STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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L 000	Initial Comments	L 000		

An unannounced Recertification Survey was conducted at this facility on August 22, 2022 to August 25, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 31 and survey sample included 20 residents.

The following complaints were investigated during this survey: No Complaints

The following facility reported incidents were investigated during this survey: DC00010445, DC00010577
DC00010898, DC00010463, DC00010502

Federal and Local deficiencies were cited related to the investigation of: DC00010445, DC00010577
DC00010898, DC00010463, DC00010502

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

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

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid

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L 000	Continued From page 1 Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner	L 000		

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L 000	Continued From page 2 O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram The following deficieinces are a result of this survey:	L 000		
L 012	3203.2 Nursing Facilties A list of all employees, with the appropriate current license or certification numbers, shall be on file at the facility and available to the Director. This Statute is not met as evidenced by: Based on records review on August 22, 2022, at approximately11:00 AM, it was determined that facility staff failed to ensure that one (1) of four (4) persons in charge, who is a certified food protection manager, obtained a District of Columbia Food Protection Manager Identification Card.	L 012		

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L 012	Continued From page 3 The findings include: During a review of dietary records on August 22, 2022, at approximately 11:00 AM, one (1) of four (4) persons in charge did not have an updated, District-issued Food Protection Manager Identification Card. The Food Protection Manager Identification Card that was presented for review was expired as of 12/21/2021. The 2012 District of Columbia Food Code, Section 203.3 of Chapter 2 states the following: 2012 District of Columbia Food Code §203 Certification and District-Issued ID Requirements Food Protection Manager, Person In Charge §203.3 A person in charge who is a certified food protection manager as required in §203.1 shall obtain a District-issued Food Protection Manager Identification Card (ID Card), issued by the Department, and shall renew the District-issued ID Card every three (3) years. These observations were acknowledged by Employee #12 during a face-to-face interview on August 25, 2022, at approximately 2:45 PM.	L 012	**L 012:** Dining manager obtaining a District of Columbia Food Protection Manager Identification card **1. Corrective action for residents affected by deficient practice.** No residents were affected. **2. Identification of other residents at risk for deficient practice.** No residents were affected. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Manager with expired credential will be re-certified by October 17, 2022. 3b) Audit expiration dates of credentials for managers/ supervisors annually. **4. Performance Monitoring/Evaluation** Report audit findings semi-annually to QAPI Committee with appropriate action identified if indicated.	8/25/22 8/25/22 10/17/22 10/27/22
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L 051		

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L 051	Continued From page 4 (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: Based on observation, record review and staff interview for one (1) of 21 sampled residents, facility staff failed to implement Resident #25's person-centered comprehensive care for contractures. The findings included... Resident #25 was admitted to the facility on 06/07/10 with multiple diagnoses including Generalized Muscle Weakness and Contracture of Right Hand and Contracture of Left. Review of a Quarterly Minimum Data Set (MDS) dated 07/22/22 revealed that facility staff coded Resident #25 with a Brief Interview for Mental Status (BIMS) summary score of "00," indicating that the resident had severe cognitive impairment. Under Section G (Functional Mobility), facility staff coded the resident as requiring extensive assistance for bed mobility,	L 051	**L 051:** Medical record does not contain comprehensive care plans for contractures for 1 of 21 residents. **1. Corrective action for residents affected by deficient practice.** Resident's care plan was immediately updated to include comprehensive care for contractures. **2. Identification of other residents at risk for deficient practice.** Care plans of residents with orders for splints or other contracture management devices were reviewed. Comprehensive care plans, including those for contracture management, were present for all residents. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) DON to provide education/competency assessments to nursing staff on developing care plans for contracture management. 3b) Therapy manager to review contracture management interventions in weekly risk management meetings. 3c) Nursing to update care plans as needed. 3d) DON to audit care plans quarterly and as needed. **4. Performance Monitoring/Evaluation** DON to report audit findings to QAPI Committee quarterly x4 quarters. Compliance threshold = 100%	8/26/22 9/14/22 9/25/22 10/27/22

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L 051	Continued From page 5	L 051		

dressing, eating, and personal hygiene. Facility staff coded the resident as being totally dependent on staff for transfers, and toilet use. Facility staff coded that the resident had limited range of motion due to impairment on both sides to the upper and lower extremities.

Review of the physician's order dated 09/16/21 directed: "OT (Occupational Therapy) clarification order: Patient to wear rolled up towel (small) donned to bilateral hands for contracture mgmt. (management) and to minimize skin breakdown. Towel to be replaced every shift for skin hygiene and grooming."

Review of the Care Plan section of the clinical record last revised on 08/18/22, documented: "Interventions [Resident #25's] will wear rolled hand towels in both hands as tolerated (Date initiated 08/18/22) ..."

During an observation on 08/23/22 at 1:30 PM, Resident #25 was lying on her bed. Both wrists were contracted, laying on each side of the resident's chest. There were no towel rolls placed under the resident's wrists.

During a face-to-face interview on 08/23/22 at 1:30 PM, Employee #6 (3West Charge Nurse) stated that she was unsure if Resident #25 had wrist splints, but would follow up with OT.

During an observation on 08/24/22 at 3:34 PM, Resident #25 was lying on her bed. Both wrists were contracted, laying on each side of the resident's chest. There were no towel rolls placed under the resident's wrists. During this observation Employee #6 observed the resident without towel rolls under her wrist. She then stated, " I will fix it."

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L 052	3211.1 Nursing Facilities	L 052	**L052:** Prevent decreased ROM and mobility for 1 of 21 residents sampled.	
	Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:		**1. Corrective action for residents affected by deficient practice.** Rolled hand towels are placed in the resident's hands daily as tolerated. Resident rounds include direct observation by DON and ADON to ensure towels are in place.	08/26/22
	(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:		**2. Identification of other residents at risk for deficient practice.** Charts of residents with orders for splints or other contracture management devices were reviewed, and direct observations were made by nursing and the occupational therapist. All devices were in place as ordered at that time.	09/14/22
	(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;		**3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) DON and occupational therapist to provide education/competency assessments to nursing staff on appropriate use of contracture management devices. 3b) Therapy manager to review contracture management interventions in weekly risk management meetings. 3c) DON to conduct competency testing on appropriate use of contracture management devices quarterly.	09/25/22
	(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;			
	(2)Use the dining room if he or she is able; and			
	(3)Participate in meaningful social and recreational activities; with eating;		**4. Performance Monitoring/Evaluation** DON will report results of competency testing to QAPI Committee quarterly x4 quarters. Competency testing threshold > 85%.	10/27/22
	(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			

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L 052	Continued From page 7	L 052		

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 observations, record review, and staff interview, for one (1) of 21 sampled residents, facility staff failed to ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. Resident #25.

The findings included:

Resident #25 was admitted to the facility on 06/07/10 with multiple diagnoses including Generalized Muscle Weakness and Contracture of Right Hand and Contracture of Left.

Review of a Quarterly Minimum Data Set (MDS) dated 07/22/22 revealed that facility staff coded Resident #25 with a Brief Interview for Mental Status (BIMS) summary score of "00," indicating that the resident had severe cognitive impairment. Under Section G (Functional Mobility), facility staff coded the resident as requiring extensive assistance for bed mobility, dressing, eating, and personal hygiene. Facility staff coded the resident as being totally dependent on staff for transfers, and toilet use. Facility staff coded that the resident had limited range of motion due to impairment on both sides to the upper and lower extremities.

Review of the physician's order dated 09/16/21 directed: "OT (Occupational Therapy) clarification

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L 052	Continued From page 8	L 052		

order: Patient to wear rolled up towel (small) donned to bilateral hands for contracture mgmt. (management) and to minimize skin breakdown. Towel to be replaced every shift for skin hygiene and grooming."

07/27/22 [Physician's Order] documented OT evaluation and treatment completed. OT skilled sessions indicated for improving both upper extremities for contracture and splint management to perform all self-care ...OT skilled services for 2xs (times) a week for 30 days ..."

07/27/22 [OT Evaluation and Plan of Treatment] documented: "Date of Service: 07/27/22 - 08/23/22. Plan of Treatment: ...Initial encounter: Orthotic management and training, each 15 min (minutes) Short -Term Goal #1: Patient will tolerate wearing right and left hand splint to both upper extremities 4 out 5 times a week to decrease contractures to perform simple ADLs (assisted daily living skills) ..."

Review of the Care Plan section of the clinical record last revised on 08/18/22, documented: "Interventions [Resident #25's] will wear rolled hand towels in both hands as tolerated (Date initiated 08/18/22) ..."

During an observation on 08/23/22 at 1:30 PM, Resident #25 was lying on her bed. Both wrists were contracted, laying on each side of the resident's chest. There were no towel rolls placed under the resident's wrists.

During a face-to-face interview on 08/23/22 at 1:30 PM, Employee #6 (3West Charge Nurse) stated that she was unsure if Resident #25 had wrist splints, but would follow up with OT.

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L 052 — L 052

Continued From page 9

During a face-to-face interview on 08/24/22 at 11:05 AM, Employee #7 (Occupational Therapist), stated, " [Resident #25's Name] just came on my caseload. I work with her twice a week. I have been working with her upper extremity range of motion. I do apply towel rolls when I am working with her. The splints have been ordered. We have trained the Certified Nurse Assistants (CNAs) to apply towel rolls and orthotics." Employee #7 did not provide documented evidence of the training to CNAs for applying hand rolls and orthotics to residents with contractures, and acknowledged the finding.

During an observation on 08/24/22 at 3:34 PM, Resident #25 was lying on her bed. Both wrists were contracted, laying on each side of the resident's chest. There were no towel rolls placed under the resident's wrists. During this observation Employee #6 observed the resident without towel rolls under her wrist. She then stated, " I will fix it."

L 091 — L 091

3217.6 Nursing Facilities

The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter.
This Statute is not met as evidenced by:
Based on observation, record review, and staff interview for one (1) of 21 sampled residents, facility staff failed to wear the required PPE (Personal Protective Equipment) when entering a resident's room and providing care for a resident that was on contact precautions due to MRSA (Methicillin-Resistant Staphylococcus Aureus).

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L 091	Continued From page 10 (Resident #131) The findings included: Review of the facility's policy titled "Infection Prevention and Control Program" date revised 12/19, revealed the following: " ...Prevention of infection a. important facets of infection prevention include: (2) instituting measures to avoid complications or dissemination ...educating staff and ensuring that they adhere to proper techniques and procedures; ...(4) communicating the importance of standard precautions and cough etiquette to visitors and family members; ... (7) implementing appropriate isolation precautions when necessary; and (8) following established general and disease -specific guidelines such as those if the Centers for Disease Control (CDC) ...The facility provides personal protective equipment , checks for its proper use, ..." Resident #131 was admitted to the facility on 08/16/22 with multiple diagnoses that include the following: Fracture of Unspecified Part of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Unspecified Dementia Without Behavioral Disturbance, Unspecified Fall, Subsequent Encounter and Methicillin Resistant Staphylococcus Aureus Infection as the Cause of Diseases Classified Elsewhere. An observation and face-to-face interview were conducted on 08/23/22 at approximately 12:00 PM, the surveyor observed that Resident #131's room door had a sign that read "Contact Precautions" and it instructed that staff and visitors must don a gown and face shield before entering room. The surveyor observed two (2)	L 091	**L091:** Proper use of PPE for 1 of 21 sampled residents. **1. Corrective action for residents affected deficient practice.** The facility staff along with agency staff were immediately in-serviced and re-educated on Contact Precautions, and use of PPE **2. Other residents at risk for deficient practice.** Because all residents are potentially at risk to be affected by this deficient practice, additional education sessions were conducted on all shifts to nursing staff on the affected unit. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Re-education of all facility staff on infection control policies and procedures, standard and transmission-based precautions, isolation policies and procedures, handling and storage of linen, hand hygiene, and social distancing. 3b) Documentation of quarterly competency testing; re-eduaction if necessary **4. Performance Monitoring/Evaluation** Infection Preventionist will report results of re-education and competency testing at quarterly QAPI meeting x6 quarters. Compliance threshold - ≥ 85%.	8/25/22 8/30/22 9/14/22 10/27/22

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L 091 — L 091

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staff enter and exit room without donning the required gown and face shield.

The surveyor questioned Employee #8 (private duty aide) at the time of observation about why she did not wear a gown and face shield before entering the resident's room and providing care and she stated "I am [Resident #131]'s private CNA from the Assisted Living so I don't need it."

L 099 — 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 observation and staff interview, facility staff failed to store and prepare foods in accordance with professional standards of practice for food services safety as evidenced by food items such as one (1) of one (1) one-gallon plastic bag with cubed pieces of ham, one (1) of one (1) container of cooked chicken wings, one (1) of one (1) one-gallon container of slaw dressing, and one (1) of one (1) one-gallon container of sweet pickle relish, that were not labeled or dated, pieces of flounder fish that were improperly being thawed, and boxes of ice cream and muffins that were inappropriately stored in one (1) of one (1) walk-in freezer.

The findings include:

During a walkthrough of the facility's kitchen on August 22, 2022, at approximately 10:00 AM, the following observations were made:

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L 099	Continued From page 12	L 099	**L 099:** Food storage, preparation and distribution	
	1. Food items in the walk-in refrigerator such as one (1) of one (1) one-gallon plastic bag with cubed pieces of ham, one (1) of one (1) container of cooked chicken wings, one (1) of one (1) one-gallon container of slaw dressing, and one (1) of one (1) one-gallon container of sweet pickle relish, were not clearly marked to indicate the date or day the food items were originally opened or stored.		**1. Corrective action for affected residents.** No residents were affected by the deficient practice.	8/25/22
			2. Other residents at risk for deficient practice. No residents were identified as at risk for deficient practice.	8/25/22
	2. Food service equipment such as one (1) of one (1) grease fryer, two (2) of two (2) food warmer carts, one (1) of one (1) panini grilled sandwich press, one (1) of one (1) convection oven, and 10 of 17 full sheet pans were soiled with left-over food deposits and stains.		**3. Measures/systemic changes to ensure deficient practice does not recur** 3a) Director to fill vacant manager position 3b) Director/manager to train staff in infection control, safe food handling practices, and other related topics 3c) Director/manager to complete Daily Inspections, using audit tool attached 3d) Director/manager to Implement and monitor Deep Cleaning Schedule, using audit tool Appendix F.	9/12/22
	3. Several pieces of fish (flounder) were improperly thawing in a sink full of water, with no running water.			
	4. In the walk-in freezer, boxes of food items such as ice cream and muffins were loosely stored directly below one (1) of one (1) ceiling mounted fire sprinkler, at less than 18 inches, and could reduce the efficacy of the fire sprinkler during a fire.		**4. Performance Monitoring/Evaluation** Director/manager to report monitoring results (Deep Cleaning process and Daily Inspections) to QAPI Committee quarterly x4 quarters. Compliance threshold - 100%.	10/27/22
	During a face-to-face interview conducted at the time of the observation, Employee #12 acknowledged the findings.			
L 128	3224.3 Nursing Facilities	L 128		
	The supervising pharmacist shall do the			

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L 128	Continued From page 13	L 128		

following:

(a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;

(b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;

(c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;

(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and

(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.
This Statute is not met as evidenced by:
Based on record review and staff interviews for two (2) of two (2) nursing units, the facility staff failed to ensure that the system used for an acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications was followed.

The findings included...

1. A review of the Shift count Narcotic records on Unit East was completed on August 24, 2022, at approximately 9:10 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates:

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L 128	Continued From page 14 4/11/2022 3-11 shift same nurse signed.coming on and going off duty 4/15/2022 3-11 shift nurses coming on duty [blank] and 11-7 going off duty [blank] 4/26/2022 3-11 shift same nurse signed coming on and going off duty 5/8/2022 11-7 shift same nurse signed coming on and going off duty 5/22/2022 11-7 shift same nurse signed coming on and going off duty 6/20/2022 11-7 shift same nurse signed coming on and going off duty 7/12/2022 11-7 shift same nurse signed coming on and going off duty 7/30/2022 11-7 shift same nurse signed coming on and going off duty 8/13/2022 3-11 shift same nurse signed coming on and going off duty 8/14/2022 3-11 shift same nurse signed coming on and going off duty 8/18/2022 3-11 shift same nurse signed coming on and going off 2. A review of the Shift count Narcotic records on Unit West was completed on August 24, 2022, at approximately 9:30 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates: 4/7/2022 3-11 shift same nurse signed coming on and going off duty 4/8/2022 3-11 shift same nurse signed coming on and going off duty 4/11/2022 3-11 shift same nurse signed coming on and going off duty 4/30/2022 11-7 shift same nurse signed coming on and going off duty 5/1/2022 3-11 shift same nurse signed coming on and going off duty	L 128	**L128:** Pharmacy Services, Procedures, & Records. **1. Corrective action for residents affected by deficient practice.** Drug verification sheets of affected residents were reviewed to ensure documentation of controlled substances was accurate at that time. **2. Identification of other residents at risk for deficient practice.** All residents with narcotic orders were at risk for the deficient practice. Drug verification sheets for all residents were reviewed by the DON for accuracy. No discrepancies were found. **3. Measures/systemic changes to ensure deficient practice does not recur.** Pharmacy Consultant will review and audit controlled substance log during monthly visits to ensure compliance with controlled substance log sign-off. **4. Performance Monitoring/Evaluation.** Audit reports to be presented during quarterly QAPI meetings x 4 quarters. Compliance threshold - 100%	8/25/22 8/26/22 9/26/22 10/27/22

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L 128	Continued From page 15 5/19/2022 7- 3 shift same nurse signed coming on and going off duty 6/7/2022 11-7 shift same nurse signed coming on and going off duty 6/15/2022 3-11 shift same nurse signed coming on and going off duty 6/17/2022 11-7 shift same nurse signed coming on and going off duty 6/19/2022 3-11 shift same nurse signed coming on and going off duty 7/3/2022 3-11 shift same nurse signed coming on and going off duty 7/9/2022 11-7 shift same nurse signed coming on and going off duty 7/16/2022 3-11 shift same nurse signed coming on and going off duty 7/17/2022 3-11 shift same nurse signed coming on and going off duty 7/19/2022 11-7 shift same nurse signed coming on and going off duty 7/20/2022 3-11 shift same nurse signed coming on and going off duty 7/21/2022 3-11 shift same nurse signed coming on and going off duty 7/26/2022 3-11 shift same nurse signed coming on and going off duty 8/1/2022 7- 3 shift same nurse signed coming on and going off duty 8/2/2022 11 -7 shift same nurse signed coming on and going off duty 8/6/2022 11-7 shift same nurse signed coming on and going off duty 8/9/2022 3-11 shift same nurse signed coming on and going off duty 8/11/2022 3-11 shift same nurse signed coming on and going off duty 8/12/2022 3-11 shift same nurse signed coming on and going off duty 8/15/2022 11-7 shift same nurse signed coming on and going off duty	L 128		

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L 128	Continued From page 16 8/20/2022 11-7 shift same nurse signed coming on and going off duty The review of the above-mentioned dates showed that the Shift count Narcotic on the East and West unit was missing the two (2) nurse's signatures (indicating it was not done) in the space allotted for one (1) nurse to sign coming on duty and another nurse to sign going off duty, and coming on/ going off spaces allotted for two (2) nurses signatures were left blank [no signatures]. A review of the facility Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count Policy states, "Reconciliation Controlled Drug Count Verification Form" directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift". The evidence showed that licensed nursing staff failed to adhere to an acceptable standard of practice to reconcile the verification of controlled substances on the aforementioned dates and shifts. A face-to-face interview was conducted with Employees #1 and #2 on August 24, 2022, at approximately 11:00 AM. They acknowledged the findings.	L 128		
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 17 (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 and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)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 201	**L201:** Evidence of residents' right to formulate advance directives missing in 6 of 21 charts. **1. Corrective action for residents affected by the deficient practice.** Affected residents were provided written information on their right to form an advance directive. Information provided is included as Appendix A. **2. Identification of other residents at risk for deficient practice.** All resident charts were audited. Sixteen (16) charts were found not to have evidence of information provided on the resident's right to form an advance directive. Information given either in person, via email, or by phone. See Appendix B for information provided to residents/representatives. **3. Measures/systemic changes to ensure incident does not recur.** 3a) Social services team were in-serviced on regulations regarding advance directives. 3b) Quarterly audits will be conducted by LICSW on all charts to ensure information on advance directives was provided during completion of initial social work assessment. **4. Performance Monitoring/Evaluation** Results of chart reviews will be presented at quarterly QAPI meeting. Compliance threshold is set at 100%.	9/1/22 9/24/22 9/14/22 10/27/22 10/27/22

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

(o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service;

(p)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;

(q)The plan of care;

(r)Consent forms and advance directives; and

(s)A current inventory of the resident's personal clothing, belongings and valuables.

This Statute is not met as evidenced by:
Based on record reviews and staff interviews for six (6) of 21 sampled residents, facility staff failed to provide documented evidence that they informed and provided written information on the right to formulate an advanced directive to residents or their representatives. Residents' #16, #18, #20, #24, #25 and #131.

The findings included:

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1. Resident #16 was admitted to the facility on 05/25/22 with diagnoses including Fracture of Unspecified Part of Neck of Left Femur, Weakness, Unspecified Glaucoma, Dependence on Supplemental Oxygen, and Non-Alzheimer's Dementia.

Review of an Admission Minimum Data Set (MDS) dated 06/30/22, revealed that facility staff coded Resident #16 with a Brief Interview for Mental Status (BIMS) summary score of "00," indicating that the resident had severe cognitive impairment.

Review of Resident #16's medical record revealed the following:

A face sheet which documented that the resident had a representative.

05/25/22 [Physician's order] documented, "Full Code."

There was no documented evidence in the medical record that the facility staff informed or provided Resident #16's representative with written information on the right to formulate an advanced directive.

2. Resident #18 was admitted to the facility on 03/12/22 with diagnoses that included, Unspecified Dementia Without Behavioral Disturbance, History of Falling, Atrial Fibrillation, and Malnutrition.

Review of an Annual Minimum Data Set (MDS) dated 07/02/22 revealed that facility staff coded Resident #18 with a Brief Interview for Mental Status (BIMS) summary score of "02," indicating that the resident had severe cognitive

L 201 Continued From page 20 L 201

impairment.

Review of Resident #18's medical record revealed:

A MOST form dated 03/12/21 that documented: "...The MOST (Medical Order for Scope of Treatment) does not replace an advanced directive ...."

A face sheet that documented that the resident had a representative.

10/24/21 [Care Plan] documented: "[Resident's Name] requested to be DNR (Do Not Resuscitate)...Interventions Code status will be documented and reflective of resident's wishes ...Code status will be reviewed and noted with Resident and Responsible Party(representative) ..."

04/07/22 [Physician's order] directed, "DNR."

There was no documented evidence in the medical record that the facility staff informed or provided Resident #18's representative with written information on the right to formulate an advanced directive.

3. Resident #20 was admitted to the facility on 10/26/17 with diagnoses including, Other Postherpetic Nervous System Involvement, Type 2 Diabetes Mellitus, Major Depressive Disorder, and Generalized Muscle Weakness.

Review of a Quarterly Minimum Data Set (MDS) dated 07/09/22 revealed that facility staff coded the resident with a Brief Interview for Mental Status (BIMS) summary score of "02," indicating that the resident had severe cognitive

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impairment.

Review of Resident #20's medical record revealed the following:

A face sheet that documented that the resident had a representative.

10/24/21 [Care Plan] documented: "[Resident's Name] requested her code status to be DNR ...Goal [Resident's Name]'s code status request will be honored during resident's stay in the Health Center ...Interventions Code status will be documented and reflective of resident's wishes ...Code status will be reviewed and noted with Resident and Responsible Party (representative) ..."

There was no documented evidence in Resident #20's medical record that the facility staff informed or provided the resident or their representative with written information on the right to formulate an advanced directive.

4. Resident #24 was admitted to the facility on 10/07/17, with diagnoses including, Unspecified Dementia Without Behavioral Disturbance, Repeated Falls, Need For Assistance With Personal Care, and Major Depressive Disorder.

Review of a Quarterly Minimum Data Set (MDS) dated 07/20/22, revealed that facility staff coded Resident #24 with a Brief Interview for Mental Status (BIMS) summary score of "10," indicating that the resident had mild cognitive impairment.

Review of Resident #24's electronic medical record revealed:

A face sheet that documented that the resident

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had a representative.

10/11/21 [Physician's order] documented, "Full Code."

11/02/21 [Care Plan] documented: "[Resident's Name] requested her code status to be DNR ...Goal [Resident's Name] code status request will be honored during resident's stay in the Health Center ...Interventions Code status will be documented and reflective of resident's wishes ...Code status will be reviewed and noted with Resident and Responsible Party ..."

Review of Resident #24's medical record lacked documented evidence that facility staff informed or provided the resident or their representative with written information on the right to formulate an advanced directive.

5. Resident #25 was admitted to the facility on 06/07/10 with diagnoses including, Unspecified Dementia Without Behavioral Disturbance, Paranoid Schizophrenia, Type 2 Diabetes Mellitus Without Complications, Generalized Muscle Weakness, Contracture of Right Hand and Contracture of Left.

Review of a Quarterly Minimum Data Set (MDS) dated 07/22/22 revealed that facility staff coded Resident #25 with a Brief Interview for Mental Status (BIMS) summary score of "00," indicating that the resident had severe cognitive impairment.

Review of Resident #25's electronic medical record revealed:

A face sheet that documented that the resident had a representative.

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07/04/19 [DC (District of Columbia) Medical Orders for Scope of Treatment Form] directed, "Section A: ...Do Not Attempt Resuscitation (DNAR)/Allow Natural Death (AND) ... Section B, "Medical Interventions," documented "Comfort Focused Treatment ...Under "Directions for Health Care Professionals," the MOST form documented, " The MOST is a set of medical orders ...The MOST does not replace an advanced directive ...."

08/27/21 [Physician's order] directed, "DNR."

12/19/21 [Care Plan] documented: "[Resident's Name] will remain as a DNR status to be DNR (Do Not Resuscitate) ...Goal [Resident's Name]'s code status request will be honored during resident's stay in the Health Center ...Interventions: Code status will be reviewed with [Resident's Name] and her responsible party ..."

Review of Resident #25's medical record lacked documented evidence that facility staff informed or provided the resident or their representative with written information on the right to formulate an advanced directive.

6. Resident #131's medical record lacked documented evidence that Resident #131 or their representatives were offered the opportunity to formulate an advanced directive.

Resident #131 was admitted to the facility on 08/16/22 with multiple diagnoses that include the following: Fracture of Unspecified Part of Neck of Right Femur, Unspecified Dementia Without Behavioral Disturbance, Subsequent Encounter and Methicillin Resistant Staphylococcus Aureus Infection...

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L 201	Continued From page 24 Review of a Admission Minimum Data Set (MDS) dated 08/22/22 revealed that facility staff coded Resident #131 with a Brief Interview for Mental Status (BIMS) summary score of "09," indicating that the resident's cognition is moderately impaired. Review of the medical record lacked any documented evidence that the facility staff offered resident the opportunity to formulate an advanced directive. During a face-to-face interview on 08/24/22 at 11:30 AM, Employee #4 (Social Services Coordinator) stated, "If there is no advanced directive, they [the residents] have a MOST (District of Columbia Medical Orders for scope of Treatment) form. At the time of interview Employee #4 was asked to review the MOST form which documented "...the MOST does not replace an advanced directive..." Employee #4 made no further comment.	L 201		
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 21 sampled residents, facility staff failed to provide written notification to the resident or resident representative of the bed hold policy	L 534		

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L 534	Continued From page 25 and the number of bed hold days remaining following residents transfer to the hospital on 01/10/22. Resident #132 The findings included: Review of the facility's policy titled, "Bed-Holds and Returns" date revised 04/19, revealed " ...Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy..." Resident #132 was admitted to the facility on 03/17/21 with multiple diagnoses that included the following: Unsteadiness on feet, Muscle Weakness, and Chronic Kidney Disease Stage 3 Unspecified. Review of a Admission Minimum Data Set (MDS) dated 12/14/21 revealed that facility staff coded Resident #132 with a Brief Interview for Mental Status (BIMS) summary score of "14" indicating that he was cognitively intact. Review of an intake for a Facility Reported Incident (FRI) DC 00010502 received by the State Agency on 01/12/22 revealed that the facility staff reported the following: " ... On 1/10/2022 at 22:04, the resident was observed lying on his left side in his room. He was unresponsive and was bleeding from a laceration on his forehead. A pressure dressing was applied to the laceration noted on his forehead with significant bleeding noted. A message was left for the primary physician and 911 called at 22:07..." Review of the nursing progress notes revealed the following:	L 534	**L534:** Notice of Bed Hold Policy Before/ Upon Transfer missing for 1 of 21 sampled residents. **1. Corrective action for affected residents.** No corrective action is available since resident was discharged January 10, 2022. **2. Identification of other residents at risk for deficient practice.** Audit was completed for residents discharged August 26-September 22. None of the residents received the bed hold policy. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Administrator to educate social services team and admissions director on Ingleside's policy on bed holds, including the Bed-Hold and Return Agreement (see Appendix C). 3b) Maintain Agreement in electronic health record (EHR). 3c) LICSW to audit EHR quarterly x 4 quarters. **4. Performance Monitoring/Evaluation.** Present audit findings to quarterly QAPI Committee. Compliance threshold - 100%.	8/25/22 9/15/22 10/3/22 10/27/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0008	A. BUILDING: ______ B. WING ______	C 08/25/2022

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L 534	Continued From page 26 01/10/22 at 10:47 PM, " ...Resident was found on the floor with head injuries when nurse supervisor went to administer medication. EMS (Emergency Medical Services) was called, and Resident was transferred to hospital." The physicians' orders were reviewed and showed the following: 01/10/22 "Transfer the resident to the nearest ER (emergency room) for evaluation post-fall ..." Review of the medical record lacked documented evidence that the facility provided written notification of the facility's bed hold policy and the number of bed hold days remaining for Resident #132 when he was transferred to the hospital. During a face-to-face interview conducted on 08/25/22 at approximately 12:00 PM, Employee #1 (Administrator) stated, "We have not been able to locate it (written notification of the facility's bed hold policy and the number of bed hold days remaining)".	L 534		
L 535	3270.2 Nursing Facilities The facility shall conduct a discharge assessment of each resident within fourteen (14) days after admission and twice annually thereafter. The discharge assessment shall include: This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 21 sampled residents, facility staff failed to develop and complete a discharge plan for Resident #31 that was planning to return to the community.	L 535		

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L 535	Continued From page 27	L 535	**L535:** Development and completion of discharge plan for return to the community for 1 resident.	
	The findings included: Resident #31 was admitted to the facility on 05/26/22, with multiple diagnoses that included the following: Presence of Left Artificial Knee Joint, Syncope and Collapse and Pain in Unspecified Joint.		**1. Corrective action for residents affected by deficient practice.** No resident was affected by the deficient practice.The resident identified was discharged May 25, 2022.	8/25/22
	Review of the Minimum Data Set (MDS) dated 06/01/22, revealed that the facility staff coded the following: In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) summary score "15" was coded indicating intact cognition.		**2. Identification of other residents at risk for deficient practice.** An audit was completed of residents discharged between August 25-September 22, 2022. All had discharge plans.	8/26/22
	In section Q (Participation in Assessment and Goal Setting) "Expects to be discharged to the community" Review of the social services progress notes documented the following: 05/31/22 at 12:47 PM " ... (Resident #31's) discharge care plan meeting will be held on 6-1-22 at 12PM, as she will be transferring back to AL (Assisted Living) with her husband ..."		**3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Therapy manager to review scheduled discharges daily in morning team meeting. 3b) Social services team to identify residents' discharge needs during weekly utilization review (UR) meetings 3c) LICSW to review charts for presence of discharge plans prior to discharge.	9/14/22
	06/01/22 at 4:55 PM " ...team all met with (Resident #31) on 6-1-22 for a plan of discharge on 6-3-22 ..." The physicians' orders were reviewed and revealed the following: 06/03/22 at 1:30 PM "Discharge home ..." Further review of the medical record which includes the care plan lacked any documented evidence of a discharge plan for Resident #31.		**4. Performance Monitoring/Evaluation** Results of chart reviews to be presented to QAPI Committee by LICSW during quarterly meetings x4 quarters. Compliance threshold - 100%.	10/27/22

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L 535	Continued From page 28 During a face-to-face interview conducted on 08/24/22 at 5:35 PM with Employee #2 (Director of Nursing) acknowledged the finding and stated, "There is no discharge plan in the record."	L 535		