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

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INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

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F 698	Continued From page 93 post dialysis. If the patient 's hemodialysis puncture sites bleed, apply pressure for 10 minutes and reapply gauze dressing when bleeding stops. No constrictive clothing, armbands, or watches should be worn on the fistula arm." www.kidneyhealth.ca/wp/wp-content/uploads/80.20.05.pdf Resident #75 was admitted to the facility on 11/12/14 with the following diagnoses that included: Chronic Kidney Disease Stage 5, Hypertension, Schizoaffective Disorder, Bipolar, and Dementia. Review of Resident #75's medical record showed the following: Dialysis treatment appointments are scheduled at the dialysis center on Tuesdays, Thursdays, and Saturdays for the second shift. Patient#75's treatment time is 11:15 AM to 2:45 PM for 3 and 1/2 hours. A physician's order dated 08/11/21 directed, "Remove pressure dressing after [before] 24hrs (hours) on the next day and leave access uncovered, everyday shift Wed, Fri, Sun [Wednesday, Friday, Sunday] for remove dressing after [before] 6 hrs". Review of Care plan dated 05/18/22 showed "Dx (diagnoses) Chronic Kidney Disease Stage 5... on hemodialysis has right hand AV (arteriovascular), remove dressing to site in 4 hours after dialysis Tuesday, Thursdays and Saturdays" Review of the Treatment Administrative Record	F 698	**MONITORING CORRECTIVE ACTION:** DON/Designee will conduct house wide audit of all residents on dialysis 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 consistent with the facility policy following physician orders and dialysis shunt care within 4 hours of return from dialysis. This audit will be conducted weekly x 4 weeks, the monthly x 3 months. The audits will be brought to QAPI monthly x 3 months for review. Any recommendations will be addressed upon discovery.	10/21/22

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F 698	Continued From page 94 (TAR) for July 2022 showed "7:00 AM -3:00 PM" as the time indicated that the pressure dressing was removed. This evidence showed that facility staff did not remove Resident #75's dialysis access site pressure dressing within 4-6 hrs after dialysis. During a face-to-face interview conducted on 08/01/22 at 9:22 AM, Employee #3 (Assistant Director of Nursing/ADON) stated, "Will clarify physician's order and educate staff."	F 698		10/21/22
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726	**F-726** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #90 had an Elopement Assessment completed, SBAR, on 7/9/22 care plan updated on 7/10/22. There are no negative findings. The resident was discharged on 7/13/22. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents at risk for elopement have the potential to be affected. No other residents were affected based on a housewide audit conducted by DON/ ADON/Unit managers on 10/20/22. **MEASURE TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** The Staff Educator/Designee will review the elopement policy and educate all staff by 10/21/22 to ensure that it is implemented properly. Staff Educator/Designee will educate nursing staff through annual competencies to ensure nursing staff has specific competencies and skilled set necessary to provide nursing care and related services. Annual competencies are currently being initiated with all licensed staff	

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F 726	Continued From page 95 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 50 sampled residents, the facility's nursing staff failed to provide nursing and related services to meet the residents' needs and promote the resident's well-being. Subsequently, a resident eloped from the facility. Resident #90. The findings included: Resident #90 was admitted to the facility on 06/03/22 with diagnoses including Encephalopathy, 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 [12:45 PM], assigned CNA (Certified Nurse Aide) went to serve 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 resident could not be found,..." A review of Resident #90's medical record revealed: An Admission Minimum Data Set (MDS) dated	F 726	Staff Educator/Designee will provide education for all staff on providing adequate monitoring and supervision of residents who are at risk for elopement and ensure that orders and care plans are followed including the frequency of resident checks. This will be completed by 10/21/22. Staff Educator/Designee will provide education for licensed nurse, 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. This will be completed by 10/21/22. Staff Educator/Designee will provide education for all licensed nurse s to ensure that proper completion of the Elopement Risk Assessment is accurate and completed on admission, readmission, significant change and quarterly. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** 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, and elopement assessment is accurate to the resident's condition. Activity Director/Designee will conduct random house wide audit of section F of the MDS to ensure that the assessment accurately reflects the resident condition. Any negative findings will be corrected upon discovery. Social Services/Designee will conduct random house wide audit of sections B, C, D, and E of the MDS to ensure that the assessment accurately reflects the resident condition. Any negative findings will be corrected upon discovery. Review of the audit findings will be reported to QAPI for recommendations. Staff Educator Director will be monitoring that annual competencies are completed and findings will be presented to the monthly QA committee meeting for recommendations monthly x3.	10/21/22

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F 726	Continued From page 96 06/07/22 showed that facility staff coded Resident #90 in the following manner: 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. 06/03/22 at 12:12 PM [Hospital Discharge Summary] 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 a [altered] mental status ..." 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." The facility staff did not complete other trigger areas of the form under sections B, C, D, E, and F. It should be noted that because facility staff failed to complete sections B, C, D, E, and of the assessment, Resident #90 was inaccurately coded as not at risk for eleopement. 07/09/22 at 1:56 PM [Situation, Background, Assessment, and Request (SBAR)]: "Situation...Missing...Assessment: Elopement ...Request: Person Contacted [Resident's Emergency Contact #2]..." During a face-to-face interview on 08/03/22 at 1:40 PM, Employee #2 (Director of Nursing) acknowledged that facility staff should have completed all of the sections in the [elopement risk] assessment.	F 726		10/21/22

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F 744	Continued From page 97	F 744		10/21/22
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. 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 and implement an individualized person centered care plan for Resident #84 who has a diagnoses of Non-Alzheimer's Dementia. The findings included: Resident #84 was admitted to the facility on 10/12/21 with diagnoses that included: History of Falling, Epilepsy and Hypertension. Review of Resident #84's medical record revealed a Quarterly Minimum Data Set (MDS) dated 06/10/22 that showed facility staff coded the following: intact cognitive response and an active diagnosis of Non-Alzheimer's Dementia. Further review of the medical record showed no documented evidence that facility staff developed and implemented a person-centered care plan to support the Dementia care needs of Resident #84. During a face-to-face interview conducted on 08/01/22 at 10:08 AM, Employee #9 (4th Floor Unit Manager) stated, "I will look into it."	F 744	**F-744** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #84 person centered care plan has been developed to support Dementia care on 8/1/22. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents with a diagnosis of dementia have the potential to be affected by this deficient practice. **MEASURES TO PREVENT REOCURRENCE OF DEFICIENT PRACTICE:** Staff Educator/Designee will provide an in-service/ education for the IDT team on proper implementation of the care plan and ensuring that residents with dementia has a person centered dementia care plan in place. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** Unit Managers/Designee will conduct a house wide audit of all residents with a diagnosis of dementia to ensure that residents have a dementia care plan that accurately reflect the resident's condition. This will be completed weekly x four (4), then monthly x three (3) months. Findings will be corrected upon discovery and presented to QA committee for recommendations.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 98 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of five (5) nursing units, the facility staff failed to ensure that the system used for an acceptable standards of practice to account for	F 755	**F-755** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** No residents were negatively affected by this deficiency. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All nursing units have the potential to be affected **MEASURE TO PREVENT REOCCURENCE OF DEFICIENT PRACTICE:** Staff Educator/Designee will provide education to all licensed nurses to ensure that acceptable standards of practice to account for the receipt, usage, disposition and reconciliation of controlled medication is practiced based on regulatory standards for narcotic count. This will be completed by 10/21/22. Staff Educator/Designee will provide education to all licensed nurses to ensure that all refrigerators on the nursing units have a complete temperature check logs. This will be completed by 10/21/22 The Unit Manager will perform a house wide audit of all unit refrigerators to ensure that the Refrigerator Temperature Log is completed timely and accurately. Staff Educator/Designee will provide education to all licensed nurses to ensure that controlled medications are accurately reconciled and accounted for. The Control Drugs Verification Count sheet will be signed by the incoming licensed nurse and going off duty licensed nurse. In cases where a licensed nurse works a double shift, at the end of the 1st shift, another licensed nurse will reconcile, sign, date and time on the narcotic reconciliation sheet with the nurse continuing to work the double shift.	10/21/22

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F 755	Continued From page 99 the receipt, usage, disposition, and reconciliation of controlled medications was followed. The findings included: Review of the facility policy entitled, "Shift Verification of Accuracy of Controlled Drug Record..." documented, "...Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift." 1. During a review of the Shift Count Narcotic record of the 4th floor completed on 07/28/22, at approximately 9:00 AM, the following was observed: 07/1/22 to 07/04/22- 3:00 PM -11: 00 PM shift, same nurse signed coming on and going off 07/05/22, 07/07/22, 07/8/2022, 07/11/22, 07/12/22- 3:00 PM -11: 00 PM shift, nurse signed coming on/sign off was blank 07/13/22 7:00 AM - 3:00 PM shift, coming on was blank and 3:00 PM -11: 00 PM shift going off was blank 07/14/22 - 07/18/22: 3:00 PM -11: 00 PM shift, same nurse signed coming on and going off 07/20/22 3:00 PM -11: 00 PM shift, same nurse signed coming on and going off 07/24/22 and 07/25/22. 3:00 PM -11: 00 PM shift, same nurse signed coming on and going off 07/26/22 (all shifts) and 07/27/22 (7:00 AM - 3:00 PM shift), same nurse signed coming on and going off 07/28/22 3:00 PM -11: 00 PM shift, coming on was blank 2. During a review of the Shift Count Narcotic	F 755	**MONITORING CORRECTIVE ACTION:** The Unit Manager will perform a house wide audit to ensure that controlled medications are accurately reconciled and accounted for, the Control Drugs Verification Count sheet are signed by the incoming nurse, going off duty nurse, performed by two licensed nurses. This will be conducted weekly times four (4), then monthly times three (3) months. The Unit Manager will perform a house wide audit of all unit refrigerators to ensure that the Refrigerator Temperature Log is completed timely and accurately. This audit will be conducted weekly times four (4), then monthly times three (3) months. All findings will be reviewed during QAPI monthly x 3 months for recommendations.	10/21/22

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F 755	Continued From page 100 record of the 5th floor completed on 07/28/22, at approximately 9: 10 AM, the following was observed: 07/01/22 3-11 shift, same nurse signed coming on and going off 07/02/22 7-3 shift, coming on was blank / 3-11going off blank 07/03/22 3-11 shift, same nurse signed coming on and going off 07/04/22 3-11 shift, same nurse signed coming on and going off 07/05/22 3-11 shift, same nurse signed coming on and going off 07/06/22 3-11 shift, same nurse signed coming on and going off 07/07/22 3-11 shift, same nurse signed coming on and going off 07/08/22 3-11 shift, same nurse signed coming on and going off 07/09/22 3-11 shift, same nurse signed coming on and going off 07/10/22 3-11 shift, same nurse signed coming on and going off 07/11/22 3-11 shift, same nurse signed coming on and going off 07/13/22 3-11 shift, same nurse signed coming on and going off 07/14/22 3-11 shift, same nurse signed coming on and going off 07/15/22 3-11 shift, same nurse signed coming on and going off 07/16/22 3-11 shift, same nurse signed coming on and going off 07/17/22 3-11 shift, same nurse signed coming on and going off 07/18/22 3-11 shift, same nurse signed coming on and going off 07/19/22 3-11 shift, same nurse signed coming	F 755		10/21/22

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F 755	Continued From page 101 on and going off 07/21/22 3-11 shift, same nurse signed coming on and going off 07/22/22 3-11 shift, same nurse signed coming on and going off 07/23/22 3-11 shift, same nurse signed coming on and going off 07/24/22 3-11 shift, same nurse signed coming on and going off 07/25/22 3-11 shift, same nurse signed coming on and going off 07/27/22 3-11 shift, same nurse signed coming on and going off 07/28/22 3-11 shift, coming on was blank The evidence showed that licensed nursing staff failed to adhere to an acceptable standard of practice to reconcile and verify controlled substances on the aforementioned dates and shifts. During a face-to-face interview on 07/29/22, at approximately 11:10 AM, Employee #3 (Assistant Director of Nursing/ADON), reviewed the document and made no further comment. 3. Facility staff failed to complete the "Refrigerator Temperature Check Log" on the 4th Floor. Review of the Refrigerator Temperature Check Log form documented, "Each night (11-7) the refrigerator is to be checked for cleanliness, correct temperature and proper storage and labeling. Normal Temperature range is 36 to 46 degrees, if not WNL (within normal limits), adjust the thermostat, notify maintenance if needed .." During an observation on 07/28/22 at approximately 10:00 AM, of the 4th-floor	F 755		10/21/22

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F 755	Continued From page 102 medication room Refrigerator Temperature Check Log, showed the following: April 28, 2022, left blank, (no temperature log) April 29, 2022, left blank, (no temperature log) May 2, 2022, left blank, (no temperature log) June 25, 2022, left blank, (no temperature log) June 26, 2022, left blank, (no temperature log) During a face-to-face interview at the time of the observation, Employee #9 (4th Floor Unit Manager) reviewed the form and made no further comment. 4. Facility staff failed to accurately reconcile and account for controlled medications during three observations. 4a. During an observation on 07/29/22 at 11:50 AM of 3rd floor medication cart #1, the "Control Drugs Verification Count" revealed that on 07/22/22, there was no licensed staff signature on the area designated for the nurse going off-duty for the 3:00 PM -11:00 PM shift. This observation indicated that facility staff failed to ensure that all the controlled medications were accounted for on 07/22/22 for the 3:00 PM-11:00 PM shift. At the time of the observation, Employee #10 (Registered Nurse) acknowledged the finding and made no further comment. 4b. During Control Drugs Verification Count on 07/29/22 at 11:52 AM of the 3rd floor medication cart #1 with Employee #10 (Registered Nurse), it was noted that a Lorazepam (antianxiety	F 755		10/21/22

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F 755	Continued From page 103 medication) 0.5 mg (milligram) blister packet for a resident had 23 tablets. However, the narcotic book documented, "24" tablets left. At the time of the observation, Employee #10 acknowledged the finding and stated that she had administered the medication but forgot to sign it out. Employee #10 further stated, "Narcotics are supposed to be signed out right when taken out." 4c. During a medication administration observation on 08/04/22 at 9:07 AM of medication cart #1 on the first floor, a review of the "Control Drugs Verification Count sheets for medication cart #1 revealed the following: On 07/26/22 and 08/20/22, the signatures to verify the controlled drug count by two different nurses, was the signed by the same nurse. During a face-to-face interview on 08/04/22 at 9:07 AM Employee #18, (1st Floor Registered Nurse) stated that when the nurses at the facility work a double shift, sometimes the same nurse will sign in both spaces instead of getting another nurse to verify the count and sign.	F 755		10/21/22
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756	**F-756** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #100 drug regimen review was conducted on 4/7/2022 by the consulting pharmacist. The drug regimen review document for resident #100 was located in the pharmacy consulting portal on 9/28/22 and reviewed with the clinical team. A meeting was conducted on 9/28/22 attended by the pharmacy consultant and the clinical leadership team to establish the ongoing process for Drug Regimen Review and proper communication with the team. Resident #100 was reassessed head to toe by licensed nurse on 9/23/22.There were no negative findings	

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F 756	Continued From page 104 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 50 sampled residents, pharmacist failed to write a report of the recommendations for Resident #100's monthly drug regimen review. The findings included	F 756	**IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents in the facility have the potential to be affected by this deficient practice. **MEASURES TO PREVENT REOCCURANCE:** Director of Nursing/designee will educate the pharmacy consultant and the Assistant Director of Nurse's and Unit managers to ensure that drug regimen reviews are completed monthly, that the pharmacy consultant shares any recommendations immediately to the DON/ADON/QA nurse and that the physician will address all pharmacy consultant recommendations and document in the resident medical records on the rationale for either accepting or rejecting the pharmacy consultant recommendations. This will be completed 09/28/22. **MONITORING CORRECTIVE ACTION:** The DON/designee will complete a house wide audit starting in September 2022 to ensure all drug regimen reviews written by the pharmacy consultant have been received and reviewed by the physician/ Medical Director immediately. This audit will be completed weekly x 4 weeks and monthly x 3 months. All findings will be corrected upon discovery. Result of findings will be presented to Quality Assurance Performance Improvement Committee for review and recommendations for a period of 3 months.	10/21/22

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F 756	Continued From page 105 Resident #100 was admitted to the facility on 10/03/01 with multiple diagnoses that included: Psychotic Disorder, Dementia with Behavioral Disturbances, Major Depressive Disorder and Type 2 Diabetes Mellitus. Review of Resident #100's medical record revealed an Annual Minimum Data Set (MDS) dated 06/14/22 that showed facility staff coded the following: intact cognition, presence of verbal behaviors directed towards others that occurred 3-4 days; active diagnoses of Non-Alzheimer's Dementia; received antipsychotic medications and GDR (gradual dose reduction) clinically contraindicated on 06/09/22. Review of the monthly "Pharmacy Drug Regimen Review" from July 2021 to July 2022 revealed that on 12/18/21 and 04/07/22, the consultant pharmacist documented, " ... Recommendations given to the IDT (interdisciplinary team) ..." and electronically signed the forms. However, there is no documented evidence that the consultant pharmacist wrote a separate report that communicated the identified recommendations to the IDT. During a face-to-face interview conducted on 08/03/22 at 4:30 PM, Employee #2 (Director of Nursing) stated, "I just spoke to the pharmacist and she stated that she did not send the recommendations for those months (December 2021 and April 2022. What we provided are the only ones she (pharmacist) sent."	F 756		10/21/22
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761	**F-761** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Resident #146 expired on 7/22/22. The facility cannot retroactively correct this deficiency. The medications for resident #146 were properly disposed off on 7/28/22.	

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F 761	Continued From page 106 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 50 sampled residents, facility staff failed to properly store expired medications for one resident that was discharged from the facility. Resident #146 The findings included: During an observation on 07/28/22 at 12:50 PM of the second-floor nursing station, a large grey plastic bin was observed on the floor, under a desk surrounded by debris. The grey bin contained multiple blister packets of the following	F 761	**IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All discharged residents can be affected by this deficiency **MEASURE TO PREVENT REOCURRENCE:** Staff Educator/Designee will provide education to all licensed nursing staff to ensure proper storage and disposal of expired medications of discharged residents immediately. This will be completed by 10/21/22. **MONITORING CORRECTIVE ACTION:** Unit Managers/Designee will conduct a house wide audit of all nursing units to ensure that no medications are stored improperly and expired medications are disposed off immediately for residents who are discharged. This will be conducted weekly times four (4), then monthly times three (3). Results will be submitted to the QAPI committee for reviewed and recommendations.	10/21/22

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F 761	Continued From page 107 medications for Resident #146: Vitamin b-12 (Vitamin Supplement)1000mg/tab Gabapentin (Anticonvulsant) 100 mg capsule Vit C (Vitamin Supplement)500mg Tab Acetaminophen (Analgesics and Antipyretic) 500mg tab Albuterol (Bronchodilator) Lidocaine (Local Anesthetics) 5% patch Aspirin (Nonsteroidal anti-inflammatory Drugs) 81 mg Tab Review of the facility's administrative records showed that Resident #146 expired on 07/22/22 at 8:30 PM. The evidence showed that facility staff failed to ensure that the resident's medications were stored properly. An interview was conducted at the time of observation with Employee #11 (Second floor Unit Manager) who stated, "He (Resident #146) went to the hospital and some of these medications are expired. I will take care of it."	F 761		10/21/22
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791	**F-791** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #87 was provided dental service consultation on 9/28/2022. Resident was reassessed from head to toe by 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 by this deficiency.	

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F 791	Continued From page 108 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. 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 assist a resident in obtaining routine dental care. The findings included:	F 791	**MEASURES TO PREVENT RECURRENCE:** Staff Educator/Designee will provide education/in-service to licensed nurse and certified nursing assistants on proper care of residents with dentures, providing routine dental care for all residents, and reporting of missing or damaged dentures to initiate dental referrals as appropriate. Staff Educator/Designee will educate the MDS staff on proper and accurate completion of the MDS Assessment- Section L (Oral and Dental Status). This will be completed by 10/21/2022. Staff Educator/designee will educate licensed nurses to complete oral and dental assessment on admission, quarterly and annually. Facility oral assessment will be completed by 10/21/2022. Unit Managers will conduct a house wide oral assessment of all residents to ensure that no additional dental services are required. Referrals will be made as appropriate based on the findings by 10/21/22. Unit Managers/Designee will conduct a house wide audit of all residents with dentures to ensure that dentures are in place, and not damaged and that routine dental care is provided. Referrals will be made as appropriate based on the findings by 10/21/22. Medical Records/Designee will conduct a house wide audit to ensure that residents are scheduled for annual/as needed dental examinations. Referrals will be made as appropriate based on the findings by 10/21/22. MDS Coordinator/Designee will conduct a house wide audit to ensure that the MDS Assessment – Section L (Oral and Dental Status) is completed accurately and timely. Findings will be corrected upon discovery.	10/21/22

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F 791	Continued From page 109 Resident #87 was admitted to the facility on 07/18/14 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Left Non-Dominant Side, Type 2 Diabetes Mellitus Without Complications, and Unspecified Lack of Coordination. During an initial tour observation and resident interview on 07/27/22 at 9:53 AM, Resident #87 reported that she wanted to see a dentist. When asked if she let the staff know that she needed a dental appointment, she stated 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 resident stated she was still waiting for some kind of follow-up appointment. During the interview, the surveyor observed a container for dentures on the resident's nightstand beside the resident's bed. The resident grabbed the container and opened it to show the surveyor that the container was empty. A review of Resident #87's medical record revealed: A Quarterly Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded Resident #87 in the following: a Brief Interview for Mental Status (BIMS) Summary Score of "12", indicating mild cognitive impairment; independent with eating and Section L (Oral/Dental status) was left blank. 09/02/2021 [Physician's Order] directed: "Consults: Dental consult and treat as needed "	F 791	**MONITORING CORRECTIVE ACTION:** Unit Managers will conduct a house wide oral assessment of all residents to ensure that no dental services are required. This audit will be completed weekly x four (4) and monthly x three (3). Referrals will be made as appropriate based on the findings by 10/21/22. Unit Managers/Designee will conduct a house wide audit of all residents with dentures to ensure that dentures are in place. and not damaged and that routine dental care is provided. This audit will be completed weekly x four (4) and monthly x three (3). Referrals will be made as appropriate based on the findings by 10/21/22. Medical Records/Designee will conduct a house wide audit to ensure that residents are scheduled for annual/as needed dental examinations. This audit will be completed weekly x four (4) and monthly x three (3). Referrals will be made as appropriate based on the findings by 10/21/22. MDS Coordinator/Designee will conduct a house wide audit to ensure that the MDS Assessment – Section L (Oral and Dental Status) is completed accurately and timely. This audit will be completed weekly x four (4) and monthly x three (3). Findings will be corrected upon discovery. All findings will be reported to the QAPI Committee for review and recommendations.	10/21/22

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F 791	Continued From page 110 11/30/21 "Dental Consultation Note" documented, "In office treatment, ready to schedule..." Care Plan reviewed on 06/09/22 with the focus area: "[Resident #87] has dental related to denture use. Resident has partial upper and partial lower dentures...will be provided with denture care x 90 days...Examine dentures for any signs of cracks or rough edges. Provide for repair/refit as necessary; Dental consult per facility policy and prn, Follow-ups and evaluation of denture wearing done at regular intervals..." A review of Resident #87's medical record lacked documented evidence that the resident had any scheduled dental appointments or consults since 11/30/21. During a face-to-face interview on 07/27/22 at approximately 10:00 AM, Employee #8, Certified Nurse Assistant (CNA), reported 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 #2, Director of Nursing (DON), and Employee #3, Assistant Director of Nursing (ADON), stated that the facility has a dentist who sees residents for appointments in the facility. Employee #2 said that she was unsure how often the appointments were, especially during COVID-19 outbreaks. Employees #3 stated that she believed Resident #87 had dentures in her room and she would look into it.	F 791		10/21/22
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804	**F-804** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Resident #67 and Resident #87 have no negative outcome. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.** All residents have the potential to be affected by this deficient practice.	

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F 804	Continued From page 111 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, facility staff failed to ensure a resident's food was palatable. Resident #67. The findings included: During a face-to-face meeting with Resident Council members on 07/28/22 at 2:30 PM, the residents stated, "The meals are cold, the food does not represent community preferences, we get cereal with no milk, pancakes without syrup, and tea bags with no hot water." During an observation on 08/05/22 at 10:00 AM, Resident #87 was observed sitting in front of her breakfast tray. The breakfast plate had pancakes that were untouched. Resident #87 stated, "Who eats pancakes without the syrup." During a face-to-face interview on 08/05/22, at the time of the observation, Employee #22 (Certified Nurse Aide) stated that the facility did not have any syrup to provide to the residents.	F 804	**MEASURE TO PREVENT REOCURRENCE OF DEFICIENT PRACTICE:** The Administrator will provide education on how to complete a full menu order to ensure the availability of all needed components for each meal. This will be completed by 10/21/22. Food Service Director/Designee will provide education to food service staff on the importance of preparing meals at an acceptable temperature and having all the essential components of the meals and available to the residents during meal time. This will be completed by 10/21/22. Food Service Director will educate the food service staff to take stock of meal supplies when creating the menus for the residents to ensure that what is needed is available to complete meals. This will be completed by 10/21/22. Administrator/Designee will conduct random satisfaction surveys to get resident input on meal satisfaction during resident council, weekly x 4 weeks. **MONITORING CORRECTIVE ACTION:** Food Service Director will conduct house wide random audit of meals to ensure that prepared meals are at an acceptable temperature and have all the essential components of the meal and available to the residents during meal time. This will be completed weekly x four (4) then monthly x three (3). Results of the findings will be presented to the QA committee for review and recommendations monthly x 3.	10/21/22
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	**F-812** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** No residents were affected by this deficient practice. Flat top grill, two convection ovens, 2 grease fryers are in working condition. The gas stove has been fully cleaned and is now on a routine cleaning schedule.	

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F 812	Continued From page 112 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 135 degrees Fahrenheit (F) on one (1) of six (6) observations. The findings include: 1. During a food test tray assessment on July 26, 2022, at approximately 1:30 PM, hot foods such as ham (125 degrees Fahrenheit), tested below the minimum required temperature of 135 degrees Fahrenheit (F). 2. Food preparation equipment such as one (1) of one (1) flat top grill, two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, and one (1) of one (1) gas stove, were soiled with burnt food residue.	F 812	**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:** Food service director will conduct an in- service to all kitchen staff on the preparation, storage, distribution and serving resident meals in accordance with professional and regulatory standards. Food Service Director will in-service all kitchen staff to ensure equipment in the kitchen is in sanitary conditions. All equipment will be assessed daily for proper functioning and if repair is required it will be communicated to the food service and maintenance Directors by 9/28/22. Food Service Director will conduct an in- service to Food service staff to take food temperatures before putting it on the food truck and log it. Findings will be discussed during At Risk weekly x 4 weeks. **MONITORING CORRECTIVE ACTION:** Food Service Director/Designee will conduct a house wide audit of all kitchen equipment for cleanliness x 4 weeks and results brought to At Risk meeting weekly 4. Administrator/Designee will conduct random temperature of food when it arrives on the floor weekly x 4 weeks. Findings will be brought to the AT Risk weekly x 4 weeks. Audit findings will be reported to the QAPI committee for review and recommendations monthly x 3 months.	10/21/22

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INSPIRE REHABILITATION AND HEALTH CENTER LLC	2131 O STREET NW WASHINGTON, DC 20037

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F 812	Continued From page 113 Employee #12 and/or Employee #13 confirmed the findings at the time of observation. F 842 SS=D Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 812	**F-842** F 842 **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #71 correct date of birth was recorded in the facility medical records on 10/21/22. The facility obtained the resident's official Date of Birth from a Federal Agency – Social Security Office. There were no negative outcomes as there were no interruptions on the resident #71's care service delivery. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All facility residents have the potential to be affected by this deficient practice. **MEASURES TO PREVENT REOCURRENCE:** Business office Manager conducted a facility wide audit on 9/23/2022 to ensure all resident birth dates are accurate based on information provided by resident or their responsible party on admission. Facility Administrator/designee to in-service the Business Office Manager to coordinate with resident, responsible parties or legal guardian on the importance of having an accurate date of birth in resident records. The Business office Manager will conduct an audit on all new Admissions/readmissions during initial IDT to ensure there are no discrepancies in birth dates. The business office manager will complete an audit weekly x 4 and monthly x 3 on new admissions and readmissions. **MONITORING CORRECTIVE ACTION:** Findings will be reported to the QAPI committee for review and recommendations monthly x3 months.	10/21/22

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F 842	Continued From page 114 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 50 sampled residents facility staff failed to maintain medical records in accordance with accepted professional standards as evidenced by not accurately documenting the date of birth. Resident #71.	F 842		10/21/22

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F 842	Continued From page 115 The findings included: 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. Review of the electronic health record revealed that Resident #71's date of birth was documented as "06/01/1902" and age "120". This was noted to be documented on the face sheet and on every section of the resident's record where there is a section to record date of birth. Review of a letter from Resident #71's legal guardian dated 07/23/20 stated the following " ...I am the Court appointed guardian for... [Resident #71] and am writing regarding a discrepancy pertaining to her date of birth. Upon information and belief.. [Resident #71's] correct date of birth is October 1, 1930... Kindly accept the nursing homes' current use of both dates of birth until such time as correct documentation might become available to eliminate the discrepancy..." Review of the both the electronic and paper medical record showed Resident's date of birth documented 06/01/1902, no other dates were in the record. The evidence showed that facility was made aware of the discrepancy but never corrected Resident #71's date of birth. During a face-to-face interview conducted on 08/05/22 at 12:19 PM, Employee #21 (Medical Records) acknowledged the findings and made no further comment.	F 842		10/21/22

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	**F-880** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #71 and resident #110 was reassessed head to toe by licensed nurse on 9/23/22. Residents suffered no negative outcomes as evidenced by no abnormal vital signs, and no abnormal signs or symptoms of infection. Employee #15 (Housekeeping) was educated on 09/26/2022 on appropriate use of personal protective equipment that is Face shield or googles in resident care areas. No resident was affected by the deficient practice of employee #26 (Registered Nurse). Employee was educated on 09/26/2022 on the importance of performing hand hygiene, disinfecting surfaces during wound care and proper disposal of biomedical waste to break the chain of possible infection. No resident was affected by this deficient practice of employee #25 (certified nursing assistant). Employee was educated on the importance of performing hand hygiene before feeding residents. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** Facility residents that are COVID-19 negative have the potential to be affected by this deficient practice. Residents have the potential to be affected by deficient practices procedures and protocols for infection control not followed by employee #26, #25, #15. No other residents had negative outcomes based on head to toe assessment of all residents on 9/23/22 by the licensed nurse as evidenced by no abnormal vital signs and no abnormal signs and symptoms of infection.	10/21/22

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F 880	Continued From page 117 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, for two (2) of 50 sampled residents, the facility staff failed to follow standards of transmission-based precautions to prevent the spread of infection as evidenced by: failure to perform hand hygiene prior to providing direct care for one resident; not following infection control practice after providing wound/dressing care for one resident; not wearing appropriate personal protective equipment (PPE); not reviewing and updating its "COVID-19 Testing for	F 880	**MEASURE TO PREVENT REOCURRENCE:** COVID-19 Policy and procedures will be reviewed and revised by 10/14/2022 or at the Infection Control Committee Meeting during the QAPI meeting. EVS/designee will complete an audit to ensure all housekeeper staff understands proper donning and doffing of PPE in resident care areas and performing proper hand washing by 10/21/22. Ongoing in-service and random audits of housekeeping staff by the EVS director will be conducted monthly during the monthly housekeeping staff meeting. The Infection Preventionist/designee will educate employees on updated CDC guidance of donning and doffing of personal protective equipment in resident care areas by 10/21/22. Staff educator/designee will complete audit by 10/21/22 to ensure clinical staff have completed their competencies on infection control. **MONITORING CORRECTIVE ACTION:** The Director of EVS will conduct audits weekly x 4, the monthly x 3 of all EVS staff in resident care areas to ensure compliance with facility PPE policy are adhered. DON/designee will conduct weekly x 4 then monthly x 3 to ensure clinical staff are performing hand hygiene in accordance with state guidance. Findings of this audit will be discussed in QA meeting for 3 months to ensure compliance. QA committee will determine the need for further audits and actions. All negative findings will be corrected by 10/21/2022.	10/21/22

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F 880	Continued From page 118 residents' staff, visitors and volunteers" policy at least annually. Residents' #71 and #110. The findings included: 1. The facility staff failed to perform hand hygiene prior to engaging in direct resident care of Resident #71. 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 a dining observation conducted in Resident #71's room on 07/27/22 at 1:15PM, Employee #25 (Certified Nurse Aide) was observed placing the resident's lunch tray on the bedside table and then lifting a mat that was on the floor. Employee #25 then proceeded to lift the cover off the resident's tray to begin feeding the resident. The employee was stopped by the surveyor. Review of the Quarterly Minimum Data Set (MDS) dated 06/01/22 revealed that the facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score "08" indicating moderately impaired cognition and required one-person physical assist for eating. During an interview conducted at the time of observation, Employee #25 stated, "I know. I will wash my hands." 2. Facility staff failed to maintain infection control	F 880		10/21/22

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F 880	Continued From page 119 practices during Resident #110's wound care. Resident #110 was admitted to the facility on 11/16/17 with several diagnoses that include Pressure Ulcer of the Sacral Region Unstageable, Non-pressure Chronic Ulcer of the Ankle, and Diabetes Mellitus. During wound care observation on 08/01/22 at 11:22 AM, Employee #26 (Registered Nurse) failed to disinfect the resident's over bed table prior to placing clean wound dressing supplies on the table. In addition, Employee #26 discarded the biomedical waste (soiled gauze and bandages) in a regular trashcan. During a face-to-face interview on 08/01/22 at approximately 12:00 PM, Employee #26 stated, "I understand" when asked about not disinfecting the overbed bedside table and not discarding used and old dressing supplies in the biohazard container. It should be noted that the soiled utility room had a biohazard container for discarding of biomedical waste. 3. Employee #15 (Housekeeper) failed to wear appropriate personal protective equipment (PPE) while in a resident care area. During an observation on 07/26/22 at 2:43 PM, Employee #15 was noted not wearing a face shield or goggles while performing her duties on the 4th floor, the facility's designated COVID-19 floor.	F 880		10/21/22

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F 880	Continued From page 120 During a face-to-face interview conducted at the time of the observation, Employee #15 stated, "I took it [face shield] off when I went to the bathroom and forgot to put it back on." 4. Facility staff failed to review and update its "COVID-19 testing for Residents, Staff, Visitors and Volunteers" policy at least annually. During a review of the facility's Infection Control and Prevention Policies and Procedures on 08/04/22 at 11:25 AM with Employee #2 (Director of Nursing/DON) and Employee #3 (Assistant Director of Nursing/ADON), it was noted that their "COVID-19 testing for testing for Residents, Staff, Visitors and Volunteers" had a revised date of "9/14/2020" documented on it. At the time of the observation, both Employees #2 and #3 acknowledged the finding and made no further comment.	F 880		10/21/22
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the	F 882	**F-882** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Facility Director of Nursing was designated as the Infection Control Preventionist (ICP) as of 9/25/22 for the facility. The Director of Nursing completed the Infection Control and Prevention certification on 9/25/22. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice.	

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F 882	Continued From page 121 facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to have a qualified Infection Preventionist (IP) who completed specialized training in infection prevention and control. The findings included: During a face-to-face interview conducted on 08/04/22 at 12:47 PM, Employee #3 (Assistant Director of Nursing/ADON), the facility's designated Infection Preventionist (IP), revealed that she had not completed the specialized training in infection prevention and control. Employee #3 stated, "I am working on completing the infection prevention and control course."	F 882	**MEASURES TO PREVENT REOCURRENCE:** Facility Administrator will ensure there is always a certified Infection Preventionist on staff. The QA Nurse and ADON has been identified to also complete the CDC infection Control Certification training 11/30/2022. **MONITORING CORRECTIVE ACTION:** Report will be presented to the QA committee monthly x 3 months for recommendations.	10/21/22
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility	F 908	**F-908** **CORRECTIVE ACTION FOR AFFECTED AREA:** Gas burners, broken grease fryer, broken food warmers were repaired on 9/23/2022 Damaged strip curtains at the loading dock was repaired on 9/23/2022. **IDENIFICATION OF OTHER EQUIPMENT WITH THE POTENTIAL TO BE AFFECTED:** All equipment has the potential to be affected by this deficient practice	

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F 908	Continued From page 122 staff failed to maintain essential equipment in safe condition as evidenced two (2) of four (4) gas burners that failed to light up when tested, one (1) of two (2) broken grease fryer, one (1) of two (2) ford warmers with a missing temperature indicator, and damaged strip curtains at the loading dock entrance/exit door. The findings include: During a walkthrough of the facility's kitchen on July 26, 2022, at approximately 9:30 AM: 1. Two (2) of four (4) burners from the gas stove did not illuminate when tested. 2. One (1) of two (2) grease fryers was inoperative. 3. One (1) of two (2) food warmers (top one) was missing a temperature set knob. 4. Strip curtains mounted to the back door (loading dock) to limit the movement of pests and contaminants were torn throughout. Employee #12 and/or Employee #13 confirmed the findings at the time of observation.	F 908	**MEASURES TO PREVENT REOCURRENCE OF DEFICIENT PRACTICE:** Facility Administrator will educate the Maintenance Director on the importance of rounding and communicating with other departments on a daily basis to ensure equipment are in workable condition. Maintenance Director will complete an audit on rounding and identifying malfunctioning tools. **MONITORING CORRECTIVE ACTION:** Finding will be presented to the QA committee meeting for review and recommendations x 3 months.	10/21/22
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921	**F-921** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** The doorknob for Resident # 71's door was fixed on 7/26/2022. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this alleged deficient practice.	

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F 921	Continued From page 123 Based on observation, record review and staff interview, for one (1) of 50 sampled residents, facility staff failed to provide a safe and functional environment for Resident #71, as evidenced by there being no doorknob on the interior side of resident's room door. The findings included: 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, the surveyor noted that there was no doorknob present on the interior of the door, that is the entrance and exit to the resident's room. Employee #11 (Second Floor Unit Manager) was present during the observation. Review of the resident's medical record: Review of the Quarterly Minimum Data Set (MDS) dated 06/01/22 revealed that the facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of "08", indicating moderately impaired cognition; required extensive assistance with 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	F 921	**MEASURE TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** Facility Maintenance department completed a house wide audit of resident rooms door knobs. Facility Administrator/designee to educate Maintenance Director on the importance of maintaining a safe environment by doing weekly rounds and audits to ensure resident environment is safe and functional on 9/23/22. Staff Educator/designee to educate all staff on timely submission of request for identifying unsafe and non functional equipment or furniture by 10/21/22. The Staff Educator/designee will in-service staff on the importance of timely reporting of any maintenance issues by 10/21/22. The Maintenance director to complete house wide audits to ensure compliance of safety standards weekly x 4 and monthly x 3 **MONITORING CORRECTIVE ACTION:** Finding will be presented to the QA committee for review and recommendations x 3 months.	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 921	Continued From page 124 "Maintain a safe environment.." During a face-to-face interview conducted on 08/03/22 at 12:57 PM, Employee #14 (Director of Maintenance) acknowledged that there was no doorknob to Resident #71's room and stated, "We went and replaced it (doorknob to Resident #71's room) on Saturday (07/30/22) and it was not to my satisfaction, it was loose."	F 921		10/21/22