STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Inspire Rehabilitation and Health Center from February 27, 2019 through March 5, 2019. Survey activities consisted of a review of 55 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 165. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations 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	F 000	**INSPIRE REHABILITATION AND HEALTH CENTER DISCLAIMER.** **Facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Department's directive to change conditions which the Department alleges are deficient under state Regulations relating to long term care. This should not be construed as either a waiver of the facility's right to appeal and to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrong doing.**	5-10-19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE: 05/03/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

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
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)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550	**Corrective action for the residents affected:** 1. Resident #65's facility record was reviewed and updated to reflect resident's name choice and preference. 2. The affected Resident #65 was reassessed on 3-2-19. 3. Resident suffered no negative outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/ Designee will Complete house wide audit of residents to Identify potential resident that the facility staff failed to address by the name of choice and preference. 3. Any issue found will be addressed	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical record, facility documents and staff interview for one (1) of 55 sampled residents, facility staff failed to address the resident by the name of his choice and preference. Resident #65. Findings included ... Resident #65 admitted to the facility on 11/6/14 with diagnoses to include Epilepsy, unspecified not intractable with Status Epilepticus, Altered Mental Status, Essential (Primary) Hypertension, Acute Kidney Failure and Lymphangioma any Site.	F 550	**Measures to prevent action:** 1. Staff Development will provide education to facility staff to ensure that residents are addressed by the name of choice and preference. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to identify/address by name of choice and preference, weekly times 4 then, monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 Review of the Admission Record Face Sheet showed in the box allocated for Resident name showed [Resident# 65] and in the box allocated for preferred name showed [GJ1] (allocated boxes showed different names). An observation of Resident #65's signage (name) on his assigned room door was conducted on 3/2/19 at 10:30 AM. At this time it was observed that name listed/shown on the signage was not the resident's preferred name (showed Resident# 65). Review of the Comprehensive Minimum Data Set [MDS] dated 10/11/18 and the Quarterly Minimum Data Set [MDS] dated 1/9/19 showed Section A: Identification Information, A1300.Optional Resident Items C. Name by which resident prefers to be addressed shows [GJ1]. Further review of the medical record showed the following documents listed under the resident's preferred name [GJ1]: " Physician Orders for Life Sustaining Treatment (dated 5/27/15) " Agreement for Admissions to the Facility (dated 12/23/14) " Admission Order and Plan of Care (dated 11/6/14) " Medication Regimen Reviews Review of the following of the medical record showed the following documents listed under the resident's name [Resident# 65]:	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 " Progress Notes " Nursing Care Plans " Pain Assessments " Situation, Background, Assessment, Recommendation [SBAR] Communication Forms " Discharge Summary (post-hospitalization) On 3/2/19 at 1:00 PM, the writer observed resident standing in the hallway, the writer approached the resident and stated his preferred name (GJ1) and then stated the name (Resident #65) and the resident did not respond or answer any questions. Observation on 3/2/19 at 2:00 PM showed medications stored in the medication cart has packets of medications with the resident's name [Resident# 65]. Further review of the medication administration record and the treatment administration record showed in the space allocated for Resident name both the resident's name [Resident# 65] and preferred name [GJ1] are listed (preferred name was in parentheses). During an interview on 3/2/19 at 2:30 PM Employee# 13 stated we are working to resolve the issue it's complicated but the administrators know about the issue and the staff call him Mr. [Resident#65] his room is [XXX]. During an interview on 3/2/19 at 2:30 with Employee # 1, Administrator at 3:00 PM, the Administrator acknowledged the finding and states this has been a problem for the past five years and the Ombudsman is aware of the problem we are working on changing the documents so all of the facility documents have	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6 the same resident name. Facility staff failed to maintain all facility documents with the resident's preferred name to ensure an accurate and systematically organized medical record in accordance with accepted professional standards and practices. During an interview on 3/2/19 at 2:30 PM Employee #1 acknowledged the finding at the time of the review.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584	**Corrective action for the residents affected:** 1. The lens covers of ceiling light sensor in the identified room #315C/D and room #515C/D were replaced on 2-27-19. 2. The remote bed controllers of the identified resident's rooms #110 and #210 were replaced on 2-27-19. 3. The eight (8) Isosource identified were Discarded on 2-27-19. 4. Marred walls, doors and ceilings in resident's Room #101: Bathroom door Room #113: Bathroom ceiling Room # 115 A/B: Bathroom ceiling Room #120: Bathroom ceiling and walls Room #215 C/D: Walls Room #216: Bathroom walls Room #310: Room ceiling Room #316: Bathroom walls Room #519: Walls behind bed Room #520: Room ceiling were all corrected on 2-27-19. 5. The identified floor tiles next to the Dishwashing machine in the main kitchen Were replaced on 2-27-19. 6. Dishwasher machine in he main kitchen was replaced on 2-27-19.	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by ceiling light sensor switches without a lens cover in two (2) of 46 resident's rooms, frayed remote bed controllers in two (2) of 46 resident's rooms, eight (8) of 28 expired Isosource 1.5 Cal, 250 ml nutritional drinks, marred walls, doors and ceilings in 10 of 46 resident's rooms and broken floor tiles next to the dishwashing machine. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM the following observations were made: 1. Ceiling light sensor switches located in two (2) of 46 resident's rooms, did not have a lens cover. (Room #315 C/D and room #515 C/D).	F 584	7. Residents suffered no negative outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. An inspection was done **throughout** the facility by the Director of Housekeeping/ Designee and Director of Maintenance/ Designee to ensure that: a. Ceiling light sensor switches located in residents' rooms have lens cover. b. The electrical wires to remote bed controllers of residents' rooms are not frayed. c. There are no expired food items in the facility. d. Ensure that there are no walls, doors and ceiling in the resident's rooms are marred. e. There are no missing or broken titles in the facility. f. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff development will provide education to facility staff to ensure that facility staff provide housekeeping services necessary to maintain a safe, clean and comfortable environment with focus on: a. Ceiling light sensor switches located in residents' rooms have lens cover	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 2. Electrical wires to remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were visible and accessible. 3. Eight (8) of 28 Isosource 1.5 Cal, 250 ml nutritional drinks were stored for use beyond their expiration date of December 16, 2018, in the clean linen room on the third floor. 4. Walls, doors and ceilings were marred in 10 of 46 resident's rooms as follows: Room #101: Bathroom door Room #113: Bathroom ceiling Room #115 A/B: Bathroom ceiling Room #120: Bathroom ceiling and walls Room #215 C/D: Walls Room #216: Bathroom walls Room #310: Room ceiling Room #316: Bathroom walls Room #519: Walls behind bed Room #520: Room ceiling 5. Floor tiles next to the dishwashing machine in the main kitchen were broken and/or missing. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 28, 2019, at approximately 3:30 PM.	F 584	b. The electrical wires to remote bed controllers of the residents' rooms are not frayed. c. There are no expired food items in the facility. d. Ensure that no walls, doors and ceiling in the resident's rooms are marred. e. Floor tiles next to the dishwashing machine in the main kitchen are not broken and/or missing. **Monitoring corrective action:** 1. An inspection will be done throughout the facility by the Director of Housekeeping/ Designee and Director of Maintenance/ Designee to ensure that facility staff provide housekeeping services necessary to maintain a safe, clean and comfortable environment weekly times 4 then monthly times 3. 2. Findings will be reported to Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641	**Corrective action for the residents affected:** 1. Resident #156 no longer reside in the facility.	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 by: Based on record review and staff interview for one (1) of 55 sampled residents, the facility staff failed to accurately code the Admission Minimum Data Set (MDS) under Section Q Discharge for Resident # 156. Findings included ... A review of the medical record for Resident #156 revealed that she was admitted to the facility on November 29, 2018, and discharged to from the facility to home on January 8, 2019. The Resident had diagnoses which include; Type 2 Diabetes Mellitus with Ketoacidosis without Coma, Hypotension, Cirrhosis of Liver, Gastro-Esophageal Reflux Disease, Acute Kidney Failure, Cognitive Communication Deficit and Pneumonitis due to Inhalation of other solids and liquids. The progress note dated December 6, 2018, at 17:50 showed the following note: "IDT (Interdisciplinary Team) Care plan conference held 12/3/18, with resident present in her room and all team members ...adjust to unit at this time she is able to make her needs known and self RP (Responsible Party) ...Resident still has plan to return to community at the end of therapy." A review of Resident # 156's Admission MDS with an Assessment Reference Date of December 6, 2018, revealed that under Section Q0300 (Resident's Overall Expectation) was coded as unknown or uncertain related to discharge to the community expectations. Q0400 (Discharge Plan) was coded as "No" indicating there is no	F 641	**Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Facility MDS Director/Designee will complete house wide audit of residents to identify potential residents facility staff failed to accurately code section Q on admission Minimum Data Set (MDS). 3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility MDS staff to accurately code section Q on admission Minimum Data Set (MDS) for residents discharge disposition. **Monitoring corrective action:** 1. Facility MDS Director/Designee will complete house wide audit of section Q of residents admission Minimum Data Set (MDS) weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10 active discharge planning already occurring for the resident to return to the community. Q0500 (Return to the Community) was coded as "No" indicating the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. There was no evidence that facility staff coded the Admission MDS to reflect Resident # 156's wishes to be discharge to the community; and to talk to facility staff regarding her returning to live in the community. During a face-to-face interview conducted on March 5, 2019, at approximately 3:00 PM with Employee #13 he stated it should have been coded for the discharge and acknowledged the findings.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655	**Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. Resident #155 no longer reside In the facility. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to develop a baseline care plan within 48 hours of the resident's admission to the facility.	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 11 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 55 sampled residents (closed record), the facility staff failed to develop a baseline care plan for Resident # 155 within 48 hours of resident's admission to the facility. Findings included.... Review of the medical record on 3/4/19 at 11:00 AM showed Resident# 155 was admitted to the	F 655	3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility staff to develop baseline care plan within 48hours of the resident's admission to the facility. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide /audit of residents to identify potential residents facility staff failed to develop baseline care plan within 48 hours of the resident's admission to the facility weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 12 facility on 12/4/18 and was discharged from the facility on 12/24/18. Review of Resident #155's Face Sheet showed that the Resident (self) was listed as the Responsible Party. Review of the medical record showed an Admission Minimum Data Set [MDS] dated 12/11/18; Section C -Cognitive Patterns: Brief Interview for Mental Status [BIMS] resident was scored as "15" which indicates resident is "cognitively intact." Section I- [Active Diagnoses] include: Atrial Flutter, Heart Failure, Hypertension, Arthritis and Asthma. Further review of the medical record failed to show evidence the facility staff developed a resident-centered baseline care plan with goals and approaches to address the care of the resident within 48 hours of admission. During an interview on 3/4/19 at 11:30 AM, Employee# 16 stated yes, I did an audit of the chart and I know the baseline care plan was not done. There was no evidence that facility staff developed a baseline care plan within 48 hours of the resident's admission to the facility. During a face-to-face interview on 3/4/19 at 11:30 AM Employee# 16 acknowledged the findings.	F 655		
			Corrective action for the residents affected:	**5-10-19**
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656	1. The affected Resient#134 was reassessed on 3-4-19, resident suffered no negative outcome. 2. The affected Resident #156 no longer Reside in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656	**Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents residents facility staff failed to: a. To ensure a resident-centered care plan with specific goals and approaches are developed for residents with Dementia. b. Ensure a focus discharge care plan with goals and approaches addressing residents wishes to live in the community after therapy is completed. **Measures to prevent Reccurrence:** 1. Staff development will provide education to the facility staff to: a. Develop a resident-centered care plan with specific goals and approaches for residents with Dementia. b. Develop a focus discharge care plan with goals and approaches to address resident wishes to live in the community after therapy is completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 Based on record review and staff interviews for two (2) of 55 sampled residents, the facility staff failed to develop a Dementia care plan for one (1) resident and failed to develop a focus discharge care plan with goals and approaches for (1) one resident who wishes to live in the community after her therapy is completed. Findings included ... 1. Resident# 134 was admitted to the facility on 2/5/19 with diagnoses which include; Essential (Primary) Hypertension, Pain Unspecified, Generalized Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Disturbance. Review of the medical record showed an Admission Minimum Data Set [MDS] dated 2/12/19; Section C-Cognitive Patterns: C0100. Cognitive Skills for Daily Decision Making (made decisions regarding tasks of daily life) "3" is selected to indicate cognition is severely impaired-never/rarely made decisions. Review of a physician telephone order dated 2/6/19 showed "psychiatric consult of medication management, diagnosis: Dementia." On 3/4/19 a review of the Behavioral Services Management Assessment sheet dated 2/11/19 showed assessment "73 year old African American Male with a history of Anxiety and Dementia is being evaluated for medication management." Behavioral Services Management Assessment sheet dated 2/25/19 showed	F 656	**Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify: a. Resident-centered care plan with specific goals and approaches for residents with Dementia. b. Focus discharge care plan with goals and approaches to address resident wishes to live in the community after therapy is completed. 2. Audits/reports will be reviewed weekly times 4, then monthly times 3months and reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15 "resident was started on Aricept for Dementia." Review of the resident care plans showed no evidence facility staff developed a care plan with specific goals and approaches to address the resident's diagnosis of Dementia. During an interview on 3/4/19 at 11:30 AM Employee# 16 stated "I know I should have a care plan for the resident's Dementia I must have missed it." Facility staff failed to develop a resident-centered care plan with specific goals and approaches for a resident with Dementia. During a face-to-face interview on 3/4/19 at 11:30 AM Employee # 16 acknowledged the findings. 2. A review of the closed record for Resident #156 revealed that she was admitted to the facility on November 29, 2018, and discharged on January 8, 2019. The Resident had diagnoses which included Type 2 Diabetes Mellitus with Ketoacidosis without Coma, Hypotension, Cirrhosis of Liver, Gastro-Esophageal Reflux Disease, Acute Kidney Failure, Cognitive Communication Deficit and Pneumonitis due to Inhalation of other solids and liquids. The progress note dated December 6, 2018, at 17:50 showed, "IDT (Interdisciplinary Team) Care plan conference held 12/3/18 with resident present in her room and all team members ...adjust to unit at this time she is able to make	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16 her needs known and self RP (Responsible Party) ...Resident still has plan to return to community at the end of therapy." A review of Resident #156's care plan on March 5, 2019, lacked evidence that facility staff developed a focus discharge care plan with goals and approaches to address Resident #156 wishes to live in the community after her therapy is completed. During a face-to-face interview on March 5, 2019, at 3:00 PM, Employee #13 acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657	**Corrective action for the residents affected:** 1. The facility cannot retroactively correct the deficiency. 2. The affected resident #135 was reassessed on 3-5-19. Resident suffered no negative outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to revise/update the care plan after change in residents pain medication. 3. Any issue found will be addressed.	**5-10-19**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 55 sampled residents facility staff failed to revise/update care plan after a change in pain medications for Resident #135. Findings included... Resident # 135 was admitted to the facility on 2/5/2019, with a diagnoses to include; Malignant Neoplasm of Prostate Ulcerative Colitis, Crohn's Disease, Depression, Asthma, Laceration Scalp, and Blindness. A review of Resident #135's Admission Nursing Home Comprehensive Minimum Data Set [MDS] dated 2/12/19, showed: Section C- Cognitive Brief Interview for Mental Status score was "15" indicating Resident #135 is cognitively intact. Section J0100 (Pain Management) showed the resident received pain medications both scheduled, PRN and indicated he was in pain at the time of the assessment. Physician's orders directed the following:	F 657	**Measures to prevent Reccurrence:** 1. Staff Development will provide education to the facility staff to revise/update the care plan after change in resident's pain medication. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to revise/update the care plan after change in resident's pain medication weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 18 2/20/2019- Tramadol (a narcotic pain medication) 50 mg 1 tablet po, every 6 hours PRN for pain- mild, moderate and severe abdominal pain. 3/4/2019 -Morphine Sulfate (Concentrate) Oral solution (a narcotic pain medication) 20mg/ml 0.025 ml po, every 4 hours PRN for dyspnea (Difficult or labored breathing; shortness of breath), for pain- mild, moderate and severe There was no evidence that the care plan was updated to include the use of opioids for treating the resident's pain. During a face-to-face interview with Employee #16 on March 5, 2019, at approximately 10:00 AM, she acknowledged the findings.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 55 sampled residents, facility staff failed to assess Resident #135's pain level prior to administering the residents narcotic medication	F 684	**Corrective action for the residents affected:** 1. The affected resident 3135 was reassessed On 3-5-19. Resident suffered no negative Outcome. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected. 2. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to assess their pain level prior to administering medication for pain and to reassess the resident to determine the effectiveness after administering the medication.	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 and failed to reassess the resident to determine the effectiveness after administering the medication. Findings included... Facility policy Titled: Policy on Pain Management..."Pain Management section", "Monitor the effectiveness of pain medication through reassessment ...Document nursing assessment, nursing intervention, behavior of resident during pain assessment; and resident response to interventions. Revised 5/30/2018" Resident # 135 was admitted to the facility on 2/5/2019, with a diagnoses to include; Malignant Neoplasm of Prostate Ulcerative Colitis, Crohn's Disease, Depression, Asthma, Laceration Scalp, and Blindness. Review Resident #135's Admission Nursing Home Comprehensive Minimum Data Set [MDS] dated 2/12/19, showed: Section C- Cognitive Brief Interview for Mental Status score was "15" indicating Resident #135 is cognitively intact. Section J0100 (Pain Management) showed the resident received pain medications both scheduled, PRN and indicated he was in pain at the time of the assessment. A review of the Physician's Progress notes showed; GI Consult "February 20, 2019 (GI)- Imp [impression] pain secondary to abdominal wall	F 684	3. Any issue found will be addressed. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to to the facility staff to assess the resident prior to administering medication for pain and to reassess the resident to determine the effectiveness after administering the medication. **Monitoring corrective action:** 1. Assistant Director of Nursing/Designee will complete house wide audit of residents to identify potential residents facility staff failed to assess their pain level prior to administering medication for pain and to reassess to determine the effectiveness after administering the medication weekly times 4, then monthly times 3 months. 2. Findings will be reported to the Quality assurance Performance Improvement committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 hernia. Only cure would be surgery which does not seem to be an option considering limited intervention. Therefore will add tramadol prn for pain to make patient more comfortable." Physician's orders directed the following: 2/20/2019- Tramadol (a narcotic pain medication) 50 mg 1 tablet po, every 6 hours PRN for pain- mild, moderate and severe abdominal pain. 3/4/2019 -Morphine Sulfate (Concentrate) Oral solution (a narcotic pain medication) 20mg/ml 0.025 ml po, every 4 hours PRN for dyspnea (Difficult or labored breathing; shortness of breath), for pain- mild, moderate and severe A review of the Medication Administration Record (MAR) revealed: February 23, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. February 25, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. February 27, 2019- Tramadol 50 mg was given to the resident however, there was no pain assessment or reassessment done. March 4, 2019- Tramadol 50 mg was given to the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 resident however, there was no pain assessment or reassessment done. March 5, 2019- Morphine Sulfate 0.25 mg was given to the resident however, there was no pain or dyspnea assessment or reassessment done. There was no evidence the facility staff consistently assessed and or reassessed the resident prior to/or after administering medication for pain to determine the residents pain level and if the narcotic given was effective. During a face-to-face interview, Employee #16 acknowledged the findings on March 5, 2019, at approximately 9:00 AM.	F 684		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842	**Corrective action for the residents affected:** 1. Resident #65 medical records, room signage and other facility documents was updated on 03-02-19 to reflect resident's preferred name to ensure accurate and systematically organized medical record in accordance with accepted professional standards and practices. 2. Resident #76 was re-assessed. Resident did not suffer any negative outcome from the identified deficient practice. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the potential to be affected.	**5-10-19**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 22 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842	2. Facility wide audit of medical records was completed 3-5-19 on resident's choice regarding name preference. 3. Facility wide audit of controlled drug record documentation was completed 3-5-19 on legible handwriting. 4. Facility narcotic utilization record has been reviewed and replaced to facilitate legible documentation. 5. Identified issues have been corrected. **Measures to prevent Reccurrence:** 1. Staff Development will provide education to facility staff on the importance of maintaining facility documents with resident's preferred name to ensure accurate and systematically organized medical record. 2. Staff Development will educate nursing staff on the importance of legible and accurate documentation on controlled drug record. **Monitoring corrective action:** 1. Social Worker/Designee will review admission face sheet information with resident family member during care conference to ensure that facility record has resident's preferred name. Review will be discussed during risk meeting weekly times 4, then monthly times 3. 2. Assistant Director of Nursing will review controlled drug record daily during clinical round to ensure that nursing staff are documenting accurately and legibly, findings will be reviewed weekly times 4, during risk meeting and reported monthly times 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 23 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for two (2) of 55 sampled residents, facility staff failed to maintain facility documents with residents preferred name for one (1) resident and to maintain a medical record that accurately documented the date and time that a controlled substance was administered to one (1) resident. Residents' # 65 and #76. Findings included ... 1.Resident #65 admitted to the facility on 11/6/14 with diagnoses to include Epilepsy, unspecified not intractable with Status Epilepticus, Altered Mental Status, Essential (Primary) Hypertension, Acute Kidney Failure and Lymphangioma any Site. Review of the Admission Record Face Sheet showed in the box allocated for Resident name showed [Resident# 65] and in the box allocated for preferred name showed [GJ1] (allocated boxes showed different names).	F 842	3. Results of audits from care conference to ensure resident's choice regarding name preference and daily clinical review on accurate controlled drug documentation will be forwarded to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24 An observation of Resident #65's signage (name) on his assigned room door was conducted on 3/2/19 at 10:30 AM. At this time it was observed that name listed/shown on the signage was not the resident's preferred name (showed Resident# 65). Review of the Comprehensive Minimum Data Set [MDS] dated 10/11/18 and the Quarterly Minimum Data Set [MDS] dated 1/9/19 showed Section A: Identification Information, A1300.Optional Resident Items C. Name by which resident prefers to be addressed shows [GJ1]. Further review of the medical record showed the following documents listed under the resident's preferred name [GJ1]: Physician Orders for Life Sustaining Treatment (dated 5/27/15) Agreement for Admissions to the Facility (dated 12/23/14) Admission Order and Plan of Care (dated 11/6/14) Medication Regimen Reviews Review of the following of the medical record showed the following documents listed under the resident's name [Resident# 65]: Progress Notes Nursing Care Plans Pain Assessments Situation, Background, Assessment, Recommendation [SBAR] Communication Forms Discharge Summary (post-hospitalization)	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 25 On 3/2/19 at 1:00 PM, the writer observed resident standing in the hallway, the writer approached the resident and stated his preferred name (GJ1) and then stated the name (Resident #65) and the resident did not respond or answer any questions. Observation on 3/2/19 at 2:00 PM showed medications stored in the medication cart has packets of medications with the resident's name [Resident# 65]. Further review of the medication administration record and the treatment administration record showed in the space allocated for Resident name both the resident's name [Resident# 65] and preferred name [GJ1] are listed (preferred name was in parentheses). During an interview on 3/2/19 at 2:30 PM Employee# 13 stated we are working to resolve the issue it's complicated but the administrators know about the issue and the staff call him Mr. [Resident#65] his room is [XXX]. During an interview on 3/2/19 at 2:30 with Employee # 1, Administrator at 3:00 PM, the Administrator acknowledged the finding and states this has been a problem for the past five years and the Ombudsman is aware of the problem we are working on changing the documents so all of the facility documents have the same resident name. Facility staff failed to maintain all facility documents with the resident's preferred name to ensure an accurate and systematically organized medical record in accordance with accepted professional standards and practices.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 26 During an interview on 3/2/19 at 2:30 PM Employee #1 acknowledged the finding at the time of the review. 2. Facility staff failed to maintain a medical record that accurately documented the date and time that a controlled substance was administered to Resident #76. Resident #76 admitted on June 7, 2012, with diagnoses which include Epilepsy, Anxiety Disorder, Schizophrenia and Chronic Pain Syndrome. According to the Physician's orders dated February 3, 2019, Resident #76 was to receive Vimpat 200 mg (used to treat partial onset of seizures) 1 tablet by mouth two times a day 9:00 Am and 5:00 PM. Review of the February and March 2019 Medication Administration Records, the resident received the medication as ordered. Review of the Resident #76's Controlled Drug Record from March 1, 2019 to March 2, 2019. showed the following entries: Date- March 1, 2019; Time- 9:00 AM; Number of medication remaining-4; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27 Date- March 1, 2019; Time- 5:00 PM; Number of medication remaining-3; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. Date- unable to read; Time- unable to read; Number of medication remaining-2; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. Date- March 2, 2019; Time- 5:00 PM; Number of medication remaining-1; nurses signature indicating that the controlled drug was removed from the drug box to administer to the resident. During the face-to-face interview on March 4, 2019 at approximately, 4:00 PM with Employee #3 and Employee #10 (the nurse who signed that she administered the medication), they show the writer the electronic Medication Administration record which indicated that Vimpat 200 mg 1 tablet was administered to the resident on March 2, 2019, at 9:00 AM. The Employees' further acknowledge that the entry written on the controlled drug record was illegible. Facility staff failed to maintain a Controlled Drug Record with an accurately documented date and time to reflect when medication was removed from the controlled drug box to administer to the resident.	F 842	**Corrective action for the residents affected** 1. Minutes of the facility Quality Assurance performance Improvement Committee meeting of March, 21,2019 was reviewed with Medical Director and his/her signature was obtained 3-7-19 for March 21,2019 Quality Assurance Performance Improvement Committee meeting after facility verified that the Medical Director was in attendance but failed to sign-in.	05-10-19
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 28 §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the quality assessment and assurance committee meeting sign-in sheets and staff interview, the facility failed to ensure the facility's medical director was present at one (1) of three (3) quality assessment and assurance meetings. The resident census on the first day of survey was 165. Findings included ... A review of the quality assessment and assurance committee meeting sign-in sheets revealed that the committee met on March 21, 2018, June 20, 2018, and September 26, 2018. After a review of the committee sign-in sheets it was noted that the medical director's signature was not on the sheet, indicating the he was not present at the meeting on March 21, 2018.	F 868	**Identification of others with the Potential to be affected:** 1. All other mandatory Quality Assurance Performance Improvement Committee members have the potential to be affected by this deficient practice. **Measures to prevent Reccurrence:** 1. The facility's Director of Quality Assurance In-serviced and educated the Medical Director on May 2, 2019 on the importance of signing the sign in sheet for the monthly Quality Assurance Performance Committee meeting when he/she is in attendance. 2. The Administrator on May 2, 2019 In-serviced the Quality Assurance Performance Improvement Committee on the importance of ensuring the Medical Director and all mandatory members of the Quality Assurance Performance Improvement Committee send a designee if the mandatory member is unable to attend. 3. The Director of Quality Assurance will audit the Quality Assurance Performance Improvement Committee signature sheet prior to the end of the Quality Assurance Performance Improvement Committee meeting to ensue all mandatory members/ designee including the Medical Director/ designee signed-in. **Monitoring corrective action:** 1. The Director of Quality Assurance or Designee will report findings of the monthly Quality Assurance Performance Improvement Committee sign-in sheet to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 29 There was no evidence that the Medical Director or his/her designee was present at the meeting to aid in the guidance of the facility's development and implementation of resident care policies and coordination of medical care. During a face-to-face interview with Employee #1 and Employee #3 on March 5, 2019 at approximately 4:00 PM, they acknowledged the findings.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880	**Corrective action for the residents affected:** 1. Resident #20, #79, #104, and #146 were assessed and none of them suffered any negative outcome. 2. Employees #5, #11, #10 have been re-educated on proper hand washing techniques with soap and water before and after care including medication administration for the purpose of decreasing spread of infection. **Identification of others with the Potential to be affected:** 1. All nursing employees have the potential to be affected by this deficient practice. 2. Assistant Director of Nursing/Designee conducted random medication pass observation no deficient findings noted. 3. Staff Development will provide education to all nursing staff on the importance of proper hand hygiene before and after care including medication administration for the purpose of decreasing spread of infection.	5-10-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880	**Measures to prevent Reccurrence:** 1. Unit managers will conduct medication pass observation of the nursing staff to ensure appropriate and hygiene is demonstrated during resident encounters. 2. Results of audits will be forwarded to the Infection Control preventionist weekly times 4 then, monthly times 3. **Monitoring corrective action:** 1. Infection Control Preventionist will present results of audits to Quality Assurance Performance Improvement Committee monthly times 3 until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that facility staff failed to maintain proper hand hygiene practices during the administration of medication for four (4) residents and testing the blood glucose level for one resident. Residents' #20, #79, #104 and #146 . Findings included... According to the Centers for Disease Control and Prevention (CDC) Guideline for Hand Hygiene in Healthcare Settings [PDF - 1.3 MB] recommends: "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." Retrieved from: https://www.cdc.gov/handhygiene/providers/index.html	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 1. Employee #5 failed to decrease the potential spread of infection by failing to wash and/or sanitize her hands prior to, during and after testing the resident's blood glucose and administering her Insulin. During a medication administration observation at approximately 10:30 AM on February 28, 2019, Employee #5 entered Resident #20's room and informed the resident that she was going to check her blood sugar level and administer her Insulin. The employee removed a pair of gloves from the resident's room and put them on her hands. The employee then sanitized the employee's fingertips, stuck the left middle finger and tested the blood glucose level after which the employee removed the gloves and discarded them along with the equipment. Employee #5 donned a new pair of gloves, sanitized the top of the Insulin bottle and drew up the Insulin. The employee then sanitized Resident #20's abdomen and administered the Insulin. The employee removed the gloves, discarded the gloves and other equipment and left the room. Employee #5 Failed to wash and/or sanitize her hands after she entered the resident's room and prior to touching the resident, prior to donning and/or removing gloves, prior to and after administering the blood test and/or the Insulin. A face-to-face interview was conducted with Employee #5 immediately after she completed the administration of the Insulin. In response to the question why she did not wash her hands prior to, during and after the procedures she	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 stated that she does not like to use the resident's sink because the resident has her personal items (tooth brush, tooth paste, mouth wash etcetera) at the sink. The employee added that she meant to put some hand sanitizer in her pocket but she forgot. Employee #14 (Manager) acknowledged that Employee #5 failed to wash and/or sanitize her hands prior to, during and after testing the resident's blood glucose and administering her Insulin during a face-to-face interview at 2:00 PM on February 28, 2019. 2. Employee #11 failed to decrease the potential spread of infection by failing to use soap when washing her hands before administering medications to Resident #79. During a medication administration observation on March 5, 2019, at approximately 1:00 PM, Employee #11 prepared medications at her medication cart outside of Resident # 79's room. After entering the room, Employee #11 introduced herself to Resident #79, explained that she was there to administer medications and placed the tray of medicine on the over-the-bed table. Employee #11 then walked to the sink (inside the resident's room), turned on the faucet, placed her hands under the water for approximately 15 seconds, turned off the faucet using paper towels, returned to the resident's bedside and administered medications. After administering the medications to the resident. Employee #11 returned to the sink, turned on the faucet, placed her hands under the water for approximately 15 seconds, turned the faucet off using paper towels and exited the resident's room.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 There was no evidence that Employee #11 used soap with the water when washing her hands. Employee #11 failed to maintained proper hand hygiene practices during the administration of medication to Resident #79. During a face-to-face interview with the Employee #11, RN, on March 5, 2019, at approximately 1:10 PM, she acknowledged the findings. 3. Employee #11 failed to decrease the potential spread of infection by failing to wash or sanitize her hands before administering medications to Resident #104. During a medication administration observation on March 5, 2019, at approximately 1:30 PM, Employee #11 prepared medications at her medication cart outside of Resident # 104's room. After entering the room, Employee # 11 introduced herself to Resident #104, explained that she was there to administer medications. The Employee then administered the medications to the resident, and then exited the resident's room without washing her hands. There was no evidence that Employee #11 washed her hands using soap and water or used hand sanitizer prior to and after administering medications to the resident. Employee #11 failed to maintained proper hand hygiene practices during the administration of medication to Resident # 104. During a face-to-face interview with the Employee	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 #11, RN, on March 5, 2019, at approximately 1:40 PM, she acknowledged the findings. 4. Employee #10 failed to decrease the potential spread of infection by failing to use soap when washing her hands before and after administering medications to Resident #146. During a medication administration observation on March 5, 2019, at approximately 8:50 AM, Employee #10 prepared medications at her medication cart outside of Resident #146's room. After entering the room, Employee # 10 explained to Resident #146 that she was there to administer medications and placed the tray of medicine on the over-the-bed table. Employee # 10 then walked into the bathroom (inside of the resident's room), turned on the faucet at the sink, ran her hands under the water for approximately 15 seconds, turned off the faucet using paper towels, returned to the resident's bedside and administered medications to Resident #146. After administering the medications to the resident. Employee #10 returned to the bathroom, turned on the faucet at the sink, placed her hands under the water for approximately 15 seconds, turned the faucet off using paper towels and exited the resident's room. There was no evidence that Employee #10 used soap with the water when washing her hands. Employee #11 failed to maintained proper hand hygiene practices during the administration of medication to Resident # 146. During a face-to-face interview with the Employee #10, LPN Preceptor, on March 5, 2019, at	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 approximately 9:00 AM, she acknowledged the findings.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by remote bed controllers with frayed electrical wires in two (2) of 46 resident's rooms. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM, remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were frayed. This deficient practice could expose the resident, staff or visitors to electrical hazards. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	F 908	**Corrective action for the residents affected:** 1. Frayed remote bed controller for resident #119 and #210 were replaced on 02-27-19. 2. No negative outcome suffered. **Identification of others with the Potential to be affected:** 1. All residents residing in the facility have the Potential to be affected. 2. An inspection was done throughout the facility by the director of Maintenance/ designee to ensure that: a. Remote bed controllers in residents' rooms are not frayed. 3. No other remote bed controller identified to be frayed. **Measures to prevent Reccurrence:** 1. Remote bed controllers will be checked daily during grand round on an ongoing basis. Deficiencies will be documented in REQQUER (Facility electronic Job order/request site) and reported to the Director of Maintenance for immediate action.	5-10-19
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 approximately 9:00 AM, she acknowledged the findings.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by remote bed controllers with frayed electrical wires in two (2) of 46 resident's rooms. Findings included ... During an environmental tour of the facility on February 27, 2019, between 11:00 AM and 3:30 PM, remote bed controllers in two (2) of 46 resident's rooms (#110 and #210) were frayed. This deficient practice could expose the resident, staff or visitors to electrical hazards. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	F 908	2. Staff development to provide education to facility staff on ensuring remote bed controller in residents rooms is not frayed. **Monitoring corrective action:** 1. Findings from daily grand rounds will be presented by Director of Maintenance to Quality Assurance Performance Improvement Committee monthly for 3 months or until sustained compliance is achieved.	
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call	F 919	**Corrective action for the residents affected:** 1. The call bell in resident's room 314A and 320B that that failed to initiate an alarm when tested was replaced during the time of survey.	**5-10-19**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING _____ B. WING _____	03/05/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 37 directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 46 resident's rooms that failed to trigger an alarm when tested. Findings included... During observations on the third floor on February 27, 2019, at approximately 12:05 PM, call bells in two (2) of 46 resident's rooms (#314A and 320B) did not alarm when activated. These breakdowns could prevent or delay the resident, staff or the public from alerting staff in an emergency. Employee #7 and/or Employee #8 acknowledged the findings during a face-to-face interview on February 27, 2019, at approximately 3:30 PM.	F 919	**Identification of others with the Potential to be affected:** 1. Other call bells in residents' rooms were checked. No other failed call bells were found. **Measures to prevent Reccurrence:** 1. The Maintenance Director will educate facility Staff to report call bell issues. 2. Director of Maintenance/Designee will conduct weekly audits for proper functioning of call bells in residents rooms weekly times 4 then, monthly times 3. **Monitoring corrective action:** 1. The Maintenance Director will present audit to Quality Assurance Performance Improvement Committee for the findings or until sustained compliance is achieved.	