and response to oxygen therapy.	10.7.18
			3b. Educate staff on policy changes.	10.15.18
			4. Collect data for policy compliance monthly. Present compliance findings to QAPI Committee monthly x12 months to determine sustainability. Expected compliance threshold = 100%.	10.25.18

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Physician orders on May 9, 2018, 4:32 PM, instructs "Give oxygen at 5 lpm [liters per minute] via face mask for spox [oxygen saturation] <80% [less than 80 percent], (2) change oxygen tubing and humidifier bottle every week on Tuesday's on 3-11 pm shift, when in use, transfer resident to nearest emergency room for further evaluation, monitor discoloration on forehead qshift til resolved."

The medical record lacked documented evidence of the observation and assessment to include the recording of physiological and behavioral signs and symptoms of distress when the resident's condition declined before arrival of the paramedics and the resident's subsequent death. The facility staff's failure to assess, evaluate interventions and promptly intervene Resident #37 resulted in harm. During a face to face interview with Employee #7, Clinical Resource Nurse on August 13, 2018, at 5:22 pm, the employee stated that he was called "early in the morning" by the Employee #4, Licensed Practical Nurse, because the resident's representative was in the building with a lot of questions. The son reported receiving "a call from his mother saying she was very weak and could not up the phone." After speaking with the son, Employee #7 went to assess the resident. Resident #37 lungs were "pretty much" clear with a little congestion. The employee placed a call to the physician and obtained an order for a chest x-ray.

When the employee returned to the unit, Employee #10, Certified Occupational Therapy

Provider's Plan of Correction — L 052:

E. Failure to Assess for Physiological and Behavioral S/S of Distress and Intervene Promptly for Change in Condition.

Corrective action	Complete date
1. Resident expired. No correction possible.	8.7.18
2. All resident charts have been reviewed to identify residents with a decline in condition to determine if nursing assessments were indicated for s/s of distress and if appropriate interventions were implemented, if needed. None were identified.	10.8.18
3. Changes in nursing assessment and documentation system were implemented. All nurses have been trained on this documentation system (SBAR and Change in Condition Note).	10.6.18
4. Nursing progress notes will be reviewed each shift to determine if any resident experienced a change in condition. SBAR and Change in Condition Note will be reviewed to determine if assessments were completed and interventions implemented. Compliance will be reported monthly to the QAPI Committee x 12 months to determine sustainability. Expected compliance threshold = 100%.	10.25.18

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L 052	Continued From page 22 Assistant, was running out of the room yelling for help. Employee #7 stated that he grabbed the crash cart and went to the resident's room. Resident #37 was on the floor. Employee #7 performed an assessed of Resident #37. "She was unresponsive but breathing." When queried about the performance of assessments by the primary nurse related to the change of condition experienced on May 8, 2018 and May 9, 2018, Employee #7 was unable to give further insight. During a face to face interview on August 13, 2018, at 5:30 PM, Employee #7 reviewed and acknowledged the findings.	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to store and distribute foods under sanitary conditions as evidenced by documented low rinse (final) temperatures from the Dish Machine Temperatures logs on 95 of 366 opportunities. Findings included ... A review of the Dish Machine Temperatures logs for the main kitchen during the months of April, May, June and July 2018 show that on numerous occasions, rinse (final) temperatures were recorded at less than 180 degrees Fahrenheit (F). There were no corrective actions initiated to	L 099	**L 099:** **Failure to store and distribute foods under sanitary conditions as evidenced by documented low rinse (final) temperatures from dish machine temperature logs on 95 of 366 opportunities.** 1. No resident was affected by the deficient practice. 2. Each associate has received in-Services on proper way to read the digital display, and what to do if the temperature does not reach final temperature of 180F. 3. The Manager on duty will audit for accuracy of all Dish Machine Logs daily and the results reported to the Director of Dining Services. 4. All daily findings will be reported to the Director of Dining service each day. The findings will be recorded and trends identified. Compliance will be reported to the QAPI Committee quarterly x 4 quarters.	8.7.18 8.14.18 8.14.18 10.25.18

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L 099	Continued From page 23 address the low rinse temperatures. According to the Dish Machine Temperatures logs, final rinse temperatures were documented as being less than 180 degrees F as follows: On 23 of 90 opportunities in April 2018 On 29 of 93 opportunities in May 2018 On 21 of 90 opportunities in June 2018 On 22 of 93 opportunities in July 2018. During a face-to-face interview with Employee #6 on August 8, 2018, at approximately 11:45 AM, he explained that staff from dietary services contacts the maintenance department when a problem occurs with the dish machine. Maintenance will then assess the situation and call Ecolab (Dish machine repair contactor) if necessary. Employee #6 confirmed there had not been any issues whatsoever with the dish machine which is new (February 2018). During a face-to-face interview on August 8, 2018, Employee #5 also confirmed no past or recent concerns with the dish machine and acknowledged the findings.	L 099		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion;	L 201		

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L 201	Continued From page 24	L 201		

(b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;

(c)Medicaid, Medicare and health insurance numbers;

(d)Social security and other entitlement numbers;

(e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;

(f)Date of discharge, and condition on discharge;

(g)Hospital discharge summaries or a transfer form from the attending physician;

(h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation;

(i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease;

(j)Current status of resident's condition;

(k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition;

(l)The resident's medical experience upon discharge, which shall be summarized by the

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L 201	Continued From page 25	L 201	**L 201:**	
	attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;		**A. Failure to provide diagnosis or clinical rationale for psychotropic medication.** **B. Failure to ensure PRN antipsychotic meds are not ordered for longer than 14 days w/o documented rationale for continued use.**	
	(m)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service;		1a. Deficient practice was corrected for Resident #13 on 8/918: diagnosis was updated.	8/9/18
	(n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services;		1b. Resident #37 expired. No corrective action was possible.	8/7/18
	(o)The plan of care; (p)Consent forms and advance directives; and		2. Chart reviews will be conducted for all residents receiving psychotropic meds to determine: a) presence/absence of diagnosis and clinical rationale for medication, b) duration of PRN medications, and c) justification for PRN meds that extend beyond 14 days.	10.10.18
	(q)A current inventory of the resident's personal clothing, belongings and valuables.		3a. Audits will be conducted by the SW quarterly to determine compliance for all residents receiving psychotropic meds.	10.10.18
	This Statute is not met as evidenced by:		3b. Unnecessary Drug Use Policy will be included as addendum to provider contracts.	10.15.18
	Based on medical record review and staff interview for two (2) of 16 sampled residents, the facility failed to ensure the medical record included a diagnosis or clinical rationale for medication prescribed and failed to ensure a PRN (as needed) antipsychotic medication was not ordered for longer than 14 days without a documented rationale for continued use. (Residents #13 and 37).		4. Compliance will be reported quarterly to the QAPI Committee. Threshold = 100%	10.25.18
	Findings included ...			
	A. Failed to provide a diagnosis or clinical rationale for psychotropic medication prescribed.			

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L 201	Continued From page 26	L 201		

Continued From page 26

Resident# 13 was admitted to the facility on 2/11/16 with diagnoses which include Cerebral Infarction due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery, Unspecified Hemorrhoids, Vascular Dementia with Behavioral Disturbance, Essential (Primary) Hypertension and Aphasia.

A review of the Quarterly Minimum Data Set [MDS] dated 6/14/18 on 8/9/18 at 3:00 PM showed Section C [Cognition] Should Brief Interview for Mental Status [BIMS] be conducted No is selected which indicates resident is rarely/never understood. Section G [Functional Status] G0110 [Activities of Daily Living (ADL) Assistance] Bed Mobility, Transfer, Dressing, Eating, Toilet use and Personal Hygiene resident is scored as 4 which indicate total dependence on staff.

A review of the nursing care plan on 8/9/18 at 3:30 PM showed Focus "Resident uses psychotropic medications related to Behavior Management." Interventions/Tasks "Administer Psychotropic medications as ordered by physician, monitor for side effects".

A further review of the Physician Order Sheet dated 7/24/18 showed "Quetiapine 50 mg tab 1 tab by mouth daily at bedtime for Behavior."

During a staff interview on 8/9/18 at 4:30 PM Employee#3 was unable to provide insight as to the clinical reason for the medication or what was meant by "behaviors." Employee# 3 stated I will call the doctor.

During a staff interview with Employee# 3 on

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L 201	Continued From page 27 8/9/18 at 4:40 PM, staff stated here is the new physician order. A further review of the medical record showed a physician's order dated 8/9/18 at 4:40 PM "Discontinue current diagnosis of Behavior to Quetiapine 50 mg. Give Quetiapine 50 mg one tablet by mouth daily at bedtime for Dementia with Psychosis". During a face-to-face interview on 8/9/19 at 4:45 PM Employee# 3 acknowledged the finding.	L 201		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record review and staff interview of one (1) of 16 sampled records reviewed, the facility failed to conduct an investigation of an alleged violation of injury of unknown source that preceded a death and have results available for review by the State Survey Agency within 48	L 204	**L 204: Failure to investigate an alleged violation of injury of unknown source with results available within 48 hours to State Agency.** 1. The resident affected by the deficient practice expired. No corrective action was possible. 2. When submitted, all incident reports are reviewed by. An investigation is initiated immediately, if indicated. 3a. Forest Hills' current Investigation Form and Incident Policy have been updated to include reporting timeframes. 3b. All staff have been educated on the policy and the revised form. 4. Review all active investigations for timely completion. Report monthly to the QAPI Committee. Threshold = 100%	8.7.18 8.14.18 10.6.18 10.15.18 10.25.18

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L 204	Continued From page 28 hours of the incident (Resident #37). Findings included ... Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip. According to the facility reported incident document submitted, on May 9, 2018, at 4:30 PM, the physical therapy staff found Resident #37 lying on the floor on her right side with both arms wrapped underneath her face, facing the wall. The incident was reported to the State Survey Agency at 1:31 AM on May 10, 2018. The facility was unable to provide documentation to demonstrate that the facility investigated an incident of unwitnessed fall with head injury and subsequent death. During a face to face interview with Employee #2, Director of Nursing, on August 13, 2018, at approximately 10:00 AM, when asked about the reporting of the incident to the State Agency, the employee stated that the facility followed their normal process for reporting falls to the State Agency. When asked to provide evidence the incident was submitted to the State Agency and the investigation, Employee #2 stated that the only had the facility incident. At approximately 1:30 PM, Employee #2 provided an email confirmation of the incident report submitted to the State Agency. However, Employee #2 was unable to provide the surveyors with documented evidence of the facility's incident investigation.	L 204		

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L 204	Continued From page 29 During a face to face interview conducted on August 14, 2018, at 8:34 AM, Employee #1, Administrator, stated that she was informed of the incident. However, an incident was not conducted because it was assumed the resident had a heart attack. In addition, the employee stated that "there were no flags that suggested concerns." Further inquiry about the showed that Employee #1 was aware the police and medical examiner was involved, but thought it was just a manner of protocol for the Emergency Medical Services (EMS) staff to notify them. Resident #37 was listed as "deceased" on the census that is used as a communication tool in "Stand-up Meeting." Employee #1 could not provide any further insight into the reason why the facility did not conduct an investigation and acknowledged the findings.	L 204		
			L 206: Failure to report unwitnessed fall to licensing agency within 8 hours of occurrence.	
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 16 sampled residents, the facility failed report an unwitnessed fall with subsequent death to the licensing agency within eight (8) hours of occurrence. (Resident #37). Finding included ... Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention,	L 206	1. The resident affected by the deficient practice expired. No corrective action was possible. 2. All residents are assessed for fall risk upon admission, quarterly and as needed. Interventions are developed based on risk scores and are designed to reduce likelihood of an unwitnessed fall. 3a. Educate all staff on regulatory guidance regarding reporting requirements (i.e., within 8 hours of allegation). 3b. Review and update policy on identifying and reporting events to State Agency. 3D. Repeat staff education annually. 4. Review all unusual occurrences weekly to identify alleged violations and determine if they have been reported per policy. Compliance will be reported monthly to the QAPI Committee x12 months. Compliance threshold = 100%	8.7.18 8.17.18 10.15.18 10.25.18

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Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip.

According to the facility reported incident document submitted, on May 9, 2018, at 4:30 PM, the physical therapy staff found Resident #37 lying on the floor on her right side with both arms wrapped underneath her face, facing the wall. The incident was reported to the State Survey Agency at 1:31 AM on May 10, 2018.

During a face to face interview with Employee #2, Director of Nursing, on August 13, 2018, at approximately 10:00 AM, when asked about the reporting of the incident to the State Agency, the employee stated that the facility followed their normal process for reporting falls to the State Agency. When asked to provide evidence the incident was submitted to the State Agency and the investigation, Employee #2 stated that they only had the facility incident. At approximately 1:30 PM, Employee #2 provided an email confirmation of the incident report submitted to the State Agency. However, Employee #2 was unable to provide the surveyors with documented evidence of the facility's incident investigation.

During a face to face to interview on August 14, 2018, at 8:34 AM, Employee #1 stated that she was informed of the incident on the May 9, 2018. The employee was aware that the resident fell; however, she was under the impression that Resident # 37 had a heart attack and feel. "There were no flags to suggest concerns." When queried about the facility's policy for investigation of unwitnessed falls, Employee #1 stated that it was the responsibility of the Director of Nursing. The employee further stated that she was aware that the police and Medical Examiner was notified

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L 206	Continued From page 31 by the Emergency Medical Services team as a "matter of protocol." However, it was not typical activity related to falls or death in the facility. During a telephonic interview on August 14, 2018, at approximately 10:00 AM, Employee #9, Medical Director, stated that it is normal practice that all incidents reports are reviewed. However, it the case with Resident #37, the employee is unsure why an investigation wasn't completed. According to Employee #9, it was difficult to determine "what happened first, she didn't have any major medical problems. And I never heard back from the Medical Examiner." Employee #1 acknowledged that the facility did not report the unwitnessed fall and subsequent death of Resident #37 to the Department of Health, Health Regualtion and Licensing Administration within eight (8) hours of occurrence.	L 206	**L 207: Failure to identify and report an unwitnessed fall as possibly involving abuse, or misappropriation, neglect; failure to report alleged violation immediately to DOH, MPD, LTC Ombudsman, and APS.** 1. The resident affected by the deficient practice expired. No corrective action was possible. 2. All residents are assessed for fall risk upon admission, quarterly and as needed. Interventions are developed based on risk scores and will be designed to reduce likelihood of an unwitnessed fall.	8. 7.18 8.15.18 10.8.18
L 207	3232.5 Nursing Facilities Incidents of abuse or neglect resulting in injury to a resident, or incidents of misappropriation of a resident's funds, shall be reported immediately to the appropriate agencies, including the Department of Health, the Metropolitan Police Department, the Long Term Care Ombudsman and Adult Protective Services. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 16 sampled residents, the facility failed report an unwitnessed fall with subsequent death immediately to the Department of Health. (Resident #37). Finding included ...	L 207	3A. Educate all staff on regulatory guidance regarding identification of abuse, neglect, exploitation or mistreatment, and misappropriation. 3B. Educate all staff on regulations regarding timely reporting of allegations of abuse, neglect, exploitation or mistreatment, and misappropriation. 3C. Review and update policy on identifying and reporting events that could be interpreted as allegations of neglect, exploitation or mistreatment, and misappropriation. Re-educate staff. 3D. Repeat staff education annually. 4. Review all unusual occurrences weekly to identify alleged violations and determine if they have been reported per policy. Compliance will be reported monthly to the QAPI Committee x 12 months. Compliance threshold = 100%	10.10.18 10.15.18 10.15.18 10.25.18

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L 207	Continued From page 32	L 207		

Resident #37 was admitted on March 15, 2018 with diagnoses to include Anxiety, Atrial Fibrillation, Osteoporosis, Urinary Retention, Hypertension, Left Wrist Fracture, Status Post fall with Open Reduction and Internal Fixation of the Left Hip.

According to the facility reported incident document submitted, on May 9, 2018, at 4:30 PM, the physical therapy staff found Resident #37 lying on the floor on her right side with both arms wrapped underneath her face, facing the wall. The incident was reported to the State Survey Agency at 1:31 AM on May 10, 2018.

During a face to face interview with Employee #2, Director of Nursing, on August 13, 2018, at approximately 10:00 AM, when asked about the reporting of the incident to the State Agency, the employee stated that the facility followed their normal process for reporting falls to the State Agency. When asked to provide evidence the incident was submitted to the State Agency and the investigation, Employee #2 stated that they only had the facility incident. At approximately 1:30 PM, Employee #2 provided an email confirmation of the incident report submitted to the State Agency. However, Employee #2 was unable to provide the surveyors with documented evidence of the facility's incident investigation.

During a face to face to interview on August 14, 2018, at 8:34 AM, Employee #1 stated that she was informed of the incident on the May 9, 2018. The employee was aware that the resident fell; however, she was under the impression that Resident # 37 had a heart attack and feel. "There were no flags to suggest concerns." When queried about the facility's policy for investigation

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L 207	Continued From page 33	L 207		

of unwitnessed falls, Employee #1 stated that it was the responsibility of the Director of Nursing. The employee further stated that she was aware that the police and Medical Examiner was notified by the Emergency Medical Services team as a "matter of protocol." However, it was not typical activity related to falls or death in the facility.

During a telephonic interview on August 14, 2018, at approximately 10:00 AM, Employee #9, Medical Director, stated that it is normal practice that all incidents reports are reviewed. However, it the case with Resident #37, the employee is unsure why an investigation wasn't completed. According to Employee #9, it was difficult to determine "what happened first, she didn't have any major medical problems. And I never heard back from the Medical Examiner."

Employee #1 acknowledged that the facility did not immediately report the unwitnessed fall and subsequent death of Resident #37 to the Department of Health.