INSPIRE
REHABILITATION & HEALTH CENTER

Sent via email: 10/26/2022

Ms. Ranada Cooper
Associate Director
Office of Health Facilities
Health Regulation and Licensing Administration
899 North Capitol St. N.E. 2nd Floor

Dear Ms. Cooper,

A Recertification, Life Safety Code, Emergency Preparedness survey was conducted by the Survey Team from the Department of Health (DOH) - Health Regulation and Licensing Administration at Inspire Rehabilitation and Health Center on July 26th, 2022 through August 5th, 2022.

Please accept this letter and Plan of Correction as part of our compliance. Please also note revisions made based on our conversation today: F-755 page 99-100. If you have any questions or need additional information, please free to contact me at my office number on 202-785-2577 ext. 6203 or on my cellular number which is 301-326-0039.

Sincerely,

Andrea Brown
Licensed Nursing Home Administrator
Inspire Rehabilitation and Health Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 July 26, 2022 - August 5, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 166 and the survey sample included 50 residents. The following complaints were investigated during this survey: DC00010454, DC00010664, DC00010690, DC00010697, DC00010814, and DC00010865. The following Facility Reported Incidents were investigated during this survey: DC00010090, DC00010263, DC00010283, DC00010303, DC00010308, DC000010353, DC00010448, DC00010411, DC00010450, DC000100501, DC00010592, DC00010639, DC00010667, DC00010669, DC00010801, DC00010687, DC00010285, DC00010421, DC00010633, and DC00010849. Federal and/or Local deficiencies were cited related to the investigation(s) of : DC00010664, DC00010690, DC00010865, DC00010303, DC00010308, DC00010448, DC00010411, DC00010592, DC00010450, DC00010501, DC00010592, DC00010639, DC00010667, DC00010801, DC00010849, DC00010687, DC00010285, and DC00010421. 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.	F 000	**Inspire Rehabilitation and Health Center Disclaimer:** The facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Departments' directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or admission of any wrong doing.	10/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Andrew D. Brown | Administrator | 10/26/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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	Continued From page 1	F 000		10/21/22

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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	Continued From page 2 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 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	F 000		10/21/22
F 578 SS=D	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	F 578		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 578	Continued From page 3 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 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.	F 578	**F-578** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #97 was provided with written information regarding formulating an advanced directive and the social worker reviewed this with the resident on 8/3/2022. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents residing in the facility has the potential to be affected. No other residents were affected based on a house wide audit conducted by Social Services on 9/29/2022. **MEASURE TO PREVENT REOCURRENCE:** The Director of Social Services/designee will complete a facility house wide audit to ensure Advance Directive instruction is given to all residents and their designated RP and orders reflected in the medical record, any issues will be corrected by 10/21/22. Staff Educator/Designee will educate Social Workers on provisions to inform and provide written information to all adult residents concerning the rights to accept or refuse medical or surgical treatments and, at the resident's option, formulate an advanced directive by 10/21/22. Admissions Director will ensure that Advance Directive is included in the Admission Documentation. Social Services will be reviewing the Advance Directives with the resident and/or RP within 48 hours during the initial admission care plan meeting, quarterly, annual and significant change care plan meetings. All findings will be reported to the monthly QAPI meeting.	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 578	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 50 sampled residents, facility staff failed to provide the resident or their representative(s) with information regarding formulating an advanced directive. Resident #97. The findings included: Review of the policy "Advance Directive" revised in February 2022 documented, "...Upon admission, Social Services staff will meet with the resident to inquire if there is an existing Advance Directive (AD)... and the right to formulate and to issue Advance Directives... provide written information to the resident... if the Resident does not have an Advance Directive and chooses not to complete one: Obtain signature on the Advance Directive status form..." Resident #97 was admitted to the facility on 03/23/22 with multiple diagnoses that included: Type 2 Diabetes Mellitus, Muscle Weakness, Hemiplegia, and Hemiparesis. Review of Resident #97's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 06/11/22 where facility staff coded Resident #97 as having moderately impaired cognition. Care Plan Focus Area "End of Life Care/Advance Care Planning" reviewed on 06/16/22 that documented, "Goal: Resident's wishes will be known and honored through next review date..." A record review conducted on 07/20/22 at 2:47	F 578	**MONITORING CORRECTIVE ACTION:** The Director of Social Work/designee will complete 100% house wide audit to ensure that Advance Directives are in place on all current residents including, new admissions and readmissions, weekly x4, then monthly x3 and quartery x3 to ensure the medical record reflects resident wishes in accordance with facility policy. All negative findings will be corrected by 10/21/22. Results from the audit will be discussed in the QA meeting monthly x 3 months and then quarterly x 3. to ensure compliance. QA Committee will determine the need for further audits and actions. All negative findings will be corrected upon discovery.	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 578	Continued From page 5 PM revealed no documented evidence that facility staff provided Resident #97 or their representative(s) written information regarding formulating an AD. During a face-to-face interview conducted on 08/01/22 at 2:46 PM, Employee #4 (4th Floor Social Worker) reviewed Resident #97's medical record, acknowledged the finding, and made no further comment.	F 578		10/21/22
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews for seven (7) of 50 sampled residents, facility staff failed to implement policies for investigating allegations of abuse and injuries of unknown origin, as evidenced by the failure to: obtain interviews or written statements from potential witnesses; and to adhere to the reporting time to the State Agency. Residents #87, #212, #313, #314, #133, #363, and #51. The findings included:	F 607	**F-607** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #212, #313, #314, #363 no longer resides in the facility. Residents #87, #212, #313, #314, #133, and #363 suffered no negative outcomes from failure to obtain interviews or written statements from potential witnesses. Resident #51 suffered no negative outcomes from failure to report within the required time frame to the State Agency. Resident #51's incident report was reported on 4/11/22. Resident #87, #133, and #51 was reassessed by licensed nurse from head to toe on 9/23/22. There were no negative outcomes. Resident #133's went to the ER for alleged sexual abuse on 2/25/22. Hospital records indicate that all systems check were negative. No other negative findings were found. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents residing in the facility has the potential to be affected. No other residents were affected based on a house wide audit of all incidents and accidents that occurred in the last 6 months conducted by the ADON on 10/13/22.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 6 Review of the facility's policy entitled "Investigating Incidents Process"revised in March 2022, stated: "...Interview and/or obtain a statement from the person reporting allegation or suspicion ...Interview and/or obtain statements from potential witnesses as determined by the scope of the investigation... Review materials and complete investigation..." Review of the facility's policy entitled "Injury of Unknown Origin" revised March 2022 documented, "... Immediately a resident is identified with an injury of unknown origin, the facility will ... interview and/or obtain statements from all potential witnesses as determined by the scope of the investigation ...review materials and complete investigation..." Review of the facility's policy titled "Prohibition of Abuse" section F "Reporting" with a revised date of 05/01/18 documented, "All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health, via the event reporting electronically, or by phone in the event of the electronic system being unavailable within twenty-four (24) hrs of knowledge of the alleged incident and within two (2) hours if serious bodily injury has occurred or there is an allegation of abuse..." 1. Facility staff failed to obtain interviews or written statements from potential witnesses to Resident #87's fall. Resident #87 was admitted to the facility on 07/18/14 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction	F 607	**MEASURES TO PREVENT REOCURRENCE:** Unit managers/Designee will conduct a house wide review of the daily 24hour report and conduct walking rounds on all residents to identify any residents with suspected abuse. Any findings will be corrected by 10/21/22. The facility licensed nurses and CNA will conduct two-hour checks on each resident and additional random checks will be conducted daily to ensure resident safety and prevent potential sexual misconduct. Any negative findings will be addressed upon identification using the steps outlined below. 1. Any alleged abuse will follow this process: Immediately ensure that the resident is safe and is separated from the alleged perpetrator. 2. Law enforcement will immediately be notified. 3. Administrator and DON will be notified immediately. 4. All alleged violations, the Administrator, Director of Nursing or designee shall notify the Department of Health, via the event reporting electronically, or by phone in the event of the electronic system being unavailable within 24 hours of knowledge of the alleged incident and within 2 hours if serious bodily has occurred or there is an allegation of abuse. 5. Alleged victim will be assessed from head to toe by licensed nurse prior to transfer to the hospital. 6. RP and physician notification will be completed prior to hospital transfer. 7. Alleged victim will be transferred to the hospital for further assessment immediately. 8. Social Workers will conduct an interview with interviewable residents on the abuse allegation	10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 7 Affecting the Left Non-Dominant Side, Type 2 Diabetes Mellitus Without Complications, Unspecified Lack of Coordination, and Abnormalities of Gait and Mobility. A Facility Reported Incident (FRI), DC00010448, received by the State Agency on 12/13/21 documented: "... Writer was informed by CNA that resident stated she fell yesterday, she told writer, '[I] went to [the] lock door [at]10:45 pm, using my walker to ambulate,on my way back to bed, [I] missed my steps and fell on my right side, [I]managed to sit up, then knelt down, held on to the rail of the bed and sat on my w/c (wheelchair) close by. I didn't tell any body cause it is[was] time [for]the staff to go home, [I] hit the right side of [my] face against [the] table.' On assessment the R (right) cheek...wrist, arm, slightly swollen stated pain is 6/10...MD aware ordered, X-ray of rt (right) wrist and face T/O (to rule out) fracture." A review of Resident #87's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 10/15/21 showed that facility staff coded Resident #87 in the following manner: Under Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) Summary Score, Resident #87 was "10" indicating mild cognitive impairment. Under Section G (Functional Mobility) required extensive assistance from at least one staff person for toileting and personal hygiene and used a walker or wheelchair for mobility. 12/10/21 at 7:00 AM [Physician's Order] directed, "X-ray of facial bones right side forearm and rt (right) wrist one-time s/p (status-post) allegedly	F 607	Going forward a thorough investigation, including obtaining written statements from relevant potential witnesses who might have had knowledge of the occurrence will be conducted per facility policy and regulation. The Staff Educator/Designee will provide training and in-service to all staff on implementing the policy and procedures to prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property. This will be completed by 10/21/22. The Staff Educator/Designee will provide training to Administrator, DON, ADON, Social Services and Department heads on conducting a thorough investigation, including obtaining written statements from all potential witnesses who might have had knowledge of the occurrence will be conducted per facility policy and regulation and timeliness of reporting to the State Agency. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** ADON/Designee will conduct a house wide audit on all future reports of alleged abuse and injury of unknown origin, to ensure that a thorough investigation, including obtaining written statements from all potential witnesses who might have had knowledge of the occurrence were conducted per facility policy and regulation and to ensure that the alleged incident is reported within 2 hours if serious bodily injury has occurred or there is an allegation of abuse. This will be conducted weekly times four (4), then monthly ongoing. All findings will be reported to the weekly at Risk meeting and monthly to the QAPI meeting 10/13/22. Data will be presented to the monthly Quality Assurance Improvement committee for review and recommendations. Any negative findings will be corrected upon discovery.	10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 8 fall ..." 12/10/21 at 7:00 AM [Physician's Order] directed, "Ensure cluster (sp.) [clutter] free environment every shift." 12/10/21 at 7:00 AM [Physician's Order] directed, "Place the bed in lowest position all the times for the safety precaution every shift." 12/10/21at 9:59 AM [Situation, Background, Assessment, and Request (SBAR)]: "...Situation: ...Resident alleges she fell around 10:45 PM yesterday but did not tell anybody; Date problem or symptom started: 12/09/2021 ...resident was ambulating with her walker and stated 'I was walking too fast,'... Background: ...Recent fall ... Request: ..X-ray of the rt (right) arm and skull to r/o FX (fracture) s/p (status-post) fall. 12/11/21 at 9:52 AM, [Change in Condition Note]: "... Resident had a fall on 12/10/21 "MD aware ordered X-ray of forearm, wrist, and face to rule out (a) fracture. Result of x-ray reveals an acute mildly displaced fracture of distal shaft of ulna. MD called made aware to send the resident to nearest ED (Emergency Department)." The facility's investigation packet lacked documented evidence of interviews or written statements from facility staff who were assigned to Resident #87 or any staff on the unit on the date of the alleged fall (12/09/21). During a face-to-face interview on 08/04/22 at approximately 1:00 PM, Employee #3 (Assistant Director of Nursing) stated that she documented what the CNA told her about Resident #87's fall in the progress notes. She acknowledged that she	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 9 did not get a separate statement from the CNA or any other employees or residents because it was an unwitnessed fall. 2. Facility staff failed to interview or obtain written statements from all potential witnesses who might have had knowledge of Resident #212's injury of unknown origin. Resident #212 was admitted to the facility on 03/16/22 with diagnoses that included Osteoporosis/Osteoarthritis, Non-Hodgkin Lymphoma, Collapse Vertebrae, Prior L2/L3 and T11[spinal cord injuries], Compensation Fractures /Vertebroplasty and Sciatic Fall, Mildly Displaced Left 7-8 Rib Fracture. Review of a Facility Reported Incident (FRI), DC00010639, received by the State Agency on 03/24/22, documented, "...Right pain, We did X-ray and she was noted to have a fracture of the mid clavicle. There is no facial bone lesion. Alignment is Anatomic. There is no soft tissue swelling or foreign identified body. Mid to moderate DJD [Degenerative Joint Disease] is noted Post-surgical screws in the humeral head region are seen." Review of Resident #212's medical record revealed the following: Admission Minimum Data Set (MDS) dated 03/22/22 showed that facility staff coded the following: cognitively intact; required extensive assistance with one person physical assistance for bed mobility, transfer, toilet use, and personal hygiene; no impairment in functional range of motion; used a walker and wheelchair for mobility. Fall prior to admission; no fall since admission to the facility, received occupational	F 607		10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 10 therapy (OT) that started on 03/17/2022 and physical therapy (PT) that began on 03/18/2022. 03/22/22 at 18:46 [6:46] PM "Situation Background Assessment Request (SBAR) ... Communication Tool... Situation painful swollen right clavicle ...Resident complains of pain, unable to determine when it started ... Primary diagnosis Compression fracture of spine ... on assessment patient observed with swollen right clavicle ... Patient c/o (complained of) pain in right clavicle. Physician contacted by phone on 03/22/2022 17:00 [5:00] PM, CRNP [Certified Registered Nurse Practitioner] notified and order given for X-Ray of the right clavicle to evaluate pain..." 03/23/22 at 9:00 AM [physician's order] "X-Ray of right clavicle..." 03/23/22 at 19:50 [8:50 PM] Radiology Results Report "...Procedure... RT [right] Clavicle ... history of Rt side neck pain. Findings: there is a displaced fracture of the mid clavicle noted. There is no focal bone lesion. Alignment is anatomical There is no soft tissue swelling or foreign body identified. Mild to moderate DJD [Degenerative Joint Disease] is noted. Postsurgical screws in the humerus head region is seen, Calcification of the supraspinatus tendon is seen. Impression There is a displaced fracture of the mid clavicle seen." 03/23/22 at 22:29 [10:29 PM] [Nurses Note] "...On 03/23/2022, she (Resident #212) complained of pain in the right clavicle, assessed and medicated as per order and Xray done. Result of Xray received this evening-There is a displaced fracture of the mid clavicle seen ... NP (Nurse	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 11 Practitioner)..., gave order to transfer resident to nearest ED (emergency department) for further evaluation and possible treatment..." 03/23/22 at 22:52 [10:52 PM] [Physician's Telephone Order] "Transfer resident to the nearest ED for evaluation and treatment secondary to displaced fracture of the mid clavicle." Review of the facility's documents revealed that facility staff failed to interview or obtain written statements from all potential witnesses who might have had knowledge of the occurrence. During a face-to-face interview on 08/02/22 at 1:50 PM, Employees #2 [Director of Nursing] and #3 [Assistant Director of Nursing] stated, "The resident was discharged so we did not do a thorough investigation. The investigation information received did not include interviews from the staff who worked with the resident.." 3. Facility staff failed to implement its "Injury of Unknown Origin" policy for Resident #313's injury of unknown source/origin on 04/06/22 evidenced by failure to interview or obtain written statements from all potential witnesses. Resident #313 was admitted to the facility on 02/09/22 with multiple diagnoses that included: Lack of Coordination, Unspecified Abnormalities of Gait and Balance and Altered Mental Status. Review of a Complaint, DC00010664, received by the State Agency on 04/07/22 documented, "...Tonight was the absolute final straw for our family, as we learned that my mother has a fractured leg that seemingly occurred without	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 12 anyone's knowledge or a report by employees..." Review of a Facility Reported Incident (FRI), DC00010667, received by the State Agency on 04/08/22 documented, "...Upon assessment, no bruises, no swelling nor any sign of trauma noted. Resident medicated as per PRN (as needed) order. Resident re-assessed later and no complains nor signs of pain noted. Resident was visited by son 04/06/22 who made staff aware that resident is in pain, area assessed, no bruises, no swelling and no sign of trauma noted. NP made aware. Order given to do XRay, [Resident's representative] was on the unit when the result came and was informed of the findings." Review of Resident #313's medical record revealed the following: Admission Minimum Data Set (MDS) dated 02/15/22 showed that facility staff coded the following: the resident was unable to complete the Brief Interview for Mental Status; required extensive assistance with one person physical assist for bed mobility; two persons physical assist for transfers; total dependence with one person physical assist for toilet use and personal hygiene; no impairment in functional range of motion; used a walker and wheelchair for mobility; no fall since admission, received occupational therapy (OT) and physical therapy (PT) that started on 02/10/22. 04/06/22 at 3:40 PM "Situation Background Assessment Request (SBAR) ... Communication Tool... Situation pain to left hip ...Resident complain pain in left hip, on assessment patient observed with pain on touch and movement to left	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 13 hip ... Patient c/o (complained of) pain in left hip, on assessment patient observed with pain on touch and movement to left hip. CRNP (Certified Registered Nurse Practitioner) notified and new order given for X-Ray of left hip..." 04/06/22 [Physician's Order] "X-Ray of left hip..." 04/06/22 Radiology Results Report "...Procedure... LT (left) hip unilateral... Findings: there is an acute intertrochanteric fracture seen..." 04/06/22 at 8:54 PM [Nurses Note] "...On 04/05/22, she (Resident #313) complained of pain in the left hip, assessed and medicated as per order and Xray done. Result of Xray received this evening-There is an acute intertrochanteric fracture seen ... NP (Nurse Practitioner)... gave order to transfer resident to nearest ED for further evaluation and possible treatment..." 04/06/22 [Physician's Order] "Transfer resident to the nearest ED (emergency department) for evaluation and treatment secondary to acute intertrochanteric fracture" Review of the facility's investigation packet lacked documented evidence that they interviewed or obtained written statements from all potential witnesses who might have had knowledge of the occurrence. During a face-to-face interview on 08/02/22 at 1:50 PM, Employee #5 (1st Floor Unit Manager) stated, "After the resident left, we did our investigation. The investigation included staff interviews and review of the medications and diagnoses."	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 14 4. Facility staff failed to implement its policies entitled "Injury of Unknown Origin" and "Investigating Incidents Process" for Resident #314's injury of unknown source/origin on 12/30/21 evidenced by failure to conduct an investigation. Resident #314 was admitted to the facility on 12/01/21 with multiple diagnoses that included: Lack of Coordination, Muscle Weakness, Reduced Mobility and Central Cord Syndrome. Review of the Facility Reported Incident (FRI), DC00010687, received by the State Agency on 01/02/22 documented, "... [Resident #314] complained during morning rounds of pain on left arm. The resident stated, "I hurt myself yesterday evening during exercise by myself in my room". On assessment, the charge nurse observed that there was swelling around the left wrist with no discoloration, and no warmth. The resident rated his pain as 5/10 ... an order to X-ray Left wrist ... was given ... X-ray was done and result showed "acute hairline fracture of the distal radius and ulna". X-ray results was read to [Physician's Name], who gave an order to transfer resident to nearest ER (emergency room) for fracture..." Review of Resident #314's medical record showed the following: Admission 5-day Minimum Data Set (MDS) dated 12/07/21 revealed that facility staff coded the following: intact cognitive response, no delusions, hallucinations or rejection of care, extensive assistance with one person physical assist for bed mobility, transfers and walking in the corridor; supervision to walk in room; unsteady balance	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 15 during transitions and walking, no impairment in functional range of motion; used a cane and wheelchair for mobility and had no fall in the last month prior to admission. 12/30/21 at 9:18 AM [Physician's Progress Note] "Pt (patient) had fall yesterday injuring left wrist. LUE (left upper extremity) is paralyzed. Right wrist is swollen and tender with mild edema left hand. Will get xray and give pt Percocet (narcotic pain reliever) as needed." 12/30/21 [Physician's Order] Percocet (narcotic pain reliever) Tablet 5-325 MG (milligram)... Give 1 tablet by mouth every 6 hours as needed for pain..." 12/30/21 [Physician's Order] "X-ray Left wrist Dx (diagnosis) pain." 12/30/21 at 9:30 AM "Situation Background Assessment Request (SBAR) ... Communication Tool... Situation... left hand pain and swelling around wrist... During morning round the writer observed the resident complaining pain at left arm. The resident said "I hurt myself yesterday evening during exercise by myself in my room". The swelling around the left wrist observed upon assessment and the resident said the pain is 5/10. Dr (doctor) ...order X-ray of Left wrist and Percocet Tablet 5-325 MG po every 6 hours as needed for pain. Pain medication given as order and it is effective. Dynamic mobile Imaging called the order is in placed, and waiting for technician..." 12/31/21 [Dynamic Mobile Imaging Patient Report] "... Findings. There is a hairline fracture of the distal radius and ulna..."	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 16 12/31/21 [Physician's Order] "Transfer resident to the nearest ER ...for acute hairline fracture of the distal radius and ulna... and for further evaluation" Review of Resident #314's medical record and the facility's administrative records lacked documented evidence that facility staff conducted an investigation of the resident's unwitnessed fall with injury on 12/31/21. During a face-to-face interview conducted on 07/28/22 at 2:14 PM, Employee #2 (Director of Nursing) stated, "This is not how we do things [investigations]." 5. Facility staff failed to implement its policies and procedures for investigating Resident #133"s allegation of rape. Resident #133 was admitted to the facility on 08/28/20 with multiple diagnoses including: Anxiety Disorder Unspecified, Muscle Weakness, Unspecified Abnormalities of Gait and Mobility, Unspecified Dementia with Behavioral Disturbance, Bipolar Disorder, and Other Psychotic Disorder Not Due to A Substance or Known Physiological Condition. Review of an intake for a Facility Reported Incident (FRI), DC#00010592, received by the State Agency on 02/25/22, revealed that the facility staff reported the following: "... On 2/25/2022, around 0200 (2:00 AM), resident called the police without informing the staff. Upon arrival, [Resident #133] told the police that everyone in the building is trying to hurt her especially the female employees. Upon follow up by the Director of Nursing and the	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 17 Administrator this morning, resident then stated that she was raped last night and declared that this was the reason that she called the police...." Review of Resident #133's medical record revealed: Review of a care plan revised on 11/24/21, with a focus area of "...[Resident #133] called 911 and said she was sexually abused, when police came to investigate she denied calling them." The continued review had the following intervention, "Investigate [Resident #133]'s concerns and addressed (sp) them in a timely manner." Review of the Quarterly Minimum Data Set (MDS) dated 12/29/21 showed that the facility staff coded the following: intact cognition; independent and needed no setup or physical help in all areas of activities of daily living (ADLs). SBAR (Situation Background Assessment Recommendation-Physician/NP(Nurse Practitioner)/PA(Physician Assistant) note dated 02/25/22, at 1:55 AM in the section titled "Situation" documented "Alleged sexual Assult (sp)". The section titled "Additional Comments" documents "...at 12:39 am, a call came from front desk that police officer (Officers Name) and a colleague are in the building responding to a call from [Resident #133], writer went met the officers at residents' room, the room was trashed by the Resident, she was abusing every body including the officers, and using N and F words intermittently..." Review of a physician order documented, 02/25/22 "Transfer resident to the nearest ER for rape testing..."	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 18 A continued review of Resident #133's medical record revealed no documented evidence that facility staff investigated the resident's allegation of rape and other abuse that the resident made on 02/25/22. During a face-to-face interview conducted on 08/05/22, at approximately 2:00 PM with Employee #2 (Director of Nursing), when asked for the facility's investigation report for Resident #133's allegation of rape and abuse, the employee stated, "At this point, we can't put our hands on it." 6. Facility staff failed to implement its policies and procedures for investigating falls by not investigating Resident # 363's unwitnessed fall with injury. Resident #363 was admitted to the facility on 09/22/21 with multiple diagnoses that included the following: Chronic Obstructive Pulmonary Disease Unspecified, Cerebral Aneurysm Nonruptured, Aphasia, Unspecified Lack of Coordination, and Epilepsy, Unspecified, Not Intractable, With Status Epilepticus. Review of an intake for a Facility Reported Incident (FRI), DC#00010285, received by the State Agency, on 09/27/21 revealed the following: "...She is alert and oriented X1 with some confusion. At 4:20AM in response to call light resident was noted lying on the floor on her left side besides the bed. She stated she slide out of the bed. Resident assisted to the bed. On assessment there is no neurological changes from her baseline. Left eye swelling noted but	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 19 denies pain. No bleeding noted. Range of motion exercises done with no issues..." Review of the medical record revealed the following: Review of the Admission Minimum Data Set (MDS) dated 09/23/21 revealed that the facility staff coded the following: Section C (Cognitive Patterns) intact cognition; Section G (Functional Status): Bed mobility, Dressing, and Personal hygiene were coded as "extensive assistance" and required one-person physical assistance from staff; toilet use required one-person physical assistance and upper and lower extremity impairment. 09/26/21 at 7:25 AM [Nursing Progress Note], "...She is alert and oriented X1(alert to person only) with some confusion. At 4:20 AM in response to room mates call light resident was noted lying on the floor on her left side besides the bed. She stated she slide out of the bed. Resident assisted to the bed. On assessment there is no neurological changes from her baseline. Left eye swelling noted but denies pain. ..." Review of the medical record lacked documented evidence that facility staff conducted an investigation of Resident #363's fall with an injury that occurred on 09/26/21. During a face-to-face interview conducted on 08/05/22 at 2:13 PM, when asked for documented evidence that the facility conducted a fall investigation for Resident #363, Employee #2 (Director of Nursing), stated: "We can't put our hands on it."	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 20 7. Facility staff failed to report an alleged violation of abuse and neglect for Resident #51 within the required timeframe to the State Agency. Resident #51 was admitted to the facility on 03/27/17 with multiple diagnoses that included: Hypertension, Diabetes Mellitus, Unspecified Psychosis, and Cognitive communication Deficit. Facility Reported Incident (FRI), DC00010669, to the State Agency dated 04/11/2022 at 16:35 (4:35 PM), documented, "Writer' attention was called to resident's room by assigned CNA, a resident observed in bed alert responsive, observed to the right of her forehead is swelling the size of a quarter, asked what happened she initially stated, "I don't know, then almost immediately, she alleged she was hit by somebody . Writer and ADON went to resident's room, upon inquiring by the ADON, resident stated I don't know what happened. Resident denies pain, no bruises or any signs of trauma. Assigned CNA taken off the schedule pending investigation." Review of Resident #51's medical record showed the following: Annual Minimum Data Set (MDS) dated 02/25/22 showed that facility staff coded the following: BIMS "09" moderately intact cognitive response. An incident/unusual occurrence report dated 04/08/22 at 2:45 PM documented, "Resident observed with quarter-sized, swelling on her right forehead when asked what happened resident initially said that "I don't know" she later stated that someone hit me." The ADON (Assistant Director of Nursing) notified the Resident's	F 607		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 607	Continued From page 21 daughter at 3:30 PM and the Physician at 3:10 PM. There was no evidence that she notified the DC Department of Health. A review of the incident investigation showed that facility staff reported the allegation of abuse to the State Agency by e-mail on 04/11/22, three (3) days after the incident occurred. During a face-to-face interview conducted on 07/29/22 at 2:37 PM, Employee #3 (ADON), stated the facility's procedure for reporting incidents/accidents is within 2-24 hours, depending on how serious the harm was. She said, "I have all the information. I will bring them to you."	F 607		10/21/22
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609	**F-609** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Resident #51 suffered no negative outcomes from failure to report within the required time frame to the State Agency. Resident #51's incident report was reported on 4/11/22. Resident #51 suffered no negative outcomes from failure to report within the required time frame to the State Agency. Resident #51's incident report was reported on 4/11/22. Resident #51 was reassessed by licensed nurse from head to toe on 9/23/22. There were no negative outcomes. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. No other residents were affected based on a house wide audit of all incidents and accidents that occurred in the last 6 months conducted by the ADON on 10/13/22.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 609	Continued From page 22 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to ensure that alleged violations involving abuse and neglect or mistreatment were reported immediately for one (1) of 50 sampled residents. Resident #51. The findings included: Review of the facility's policy titled "Prohibition of Abuse" section F "Reporting" with a revised date of 05/01/18 documented, "All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health, via the event reporting electronically, or by phone in the event of the electronic system being unavailable within twenty-four (24) hrs of knowledge of the alleged incident and within two (2) hours if serious bodily injury has occurred or there is an allegation of abuse..." Resident #51 was admitted to the facility on 03/27/17 with multiple diagnoses that included: Hypertension, Diabetes Mellitus, Unspecified Psychosis, and Cognitive communication Deficit. Facility Reported Incident (FRI), DC00010669, to	F 609	**MEASURES TO PREVENT REOCCURRENCE** Facility Staff to be educated by Staff Educator/ Designee regarding the reporting requirements on any abuse or injuries of unknown origin in accordance with facility policy and DOH regulations. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION** ADON/Designee will conduct a house wide audit on all reports of alleged abuse and injury of unknown origin, to ensure that they are reported within 24 hours of knowledge of the alleged incident and within 2 hours if serious bodily has occurred or there is an allegation of abuse. This will be conducted weekly times four (4), then monthly ongoing. Any negative findings will be corrected upon discovery. All findings will be reported to the weekly at-Risk meeting and monthly to the QAPI meeting. Any negative findings will be corrected upon discovery.	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 609	Continued From page 23 the State Agency dated 04/11/2022 at 16:35 (4:35 PM), documented, "Writer' attention was called to resident's room by assigned CNA, a resident observed in bed alert responsive, observed to the right of her forehead is swelling the size of a quarter, asked what happened she initially stated, "I don't know, then almost immediately, she alleged she was hit by somebody . Writer and ADON went to resident's room, upon inquiring by the ADON, resident stated I don't know what happened. Resident denies pain, no bruises or any signs of trauma. Assigned CNA taken off the schedule pending investigation." Review of Resident #51's medical record showed the following: Annual Minimum Data Set (MDS) dated 02/25/22 showed that facility staff coded the following: BIMS "09" moderately intact cognitive response. An incident/unusual occurrence report dated 04/08/22 at 2:45 PM documented, "Resident observed with quarter-sized, swelling on her right forehead when asked what happened resident initially said that "I don't know" she later stated that someone hit me." The ADON (Assistant Director of Nursing) notified the Resident's daughter at 3:30 PM and the Physician at 3:10 PM. There was no evidence that she notified the DC Department of Health. A review of the incident investigation showed that facility staff reported the allegation of abuse to the State Agency by e-mail on 04/11/22, three (3) days after the incident occurred	F 609		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 609	Continued From page 24 During a face-to-face interview conducted on 07/29/22 at 2:37 PM, Employee #3 (ADON), stated the facility's procedure for reporting incidents/accidents is within 2-24 hours, depending on how serious the harm was. She said, "I have all the information. I will bring them to you."	F 609		10/21/22
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for six (6) of 50 sampled residents, facility staff failed to: investigate allegations of rape for one resident; conduct a thorough investigation for three residents with an injury of unknown injuries; and conduct a thorough investigation for unwitnessed falls with injury for two residents. Residents' #133, #212, #363, #313, #314, and	F 610	**F-610** **CORRECTIVE ACTION FOR AFFECTED RESIDENT:** Resident #212, #313, #314, #363 no longer resides in the facility. Residents #87, #212, #313, #314, #133, and #363 suffered no negative outcomes from failure to obtain interviews or written statements from potential witnesses. Resident #51 suffered no negative outcomes from failure to report within the required time frame to the State Agency. Resident #51's incident report was reported on 4/11/22. Resident #87 and #133 were reassessed by licensed nurse from head to toe on 9/23/22. There were no negative outcomes. Resident #133 went to the ER for alleged sexual abuse on 2/25/22. The results of her pelvic exam showed normal genitalia without obvious trauma. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. No other residents were affected based on a house wide audit of all incidents and accidents that occurred in the last 6 months conducted by the ADON on 10/13/22. Social Workers will conduct an interview with interviewable residents on the abuse allegation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 25 #87. The findings included: Review of the facility's policy titled, "Investigating Incidents Process" with a revision date of March 2022, showed "... Document date and time all notifications per facility policy... Interview and or/obtain statement from person reporting allegation or suspicion ... Interview and/or obtain statement from victim/resident(s)...Interview and /or obtain statements from potential witnesses as determined by the scope of the investigation... Review materials and complete investigation...Timeline of event and investigation and notification will be documented in the resident medical record ..." Review of the policy, "Injury of Unknown Origin" revised March 2022 documented, "... Immediately a resident is identified with an injury of unknown origin, the facility will ... interview and/or obtain statements from all potential witnesses as determined by the scope of the investigation ...review materials and complete investigation ..." Review of the facility's policy titled, "Mobility and Falls/Fall With Injury Prevention" with a revision date of 05/2022, showed "...This policy will assure proper assessment and documentation of potential risks for fall, actual occurrence of falls; and interventions to prevent future occurrences...When actual fall occurs...Document accident/incident...as a new event in the Risk Management System... Investigation using the incident and accident form... Witnesses' statement if fall was witnessed..."	F 610	**MEASURE TO PREVENT REOCCURRENCE:** Unit managers/Designee will conduct a house wide review of the daily 24 hour report and conduct walking rounds on all residents to identify any residents with suspected abuse. Any findings will be corrected upon discovery. A thorough investigation will be conducted for any alleged abuse, including obtaining written statements from all potential witnesses who might have had knowledge of the occurrence will be conducted per facility policy and regulation. Regarding all alleged violations, the Administrator, Director of Nursing or designee shall notify the Department of Health, via the event reporting electronically, or by phone in the event of the electronic system being unavailable within 24 hours of knowledge of the alleged incident and within 2 hours if serious bodily has occurred or there is an allegation of abuse. The Staff Educator/Designee will provide training and in-service to all staff on implementing the policy and procedures to prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property. This will be completed by 10/21/22. The Staff Educator/Designee will provide training to Administrator, DON, ADON, Social Services and Department heads on conducting a thorough investigation, including obtaining written statements from all potential witnesses who might have had knowledge of the occurrence are conducted per facility policy and regulation and timeliness of reporting to the State Agency. This will be completed by 10/21/22	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 26 1. The facility staff failed to investigate allegations of rape made by Resident #133. Resident #133 was admitted to the facility on 08/28/20 with multiple diagnoses including: Anxiety Disorder Unspecified, Muscle Weakness, Unspecified Abnormalities of Gait and Mobility, Unspecified Dementia with Behavioral Disturbance, Bipolar Disorder, and Other Psychotic Disorder Not Due to A Substance or Known Physiological Condition. Review of an intake for a Facility Reported Incident (FRI), DC#00010592, received by the State Agency on 02/25/22, revealed that the facility staff reported the following: "... On 2/25/2022, around 0200 (2:00 AM), resident called the police without informing the staff. Upon arrival, [Resident #133] told the police that everyone in the building is trying to hurt her especially the female employees....Upon follow up by the Director of Nursing and the Administrator this morning, resident then stated that she was raped last night and declared that this was the reason that she called the police...." Review of Resident #133's medical record revealed: Review of a care plan revised on 11/24/21, with a focus area of "...[Resident #133] called 911 and said she was sexually abused, when police came to investigate she denied calling them." The continued review had the following intervention, "Investigate [Resident #133]'s concerns and addressed (sp) them in a timely manner." Review of the Quarterly Minimum Data Set (MDS) dated 12/29/21 showed that the facility	F 610	**MONITORING THE CORRECTIVE ACTION:** ADON/Designee will conduct a house wide audit on all reports of alleged abuse and injury of unknown origin, to ensure that a thorough investigation, including obtaining written statements from all potential witnesses who might have had knowledge of the occurrence were conducted per facility policy and regulation and to ensure that they are reported within 24 hours of knowledge of the alleged incident and within 2 hours if serious bodily has occurred or there is an allegation of abuse. This will be conducted weekly times four (4), then o monthly ongoing. All findings will be reported to the weekly at-Risk meeting and monthly to the QAPI meeting. **Any findings will be corrected upon discovery.**	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 27 staff coded the following: intact cognition; independent and needed no setup or physical help in all areas of activities of daily living (ADLs). SBAR (Situation Background Assessment Recommendation-Physician/NP(Nurse Practitioner)/PA(Physician Assistant) note dated 02/25/22, at 1:55 AM in the section titled "Situation" documented "Alleged sexual Assult (sp)". The section titled "Additional Comments" documents "...at 12:39 am, a call came from front desk that police officer (Officers Name) and a colleague are in the building responding to a call from [Resident #133], writer went met the officers at residents' room, the room was trashed by the Resident, she was abusing every body including the officers, and using N and F words intermittently..." Review of a physician order documented, 02/25/22 "Transfer resident to the nearest ER for rape testing..." A continued review of Resident #133's medical record revealed no documented evidence that facility staff investigated the resident's allegation of rape and other abuse that the resident made on 02/25/22. During a face-to-face interview conducted on 08/05/22, at approximately 2:00 PM with Employee #2 (Director of Nursing), when asked for the facility's investigation report for Resident #133's allegation of rape and abuse, the employee stated, "At this point, we can't put our hands on it." 2. Facility staff failed to conduct a thorough investigation of Resident #212's injury of	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 28 unknown source/origin. Resident #212 was admitted to the facility on 03/16/22 with diagnoses that included Osteoporosis/Osteoarthritis, Non-Hodgkin Lymphoma, Collapse Vertebrae, Prior L2/L3 and T11[spinal cord injuries], Compensation Fractures /Vertebroplasty and Sciatic Fall, Mildly Displaced Left 7-8 Rib Fracture. Review of a Facility Reported Incident (FRI), DC00010639, received by the State Agency on 03/24/22, documented, "...Right pain, We did X-ray and she was noted to have a fracture of the mid clavicle. There is no facial bone lesion. Alignment is Anatomic. There is no soft tissue swelling or foreign identified body. Mid to moderate DJD [Degenerative Joint Disease] is noted Post-surgical screws in the humeral head region are seen." Review of Resident #212's medical record revealed the following: Admission Minimum Data Set (MDS) dated 03/22/22 showed that facility staff coded the following: cognitively intact; required extensive assistance with one person physical assistance for bed mobility, transfer, toilet use, and personal hygiene; no impairment in functional range of motion; used a walker and wheelchair for mobility; Fall prior to admission; no fall since admission to the facility, received occupational therapy (OT) that started on 03/17/2022 and physical therapy (PT) that began on 03/18/2022. 03/22/22 at 18:46 [6:46] PM "Situation Background Assessment Request (SBAR) Communication Tool... Situation painful swollen	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 29 right clavicle ...Resident complains of pain, unable to determine when it started ... Primary diagnosis Compression fracture of spine ... on assessment patient observed with swollen right clavicle ... Patient c/o (complained of) pain in right clavicle. Physician contacted by phone on 03/22/2022 17:00 [5:00] PM, CRNP [Certified Registered Nurse Practitioner] notified and order given for X-Ray of the right clavicle to evaluate pain..." 03/23/22 at 9:00 AM [physician's order] "X-Ray of right clavicle..." 03/23/22 at 19:50 [8:50 PM] Radiology Results Report "...Procedure... RT [right] Clavicle ... history of Rt side neck pain. Findings: there is a displaced fracture of the mid clavicle noted. There is no focal bone lesion. Alignment is anatomical There is no soft tissue swelling or foreign body identified. Mild to moderate DJD [Degenerative Joint Disease] is noted. Postsurgical screws in the humerus head region is seen. Calcification of the supraspinatus tendon is seen. Impression There is a displaced fracture of the mid clavicle seen." 03/23/22 at 22:29 [10:29 PM] [Nurses Note] "...On 03/23/2022, she (Resident #212) complained of pain in the right clavicle, assessed and medicated as per order and Xray done. Result of Xray received this evening-There is a displaced fracture of the mid clavicle seen ... NP (Nurse Practitioner)..., gave order to transfer resident to nearest ED (emergency department) for further evaluation and possible treatment..." 03/23/22 at 22:52 [10:52 PM] [Physician's Telephone Order] "Transfer resident to the	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 30 nearest ED for evaluation and treatment secondary to displaced fracture of the mid clavicle." Review of the facility's documents revealed that facility staff failed to interview or obtain written statements from all potential witnesses who might have had knowledge of the occurrence. During a face-to-face interview on 08/02/22 at 1:50 PM, Employees #2 [Director of Nursing] and #3 [Assistant Director of Nursing] stated, "The resident was discharged so we did not do a thorough investigation. The investigation information received did not include interviews from the staff who worked with the resident.." 3. Facility staff failed to investigate an unwitnessed fall with injury for Resident #363. Resident #363 was admitted to the facility on 09/22/21 with multiple diagnoses that included the following: Chronic Obstructive Pulmonary Disease Unspecified, Cerebral Aneurysm Nonruptured, Aphasia, Unspecified Lack of Coordination, and Epilepsy, Unspecified, Not Intractable, With Status Epilepticus. Review of an intake for a Facility Reported Incident (FRI), DC#00010285, received by the State Agency, on 09/27/21 revealed the following: "...She is alert and oriented X1 with some confusion. At 4:20AM in response to call light resident was noted lying on the floor on her left side besides the bed. She stated she slide out of the bed. Resident assisted to the bed. On assessment there is no neurological changes from her baseline. Left eye swelling noted but denies pain. No bleeding noted Range of motion	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 31 exercises done with no issues..." Review of the medical record revealed the following: Review of the Admission Minimum Data Set (MDS) dated 09/23/21 revealed that the facility staff coded the following: Section C (Cognitive Patterns) intact cognition; Section G (Functional Status): Bed mobility, Dressing, and Personal hygiene were coded as "extensive assistance" and required one-person physical assistance from staff; toilet use required one-person physical assistance and upper and lower extremity impairment. 09/26/21 at 7:25 AM [Nursing Progress Note], "...She is alert and oriented X1(alert to person only) with some confusion. At 4:20 AM in response to room mates call light resident was noted lying on the floor on her left side besides the bed. She stated she slide out of the bed. Resident assisted to the bed. On assessment there is no neurological changes from her baseline. Left eye swelling noted but denies pain. ..." Review of the medical record lacked documented evidence that facility staff conducted an investigation of Resident #363's fall with an injury that occurred on 09/26/21. During a face-to-face interview conducted on 08/05/22 at 2:13 PM, when asked for documented evidence that the facility conducted a fall investigation for Resident #363, Employee #2 (Director of Nursing), stated: "We can't put our hands on it."	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 32 4. Facility staff failed to conduct a thorough investigation of Resident #313's injury of unknown source/origin that occured on 04/06/22. Resident #313 was admitted to the facility on 02/09/22 with multiple diagnoses that included: Lack of Coordination, Unspecified Abnormalities of Gait and Balance and Altered Mental Status. Review of a Complaint, DC00010664, received by the State Agency on 04/07/22 documented, "...Tonight was the absolute final straw for our family, as we learned that my mother has a fractured leg that seemingly occurred without anyone's knowledge or a report by employees..." Review of a Facility Reported Incident (FRI), DC00010667, received by the State Agency on 04/08/22 documented, "...Upon assessment, no bruises, no swelling nor any sign of trauma noted. Resident medicated as per PRN (as needed) order. Resident re-assessed later and no complains nor signs of pain noted. Resident was visited by son 04/06/22 who made staff aware that resident is in pain, area assessed, no bruises, no swelling and no sign of trauma noted. NP made aware. Order given to do XRay, [Resident's representative] was on the unit when the result came and was informed of the findings." Review of Resident #313's medical record revealed the following: Admission Minimum Data Set (MDS) dated 02/15/22 showed that facility staff coded the following: the resident was unable to complete the Brief Interview for Mental Status; required extensive assistance with one person physical	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 33 assist for bed mobility; two persons physical assist for transfers; total dependence with one person physical assist for toilet use and personal hygiene; no impairment in functional range of motion; used a walker and wheelchair for mobility; no fall since admission, received occupational therapy (OT) and physical therapy (PT) that started on 02/10/22. 04/06/22 at 3:40 PM "Situation Background Assessment Request (SBAR) ... Communication Tool... Situation pain to left hip ...Resident complain pain in left hip, on assessment patient observed with pain on touch and movement to left hip ... Patient c/o (complained of) pain in left hip, on assessment patient observed with pain on touch and movement to left hip. CRNP (Certified Registered Nurse Practitioner) notified and new order given for X-Ray of left hip..." 04/06/22 [Physician's Order] "X-Ray of left hip..." 04/06/22 Radiology Results Report "...Procedure... LT (left) hip unilateral... Findings: there is an acute intertrochanteric fracture seen..." 04/06/22 at 8:54 PM [Nurses Note] "...On 04/05/22, she (Resident #313) complained of pain in the left hip, assessed and medicated as per order and Xray done. Result of Xray received this evening-There is an acute intertrochanteric fracture seen ... NP (Nurse Practitioner)... gave order to transfer resident to nearest ED for further evaluation and possible treatment..." 04/06/22 [Physician's Order] "Transfer resident to the nearest ED (emergency department) for evaluation and treatment secondary to acute	F 610		10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 34 intertrochanteric fracture" Review of the facility's investigation packet lacked documented evidence that they interviewed or obtained written statements from all potential witnesses who might have had knowledge of the occurrence. During a face-to-face interview on 08/02/22 at 1:50 PM, Employee #5 (1st Floor Unit Manager) stated, "After the resident left, we did our investigation. The investigation included staff interviews and review of the medications and diagnoses." 5. Facility staff failed to conduct an investigation of Resident #314's injury of unknown source/origin that occurred on12/30/21. Resident #314 was admitted to the facility on 12/01/21 with multiple diagnoses that included: Lack of Coordination, Muscle Weakness, Reduced Mobility and Central Cord Syndrome. Review of the Facility Reported Incident (FRI), DC00010687, received by the State Agency on 01/02/22 documented, "... [Resident #314] complained during morning rounds of pain on left arm. The resident stated, "I hurt myself yesterday evening during exercise by myself in my room". On assessment, the charge nurse observed that there was swelling around the left wrist with no discoloration, and no warmth. The resident rated his pain as 5/10 ... an order to X-ray Left wrist ... was given ... X-ray was done and result showed "acute hairline fracture of the distal radius and ulna". X-ray results was read to [Physician's Name], who gave an order to transfer resident to	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 35 nearest ER (emergency room) for fracture..." Review of Resident #314's medical record showed the following: Admission 5-day Minimum Data Set (MDS) dated 12/07/21 revealed that facility staff coded the following: intact cognitive response, no delusions, hallucinations or rejection of care, extensive assistance with one person physical assist for bed mobility, transfers and walking in the corridor; supervision to walk in room; unsteady balance during transitions and walking, no impairment in functional range of motion; used a cane and wheelchair for mobility and had no fall in the last month prior to admission. 12/30/21 at 9:18 AM [Physician's Progress Note] "Pt (patient) had fall yesterday injuring left wrist. LUE (left upper extremity) is paralyzed. Right wrist is swollen and tender with mild edema left hand. Will get xray and give pt Percocet (narcotic pain reliever) as needed." 12/30/21 [Physician's Order] Percocet (narcotic pain reliever) Tablet 5-325 MG (milligram)... Give 1 tablet by mouth every 6 hours as needed for pain..." 12/30/21 [Physician's Order] "X-ray Left wrist Dx (diagnosis) pain." 12/30/21 at 9:30 AM "Situation Background Assessment Request (SBAR) ... Communication Tool... Situation... left hand pain and swelling around wrist During morning round the writer observed the resident complaining pain at left arm. The resident said "I hurt myself yesterday evening during exercise by myself in my room".	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 36 The swelling around the left wrist observed upon assessment and the resident said the pain is 5/10. Dr (doctor) ...order X-ray of Left wrist and Percocet Tablet 5-325 MG po every 6 hours as needed for pain. Pain medication given as order and it is effective. Dynamic mobile Imaging called the order is in placed, and waiting for technician..." 12/31/21 [Dynamic Mobile Imaging Patient Report] "... Findings: There is a hairline fracture of the distal radius and ulna..." 12/31/21 [Physician's Order] "Transfer resident to the nearest ER ...for acute hairline fracture of the distal radius and ulna... and for further evaluation" Review of Resident #314's medical record and the facility's administrative records lacked documented evidence that facility staff conducted an investigation of the resident's unwitnessed fall with injury on 12/31/21. During a face-to-face interview conducted on 07/28/22 at 2:14 PM, Employee #2 (Director of Nursing) stated, "This is not how we do things [investigations]." 6. Facility staff failed to obtain interviews or written statements from potential witnesses to Resident #87's fall. Resident #87 was admitted to the facility on 07/18/14 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side, Type 2 Diabetes Mellitus Without Complications, Unspecified Lack of Coordination, and Abnormalities of Gait and Mobility.	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 37 A Facility Reported Incident (FRI), DC00010448, received by the State Agency on 12/13/21 documented: "... Writer was informed by CNA that resident stated she fell yesterday, she told writer, '[I] went to [the] lock door [at]10:45 pm, using my walker to ambulate,on my way back to bed, [I] missed my steps and fell on my right side, [I]managed to sit up, then knelt down, held on to the rail of the bed and sat on my w/c (wheelchair) close by. I didn't tell any body cause it is[was] time [for]the staff to go home, [I] hit the right side of [my] face against [the] table.' On assessment the R (right) cheek...wrist, arm, slightly swollen stated pain is 6/10...MD aware ordered, X-ray of rt (right) wrist and face T/O (to rule out) fracture." A review of Resident #87's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 10/15/21 showed that facility staff coded Resident #87 in the following manner: Under Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) Summary Score, Resident #87 was "10" indicating mild cognitive impairment. Under Section G (Functional Mobility) required extensive assistance from at least one staff person for toileting and personal hygiene and used a walker or wheelchair for mobility. 12/10/21 at 7:00 AM [Physician's Order] directed, "X-ray of facial bones right side forearm and rt (right) wrist one-time s/p (status-post) allegedly fall ..." 12/10/21 at 7:00 AM [Physician's Order] directed, "Ensure cluster (sp.) [clutter] free environment	F 610		10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 610	Continued From page 38 every shift." 12/10/21 at 7:00 AM [Physician's Order] directed, "Place the bed in lowest position all the times for the safety precaution every shift." 12/10/21at 9:59 AM [Situation, Background, Assessment, and Request (SBAR)]: "...Situation: ...Resident alleges she fell around 10:45 PM yesterday but did not tell anybody; Date problem or symptom started: 12/09/2021 ...resident was ambulating with her walker and stated 'I was walking too fast,'... Background: ...Recent fall ... Request: ..X-ray of the rt (right) arm and skull to r/o FX (fracture) s/p (status-post) fall. 12/11/21 at 9:52 AM, [Change in Condition Note]: "... Resident had a fall on 12/10/21 "MD aware ordered X-ray of forearm, wrist, and face to rule out (a) fracture. Result of x-ray reveals an acute mildly displaced fracture of distal shaft of ulna. MD called made aware to send the resident to nearest ED (Emergency Department)." The facility's investigation packet lacked documented evidence of interviews or written statements from facility staff who were assigned to Resident #87 or any staff on the unit on the date of the alleged fall (12/09/21). During a face-to-face interview on 08/04/22 at approximately 1:00 PM, Employee #3 (Assistant Director of Nursing) stated that she documented what the CNA told her about Resident #87's fall in the progress notes. She acknowledged that she did not get a separate statement from the CNA or any other employees or residents because it was an unwitnessed fall.	F 610		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 622 SS=D	Continued From page 39 Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622 F 622	**F-622** **CORRECTIVE ACTION FOR AFFECTED RESIDENT:** The facility cannot retroactively correct this deficiency. Resident #110 did not receive any negative outcomes as a result of an incomplete transfer packet. Resident #110 was reassessed from head to toe by the licensed nurse on 9/23/22. Resident suffered no negative findings. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents with the potential to be discharged from the facility have the potential to be affected. No other residents were negatively affected based on the house wide audit of all transfers in the last 6 months conducted by the QA Director on 10/13/22. **MEASURE TO PREVENT REOCCURRENCE** Staff Educator/Designee will educate all licensed nurses on ensuring that facility provides a complete transfer packet with all the required documentation including care plan goals prior to a resident transfer per policy. This will be completed by 10/21/22. **MONITORING THE CORRECTIVE ACTION:** QA Director/Designee will conduct a house wide audit of all transfers to ensure the correct documents are sent with the transferring resident. This will be done weekly times four (4), then monthly times three (3) months. Any negative findings will be corrected by 10/21/22. The Plan of correction will be reviewed during QAPI monthly meeting x 3 months for recommendations. Any issues found will be corrected upon discovery.	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 622	Continued From page 40 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information	F 622		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 622	Continued From page 41 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 50 sampled residents, the facility's staff failed to convey all of the required documents to the receiving health care provider when the resident transferred from the facility. Resident #110. The findings included: Resident #110 was admitted to the facility on 11/16/17 with multiple diagnoses that included: Diabetes Mellitus, Hypertension, Hyperlipidemia, Osteoporosis, Dementia, and Alzheimer's. Review of the medical record revealed: The physician's telephone order dated 07/16/22 at 9:15 AM, directed, "Transfer Resident to the hospital to [Hospital's name] via 911". 07/29/22 at 10:05 AM [Facility transfer/discharge packet] showed: a physician's order documenting the reason for transfer/discharge, diagnoses, allergies, recent vital signs, Face sheet, advance directives, comprehensive care plan goals, copy of bed hold notice, copy 6-10B C (transfer or discharge notice sent to ombudsman), recent labs, diagnostic test and immunization,	F 622		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 622	Continued From page 42 precautions isolation or contacts, special risk assessments (fall, elopement, pressure ulcer, etc.,) baseline and current mental and behavioral functioning, medication reconciliation record and discharge summary. The transfer packet lacked documented evidence that the facility staff sent the care plan goals with Resident #110. During a face-to-face interview conducted on 07/29/22 at approximately 10:30 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment.	F 622		10/21/22
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623	**F-623** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** The facility cannot retroactively correct this deficiency. RESIDENT #47 and #415 did not suffer any negative outcomes as a result of failure to notify the resident or their representative of the residents transfer to the hospital in writing and failure to send a copy of the notice of transfer to the Office of the State Long Term Care Ombudsman. Resident #47 and #415 were reassessed from head to toe on 9/23/22, with no negative findings. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** Residents in the facility have the potential to be affected by this deficient practice. No other residents were negatively affected based on the house wide audit of all transfers in the last 6 months conducted by the QA Director on 10/13/22.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 623	Continued From page 43 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623	**MEASURE TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** The staff educator/designee will educate the Social Service Director/designee on the facility policy of resident transfer/discharge to ensure that residents and their representatives are given notice in writing, and a copy of the notice of transfer to the Office of the State Long Term Care Ombudsman is provided. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** The Director of Social Services/designee will complete a house wide audit of resident transfers to ensure that proper notification is completed and provided to the resident and a copy is given to the Office of the State Long Term Care Ombudsman. This audit will be conducted weekly audit times four (4), then monthly times three (3) months. All negative finding will be corrected by 10/21/22. Results from the audit will be discussed in the QA meeting for 3 months to ensure compliance. QA Committee will determine the need for further audits and action. All negative finding will be corrected upon discovery.	10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 623	Continued From page 44 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews, for two (2) of 50 sampled residents, facility staff failed to notify the resident or their representative(s) of the resident's transfer to the hospital in writing, and failed to send a copy of the notice of transfer to	F 623		10/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 623	Continued From page 45 the Office of the State Long-Term Care Ombudsman. Residents #47 and #415. The findings included: 1. Resident #47 was admitted to the facility on 09/18/19 with multiple diagnoses that included: Cerebrovascular Accident (CVA), Hemiplegia or Hemiparesis, Muscle Weakness, and Chronic Kidney Disease (Stage 3). Review of the medical record revealed: A copy of Resident # 47's face sheet documented that the resident had a legal guardian/conservator. A Quarterly Minimum Data Set (MDS) dated 02/24/22 showed that facility staff coded the following: a Brief Interview for Mental Status summary score of "99," indicating the resident was unable to complete the interview. 04/28/22 at 2:17 PM [Change in Resident Condition]: "...[Resident #47] returned from [a] friend's visit downstairs, complaining of abdominal pain ...taken to his room for assessment, though nonverbal...expressed grimacing and pushing (the) writer's hand away...No nausea, no vomiting...Abdomen tender to touch...nodded pain scale as a 5/10. Per MD (medical doctor)...send to ED (Emergency Department) for evaluation and needed treatment. Resident transferred to [Name of Local Hospital]; included in the transfer package are care plan goals, bed hold policy, code status, and all relevant clinical papers." The facility's transfer packet lacked documented	F 623		10/21/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 623	Continued From page 46	F 623		10/21/22

evidence that facility staff provided Resident #47's legal guardian with written notification of the resident's hospital transfer. In addition, the resident's medical record lacked documented evidence that facility staff sent a copy of the notice of transfer to the Office of the State Long-Term Care Ombudsman.

During a face-to-face interview on 08/04/22 at 11:15 AM, Employee #2 (Director of Nursing/DON) stated she could not find documented evidence that facility staff provided a notice of transfer to the resident representative (legal guardian) or the Office of the State Long-Term Care Ombudsman.

2. Resident #415 was admitted to the facility on 08/26/21 with multiple diagnoses that included: Cerebrovascular Accident (CVA), Other Abnormalities of Gait and Mobility, Unspecified Lack of Coordination, and Alcohol Use Unspecified With Unspecified Alcohol-Induced Disorder.

A review of the Facility Reported Incident (FRI), DC00010303, received by the State Agency on 09/30/21, revealed: "... Resident was observed lying on his back on the floor beside his bed... Resident was transferred to [Local Hospital] ER (Emergency Room) at 3:30 am, RP (representative)... made aware, VS (vital signs BP(blood pressure) 130/66, P (pulse) 73, R (respirations) 16, 02 (oxygen) sat (saturation) 97% with O2 @ 2L/min (2 liters/ minutes) via NC (nasal cannula)."

A review of Resident #415's medical record revealed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	C 08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

(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 623	Continued From page 47 A Quarterly Minimum Data Set (MDS) dated 09/01/21 where facility staff coded: Resident #415 in the following manner: Brief Interview for Mental Status (BIMS) summary score "04," indicating the resident had severe cognitive impairment; and required extensive assistance from one staff person for bed mobility, dressing, toilet use, and personal hygiene; always incontinent for bowel and bladder. A copy of Resident # 415's face sheet documented that the resident had a representative. 09/30/21 at 2:32 AM [Change in Resident Condition Note]: "... writer was called to resident's room at 2:30 AM; on (upon) getting there, the resident was observed lying on the posterior position on the floor beside the bed...stated... wanted to use the bathroom and fell, hitting...forehead on the wall. Head-to-toe assessment done with laceration of 1 cm (centimeter) noted...on forehead...[physician's name] notified and ordered to send the resident to nearest ER (Emergency Room) for further evaluation..911 called, arrived at 2:45 AM, and resident was taken to [Name of Local Hospital] ... all transfer papers including care plan goals, e-interact, advanced directives... Message left for RP (resident representative) [Name of Resident #415's representative]." 09/30/21 [Physician's Order]: "Transfer resident to ER evaluation of forehead laceration S/P (status post) fall. One time only for 1 Day " The facility's transfer packet lacked documented evidence that facility staff provided Resident #415's representative with written notification of	F 623		10/21/22