INSPIRE
REHABILITATION & HEALTH CENTER

Sent via email: 10/26/2022

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

Dear Ms. Cooper,

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

Please accept this letter and Plan of Correction as part of our compliance. If you have any questions or need additional information, please free to contact me at my office number on 202-785-2577 ext. 6203 or on my cellular number which is 301-326-0039.

Sincerely,

Andrea Brown
Licensed Nursing Home Administrator
Inspire Rehabilitation and Health Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0001	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) COMPLETE DATE
L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility on July 26, 2022 - August 5, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 166 and the survey sample included 50 residents. The following complaints were investigated during this survey: DC00010454, DC00010664, DC00010690, DC00010697, DC00010814, and DC00010865. The following Facility Reported Incidents were investigated during this survey: DC00010090, DC00010263, DC00010283, DC00010303, DC00010308, DC000010353, DC00010448, DC00010411, DC00010450, DC000100501, DC00010592, DC00010639, DC00010667, DC00010669, DC00010801, DC00010687, DC00010285, DC00010421, DC00010633, and DC00010849. Federal and/or Local deficiencies were cited related to the investigation(s) of : DC00010664, DC00010690, DC00010865, DC00010303, DC00010308, DC00010448, DC00010411, DC00010592, DC00010450, DC00010501, DC00010592, DC00010639, DC00010667, DC00010801, DC00010849, DC00010687, DC00010285, and DC00010421. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the	L 000	**Inspire Rehabilitation and Health Center Disclaimer:** The facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Departments' directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or admission of any wrong doing.	10/21/22

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report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)

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L 000	Continued From page 2 M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		10/21/22
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any	L 051	**L-051** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** 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.	

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L 051	Continued From page 3 required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for six (6) of 50 sampled residents, facility's staff failed to review plans of care for appropriate goals, approaches and revisions as needed. Residents #71, #87, #90, #414, #84 and #312. 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..." 1. Facility staff failed to review 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.	L 051	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. 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 #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, 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. **MEASURES TO PREVENT REOCURRENCE:** Staff educator/designee will educate the IDT 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

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L 051	Continued From page 4 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, of Resident #71's, the surveyor observed three trash cans, three 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..." 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	L 051	**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. **L 051** **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 30 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.	10/21/22

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L 051	Continued From page 5 Floor Unit Manager) acknowledged the finding and made no further comment. 2. Facility staff failed to review Resident #87's dental care plan. 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 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	L 051	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 **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 for review and recommendations for a period of 3 months. Any concerns will be addressed at the time of discovery.	10/21/22

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L 051	Continued From page 6 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..." Review of Resident #87's medical record lacked documented evidence that facility staff reviewed the goals and approaches in the resident's dental care plan. During a face-to-face interview on 07/27/22 at approximately 10:00 AM, Employee #8, the assigned Certified Nurse Aide 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 #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. 3. Facility staff failed to review 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,	L 051		10/21/22

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L 051	Continued From page 7 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 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.	L 051		10/21/22

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L 051	Continued From page 8 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 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 review 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. 4. Facility staff failed to review 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	L 051		10/21/22

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L 051	Continued From page 9 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Generalized Muscle Weakness, and Dysphagia. 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 ..." Review of Resident #414's medical record lacked documented evidence that facility staff conducted	L 051		10/21/22

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L 051	Continued From page 10 weekly wound rounds as specified in the care plan. 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. 5. Facility staff failed to review 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 (status post) 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 (rule-out) 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	L 051		10/21/22

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L 051	Continued From page 11 Tool] "Situation ... unwitnessed fall ..." 12/13/21 [Physician's Order] "Check bed alarm on [the] resident bed and ensure bed alarm is 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 review the care plan intervention of having a bed alarm for Resident #84. 6. Facility staff failed to revise the comprehensive care plan for Resident #312 to include the resident's risk for falls. Review of the policy "Mobility and Falls/Fall with Injury Prevention," revised in May 2022,	L 051		10/21/22

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L 051	Continued From page 12 documented, "...Update care plan to reflect new interventions..." 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..." Resident #312 was admitted to the facility on 07/23/21 with multiple diagnoses that included: Dementia without Behavioral Disturbances and Hypertension. Review of Resident #312's medical record revealed the following: 07/23/21 [Physician's Order] "Precautions: fall 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	L 051		10/21/22

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L 051	Continued From page 13 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 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.	L 051		10/21/22
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and	L 052	**L 052** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #90 had an Elopement Assessment completed, SBAR on 7/9/2022 and care plan updated on 7/10/2022. There are no negative findings. The resident was discharged on 7/13/2022.	

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L 052	Continued From page 14 rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help.	L 052	**IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents at risk for elopement have the potential to be affected. **MEASURE TO PREVENT REOCCURRENCE:** 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 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. 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. 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. Staff Educator/Designee will provide education for MDS, activities, and social services to ensure that sections B, C, D, E and F are completed accurately and consistent with the resident's condition.	10/21/22

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L 052	Continued From page 15 This Statute is not met as evidenced by: Based on observations, record reviews, and staff interviews, for four (4) of 50 sampled residents, facility staff failed to ensure sufficient nursing time was given to each resident to ensure: adequate assessment and monitoring of one resident to prevent elopement; one resident's room was free from clutter and hazards; one resident received necessary care and services to maintain good personal hygiene. Residents' #90, #71, #86 and #146. 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 care 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..." 1.1. 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.	L 052	**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. **L 052** **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 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. Staff Eduacator/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.	10/21/22

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L 052	Continued From page 16 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..." 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	L 052	Staff Educator/Designee will provide education for MDS, activities, and social services to ensure that sections G, B, C, D, E and F are completed accurately and consistent with the resident's condition. 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. **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 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 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.	10/21/22

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L 052	Continued From page 17 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 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	L 052	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 x 3 months for monitoring.	10/21/22

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L 052	Continued From page 18 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 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. The 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.	L 052		10/21/22

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L 052	Continued From page 19 Review of the resident's medical record revealed: 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 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." 3. 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. Resident #86 was admitted to the facility on 12/19/17 with multiple diagnoses that included: 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	L 052		10/21/22

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L 052	Continued From page 20 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 other resident [finger]nails as part of daily care." 4. Facility staff failed to provide a resident with treatment and 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	L 052		10/21/22

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L 052	Continued From page 21 (Unstageable). Resident #146. 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: 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 ... He 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) 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;	L 052		10/21/22

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L 052	Continued From page 22 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 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]	L 052		10/21/22

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	HFD02-0001	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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L 052	Continued From page 23 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 ... 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 his 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.	L 052		10/21/22
L 056	3211.5 Nursing Facilities	L 056		

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L 056	Continued From page 24 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, it was determined that the Nursing Facility failed to meet the four and one tenths (4.1) hours of direct nursing care per resident per day on sixteen (16) of seventeen (17) days reviewed and the 0.6 [six tenths] hour for Registered Nurses/Advanced Practice Registered Nurse hours on three (3) of the seventeen (17) days reviewed, in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: A review of Nurse Staffing was conducted on 08/05/22, at approximately 9:30 AM. Of the 17 days reviewed, 3 of the days failed to meet the 0.6 [six tenths] hours of direct nursing care per resident day for Registered Nurse/APRN [Advanced Practice Registered Nurse] as follows: February 9, 2022, 0.59 February 17, 2022, 0.45 April 4, 2022, 0.45 Of the 17 days reviewed, 16 of the days failed to meet a minimum daily average of four and	L 056	**L 056** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** No resident was affected by this deficient practice **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.** All residents have the potential to be affected by the HPPD being lower than 4.1 **MEASURE TO PREVENT REOCURRENCE:** Hiring bonuses approved and implemented, for both new hires and the referring employees. Significant raises implemented for all nursing direct care givers. Bonuses for perfect attendance implemented for all staff. Staffing needs will be evaluated daily by the staffing coordinator and leadership team. Facility utilizes a variety of multimedia help wanted services daily to receive applicants. Labor meeting on recruitment conducted weekly consisting of corporate HR, Facility HR, Administrator and others as requested. Administrator/ designee will in-service the staffing coordinator, Human Resource, DON on the need to maintain state mandated HPPD. Human Resource/designee to educate staff on attendance, offer options, and or disciplinary actions in accordance with facility policy.	10/21/22

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L 056	Continued From page 25 one-tenth (4.1) hours of direct nursing care per resident per day as follows: December 29, 2021, 2.90 December 30, 2021, 3.22 December 31, 2021, 2.93 February 17, 2022, 3.45 February 18, 2022, 3.55 February 19, 2022, 3.72 April 4, 2022, 3.87 April 5, 2022, 3.89 April 6, 2022, 3.97 July 24, 2022, 2.92 July 25, 2022, 3.40 July 26, 2022, 3.50 July 27, 2022, 3.81 July 28, 2022, 3.55 July 29, 2022, 3.16 July 30, 2022, 2.68 During a face-to-face interview on 08/05/22, at approximately 12:00 PM, Employee #32 (Staffing Coordinator) acknowledged the findings and made no further comment.	L 056	**Monitoring Corrective Action:** Staffing coordinator to conduct weekly audits on staffing issues to the weekly At Risk meeting x 4 Human Resource Director/designee to conduct weekly report on vacancies/hires to the facility Administrator.	10/21/22
L 087	3217.2 Nursing Facilities The Chairperson of the Infection Control Committee shall be knowledgeable about or have experience in infection control. This Statute 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	L 087	**L 087** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Facility currently has a certified Infection Control Preventionist as of 9/26/2022. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** No resident was affected by this deficient practice. **MEASURES TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** Facility Administrator will ensure there is always a certified Infection Preventionist on staff.	

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L 087	Continued From page 26 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."	L 087	The QA Nurse and ADON has been identified to complete the CDC infection Control Certification training 10/30/2022. **MONITORING CORRECTIVE ACTION:** Report will be presented to the QA committee monthly x 3 months for recommendations.	10/21/22
L 090	3217.5 Nursing Facilities The Infection Control Control Committee shall review infection control policies and procedures annually and revise them as needed. This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to review and update its "COVID-19 testing for Residents, Staff, Visitors and Volunteers" policy at least annually. The findings included: 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.	L 090		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental	L 091		

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L 056	Continued From page 25 one-tenth (4.1) hours of direct nursing care per resident per day as follows: December 29, 2021, 2.90 December 30, 2021, 3.22 December 31, 2021, 2.93 February 17, 2022, 3.45 February 18, 2022, 3.55 February 19, 2022, 3.72 April 4, 2022, 3.87 April 5, 2022, 3.89 April 6, 2022, 3.97 July 24, 2022, 2.92 July 25, 2022, 3.40 July 26, 2022, 3.50 July 27, 2022, 3.81 July 28, 2022, 3.55 July 29, 2022, 3.16 July 30, 2022, 2.68 During a face-to-face interview on 08/05/22, at approximately 12:00 PM, Employee #32 (Staffing Coordinator) acknowledged the findings and made no further comment.	L 056	**L 087 & L 090** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #71 and resident #110 suffered no negative outcome. 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.	
L 087	3217.2 Nursing Facilities The Chairperson of the Infection Control Committee shall be knowledgeable about or have experience in infection control. This Statute 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	L 087	**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 are not followed by employee #26, #25, #15. **MEASURE TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** COVID-19 Policy and procedures will be reviewed and revised by 10/21/2022 or at the Infection Control Committee Meeting during the QAPI meeting.	

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L 087	Continued From page 26 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."	L 087	**L 087 & L090** EVS/designee will complete and audit to ensure all housekeepers' staff understands in-services on donning and doffing PPE in resident care areas and performing hand washing. Ongoing in-service and random audits of housekeeping staff by the EVS director. The Infection Preventionist/designee will educate employees on updated CDC guidance of donning and doffing of personal protective equipment in resident care areas. Staff educator/designee will complete audit to ensure clinical staff have completed there 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.	
L 090	3217.5 Nursing Facilities The Infection Control Control Committee shall review infection control policies and procedures annually and revise them as needed. This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to review and update its "COVID-19 testing for Residents, Staff, Visitors and Volunteers" policy at least annually. The findings included: 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.	L 090		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental	L 091		

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L 091	Continued From page 27 services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, for two (2) of 50 sampled residents, the facility staff failed to implement the standards for infection control and prevention 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; and not wearing appropriate personal protective equipment (PPE). Residents' #71 and #110. The findings included: 1. The facility staff failed to perform hand hygiene before 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	L 091	**L 091** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #71 and resident #110 suffered no negative outcome. 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 are not followed by employee #26, #25, #15. **MEASURE TO PREVENT REOCURRENCE OF DEFICIENT PRACTICE:** COVID-19 Policy and procedures will be reviewed and revised by 10/21/2022 or at the Infection Control Committee Meeting during the QAPI meeting.	10/21/22

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L 091	Continued From page 28 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 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 over bed 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.	L 091	EVS/designee will complete and audit to ensure all housekeepers' staff understands in-services on donning and doffing PPE in resident care areas and performing hand washing. Ongoing in-service and random audits of housekeeping staff by the EVS director. The Infection Preventionist/designee will educate employees on updated CDC guidance of donning and doffing of personal protective equipment in resident care areas. Staff educator/designee will complete audit to ensure clinical staff have completed there 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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L 091	Continued From page 29 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. 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."	L 091		
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute 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 140 degrees Fahrenheit (F) on four (4) 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), mashed potatoes (138 degrees Fahrenheit), puree ham (136 degrees Fahrenheit), puree mashed potatoes (139 degrees Fahrenheit) tested below the minimum required temperature of 140 degrees Fahrenheit (F).	L 108	**L 108** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Resident #67 and Resident #87 have no negative outcome. **IDENTIFICATION OF OTHER RESIDENTS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. **MEASURE TO PREVENT REOCCURRENCE 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.	

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L 108	Continued From page 30 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. Employee #12 and/or Employee #13 confirmed the findings at the time of observation.	L 108	**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.	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.	L 128		

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L 091	Continued From page 29 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. 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."	L 091		10/21/22
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute 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 140 degrees Fahrenheit (F) on four (4) 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), mashed potatoes (138 degrees Fahrenheit), puree ham (136 degrees Fahrenheit), puree mashed potatoes (139 degrees Fahrenheit) tested below the minimum required temperature of 140 degrees Fahrenheit (F).	L 108	**L 108** **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. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents have the potential to be affected by this deficient practice. **MEASURE TO PREVENT REOCCURRENCE OF DEFICIENT PRACTICE:** 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 9/28/2022. 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.	

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L 108	Continued From page 30 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. Employee #12 and/or Employee #13 confirmed the findings at the time of observation.	L 108	**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
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.	L 128	**L 128** **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:** 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	

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L 128	Continued From page 31 This Statute 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 established for the account of 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	L 128	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 nurse and going off duty nurse. This will be completed by 10/21/22. **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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L 128	Continued From page 32 was blank 2. During a review of the Shift Count Narcotic 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	L 128		10/21/22

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L 128	Continued From page 33 on and going off 07/19/22 3-11 shift, same nurse signed coming 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	L 128		10/21/22

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L 128	Continued From page 34 approximately 10:00 AM, of the 4th-floor 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 medication) 0.5 mg (milligram) blister packet for a	L 128		10/21/22

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L 128	Continued From page 35 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.	L 128		10/21/22
L 134	3225.1 Nursing Facilities A medication may only be administered to a resident if it has been ordered in writing by a physician, except as provided by subsection 3225.2 This Statute is not met as evidenced by: Based on observations, record review, and staff interviews for one (1) of 50 sampled residents, facility staff failed to ensure that a resident had a physician order to receive continuous supplemental oxygen from 06/30/22 to 07/29/22 (29 days). Resident #147.	L 134	**L 134** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** After being notified,resident # 147 was given an order for continuous oxygen by MD on 7/29/2022. Resident #147 no longer resides in the facility. **INDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents residing in the facility have the potential to be affected with orders for oxygen therapy.	

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L 134	Continued From page 36 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 facility 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 inhalers, Albuterol (asthma medication) ...Attending Attestation: "...COPD exacerbation will monitor WOB (work of breathing) carefully. Rest of the plan as above." 06/30/22 at 11:29 PM [Routine Skilled Nursing Shift Note], documented " ...admitted from [Name of Local Hospital] ...List of medication and treatment reviewed with [Physician's Name] and approved ..." 07 /01/22 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	L 134	**MEASURE TO PREVENT REOCCURRENCE:** 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 residents using oxygen therapy to ensure proper physician orders are in place. Audit will be conducted weekly times four (4) then monthly times three (3). Any negative findings will be corrected by 10/21/22. Results of audits will be reviewed during QAPI monthly x 3 months for recommendations.	10/21/22

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L 134	Continued From page 37 impairment and, in Section O (Special Treatments), received oxygen therapy while a resident. A review of Resident #147's medical record lacked documented evidence that from 06/30/22 to 07/29/22, facility staff had 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 she did not enter the order for Resident #147 to receive continuous oxygen.	L 134		10/21/22
L 162	3227.13 Nursing Facilities Each medication that is no longer in use shall be destroyed or returned to the in-house pharmacy. This Statute is not met as evidenced by: Based on observation and staff interview for one (1) of 50 sampled residents, facility staff failed to properly remove expired medications to have them be destroyed or returned to the pharmacy as evidenced by the presence of a large plastic container observed under the nursing station desk that contained multiple medications for one resident. 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 medications for Resident #146:	L 162	**L 162** **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. **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 timely. This will be completed by 10/21/22.	

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L 162	Continued From page 38 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."	L 162	**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 timely 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
L 188	3230.4 Nursing Facilities Each facility shall provide the following: (a)A diversity of physical, social, intellectual, spiritual, cultural, and recreational activities; (b)Activities for bedridden residents, including, but not limited to: (1) Large print books, current magazines and periodicals; (2)A record or tape player;	L 188	**L 188** **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.	

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L 188	Continued From page 39 (3)A television; (4)A radio; (5)Craft supplies; and (6)Puzzles, games and playing cards; (c)Locked storage for recreational equipment and supplies; (d)Opportunity for interested family members and friends of residents to participate in facility activities that are specifically designed to include interested family members and friends; (e)Opportunity to participate in community activities; (f)Indoor and outdoor activities; and (g)The opportunity to implement a pet program and, if adopted, development of policies and procedures for the care and maintenance of the animals. This Statute 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	L 188	**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. The results of the audits will be reviewed during At-Risk meeting and QAPI for recommendations.	10/21/22

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L 188	Continued From page 40 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 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	L 188		10/21/22

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	HFD02-0001	A. BUILDING: _____ B. WING _____	C 08/05/2022

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L 188	Continued From page 41 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 the activities aide assigned to this unit and also check if the resident gets newspapers delivered on a daily basis."	L 188		10/21/22
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician;	L 201	**L 201** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #97 was provided with written information regarding formulating an advanced directive and the social worker reviewed this with the resident on 8/3/2022. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All residents residing in the facility has the potential to be affected. **MEASURE TO PREVENT REOCURRENCE:** The Director of Social Services/designee will complete a facility house wide audit to ensure Advance Directive instruction is given to residents and their designated RP and orders reflected in the medical record, any issues will be corrected by 10/21/22. Staff Educator/Designee will educate Social Workers on provisions to inform and provide written information to all adult residents concerning the rights to accept or refuse medical or surgical treatments and, at the resident's option, formulate an advanced directive by 10/21/22.	

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L 201	Continued From page 42 (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social	L 201	**MONITORING CORRECTIVE ACTION:** The Director of Social Work/designee will complete 100% house wide audit to ensure that Advance Directives are in place on all admissions weekly x4, then monthly x3 months to ensure the medical record reflects resident wishes in accordance with facility policy. All negative findings will be corrected by 10/21/22. Results from the audit will be discussed in the QA meeting for 3 months to ensure compliance. QA Committee will determine the need for further audits and actions All negative findings will be corrected by 10/21/22. L 201 **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #71 date of birth in facility records is inconsistent with the date of birth that was provided by the resident legal Guardian. **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 REOCCURRENCE OF DEFICIENT PRACTICE:** 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.	10/21/22

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L 201	Continued From page 43 services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 50 sampled residents, facility staff failed to provide the resident or their representative(s) with information regarding formulating an advanced directive for one resident and the facility staff failed to accurately document a resident's date of birth in the medical record for one resident. Resident #97 and #71 The findings included: 1) Facility staff failed to provide documented evidence that they provided Resident #97 or their representative with information regarding formulating an advanced directive. Review of the policy "Advance Directive" revised in February 2022 documented, "...Upon admission, Social Services staff will meet with the resident to inquire if there is an existing Advance Directive (AD)... and the right to formulate and to issue Advance Directives... provide written information to the resident... if the Resident does not have an Advance Directive and chooses not to complete one: Obtain signature on the Advance Directive status form..." Resident #97 was admitted to the facility on 03/23/22 with multiple diagnoses that included:	L 201	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. **L 201** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:** Resident #97 inventory sheet was updated on 9/19/2022. **IDENTIFICATION OF OTHER WITH THE POTENTIAL TO BE AFFECTED:** No resident was affected by this deficient practice **MEASURE TO PREVENT REOCURRENCE:** Staff development/designee will in-service nurse's/certified nursing assistants, activities department staff and social service on the importance of utilizing the personal inventory sheets to record resident personal belongings upon delivery to the facility on admission, quarterly or as belongings are brought to the facility.	10/21/22

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L 201	Continued From page 44 Type 2 Diabetes Mellitus, Muscle Weakness, Hemiplegia, and Hemiparesis. Review of Resident #97's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 06/11/22 where facility staff coded Resident #97 as having moderately impaired cognition. Care Plan Focus Area "End of Life Care/Advance Care Planning" reviewed on 06/16/22 that documented, "Goal: Resident's wishes will be known and honored through next review date..." A record review conducted on 07/26/22 at 2:47 PM revealed no documented evidence that facility staff provided Resident #97, or their representative(s) written information regarding formulating an AD. During a face-to-face interview conducted on 08/01/22 at 2:46 PM, Employee #4 (4th Floor Social Worker) reviewed Resident #97's medical record, acknowledged the finding, and made no further comment. 2) Facility staff failed to accurately document Resident #71's date of birth in the medical record. 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	L 201	**MONITORING CORRECTIVE ACTION:** Medical Records department will conduct weekly audits and report findings to the leadership team meeting x 4 weeks. Findings will be reported to the QA committee meeting monthly x 3 for recommendations.	10/21/22

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L 201	Continued From page 45 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.	L 201		10/21/22
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident;	L 204	**L 204** **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:** Resident #212, #313, #314, #363 no longer resides in the facility. Residents #87, #212, #313, #314, #133, and #363 suffered no negative outcomes from failure to obtain interviews or written statements from potential witnesses.	

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L 204	Continued From page 46 (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for six (6) of 50 sampled residents, facility staff failed to: investigate allegations of rape for one resident; conduct a thorough investigation for three residents with an injury of unknown injuries; and conduct a thorough investigation for unwitnessed falls with injury for two residents. Residents' #133, #212, #363, #313, #314, and #87. The findings included: Review of the facility's policy titled, "Investigating Incidents Process" with a revision date of March 2022, showed "... Document date and time all notifications per facility policy... Interview and or/obtain statement from person reporting allegation or suspicion ... Interview and/or obtain statement from victim/resident(s)...Interview and /or obtain statements from potential witnesses as determined by the scope of the investigation... Review materials and complete investigation...Timeline of event and investigation and notification will be documented in the resident medical record ..." Review of the policy, "Injury of Unknown Origin" revised March 2022 documented, "... Immediately a resident is identified with an injury of unknown origin, the facility will ... interview and/or obtain	L 204	Resident #51 suffered no negative outcomes from failure to report within the required time frame to the State Agency. Resident #51's incident report was reported on 4/11/22. Resident #87, #133, and #51 was reassessed by licensed nurse from head to toe on 9/23/22. There were no negative outcomes. Resident #133's went to the ER for alleged sexual abuse on 4/3/22. The results of her pelvic exam showed normal genitalia without obvious trauma. **IDENTIFICATION OF OTHERS THAT COULD HAVE THE POTENTIAL TO BE AFFECTED** All residents residing in the facility has the potential to be affected. **MEASURES TO PREVENT REOCURRENCE:** Unit managers/Designee will conduct a house wide review of the daily 24hour report and conduct walking rounds on all residents to identify any residents with suspected abuse. Any findings will be corrected by 10/21/22. Going forward a thorough investigation, including obtaining written statements from relevant potential witnesses who might have had knowledge of the occurrence will be conducted per facility policy and regulation. All alleged violations, the Administrator, Director of Nursing or designee shall notify the Department of Health, via the event reporting electronically, or by phone in the event of the electronic system being unavailable within 24 hours of knowledge of the alleged incident and within 2 hours if serious bodily has occurred or there is an allegation of abuse.	10/21/22