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 48 the resident's hospital transferl. In addition, the resident's medical record lacked documented evidence that facility staff sent a copy of the notice of transfer to a representative of 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 (DON) acknowledged the finding and made no further comment.	F 623		10/21/22
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625	**F-625** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The facility cannot retroactively correct this citation. Resident #47, #71, #415, #313 and #314 did not have negative outcomes as a result of failure to provide a bed hold policy to the resident or resident representative. Resident #47, #71 were reassessed on 9/23/22. There were no negative findings. Resident #415, #313 and #314 are no longer in the facility. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents transferred out of 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 REOCURRENCE:** Staff Educator/designee will provide an in-service to the Social Services and licensed nurses on providing residents and/or resident representatives with a written Bed Hold Policy upon discharge from the facility. This will be completed by 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 625	Continued From page 49 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for five (5) of 50 sampled residents, facility staff failed to provide written information related to the facility's bed hold policy for the resident and/or resident's representative. Residents' #71 #47, #415, #313, and #314. The findings included: Review of the facility policy, "18-Day Bed Hold for Medicaid Residents with Long Term Care Medicaid," revised on 09/27/19, revealed, "We are required to provide you with our facility policy for requesting a bed to be held due to hospital transfer..." 1. Resident #71 was admitted to the facility on 03/25/11 with multiple diagnoses that included: Muscle Weakness, Heart Failure, and Unspecified Dementia Without Behavioral Disturbance. Review of Resident #71's medical record revealed the following: A copy of Resident # 71's face sheet documented that the resident had a guardian. Review of the Quarterly Minimum Data Set (MDS) dated 06/01/22 revealed that the facility staff coded a Brief Interview for Mental Status (BIMS) summary score "08", indicating moderately impaired cognition 06/12/22 at 7:11 AM [Physician's Note]	F 625	**MONITORING CORRECTIVE ACTION:** ADON/ Designee will conduct a house wide audit to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy when a resident is out of the facility and update them in writing of the number of bed hold days remaining. This audit will be completed weekly times four (4) and monthly times three (3). Findings to be reported to the monthly QAPI meeting. Any recommendations will be implemented 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 625	Continued From page 50	F 625		10/21/22

documented: "...Received a call from charge nurse to report to residents' room due to a fall. Resident was found lying on the floor mat with her head touching the bedside table. Head-to-toe assessment done. There is a laceration on the left side of her head...[hysician's name] made aware and given to send residents to nearest ER (Emergency room) for evaluation and possible treatment..."

There is no documented evidence in the medical record that the facility staff provided the resident or their representative with notice of its bed hold policy when the resident transferred to the hospital emergency room.

During a face-to-face interview conducted on 08/04/22 at 2:02 PM, Employee #2 (Director of Nursing) stated, "We do not have the notice of bed hold policy for June 12, 2022."

2. 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 could not complete the interview.

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 625		F 625		10/21/22

Continued From page 51
04/28/22 at 1:05 PM [E-interact Note/Nursing Home to Hospital Transfer Form]: "...Reason for transfer: Abdominal pain ...Contact Person [Name and telephone number of Resident #47's Legal Guardian] Notified of transfer: Yes, Aware of clinical condition: Yes..."

04/28/22 at 2:17 PM [Change in Resident Condition Note]: "(Resident #47)...complaining of abdominal pain ...expressed pain, 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...send to ED (Emergency Department) for evaluation and needed treatment. Resident transferred to [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 documents and Resident #47's medical record lacked documented evidence that facility staff provided tthe resident or their legal guardian written information that specified the facility's bed hold policy.

During a face-to-face interview on 08/04/22 at 11:15 AM, Employee #2 (Director of Nursing/DON) stated she had no documentation to show that facility staff provided the resident or the resident's representative information that specified the facility's bed hold policy.

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

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
				10/21/22
F 625	Continued From page 52 A review of Resident #415's medical record revealed: A copy of Resident #415's face sheet documented that the resident had a legal guardian/conservator. A Quarterly Minimum Data Set (MDS) dated 09/01/21 showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary of "04" indicating severe cognitive impairment. 09/30/21 at 2:32 AM [Change in Resident Condition Note]: "... (The) writer was called to [the] resident's room at 2:30 AM...(resident) was observed lying on the posterior position on the floor beside the bed...wanted to use the bathroom and fell, hitting...forehead on the wall. Head-to-toe assessment done with laceration of 1 cm noted...on [the] 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 the resident was taken to [Name of Local Hospital]...all transfer papers including care plan goals, e-interact, advanced directives...Message left for RP (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 and Resident #415's medical record lacked documented evidence that facility staff provided the resident or the resident's representative with written information that specified the facility's bed-hold policy.	F 625		

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 625	Continued From page 53 During a face-to-face interview on 08/04/22 at 11:15 AM, Employee #2 (DON) stated that Resident #415 went to the hospital and returned to the facility on the same day. 4. Facility staff failed to make Resident #313's representative aware of the facility's bed-hold and reserve bed payment policy within 24 hours of transfer to the emergency room (ER). 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."	F 625		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
				10/21/22
F 625	Continued From page 54 Review of Resident #313's medical record showed the following: A copy of Resident #313's face sheet documented that the resident had a responsible party. An Admission Minimum Data Set (MDS) dated 02/15/22 showed that facility staff coded that the resident could not complete the Brief Interview for Mental Status. 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 [an] order to transfer resident to nearest ED for further evaluation and possible treatment. Included in the transfer package are all relevant clinical papers...bed hold policy ..." 04/07/22 at 11:49 AM [Social Work Progress Note] "Resident hospitalized..." The evidence showed the resident was transferred to the hospital on 04/06/22. However, review of the bed hold policy revealed that facility staff made Resident #313's responsible party aware on 04/08/22 (two days later). During a face-to-face interview conducted on 08/01/22 at 2:46 PM, Employee #4 (Social Worker) acknowledged the finding and made no further comment. 5. Facility staff failed to provide Resident #314 written notice of the bed-hold policy when he	F 625		

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 625	Continued From page 55 transferred to the hospital on 12/31/21. 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, "...He (Resident #314) complained during morning rounds of pain on left arm... 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: An Admission 5-day MDS dated 12/07/21 revealed that facility staff coded the resident a having intact cognitive response. 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 revealed that the facility failed to provide the resident a written notice of the facility's bed hold policy upon transfer to the ER. During a face-to-face interview conducted on 08/01/22 at 2:46 PM, Employee #4 (Social Worker) acknowledged the finding and made no further comment.	F 625		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 635	Continued From page 56	F 635		10/21/22
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, for one (1) of 50 sampled residents, facility staff failed to ensure that Resident #147 had a physician's order to receive continuous supplemental oxygen. The findings included: Resident #147 was admitted to the facility on 06/30/22 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Fibrosis, Chronic Respiratory Failure, and Moderate Persistent Asthma. During a tour on 07/26/22 at approximately 11:00 AM, the surveyor observed Resident #147 lying on her back while in bed. The resident was receiving supplemental, humidified oxygen via nasal cannula at 2 liters per minute. Review of Resident #147's medical record revealed: 06/29/22 at 10:48 AM [Hospital Discharge Summary] read: "...Assessment/Plan ...COPD: On 2 L (liters) at baseline, Continue home inhalors, Albuterol (asthma medication) Attending Attestation: "...COPD exacerbation will monitor WOB (work of breathing) carefully. Rest of the plan as above."	F 635	**F-635** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** After being notified,resident # 147 was given an order for continuous oxygen by MD on 7/29/22. Resident #147 no longer resides in the facility. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents in need of oxygen therapy in the facility have the potential to be affected. No other residents were negatively affected based on the house wide audit of all residents with oxygen therapy orders in the last 6 months as conducted by the QA Director on 10/13/22. **MEASURE TO PREVENT RECURRENCE OF DEFICIENT PRACTICE:** Staff Educator/Designee will provide an in-service to all Licensed Nurses to ensure orders for oxygen therapy is in place on the medical record according to the physician's order. **MONITORING CORRECTIVE ACTION:** Unit managers/designee will conduct a house wide audit of all current residents, new admissions and readmissions using oxygen therapy to ensure that physician oxygen therapy orders include, amount, frequency, route and indication. Audit will be conducted weekly times four (4) then monthly times three (3). Any negative findings will be corrected by 10/21/22. Ongoing random audits will also be conducted by the Unit managers/ designee. Any findings will be corrected upon discovery.	

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 635	Continued From page 57 07 /01/22 at 12:06 AM [Admission Note] read: "...Medications were reconciled with [Physician's Name] and were electronically entered into the system ..." A Quarterly Minimum Data Set (MDS) dated 07/05/22 showed that facility staff coded a Brief Interview for Mental Status (BIMS) Summary Score of "09", indicating mild cognitive impairment and, in Section O (Special Treatments), received oxygen therapy while a resident. A review of Resident #147's medical record on 07/29/22 lacked documented evidence that facility staff obtained a physician's order for the resident to receive 2 liters of continuous oxygen per minute. During a face-to-face interview on 07/29/22 at 3:17 PM, Employee #17 (Registered Nurse), the admitting nurse, acknowledged that there was no order for Resident #147 to receive continuous oxygen.	F 635		10/21/22
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655	**F-655** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The facility cannot retroactively correct this deficiency. Resident #146 expired on 7/22/22. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. No other residents were negatively affected based on a house wide audit of baseline care plans of all residents in the last 6 months conducted by DON on 9/30/22.	

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 655	Continued From page 58 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. 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 develop a baseline care plan (within 48 hours of admission) to address resident #146's sacral wounds. Resident #146.	F 655	**MEASURE TO PREVENT RECURRENCE OF DEFICIENT PRACTICE:** Staff Educator/Designee will provide education/in-service to the interdisciplinary team on the accurate and timely development of person centered baseline care plans within 48 hours of admision/readmission. This will be completed by 10/21/22. DON/Designee will review all new admissions during stand down to ensure compliance with baseline care plans and completion within 48 hours. Any issues will be corrected by 10/21/22. **MONITORING CORRECTIVE ACTION:** DON/Designee will conduct a house wide audit to ensure that all new admissions and readmissions have a patient centered baseline care plan and completed within 48 hours. This audit will be done weekly times four (4), then monthly times three (3). Any negative findings will be corrected by 10/21/22. This will be reported monthly to the Quality Assurance and Performance Improvement team. Any findings will be corrected upon discovery.	10/21/22

(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 655	Continued From page 59 The findings included: Review of the policy, "Interdisciplinary Team Meeting (care Plan Meeting)" revised in March 2022 showed, " ... A baseline care plan must be developed within 48 hours and include the minimum information necessary to properly care for a patient ..." Resident #146 was admitted to the facility on 04/20/22 with multiple diagnoses that included: Fluid Overload, Chronic Kidney Disease and Dysphagia. Review of Resident #146's medical record revealed the following: 05/26/22 [Quarterly Minimum Data Set (MDS)]: facility staff coded: moderate impaired cognition; one (1) unstageable pressure ulcer and two (2) venous and arterial ulcers. 06/13/22 at 8:33 PM [Admission Note] " ...admitted from [Hospital Name] ... Resident has the following skin issue: Mid Sacral wound: 7 X 5 X < 0.2, Left Sacral Area: 4 X 2 X < 0.1. At the hospital the wound is unstageable with dry to moist slough in wound bed unable to debride. The entire bilateral lower Extremities are very dry, has poor circulation and appears gangrene. The bilateral legs are evidence of hyperkeratosis and scalling (sp) with chronic epithelial venous stasis changes. There are not open area on the bilateral lower extremities ..." The evidence showed that Resident #146 was readmitted to the facility on 06/13/22 with sacral wounds. Further review of Resident #146's	F 655		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
				10/21/22
F 655	Continued From page 60 medical record showed that facility staff failed to initiate a baseline care plan (within 48 hours of admission) with goals and interventions to address the residents sacral wounds. During a face-to face interview conducted on 08/03/22 at 9:30 AM, Employee #11 (2nd Floor Unit Manager) acknowledged the finding and made no further comment.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	**F-656** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #19 comprehensive care plan was reviewed to ensure that care plan for hypoglycemia is accurate and interventions are properly implemented on 9/20/2022. Resident #15 comprehensive care plan was reviewed to ensure care plan for low vision and cataracts is accurate and interventions are properly implemented on 9/28/2022 Resident #15 care plan was also reviewed to ensure refusal to wear glasses and receive treatment for the cataracts are accurate and interventions and properly implemented on 8/9/2022. Resident #71 comprehensive care plan was reviewed to ensure that it addresses resident's fall and interventions are properly implemented including maintaining a clutter free environment and a doorknob put in place in resident's room on 9/28/2022. Resident #87 comprehensive care plan was reviewed to ensure that it addresses the resident's dental condition accurately and proper intervention is in place with regards to the resident's dentures on 9/28/2022.	

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 656	Continued From page 61 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for eight (8) of 50 sampled residents, the facility's staff failed to: implement Resident #71's fall care plan; develop a care plan to address Resident #19's hypoglycemia; develop a care plan to address Resident #15's diagnosis of cataracts and refusal to wear glasses; develop a care plan to address Resident #87's dental care; implement Resident #90's elopement care plan; implement Resident #414's wound care plan; implement Resident #84's use of a bed alarm, and develop a care plan to address Resident #314's use of an arm sling. Residents' #71, #19, #15, #87, #90, #414, #84, and #314. The findings included: Review of the policy, "Interdisciplinary Team Meeting (Care Plan Meeting)," revised on March 2022, showed, "It is the policy of [Facility Name] to develop and implement a person-centered care plan for each resident..."	F 656	Resident #84 comprehensive care plan was reviewed to ensure the resident's bed alarm is addressed and that it is properly implemented on 9/23/22. Residents #19, #15, #71, #84 and #87 were reassessed by the licensed nurse from head to toe on 9/23/22. No negative outcomes were found. Residents #90, #414, #314 have been discharged and the facility cannot retroactively correct this deficiency. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE:** Staff educator/designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person centered care plan that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This will be completed by 10/21/22. MDS team will conduct a house wide audit of all new admissions in the last 10 days to ensure that an accurate person-centered comprehensive care plan is in place that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Any findings will be corrected 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 656	Continued From page 62 1. Facility staff failed to implement Resident #71's fall care plan, as evidenced by having the entrance to the room filled with clutter and the entrance door interior not having a doorknob. Resident #71 was admitted to the facility on 03/25/11 with multiple diagnoses that included the following: Muscle Weakness, Cognitive communication Deficit, Heart Failure, and Unspecified Dementia Without Behavioral Disturbance. During an observation on 07/26/22 at approximately 2:20 PM, Resident #71's room 206 A, the surveyor observed 3 trash cans, 3 linen bins, a walker, and a wheelchair filled with clothes and pillows blocking the interior residents' door. The entrance door could not be fully opened due to all the bins blocking the entrance and behind the door. The interior of the door did not have a doorknob. The surveyor reported these observations to Employee #11 (2nd-floor Unit Manager). Review of Resident #71's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 06/01/22 showed that the facility staff coded the resident as having moderately impaired cognition; having no impairment in the upper or lower extremities, and a wheelchair. Review of the care plan with a focus area of "(Resident #71) is at risk for fall due to imbalance" revised on 06/07/22, with an intervention of "Maintain [a] safe environment. Adequate lighting, clutter-free pathways..."	F 656	**MONITORING CORRECTIVE ACTION:** QA director/Designee will conduct a house wide audit of comprehensive care plans to ensure that they include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Any findings will be corrected by 10/21/22. This audit will be conducted weekly times four (4), then monthly times three (3) to be reviewed during At Risk meeting weekly x 4 weeks and in the QAPI meeting x 3 months. Any concern will be addressed at the time of 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 656	Continued From page 63 The evidence showed that facility staff failed to maintain a safe and clutter-free environment for Resident #71. During a face-to-face interview conducted on 08/04/22 at 12:10 PM, Employee #11 (Second Floor Unit Manager) acknowledged the finding and made no further comment. 2. Facility staff failed to develop a care plan to address Resident #19's hypoglycemic episodes. Resident #19 was admitted to the facility on 01/14/15 with multiple diagnoses that included: Type 2 Diabetes Mellitus with Diabetic Neuropathy and Morbid (Severe) Obesity Due to Excess Calories. Review of Resident #19's medical record revealed: Review of the physician's orders documented the following: 10/27/20 "If blood glucose is less than 50 mg/dl (milligrams per deciliter) & able to swallow, administer approximately 15 GM (Grams) Glucose Gel*or 8 oz juice* or 8 oz milk & check blood sugar again in 30 minutes* If unable to swallow administer 1 mg of Glucagon IM* Check blood sugar 15 minutes after treatment* If blood sugar is below 60 mg/dl or unable to arouse call 911 and notify the physician immediately ..." 01/10/2022 "Insulin Lispro Solution (Antidiabetic fast-acting insulin) Inject 58 units subcutaneously with meals ..." 01/10/22 "Lantus Solution (Antidiabetic long-acting insulin) 100 Unit/Ml (milliliter) ..."	F 656		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 656	Continued From page 64	F 656		10/21/22

Review of the Quarterly Minimum Data Set (MDS) dated 04/28/22, revealed that the facility staff coded the following:
In section C (Cognitive Patterns) Brief Interview for Mental Status summary score was "15," indicating intact cognition.
Section N (Medications) The facility staff coded that the resident had orders for insulin and received insulin injections during the last seven days since admission entry or reentry.

A care plan with a focus area of (Resident #19) has a diagnosis of DM (Diabetes Mellitus) revised on 05/03/22 had the following interventions "Administer medications as ordered ...Diet as ordered ...Monitor FBS (fasting blood sugar) as ordered."

Review of an SBAR (Situation Background Assessment Recommendation) -Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 06/29/22 at 4:35 PM, revealed in the section titled "situation" " ...Altered mental status due to hypoglycemia."

06/29/22 at 11:13 PM [Nurses Note] "...Per assigned Nurse, reported that she observed resident in bed around 4:10pm when she was doing her rounds, she noted resident foaming from mouth and unresponsive when called Residents ['s] blood sugar was checked and was 153 mg/dl (milligrams per deciliter)... [physician's name] was notified ...911 called and resident was transferred to the ER (emergency room) .."

There was no documented evidence in the medical record of a hypoglycemia care plan for Resident #19.

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 656	Continued From page 65 During a face-to-face interview on 08/02/22 at 1:35 PM, Employee #11 (2nd Floor Unit Manager) acknowledged findings. 3A. Facility staff failed to develop a comprehensive person-centered care plan that addressed Resident #15's low vision and cataracts. Resident #15 was admitted to the facility on 06/04/21 with multiple diagnoses, including the following: Combined Forms of Age-Related Cataract, Bilateral, Muscle Weakness, and Encephalopathy. Review of the Annual Minimum Data Set (MDS) dated 05/03/22 revealed that facility staff coded the following: Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) summary score "07" indicating severe cognitive impairment. Review of the Ophthalmologist consult assessment in the medical record dated 07/19/22 documented "...Cataract, mixed; Hyperopia and presbyopia; Low vision, both eyes; Patient behavior limits Examination." The medical record lacked documented evidence that facility staff developed a care plan that addressed Resident #15's low vision and cataracts. 3B. Facility staff failed to develop a refusal care plan for Resident #15 Resident #15 was admitted to the facility on 06/04/21 with multiple diagnoses, including the following: Combined Forms of Age Related	F 656		10/21/22

(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 656	Continued From page 66 Cataract, Bilateral, Muscle Weakness, and Encephalopathy. During an Observation on 08/02/22 at approximately 2:45 PM the surveyor and Employee #11 located the resident's eyeglasses in the resident's room, and Resident #15 stated that they were not her glasses and that she did not want to wear them. Review of the Annual Minimum Data Set (MDS) dated 05/03/22 revealed that facility staff coded the following: Section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) summary score "07," indicating severe cognitive impairment. Review of the Ophthalmologist's consult assessment in the medical record dated 07/19/22 documented "...Cataract, mixed; Hyperopia and presbyopia; Low vision, both eyes; Patient behavior limits Examination." The medical record lacked documented evidence that facility staff developed a care plan that addressed Resident #15's refusal to wear glasses and get treatment for cataracts. During a face-to-face interview conducted on 08/02/22 at 3:00 PM, Employee #11 (2nd Floor Unit Manager) acknowledged the findings and stated, " [The] Resident refuses to wear glasses and does not want treatment for cataracts." 4. Facility staff failed to implement a resident's dental care plan. Resident #87 was admitted to the facility on 07/18/14 with diagnoses including, Hemiplegia	F 656		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
				10/21/22
F 656	Continued From page 67 and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side and Type 2 Diabetes Mellitus Without Complications. During an observation and interview on 07/27/22 at 9:53 AM, Resident #87 reported that she wanted to see a dentist and that the facility staff was aware. The resident explained that she was supposed to receive a new set of dentures and that facility staff had provided the container for dentures about a year ago, but no dentures. The surveyor observed an empty container for dentures on the resident's nightstand. Review of Resident #87's medical record revealed: 09/02/21 [Physician's Order] directed: "Consults: Dental consult and treat as needed." A Quarterly Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "12," indicating mild cognitive impairment. The facility staff did not complete Section L (Oral/Dental status). Care plan with the focus area, "[Resident #87] has dental related to denture use... has partial upper and partial lower dentures" reviewed on 06/09/22" documented, "Goal: [Resident #87] will be provided with denture care x 90 days... Interventions... Dental consult per facility policy and prn (as needed), Follow-ups and evaluation of denture wearing done at regular intervals..." During a face-to-face interview on 07/27/22 at approximately 10:00 AM, Employee #8, the assigned Certified Nurse Aide CNA), reported	F 656		

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
				10/21/22
F 656	Continued From page 68 that she did not recall seeing dentures in Resident #87's room. During a face-to-face interview on 08/03/22 at 1:40 PM, Employee #3, Assistant Director of Nursing (ADON), stated that she believed Resident #87 had dentures in her room and would look into it. However, Employee #3 could not provide evidence that Resident #87 had dentures as specified in her care plan. The evidence showed that facility staff failed to implement/ provide Resident #87 with partial upper and lower dentures. 5. Facility staff failed to implement Resident #90's elopement care plan. Resident #90 was admitted to the facility on 06/03/22 with diagnoses including Encephalopathy, Unspecified, Dysphagia, Generalized Muscle Weakness, Schizoaffective Disorder, Cognitive Communication Deficit, and Unspecified Lack of Coordination. A Facility Reported Incident (FRI), DC00010849, received by the State Agency on 07/09/22, documented: "...At around 12.45, assigned CNA (Certified Nurse Aide) went to serve [the] resident his lunch, but he was nowhere to be found. Room to room and all ares (areas) of the unit were searched,...code pink called and ares (areas) of the facility and outside were searched [the] resident could not be found..." A review of Resident #90's medical record revealed: An "Initial Safety Risk Assessment/Elopement	F 656		

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
				10/21/22

F 656 Continued From page 69

Risk Evaluation" dated 06/03/22 at 8:23 PM showed, "Section A. Behavior/Mood Orientation... Resident is oriented to: Person, Place, and Time... Section G- Resident is not at risk for elopement." The facility staff did not complete other trigger areas of the form in sections B, C, D, E, and F.

An Admission Minimum Data Set (MDS) dated 06/07/22 revealed that facility staff coded Resident #90 in the following manner: Brief Interview for Mental Status (BIMS) Summary Score, "09", indicating mild cognitive impairment; required supervision for locomotion off the unit; no impairment in functional range of motion, and used walker mobility device. Under "Section E (Behavior), facility staff did not code the resident for wandering.

07/09/22 at 1:56 PM [Situation, Background, Assessment, and Request (SBAR)]: "Situation: ...Describe the problem/symptom: Missing, Date problem or symptom started: 07/09/22 ...Background: Mental Status or Neuro Changes: Confusion ...Assessment: Elopement ...Request: Person Contacted [Name of Resident's Emergency Contact #2] ..."

07/10/22 [Care Plan) documented: "Focus Area: Risk for Elopement... Interventions: Check for the resident's whereabouts q (every) hourly (hour). Keep the resident in full view..."

On 08/03/22 at approximately 3:15 PM, the surveyor observed a binder labeled "First Floor Hourly Census" at the first floor nurses' station. The binder contained a page labeled for each day of the month with the names of each first-floor resident (to include Resident #90) and each

F 656

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
				10/21/22

F 656 Continued From page 70

resident's location on a twenty-four-hour basis. A review of the binder revealed no documentation of Resident #90's hourly location from 07/11/22 until the resident's discharge on 07/13/22.

The evidence showed that facility staff failed to implement the care plan intervention of monitoring Resident #90 every hour as specified.

During a face-to-face interview on 08/03/22 at approximately 4:00 PM, Employee #5 (1st Floor Unit Manager) stated that the CNAs are responsible for documenting the hourly location of the first-floor residents they are assigned to during a shift.

6. Facility staff failed to implement Resident #414's Wound Care plan.

Review of Facility Reported Incident (FRI), DC00010501, received by the State Agency on 01/12/22, documented, "...Resident observed with unstable wound on her sacral area and bilateral ankle blisters.No drainage,peri-wound area intact and she denies pain upon assessment. [Nurse Practitioner's Name] made aware, order given for resident to be seen by the wound nurse. Wound nurse called,responded immediately spoke with the Wound NP (Nurse Practitioner), who gave order for x-ray sacral area. X-ray called in, low air mattress put in place ...[Name of Resident #414's representative] notified."

Resident #414 was admitted to the facility on 11/05/21 with diagnoses that included: Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Generalized Muscle Weakness, and Dysphagia.

F 656

(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 656	Continued From page 71	F 656		10/21/22

Continued From page 71

A review of Resident #414's medical record revealed:

A Quarterly Minimum Data Set (MDS) dated 12/08/21 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "14," indicating that the resident had intact cognition; required extensive assistance for bed mobility; was totally dependent for toilet use and personal hygiene; was always incontinent for bladder and bowel; and was at risk of developing pressure ulcers/injuries.

01/12/22 at 11:24 AM [Braden Scale for Predicting Pressure Ulcers] documented: "...Braden Category: Very High Risk... Score: 8..."

01/12/22 at 2:55 PM [Change in Condition Note]: "Type of Change in Condition: Unstageable Pressure Ulcer and bilateral heel blisters ...Resident observed with [an] unstageable wound on her sacral area and bilateral heel blisters. No drainage, peri-wound intact, and she denies pain upon assessment...[Nurse Practitioner's Name] made aware, order given for resident to be seen by the wound nurse... Wound nurse called, responded immediately spoke with the Wound NP (Nurse Practitioner)..."

01/12/22 [Care Plan] documented: "Focus: [Resident #414] has altered skin integrity related to sacral wound .. Interventions ... Weekly wound rounds by the Wound Team ..."

Continued review of Resident #414's medical record lacked documented evidence that facility staff conducted weekly wound rounds as specified in the care plan.

(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 656	Continued From page 72	F 656		10/21/22

During a face-to-face interview on 08/01/22 at 12:14 PM, Employee #28 (3rd Floor Unit Manager) did not provide any documentation to show that Resident #414 received weekly wound assessments by the Wound Care Team.
7. Facility staff failed to implement the care plan intervention for having a bed alarm on Resident #84's bed.

Resident #84 was admitted to the facility on 10/12/21 with diagnoses that included: History of Falling, Epilepsy and Hypertension.

Review of the Facility Reported Incident (FRI), DC00010450, received by the State Agency on 12/13/21 documented, "... Resident had a fall on 12/04/21, no bruises, swelling or any skin issue and he denied pain. Was seen by rehab s/p fall... Later complained of pain (scale 4/10) when he wanted to turn, upon assessment of the left hip, area is non tender, no swelling, no bruises...order written for x-ray left hip to r/o fracture. Result of x-ray reveals-There is an acute fracture of the proximal femur noted ...order given to send Resident to nearest ED."

Review of Resident #84's medical record revealed the following:

10/12/21 [Physician's Order] "Precaution: Fall every shift"

12/05/21 at 12:00 AM [Situation Background Assessment Request (SBAR) ...Communication Tool] "Situation ... unwitnessed fall ..."

12/13/21 [Physician's Order] "Check bed alarm on [the] resident bed and ensure bed alarm is

10/21/22

F 656 Continued From page 73
functional every shift"

A Quarterly Minimum Data Set (MDS) dated 06/10/22 that showed facility staff coded the following: intact cognitive response and no functional limitations in range of motion in upper extremities.

06/16/22 (review date) [Care Plan] "[Resident #84] is at risk for fall repetition... Bed alarm will be installed on [the] resident bed..."

06/16/22 (review date) [Care Plan] "[Resident #84] has limited physical mobility...Bed /chair alarm when resident is in bed or on the wheelchair..."

On 08/01/22 at 9:06 AM, Employee #8 (Assigned CNA) accompanied the surveyor to Resident #84's room (#420 bed A). Resident #84 was observed in bed, but there was no bed alarm on the bed. When asked where the Resident's bed alarm is, the Employee stated, "I am not sure; I will have to ask the nurse."

The evidence showed that facility staff failed to implement the care plan intervention of having a bed alarm for Resident #84.

8. Facility staff failed to implement a comprehensive care plan for Resident #314's use of an arm sling.

Review of the Facility Reported Incident (FRI), DC00010687, received by the State Agency on 01/02/22, documented, "...He (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".

F 656

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 656	Continued From page 74	F 656		10/21/22

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..."

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 Resident #314's medical record showed the following:

12/07/21 [Admission 5-day Minimum Data Set (MDS)] revealed that facility staff coded intact cognitive response.

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."

01/01/22 at 7:16 AM [Nurses Note] "Resident came back from [Hospital Name] to the facility accompanied by ambulance personnel at 12:28 am with a report which says '...We splint your wrist and give you medicine for pain. Follow up with orthopedic surgery in 1 to 2 weeks re-evaluation and xray..."

01/03/22 at 8:57 AM [Physician Progress Note] "Pt seen in ER xrays negative for fracture left wrist. Pt notes significant improvement in pain with splint ... Plan- splint, analgesics, orthopedic

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 656	Continued From page 75 follow up." Review of Resident #314's comprehensive care plan revealed that facility staff failed to develop a person-centered care plan with goals and interventions to address his use of a left wrist splint after returning from the emergency room. During a face-to-face interview conducted on 07/28/22 at approximately 2:20 PM, Employee #2 (Director of Nursing) stated, "Anything nursing related, the charge nurse or Unit Managers would initiate the care plan."	F 656		10/21/22
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	**F-657** **CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Resident #312 expired on 5/25/2022 and the facility cannot retroactively correct this deficiency. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents residing in the facility have the potential to be affected by this deficient practice. The unit managers/designee will complete audit of all residents with fall related injuries in the last 180 days to ensure care plan is timely and accurate interventions are implemented accordingly. Any findings will be corrected by 10/21/22. **MEASURE TO PREVENT REOCCURRENCE:** The Staff Educator/designee will provide education/ in-service to members of the interdisciplinary team and licensed nurses. The education/in-service will explain the importance of timely updating the comprehensive care plan with new interventions for residents with new fall related injuries.	

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 657	Continued From page 76 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 ensure that a resident's care plan was reviewed and revised by the interdisciplinary team. Resident #312. The findings included: Review of the policy "Mobility and Falls/Fall with Injury Prevention," revised in May 2022, documented, "...Update care plan to reflect new interventions..." Resident #312 was admitted to the facility on 07/23/21 with multiple diagnoses that included: Dementia without Behavioral Disturbances and Hypertension. Review of the Facility Reported Incident (FRI), DC00010421, received by the State Agency on 12/02/21, documented, "... Residents has H/O (history of) attempts to leave the floor. She missed her step and fell forward as she tried to rush into an opened elevator before it closes ... Upon assessment mild bleeding noted from mouth ...Resident to be transferred to the hospital for evaluation..." Review of Resident #312's medical record revealed the following: 07/23/21 [Physician's Order] "Precautions: fall	F 657	**MONITORING CORRECTIVE ACTION:** The QA Director/Designee will complete a house wide audit, weekly x 4 then monthly x 3 to ensure that fall with or without injuries interventions are implemented timely and accurately in accordance with the facility policy. Data will be presented to Quality Assurance Performance Improvement Committee meeting for review and recommendations for a period of 3 months. Any concerns will be addressed at the time of 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 657	Continued From page 77	F 657		10/21/22

every shift."

Care Plan Focus Area "[Resident #312] has risks for fall r/t (related to) dx (diagnoses) of impaired judgment..." initiated on 07/23/21.

Fall Risk Assessment/Evaluation dated 10/23/21 showed "Moderate Risk."

A Quarterly Minimum Data Set dated 10/29/21 showed that facility staff coded Resident #312 as: having severely impaired cognition; requiring supervision for locomotion off and off the unit; having unsteady balance but able to stabilize without staff assistance; having no limitations in range of motion; no use of mobility devices; active diagnosis of Lack of Coordination and no falls since admission/entry, reentry or prior assessment.

12/01/21 at 2:07 PM [Change in Resident Condition Note] "Time of Observation: 12:30 pm. Type of Change in Condition: Fall with face down ... She missed her step and fell forward as she tried to rush into an opened elevator before it closes. Resident wearing nonskid shoes, environment well lit and free of any wetness nor clutter. Upon assessment mild bleeding noted from mouth ... MD (medical doctor) made aware. Resident to be transferred to the hospital for evaluation."

12/02/21 at 1:20 AM [Nurses Note] "Resident returned to facility today from [Hospital Name] at 12: 14 AM. Resident was transferred to the ER this morning for evaluation post fall ...Fall and safety precautions maintained..."

Continued review of Resident #312's medical

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 657	Continued From page 78 record lacked documented evidence that facility staff updated the resident's comprehensive care plan with new interventions after she sustained a fall with injury. During a face-to-face interview on 08/01/22 at 4:25 PM, Employee #2 (Director of Nursing) acknowledged the finding and made no further comment.	F 657		10/21/22
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, for one (1) of 50 sampled residents, facility staff failed to ensure that Resident #86, who is unable to carry out activities of daily living, received the necessary care and services to maintain good personal hygiene. The findings included: Review of the policy, "Activity of Daily Living (ADL)" revised in May 2022 documented, "...It is the policy of [Facility Name] to ensure that we provide best carc possible ...activities of daily are provided by our CNAs (Certified Nurse Aides), LPNs (Licensed Practical Nurses), RNs (Registered Nurses) ... activities of daily living includes: bathing, showers...grooming..." Resident #86 was admitted to the facility on 12/19/17 with multiple diagnoses that included:	F 677	F-677 **CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Resident #86 was provided nail care and services on 7/28/22 to maintain hygiene. Head to toe assessment was completed by license nurse on 9/23/22, no negative findings. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents who are unable to carry out activities of daily living to maintain good nutrition, grooming and personal and oral hygiene, have the potential to be affected. **MEASURE TO PREVENT REOCCURRENCE:** Staff educator/designee will educate license nurses and certified nursing assistants to ensure residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal oral hygiene to be completed by 10/14/2022. Staff educator/designee to educate certified nursing assistants and licensed nurses on performing ADL care for those residents that need assistance to be completed by 10/21/2022.	

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 677	Continued From page 79 Muscle Weakness, Hypertension and Hyperlipidemia. On 07/26/22 (Tuesday) at 11:01 AM and 07/28/22 (Thursday) at 3:07 PM, Resident #86's fingernails were observed to be long and soiled. Review of Resident #86's medical record showed the following: 02/01/22 [Physician's Order] "Head-to-toe weekly assessment due on Tuesday 7-3 Shift every day shift every Tue (Tuesday)." 06/05/22 [Quarterly Minimum Data Set (MDS)] revealed that facility staff coded: severe cognitive impairment, no rejection of care, and extensive assistance with one person physical assistance for personal hygiene. 06/06/22 (review date) [Care Plan] "[Resident #86] have limited physical mobility ... Staff will provide assistance with adls (activities of daily living) at all time..." July 2022 Treatment Administration Record (TAR) showed that facility staff initialed to indicate that the "Head-to-toe weekly assessment due on Tuesday 7-3 Shift" task was completed. The evidence showed that facility staff failed to provide Resident #86 with nail care and services to maintain good personal hygiene. During a face-to-face interview conducted on 07/28/22 at 3:15 PM, Employee #6 (3rd-floor Unit Manager) stated, "Nurses cut the [finger] nails of residents who are diabetic. Otherwise, the CNAs (Certified Nurse Aides) know to clean and cut all	F 677	**MONITORING CORRECTIVE ACTION:** Unit Manager/Designee will complete a house wide audit of residents who are unable to carry out activities of daily living to ensure grooming, personal and oral hygiene is provided to them per physician order. This audit will be completed weekly x 4. the monthly x 3. Any negative findings will be corrected by 10/21/22. Unit Manager/Designee will conduct random audits to be conducted weekly x 4 and reviewed during At Risk to ensure compliance with resident hygiene. Any findings will be corrected by 10/21/22. Findings of the audit will be presented monthly x 3, then quarterly x 3 to the Quality Assurance Performance Improvement Committee. 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 677	Continued From page 80 other resident [finger]nails as part of daily care."	F 677		10/21/22
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, for one (1) of 50 sampled residents, facility staff failed to provide Resident #84 with individual activities designed to meet the interests of and support the resident's choice. The findings included: Resident #84 was admitted to the facility on 10/12/21 with diagnoses that included: History of Falling, Epilepsy, and Hypertension. During an observation and interview on 08/01/22 at approximately 10:00 AM, Resident #84 was observed with a newspaper dated "July 01, 2022." At the time of the observation, Resident #84 stated, "I would like to have a fresh newspaper to read. That's all I want." Review of Resident #84's medical record	F 679	**F-679** **CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Resident #84 was assessed by the licensed nurse on 9/23/22. No negative findings found. The resident was interviewed by the activity department to ensure that individual activities are designed to meet resident's interests and support the resident's choice on 9/2/22. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE:** Staff Educator/designee will educate activities staff regarding ensuring that residents have individualized activities designed to meet their interest and choice. Care plans to reflect the resident's individual choice. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** Activity Director/Designee will conduct a house wide audit to ensure that all residents have individualized activities designed to meet their interest and choice and the care plan is consistent with the resident's choice and is implemented accordingly. This audit will be conducted weekly times four (4) and monthly times three (3). Any negative findings will be corrected immediately. The results of the audits will be reviewed during At-Risk meeting and QAPI for recommendations monthly.	

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
				10/21/22
F 679	Continued From page 81 revealed the following: 06/10/22 at 8:40 AM [Activities Note] "...[Resident #84] enjoys being in the comforts of his own room watching TV (television). He is receiving 1:1 such as reality orientation, conversing with staff, and activity calendar orientation. Activities staff will invite, remind [resident] of activity participation of his choice and will continue to monitor for any changes weekly within the next 90 days." A Quarterly Minimum Data Set (MDS) dated 06/10/22 showed facility staff coded the following: intact cognitive response and no functional limitations in range of motion in upper extremities. 06/16/22 (review date) Care Plan "[Resident #84] is dependent on staff for activities, cognitive stimulation, social interaction r/t (related to) physical limitations ...[Resident #84] needs 1 to 1 bedside/in-room visits and activities if unable to attend out-of-room events..." Review of the progress notes showed that Resident #84 had not participated in any activity, nor was provided with any 1 to 1 activity from 06/10/22 to 08/01/22 (52 days). During a face-to-face interview conducted on 08/01/22 at 10:31 AM, Employee #7 (Activities Director) stated, "For bed-bound residents, we provide in room activities, aroma therapy, music, reality orientation, trivia, and games. Each time an activities aide sees the resident, it should be documented in PCC (Point Click Care). If the resident refused, that is also documented in PCC." Employee #7 acknowledged that Resident #84 has had no documented activity since 06/10/22 (52 days) and stated, "I will check with	F 679		

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 679	Continued From page 82 the activities aide assigned to this unit and also check if the resident gets newspapers delivered on a daily basis."	F 679		10/21/22
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 50 sampled residents (#146), facility staff failed to provide a resident with services consistent with the professional standards of practice to prevent pressure ulcer/injury development. Subsequently, when the resident's pressure ulcer was first observed, it was at an advanced stage (Unstageable). The findings included: Resident #146 was admitted to the facility on 04/20/22 with multiple diagnoses that included: Fluid Overload, Chronic Kidney Disease and Dysphagia.	F 686	**F-686** **CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Resident #146 had a skin observation assessment, SBAR, change in condition progress note RP and MD notification on 5/9/22. The wound NP saw the resident on 5/10/22 and wrote orders for wound care. Resident #146 expired on 7/23/22. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All facility residents have the potential to be affected **MEASURE TO PREVENT REOCCURRENCE:** House wide skin sweep assessment was completed on all residents to identify any skin issues on 9/23/22. Findings were addressed upon discovery. The licensed nurse will complete a skin assessment upon admission and the wound nurse/designee will complete a thorough skin assessment within 24-48 post-admission and validate all impaired areas were documented and treatments are ordered and care plan is initiated. Staff Educator/Designee will conduct in-service/ education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place. This will be completed by 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 686	Continued From page 83	F 686		10/21/22

F 686 (summary statement):

Continued From page 83

Review of Resident #146's medical record revealed:

04/20/22 at 8:35 PM [Admission/Readmission Screener] "... Bilateral dry lower extremities (Skin Not open)..."

4/20/2022 at 9:42 PM [Admission Note] "...admitted from [Hospital Name] ... Head-to-toe assessment was conducted ... [Resident] has bilateral very dry lower extremities. Resident does not have open skin issue..."

04/20/22 [Physician's Order] "Head-to-toe assessment and document in nurses note, notify MD (medical doctor)/RP (representative) of changes every evening shift every Wed (Wednesday)."

04/20/22 [Physician's Order] "Braden Scale: weekly x 4 wks (weeks) post-admission, then quarterly [and] PRN (as needed)."

Braden Scale for Predicting Pressure Ulcers dated 4/20/22 showed, "Admission ...Low Risk [for developing pressure ulcers]."

Admission Minimum Data Set (MDS) assessment dated 04/24/22 showed facility coded: required extensive assistance with two plus persons physical assistance for bed mobility, toilet use, and personal hygiene; had an indwelling catheter; always incontinent of bowel; at risk for developing pressure ulcers and had no pressure ulcers, lesions, skin tears or moisture associated skin damage (MASD).

The Treatment Administration Record (TAR) for 05/05/22 [Thursday] showed that facility staff

F 686 (plan of correction, completion date 10/21/22):

Staff Educator/Designee will conduct in-service/ education to all licensed nurses on their responsibility regarding monitoring the nursing assistant to ensure showers are being given and skin assessment completed timely for residents and turning and positioning is properly implemented per physician orders. This will be completed by 10/21/22.

Staff Educator/Designee will conduct an in-service/ education to all licensed nurse and certified nursing assistants to ensure that documentation on bath and shower sheets and skin assessments accurately reflect the resident's condition. This will be completed by 10/21/22.

MONITORING CORRECTIVE ACTION:
Unit Manager/Designee will conduct an audit of the bath and shower sheet and weekly skin assessments to ensure that these are completed timely and accurately.

Any findings will be corrected upon discovery weekly times four (4) then monthly times three (3). Results reviewed during At-Risk and will be brought to QAPI monthly x3 months for recommendations and review.

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 686	Continued From page 84 initialed in the designated location that they conducted a "head-to-toe assessment" of Resident #146 per the physician's order. The staff also recorded that the head-to-toe assessment was completed in the nursing notes on the same day. From 05/05/22 evening shift (3:00 PM - 11:00 PM) to 05/07/22 night shift (11:00 PM- 7: 00 AM), a total of eight (8) shifts, the Certified Nurse Aide (CNA) documentation showed that Resident #146 did not receive a bed bath or shower. The Bath and Shower Sheet dated 05/07/22 showed "...bath/shower days: Wed (Wednesday), Sat (Saturday), 3 PM-11 PM...[recorded Resident #146's skin as:] Normal- yes, redness/rash- no, peeling- no, open area- no, bruise-no..." This form was signed by the assigned CNA and a licensed nurse. 05/08/22 at 3:40 PM [Daily Skilled Note] "...ADLs (activities of daily living) care done, assisted with feeding. TURP (turning and repositioning) done q (every) 2 hrs (hours) for comfort and pressure relief ... skin is dry and warm to touch..." 05/09/22 at 12:06 PM [Tissue Analytics] "Wound ...Location: Sacrum. Length: 2.17 cm ...Width: 6.07 cm ...Observations: % (percent) granulation-10.00, % slough/eschar 90%. Wound Status- new. Acquired in House? Yes ..." [unstageable pressure ulcer]. 05/09/22 at 12:18 PM "Situation Background Assessment Request (SBAR) ... Communication Tool...Situation: open blister on right buttock ... Resident observed with open blister on right buttock, NP (Nurse Practitioner)... notified...	F 686		10/21/22

(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
				10/21/22
F 686	Continued From page 85 Wound team in house and assessed the wound. Responsible party... made aware..." However, the Skin/Wound Noted dated 05/09/22 at 9:03 PM documented, "...Sacral Ulcer/Sacral/Unstgble (unstageable) ... Procedures: Ulcer debridement site... location: sacrum...Post-debridement [the removal of damaged tissue or foreign objects from a wound] length (cm- centimeter): 2.17 ... width (cm): 6.07... depth (cm): 0.2 ... Percent debrided: 100%...Surgical debridement done to ulcer site...New unstageable pressure ulcer noted to sacrum. Area debrided at visit today...." Care Plan initiated on 05/09/22 "[Resident #146] has open blister on right buttock..." There was no documented evidence that from 05/01/22 to 05/08/22 (8 days), the facility staff observed any new skin issues/impairment on Resident #146. Subsequently, on 05/09/22, Resident #146 was observed with an unstageable pressure ulcer to the right sacrum/buttocks area that required surgical debridement. During a face-to-face interview on 08/03/22 at 1:51 PM, Employee #5 (1st Floor Unit Manager) acknowledged the finding and made no further comment.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689	**F-689** **CORRECTIVE ACTION FOR AFFECTED RESIDENTS:** Resident #90's elopement care plan, elopement assessment and RP and MD notification was completed on 7/9/22. Law enforcement was contacted and incident was reported to DOH. MD and RP were notified. The facility contacted the last place of resident's residence and the local area emergency room.	

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 689	Continued From page 86 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, for two (2) of 50 sampled residents, facility staff failed to adequately assess and monitor one resident who eloped from the facility; and failed to ensure one resident's room was free from clutter and hazards. Residents' #90 and #71. The findings included: 1. Facility staff failed to provide adequate monitoring and supervision to Resident #90 who had a history of elopement behaviors before his admission to the facility. Subsequently, the resident eloped from the facility on 07/09/22. Resident #90 was admitted to the facility on 06/03/22 with diagnoses including Encephalopathy, Unspecified, Dysphagia, Generalized Muscle Weakness, Schizoaffective Disorder, Cognitive Communication Deficit, and Unspecified Lack of Coordination. A Facility Reported Incident (FRI), DC00010849, received by the State Agency on 07/09/22, documented, "...At around 12.45, assigned CNA (Certified Nurse Aide) went to serve resident his lunch, but he was nowhere to be found. Room to room and all [areas] of the unit were searched...code pink called and [areas] of the facility and outside were searched resident could not be found..."	F 689	Onsite and offsite conducted by staff. Resident was located in the community and returned back in the facility on 7/9/22. Head to toe assessment was completed by the licensed nurse. The resident was reassessed for elopement risk. No negative findings were found. Resident #90 was discharged on 7/13/22. This cannot be corrected retroactively. Resident #71's door knob was fixed on 7/26/22 and the room was cleaned of clutter on 7/26/22. Resident was assessed head to toe by the licensed nurse on 9/23/22. No negative findings **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected. **MEASURE TO PREVENT REOCCURRENCE:** The Staff Educator/Designee will be reviewed the elopement policy and it will be reviewed with all staff by 10/21/22, to ensure that it is implemented properly. Staff Educator/Designee will provide education for licensed nursing staff, certified nursing staff, housekeeping, and maintenance to ensure resident environment remains free of accident hazards, free of clutter as possible and each resident receives adequate supervision and assistance devices to prevent accidents by 10/21/22. Staff Educator/Designee will provide education for all staff on providing adequate monitoring and supervision of residents at risk for elopement and ensure that orders and care plans are followed including the frequency of resident checks by 10/21/22. Maintenance will complete a full house audit of all resident rooms for any maintenance issues including door knobs that may require repairs. Any findings will be resolved 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 689	Continued From page 87 A review of Resident #90's medical record revealed: A Hospital Discharge Summary dated 06/03/22 at 12:12 PM documented, "...History of Present Illness ...history of schizoaffective disorder (lives in a home with others but independently comes and goes during the day) presented with an alerted mental status ..." 06/03/22 at 10:00 PM [Physician's Orders] directed: "Check every two hours to confirm if resident is physically in the facility or out of the facility ...Notify DON (Director of Nursing) and Administrator." An "Initial Safety Risk Assessment/Elopement Risk Evaluation" dated 06/03/22 at 8:23 PM showed, "Section A. Behavior/Mood Orientation... Resident is oriented to: Person, Place, and Time... Section G- Resident is not at risk for elopement." All other trigger areas of the form, sections B, C, D, E, and F were not completed. An Admission Minimum Data Set (MDS) dated 06/07/22 where facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "09", indicating mild cognitive impairment; required supervision for locomotion off the unit; no impairment in functional range of motion, and used walker mobility device. Of note for "Behavior," resident was not coded for wandering. 07/09/22 at 1:56 PM [Situation, Background, Assessment, and Request (SBAR)]: "Situation...Missing. Date problem or symptom started: 07/09/22 ...Background: Mental Status or	F 689	**MONITORING CORRECTIVE ACTION:** Maintenance Department Head/Designee will conduct a house wide audit of all resident doors to ensure that the equipment is functioning properly. This will be completed weekly x 4 weeks, then monthly x 3 months. Housekeeping Director/ Designee will conduct a house wide audit of all resident rooms to ensure the resident environment is free of accident hazards and free of clutter. This audit will be completed weekly x 4 weeks, then monthly x 3 months. ADON/Designee will conduct a house wide audit of all residents at risk for elopement to ensure that physician orders are in place and are followed, care plan is up to date, elopement risk assessment is accurate to the resident's condition. Any negative findings will be corrected upon discovery Review of the audit findings will be reported to QAPI for recommendations x 3 months for monitoring.	10/21/22

(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
				10/21/22
F 689	Continued From page 88	F 689		

Neuro Changes: Confusion ...Assessment: Elopement ...Request: Person Contacted [Name of Resident's Emergency Contact #2]..."

07/09/22 at 2:02 PM [Nurses Note] documented: "...At around 12:45 (PM), assigned CNA went to serve resident his lunch, but he was nowhere to be found. Room-to-room and all ares (sp) of the unit were searched, (the) resident could not be found, code pink called at 2:00 PM and ares (sp) of the facility and outside were searched resident could not be found, (the) unit manager called, who called the ADON (Assistant Director of Nursing), DON was also called, and all reported to the facility. [Name of Resident's Responsible Party] called, message left on [the] phone...Police notified..."

July 2022 Treatment Administration Record (TAR) revealed that on 07/09/22 from 12:00 Midnight to 12:00 PM facility staff documented that the resident was in the facility. On 07/09/22 at 2:00 PM, the facility staff documented that the resident was not in the facility.

07/10/22 at 3:14 PM [Nurses Note] documented: "...Resident who went missing yesterday was found and brought back to the facility today around 2:00 PM by a staff member ...[Name of Physician] made aware ..."

The evidence showed that facility staff failed to provide adequate monitoring and supervision to Resident #90. Subsequently, the resident eloped from the facility. He was found approximately 24 hours later and returned to the facility.

During a face-to-face interview on 08/03/22 at

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 689	Continued From page 89 1:40 PM, Employee #2, Director of Nursing (DON), stated that there was a physician's order to check every two hours to confirm if the resident was physically in the facility or out of the facility and it was documented on the resident's TAR. 2. Facility staff failed to ensure Resident #71's environment was free from hazards, as evidenced by clutter blocking the entrance/exit door to the resident's room. Resident #71 was admitted to the facility on 03/25/11 with multiple diagnoses that included the following: Muscle Weakness, Cognitive Communication Deficit, Heart Failure, and Unspecified Dementia Without Behavioral Disturbance. During an observation of Resident #71's room (206 A) on 07/26/22 at approximately 2:20 PM, upon entrance to the resident's room, the door did not fully open due to four trash bins, three linen bins, a walker, and a wheelchair filled with clothes and pillows that were blocking the pathway into the resident's room. The surveyor also noted that there was no doorknob present on the interior of the door, which is the entrance and exit to the resident's room. Employee #11 (2nd Floor Unit Manager) was present during the observation. Review of the resident's medical record: A Quarterly Minimum Data Set (MDS) dated 06/01/22 where facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "08", indicating moderately impaired cognition; required extensive assistance with	F 689		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 689	Continued From page 90 two-persons physical for bed mobility; one-person physical assist for transfers; no functional impairment in range of motion; and used a wheelchair for mobility. Review of the care plan with a focus area of "[Resident #71] is at risk for fall due to imbalance" revised on 06/07/22, had an intervention of "Maintain a safe environment. Adequate lighting, clutter-free pathways..." During an interview conducted on 07/26/22 at approximately 2:20 PM, Employee #11 (Second Floor Unit Manager) stated, "I will call housekeeping."	F 689		10/21/22
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 ensure that one (1) resident received pain medication treatment and care related to pain management in accordance with professional standards of practice. Resident #98. The findings included: Resident #98 was admitted to the facility on 04/22/21 with the following diagnoses that included: Anemia, Gastroesophageal Reflux	F 697	**F-697** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #98 still resides in the facility; orders were reviewed to ensure resident pain level is assessed every shift in accordance with facility policy. Head to toe reassessment was completed on 9/23/22 by the licensed nurse. No negative findings. The resident suffered no negative findings from not documenting her pain level before and after pain medication administration as evidenced by the Q Shift Pain assessment documented in the Treatment Administration Record. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents in the facility have the potential to be affected. **MEASURE TO PREVENT REOCCURRENCE:** Staff Educator/designee will provide in-service/ education to all licensed nurses on properly assessing and evaluating residents using the numeric or PINAND pain assessment, and conducting a pain assessment prior to and after receiving pain medications consistent with professional standards. This will be completed by 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 697	Continued From page 91 Disease, Pressure Ulcer at Right Buttocks Stage 3, and Pressure Ulcer of Sacral Region, and Multiple Sclerosis. A review of medical record showed the following physician's orders: 06/02/21 "Evaluate and Document the presence of pain each shift every shift." 06/02/21 "Acetaminophen (pain reliever) tablet 500MG (milligram) Give 2 tablets by mouth every 4 hours as needed for pain." 06/02/21 "Tylenol Extra Strength (pain reliever) Tablet 500MG Give 2 tablets by mouth every day shift for pain Give 30 minutes prior to wound dressing change daily." 06/17/21 "Oxycodone (opioid pain reliever) HCL (hydrochloride) tablet 5 mg (milligram), "Give one tablet by mouth every 6 hours for pain management." Review of the Medication Administration Record (MAR) for 07/01/22 to 08/02/22, showed the following: "Staff initialed at administering Oxycodone 5mg every 6 hours for pain management. However, the box marked "Pain level" was left blank. "Staff initialed at administering Tylenol Extra Strength Tablet 500MG 2 tablets everyday shift for pain. However, the box allotted to evaluate and document the presence of pain each shift showed "0", indicating no pain. Resident #98's Medication Administration Record	F 697	Unit Managers/Designee will conduct house wide audit of all residents with an order of pain medications to ensure that physician orders have a pain level/scale and pain assessment is completed prior to and after receiving pain medications consistent with professional standards. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** The Unit managers will complete a house wide pain management audit to ensure orders are in the EHR system for pain medication with pain level/scale, and that pain assessments are completed prior to and after receiving medications consistent with professional standards weekly x 4 then monthly x 3. Data will be reported to the Quality Assurance committee for review and recommendations for a period of 3 months. Any concerns will be addressed at the time of 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 697	Continued From page 92 from 07/01/22 to 08/02/22, lacked documented evidence that facility staff performed pain assessment to determine the resident's pain level pre and post-administration of pain medication. During a face-to-face interview conducted on 08/04/22 at 9:22 AM, Employee #3 (Assistant Director of Nursing/ADON) stated, "Pain assessments should be performed before and after pain medication is administered to residents. We have all new nurses and will educate them."	F 697		10/21/22
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 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 ensure that a resident who required dialysis, received appropriate care consistent with professional standards of practice for removing the dialysis access site dressing after hemodialysis. Resident #75. The findings included: According to Kidney Health Care, "Fistula Care... Check patency of fistula daily by feeling the thrill over the anastomosis and along the fistula and by listening for bruit with a stethoscope. Notify a hemodialysis nurse or nephrologist if fistula is not functioning. Remove fistula dressing 4 - 6 hours	F 698	**F-698** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #75 returned from dialysis with pressure dressing in place on 8/1/2022. Upon identification the shunt dressing was removed. Ongoing the resident's shunt site is assessed by licensed nurse and shunt dressing removed 4 hours after dialysis. Head to toe assessment was conducted by the licensed nurse on 9/23/22. Resident suffered no negative findings as evidence by no clotting of residents shunt site. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All facility dialysis residents have the potential to be affected. **MEASURE TO PREVENT REOCCURRENCE:** DON/Designee will conduct a house wide audit of all dialysis residents to ensure orders are correct and in place for shunt care and care completed as ordered. Any negative findings will be corrected upon discovery. Staff Educator/Designee will educate licensed nurses to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences and consistent with the facility policy following physician orders and dialysis shunt care within 4 hours of return from dialysis. This will be completed by 10/21/22.	