STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096028	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 21 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	F 000	Ingleside at Rock Creek is filing this Plan of Correction for the purpose of regulatory compliance with applicable laws and not as a statement of agreement with alleged deficiencies herein. To remian in compliance with all Federal and State regulations, Ingleside of Rock Creek has taken or will take the actions set forth in the following Plan of Correction, which constitutes this facility's response to allegations of non-compliance such that alleged deficiencies cited have been or will be corrected by the date(s) indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Savoy | TITLE: Administrator | (X6) DATE: 10/04/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 CMS - Centers for Medicare and Medicaid 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	F 000		

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F 000	Continued From page 2 NFPA - National Fire Protection Association NP - Nurse Practitioner 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:	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		

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F 578	Continued From page 3 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT 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.	F 578	**F578:** 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 intial social work assessment completed at time of admission. **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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F 578	Continued From page 4 The findings included: 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)	F 578		

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F 578	Continued From page 5 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 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.	F 578		

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F 578	Continued From page 6	F 578		

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 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

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F 578	Continued From page 7 that the resident had mild cognitive impairment. Review of Resident #24's electronic medical record revealed: A face sheet that documented that the resident 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	F 578		

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F 578	Continued From page 8 impairment. Review of Resident #25's electronic medical record revealed: A face sheet that documented that the resident had a representative. 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.	F 578		

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F 578	Continued From page 9 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... 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.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582		

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F 582	Continued From page 10 Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F 582	**F 582:** Notice of Medicare Non-Coverage (NOMNC) not provided in sufficient time to allow Medicare appeal for 1 of 3 residents. **1. Corrective action for affected residents.** Corrective action is not available to affected resident who was discharged June 17, 2022. **2. Identification of other residents at risk for deficient practice.** An audit of NOMNCs presented to five (5) discharged residents from August 26 - Sept. 22 (100% of discharges) revealed 2 were issued without sufficient time to provide residents an opportunity to appeal. **3. Measures systemic changes to ensure deficient practice does not recur.** 3a) Administrator provided additional training to social services team on dates/ timing, and signatures required for the NOMNC. See Appendix C. 3b) Social Services Coordinator to review NOMNCs during weekly UR meetings for appropriate issue date. **4. Performance Monitoring/Evaluation.** Report results of weekly reviews quarterly to QAPI Committee x 4 quarters. Compliance threshold is 100%.	8/25/22 9/27/22 9/29/22 10/27/22

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F 582	Continued From page 11 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that one (1) of three (3) Beneficiary Notices contained sufficient information to ensure that the resident and/or responsible party had sufficient time to appeal the facility's decision to terminate Medicare services (Resident #133). The findings included: Resident #133 was admitted to the facility on 05/09/22, with diagnoses included the following: Discitis of the Cervical Region, Spinal Stenosis, Unspecified Injury of the Neck, and Need for Assistance with Personal Care. Review of an Admission Minimum Data Set (MDS) dated 05/15/22 revealed that facility staff coded Resident #133 with a Brief Interview for Mental Status (BIMS) summary score of "14," indicating that the resident had intact cognition. Review of the instruction on the Notice of Medicare Non-Coverage (NOMNC) stipulates, "How to ask for an Immediate Appeal ...Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above ..."	F 582		

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F 582	Continued From page 12 Review of Resident #133's medical record revealed a, " Notice of Medicare Non-Coverage," that documented LCD (last day of coverage) as 06/16/22. The resident signed and dated the form on 06/16/22, indicating that the facility notified the resident on the same day his or her skilled services covered by Medicare ended. There was no evidence that facility staff provided Resident #133 with the Notice of Medicare Non-Coverage as soon as reasonably possible, so that if the resident wished to file an appeal he or she had time to do so. During a face-to-face interview on 08/25/22, at approximately 3:45 PM, Employee #1 (Administrator), after reviewing Resident #133's NOMNC, stated, " The notice was provided too late to the resident."	F 582		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 13 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT 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 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)	F 625	**F 625:** 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 D). 3b) Maintain Agreement in electronic health record (EHR). 3c) LICSW to audit EHR quarterly x 4 quarters for evidence bed-hold policy was issued. **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

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	095028	A. BUILDING _____ B. WING _____	C 08/25/2022

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F 625	Continued From page 14	F 625		

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:

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

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F 625	Continued From page 15 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)".	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	**F 656:** 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 forcontracture 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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F 656	Continued From page 16 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT 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, 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.	F 656		

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F 656	Continued From page 17 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."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		

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F 658	Continued From page 18 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure that the nurse's care and services for verification of shift count for narcotics drugs met the professional standard of practice. The findings included: According to All Care Pharmacy..."All controlled substances ... must be counted at each shift change. Both the oncoming and outgoing nurse should look at the card and the narcotic book to ensure accuracy..." www.allcarepharmacy.com/facilityresources/assets/documents/Controlled A review of the facility "Control Drugs Verification Count /Shift Count Sheet for Narcotics" book on August 24, 2022, showed that the space allotted for (1) correct drug count -yes/no, (2) Balance verified by a nurse coming on duty (one signature only), (3) Balance verified by a nurse going off duty (one signature only) was being signed by one nurse in both space or is being left blank. This indicated, "That professional standard of practice were not being met." During a face-to-face interview conducted with Employee #10 [East medication nurse] on 08/22/22 at 11:12 AM and Employee #6 [West medication nurse] on 08/24/22 at approximately 10:30 AM, both nurses acknowledged the findings when they were made aware that there	F 658	**F658:** Professional standards of practice used for narcotic count. **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 for accuracy. No discrepancies were found. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Licensed nurses and shift supervisors were inserviced by DON on Ingleside's policy on controlled substances. 3b) Policy was updated by Director of Clinical Services to specify that two nurses must complete narcotic counts at shift change, Appendix E. 3c) Monthly pharmacy audit reports will be used to validate that narcotic counts meet professional standards of practice. **4. Performance Monitoring/Evaluation.** Results of pharmacy audits will be presented at quarterly QAPI meetings x6 quarters. Compliance threshold - 100%.	8/25/22 8/26/22 9/26/22 10/27/22

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F 658	Continued From page 19 was a concern with one nurses signing on both going off and comming on duty spaces that allotted for two nurses to verify the count, and nurses leaving signature area blank did not meet professional standard of practice.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.	F 660	**F 660:** Development and completion of discharge plan for return to the community for 1 resident. **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. **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. **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. **4. Performance Monitoring/Evaluation** Results of chart reviews to be presented to QAPI Committee by LICSW during quarterly meetings x4 quarters. Compliance threshold - 100%.	8/25/22 8/26/22 9/14/22 10/27/22

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F 660	Continued From page 20 (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the	F 660		

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F 660	Continued From page 21 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT 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. 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. 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. 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 ..."	F 660		

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F 660	Continued From page 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. 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."	F 660		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		

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F 688	Continued From page 23 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 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	F 688	**F 688:** Prevent decreased ROM and mobility for 1 of 21 residents sampled. **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. **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. **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. **4. Performance Monitoring/Evaluation** DON will report results of competency testing to QAPI Committee quarterly x4 quarters. Competency testing threshold ≥ 85%.	08/26/22 09/14/22 09/25/22 10/27/22

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F 688	Continued From page 24 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. 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	F 688		

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	095028	A. BUILDING _____ B. WING _____	C 08/25/2022

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INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 688	Continued From page 25 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."	F 688		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

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F 755	Continued From page 26 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT 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: 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	F 755	**F 755:** 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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F 755	Continued From page 27 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 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	F 755		

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F 755	Continued From page 28 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 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	F 755		

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F 755	Continued From page 29 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.	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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F 812	Continued From page 30 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT 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 included: During a walkthrough of the facility's kitchen on August 22, 2022, at approximately 10:00 AM, the following observations were made: 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.	F 812	**F 812:** Food storage, preparation and distribution **1. Corrective action for affected residents.** No residents were affected by the deficient practice. **2. Other residents at risk for deficient practice.** No residents were identified as at risk for deficient practice. **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 Appendix F. 3d) Director/manager to implement and monitor Deep Cleaning Schedule, using scheduling tool attached. **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%	8/25/22 8/25/22 9/12/22 10/27/22

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F 812	Continued From page 31 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. 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. During a face-to-face interview conducted at the time of the observation, Employee #12 acknowledged the findings.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 32 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842	**F 842:** Inaccurate information in 1 of 21 sampled residents' medical record **1. Corrective action for residents affected by the deficient practice.** Affected resident was re-assessed to validate falls risk score and reconcile chart documentation with hospital record. **2. Other residents at risk for deficient practice.** Falls risk assessments were reviewed for all other residents and risk scores verified. **3. Measures/systemic changes to ensure deficient practice does not recur.** 3a) Re-educate nurses on completion of falls risk evaluation tool 3b) Complete competency assessments and testing to determine comprehension 3c) DON/ADON to audit falls risk assessment documentation completed upon admission, post fall occurrence, and PRN quarterly. Repeat education if indicated. **4. Performance Monitoring/Evaluation** Report audit findings at quarterly QAPI meeting. Compliance threshold - 100%	8/25/22 8/26/22 9/14/22 10/27/22

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F 842	Continued From page 33 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 21 sampled residents, facility staff failed to ensure that Resident #131's medical record did not contain inaccurate information as evidenced by staff documenting resident did not have any falls in the past 3 months on multiple falls assessment despite the resident having a documented history of falls in the medical record. Resident #131 The findings included: 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... Review of a Admission Minimum Data Set (MDS) dated 08/22/22 revealed that facility staff coded	F 842		

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F 842	Continued From page 34 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 resident's hospital discharge documents in the medical record dated 08/16/22 in the section titled "History of Present Illness/Hospital Course" revealed " ...The patient was initially admitted to (hospital name) but had a fall while inpatient and was transferred to this hospital for orthopedic surgery ..." Review of the baseline care plan dated and signed on 08/18/22, in section (H) "Safety Risks" documented the following: "Does resident have a history of falls? Yes ...Did the resident have a fall any time in the last month prior to admission/entry or reentry? Yes ... Specify the fall during the last month prior to admission. Had a fall and had hip fracture per D/C (discharge) summary ..." Review of the "falls risk evaluation" (falls assessment) in the medical record on the following dates 08/18/22, 08/19/22, 08/22/22 and 08/23/22 all documented that the resident has no history of falls in the last 3 months. During a face-to-face interview conducted on 08/24/22 at 5:41 PM with Employee #2 (Director of Nursing) acknowledged the findings and stated "The assessment is inaccurate."	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 35 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880	**F880:** Proper use of PPE for 1 of 21 sampled residents. **1. Corrective action for residents affected by 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 **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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F 880	Continued From page 36 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT 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). 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INGLESIDE AT ROCK CREEK	3050 MILITARY ROAD NW WASHINGTON, DC 20015

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F 880	Continued From page 37 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) 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 38 and she stated "I am [Resident #131]'s private CNA from the Assisted Living so I don't need it." Review of the physicians' orders revealed the following: 08/18/22 "Contact Isolation Precautions Secondary to MRSA in Nares every shift until 08/26/22..." Review of the baseline care plan dated and signed on 08/18/22, showed the following: "...Currently on Contact Isolation due to Positive MRSA in nares ..." During a face-to-face interview conducted on 08/25/22 at 4:20 PM, with Employee #5 (Infection Preventionist) stated that she observed Employee #8 not wearing the proper PPE and education was provided and the facility is contacting Employee #8's agency.	F 880		