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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. BUILDING ______ B. WING ______	01/06/2021

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

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on December 30, 2020 through January 6, 2021. Survey activities consisted of a review of eight (8) sampled residents. 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. This includes the facility's non compliance with 42 CFR §483.80 infection control regulations. The resident census was 161. 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 CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)	F 000	Facility submits this plan of correction under the procedure 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 an admission of any wrong doing or as a waiver of the facility's right to appeal and challenge the accuracy or severity of the alleged deficiencies	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
MOLAJI LAKANSE-LNHA	ADMINISTRATOR	02/08/2

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.

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F 000	Continued From page 1 G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team 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 NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656	**Corrective action for residents affected:** The error in the documented plan of care for resident #1 was revised on 1/8/2021to reflect facility standard of practice to document	

document

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F 656	Continued From page 2 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (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	F 656	potential complications of COVID-19 every shift and as needed and to document vitals signs for COVID-19 patients every shift and as needed. **Identification of others with the potential to be affected:** All residents with a confirmed diagnosis of COVID-19 in the facility have the potential to be affected by this deficient practice. a. The Unit Manager/Designee will complete an audit of all resident with an active diagnosis of COVID-19 to ensure care plan interventions for monitoring signs and symptoms as well as monitoring vitals signs including oxygen saturations are implemented without any errors. b. Any issues found will be immediately addressed. **Measures to prevent reoccurrence of deficient practice**: The Facility's Quality Assurance & Performance Improvement Director/Designee will provide an education/in-service to all the Unit Managers and Nursing Supervisors. The education/ in-service will explain the importance of accurate and error-free documenting of the implemented plan of care interventions for monitoring signs and symptoms for potential complications of COVID-19 as well as monitoring of vitals signs for confirmed COVID-19 residents.	

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F 656	Continued From page 3 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) out of eight (8) sampled residents, facility staff failed to implement the care plan interventions for monitoring a resident for potential complications of COVID-19. Resident #1. Findings included ... Resident #1 was admitted to the facility on 11/14/2020, with diagnoses that included Shortness of Breath, Chronic Respiratory Failure with Acute Hypoxia, Right Heart Failure, Pulmonary Embolism and Obesity. Review of the medical record revealed a nursing note dated 12/29/20, at 22:23 (10:23 PM) that documented, "Nasal Swab Result: Result received indicates that the resident tested positive for COVID-19 for test done on 12/28/2020..." Review of the resident's care plan dated 12/29/2020, showed a focus area of "confirmed diagnosis COVID-19 and is at risk for complications". The focus area included an intervention that instructed staff to, "observe [Resident's name] Q4 (every four hours) for s/sx (signs and symptoms) [for complications of COVID-19], and monitor vital signs including O2 [oxygen] saturations."	F 656	**Monitoring of corrective actions to prevent occurrence of deficient practice:** a. The facility's Unit Managers/Designee will conduct weekly audits for three months to ensure all documented plan of care for residents with confirmed COVID-19 diagnosis is accurately documented without errors to reflect care plan interventions for monitoring signs and symptoms for potential complications of COVID-19 as well as monitoring vitals signs per facility's standard of practice. b. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI).	2-8-21

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F 656	Continued From page 4 Further review of the resident's nursing notes and treatment administration records dated from 12/29/2020 to 1/6/2021, that lacked documented evidence that staff observed Resident #1 for potential complications (elevated temperature, cough, lack of taste or smell) of COVID-19. The previously mentioned records dated 12/29/2020 to 1/6/2021, also lacked documented evidence that the staff monitored Resident #1's blood pressure, pulse, or respiration every 4 hours, as outlined in the care plan. During a telephone interview conducted on 1/7/2021, at 11:45 AM, Employee #10 (Unit manager) acknowledged the finding and stated that the intervention was written in error.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, for one (1) out of eight (8) sampled residents, facility staff failed to ensure the resident's care plan was updated to include patient-centered goals and interventions for the use of oxygen. Resident #1. Finding included ...	F 658	**Corrective action for residents affected:** Resident #1 patient's centered goals were updated on 01/07/2021 to include an intervention for the use of oxygen therapy. **Identification of others with the potential to be affected:** All residents with physician orders for the use of oxygen therapy have the potential to be affected by this deficient practice. a. The Unit Manager/Designee will complete an audit of all residents with physician orders for the use of oxygen therapy to ensure that the residents' plan of care is updated to include patient-centered goals and interventions for the use of oxygen. b. Any issues found will be immediately addressed.	

addressed.

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F 658	Continued From page 5 Resident #1 was admitted to the facility on 11/14/2020, with diagnoses that included Shortness of Breath, Chronic Respiratory Failure with Acute Hypoxia, Right Heart Failure, Pulmonary Embolism and Obesity. Review of the medical record showed a physician's order dated 11/14/2020 that ordered, "Oxygen Continous 2L (liter) / MIN (minute) for SOB (shortness of breath) via (by way of) Nasal Cannula every shift." Review of Resident #1's care plan dated 11/14/2020, showed it lacked documented evidence of goals and interventions to address the resident's use of continuous oxygen therapy. During a telephone interview conducted on 1/7/2021, at 12:00 PM, Employee #9 (Unit Manager) acknowledged the finding. Facility staff failed to include goals and interventions to address Resident #1's use of continuous oxygen therapy via nasal cannula every shift.	F 658	**Measures to prevent reoccurrence of deficient practice:** The Facility's Quality Assurance & Performance Improvement Director/Designee will provide an education/in-service to all the Unit Managers & Nursing Supervisors on the importance of ensuring all residents who have orders for the use of oxygen therapy have a patient-centered goal and intervention care plan for the use of oxygen. **Monitoring of corrective actions to prevent reoccurrence of deficient practice:** a. The facility's Unit Managers/Designee will conduct weekly audits for three months to ensure all residents with orders for the use of oxygen therapy have a patient-centered goal and intervention care plan for the use of oxygen. b. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI).	2-8-21
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	F 880	**Corrective action for residents affected:** a. Resident's rooms 406-421 were provided with adequate trash receptacles to discard used Personal Protective Equipment (PPE) prior to close of business on 2/2/21. b. No resident was affected by this deficient practice. Employee #11 was provided a final written warning on 12/31/20 and has now been suspended pending corporate approval for termination.	

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(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

F 880

c. No resident was affected by this deficient practice. Contractor/Employee # 5 & Contractor/Employee #6 were re-in Serviced on 02/03/21 on the facility's policy on Transmission Based Precaution, PPE Usage, Donning & Doffing of PPE and following signs posted on residents doors for those on Transmission Based Precaution.
d. On 2/3/21, Employee #8 was educated/ in-serviced on the importance of honestly disclosing asked symptoms on the facility's COVID-19 screening questionnaire form prior to entering the facility.

Identification of others with the potential to be affected:

a. All residents' rooms in the COVID-19 designated wing have the potential to be affected by this deficient practice. The Director of House Keeping/ Designee will audit all rooms in the COVID-19 designed wing to ensure they have adequate trash receptacles with lids to dispose used PPE.
b. All Environmental Services (EVS) employees have the potential to be affected by this deficient practice. The Director of EVS/Designee will complete an audit to ensure all house keepers have a storage area to keep cleaning supplies in a sanitary manner.
c. All contractors working in residents rooms have the potential to be affected by this deficient practice. The Director of QAPI will meet with current contractors working in

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contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

Based on observations, record review and staff interview, facility staff failed to have adequate trash receptacles to dispose of used personal protective equipment (PPE) in residents' rooms on the COVID-19 Unit, failed to ensure an employee stored cleaning supplies in a sanitary manner on the COVID-19 Unit, failed to wear required PPE while in a resident care area and failed to comply with the COVID-19 screening process. Employees' #5, #6 and #8.

Findings included ...

1. The facility staff failed to have adequate trash receptacles to dispose of used PPE in residents' rooms on the COVID-19 Unit.

During a unit tour of the COVID-19 Unit (4th floor) on 12/30/2020, at approximately 11:00 AM,

F 880 (Plan of Correction)
resident care areas to evaluate and audit if they understood previous in-service on PPE, Social Distancing & Handwashing. The Director of QAPI will also evaluate if the contractors understood the training for the purpose of making future education changes in order to promote compliance.

d. The Director of Human Resources/ Designee will complete an audit/look back of all employees screening questionnaires for the past 14 days (14 days is the required quarantine timeline established by the Centers for Disease Control & Prevention- CDC for symptoms monitoring). The audit Will reconcile answers given by employees on the screening questionnaire with symptomatic/asymptomatic section of COVID-19 positive employee's line listing to ensure consistency. Any issues found will be immediately addressed.

Measures to prevent reoccurrence of deficient practice:

a. The Facility's Administrator will in-service the Purchasing Coordinator on the importance of only ordering trash receptacles with lids in residents room and not to order trash cans without lids in order to mitigate against the spread of infection.

The Director of EVS will educate all EVS employees about the importance of ensuring that only adequate trash receptacles with lids are in resident's rooms regardless of the room's current transmission based precaution status.

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rooms 406 to 421 (15 rooms in total) were observed having small trash cans without lids that were filled with discarded used PPEs.

During a face-to-face interview conducted on 12/30/2020, at approximately 1:00 PM, Employee #2 acknowledged the finding and stated that the facility staff would place foot operated trash cans with lids in residents' rooms 406 to 421.

At the time of the survey, facility failed to have adequate trash receptables to discard used PPEs on the COVID-19 Unit (4th floor) of residents' room 406 to 421 (15 rooms).

2. Employee #11 (housekeeper) failed to store cleaning supplies in a sanitary manner on the COVID-19 Unit.

During a unit tour of the COVID-19 Unit (4th floor) on 12/30/2020, at approximately 11:30 AM, observation revealed a large, clear trash bag with multiple cleaning supplies including wipes and gloves on the hallway floor in front of room 401.

During a face-to face interview on 12/30/2020, at 11:35 AM, Employee #11 acknowledged the findings and stated, "I don't have anywhere to store my cleaning supplies today, so I put them in the bag. I usually store them in an office, but the office is locked today." Employee #11, then dragged the bag on the floor, moving it into the doorway of room 401.

At the time of the survey, Employee #11 failed to store cleaning supplies in a sanitary manner on the COVID-19 Unit (4th floor).

F 880

b. The Director of EVS/Designee will provide education to all EVS employees about the importance of storing cleaning supplies in a sanitary manner. All cleaning supplies are supposed to be stored in the EVS movable cleaning cart located on each floor. Cleaning supplies are not to be stored in trash bags or dragged on the floor. Each floor has a cleaning cart that must be utilized in order to prevent the spread of infection in the facility. Any EVS employee who for any reason cannot access the cleaning cart must immediately notify the Director of EVS/Designee, the Director of QAPI or the facility Administrator.

c. The Director of QAPI and Director of Human Resources who speaks Spanish will provide current facility contractors working in resident care areas with a second in-service about the importance of following facility's policy on Transmission Based Precaution, PPE Usage, Donning & Doffing of PPE and following signs posted on residents doors for those on Transmission Based Precaution. This in-service will be provided in English and Spanish. Spanish speaking contractors will be provided written materials translated into Spanish for better understanding and compliance.

d. The Administrator, Department Heads, Nursing Supervisors/Designee will educate all facility staff on the importance of honestly disclosing answers to the asked questions/symptoms on the facility's COVID-19 screening questionnaire form prior to entering the facility.

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F 880	Continued From page 9 3. Facility staff failed to wear the required PPE while in a resident care area. A review of the facility's policy entitled, "Personal Protective Equipment (PPE)" dated 9/30/20, showed, "[Facility name] requires all employees (to include contractors) to follow infection control policies and procedures to prevent the spread of infection." During a tour of the 3rd floor on 12/30/2020, at approximately 11:00 AM, Employee #5 (contractor) and Employee #6 (contractor) failed to don gloves and gowns before entering a resident's room who was on transmission-based contact and droplet precaution. Review of the training document entitled, "Construction Orientation" dated 12/17/2020, showed that both Employee #5 and #6 signed in, indicating that they received the in-service training on "Infection Control (PPE usage, social distancing and hand washing)". The document also revealed Employee #7 (Director of Human Resources) provided English and Spanish language translation at the time of orientation. Facility staff failed to wear the required PPE while in a resident care area. During a face-to-face interview conducted on 12/30/2020, at approximately 12:30 PM, Employee #4 (Quality Assurance/ Staff Development) stated that the contractors are educated and trained before they can work in the facility. Employee #4 also stated, "[Employee name] (Employee #7) provided Spanish	F 880	Truthful disclosures are necessary for contact tracing, isolation, quarantining, infection control spread mitigation, line listing and for accurate record keeping. **Monitoring of corrective actions to prevent reoccurrence of deficient practice:** a. The Facility's Director of EVS will conduct weekly visual audits of all residents' rooms for three months to ensure all resident's rooms have adequate trash receptacles which have lids. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI). b. The Facility's Director of EVS will conduct weekly visual audits of all floors and the lobby level to ensure all EVS employees are storing cleaning supplies in a sanitary manner and that each assigned EVS staff on the resident's floors and lobby area have an adequate cart to store cleaning supplies. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI). c. The Facility's Director of Maintenance will conduct weekly visual audits of all contractors working in resident care areas to ensure they are in compliance with facility's PPE policy while in resident care areas. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI).	2-8-21

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F 880	Continued From page 10 translation at the time of the [aforementioned] training to ensure they (contractors) understood the material being taught." Employee #4 acknowledged the findings at the time of the interview. 4. A staff member failed to disclose his/her symptoms when answering the questions on the facility's COVID-19 screening form prior to entering the facility. Facility Policy: "Return to Work Policy" dated 5/15/20, stipulates, "Employees who don't have access to immediate testing will be allowed to set up an immediate appointment at the facility to get tested in the designated testing area (Small Conference Room). Immediate testing of symptomatic employee is necessary for timely contact tracing, testing and quarantining of expose residents ... Every HCP (health care professional) will be screened for signs/symptoms... before entering the healthcare facility by answering the questionnaire ..." During a telephone interview conducted on 1/5/2021, at approximately 1:00 PM, Employee #2 (Director of Nursing) stated that on 12/28/2020, Employee #8 (certified nursing aide) reported "chills and fatigue" and called in sick for her scheduled 3-11 PM shift. Review of the document entitled, "Screening Questionnaire" dated 12/28/2020, showed at 2:01 PM, Employee #8 came into the facility and	F 880	d. The Facility's Director of Human Resources will conduct a weekly reconciliation audit of screening questionnaire against the employee COVID-19 line listing to ensure disclosure of symptoms are done when answering the facility's screening form prior to entering the facility. Findings of this audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI).	

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 ______	01/06/2021

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

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F 880	Continued From page 11 answered "no" to the screening question that asked, "Do you have any signs or symptoms of respiratory infection ... chills ...?" Review of the facility's document entitled, "COVID-19 Line Listing" showed Employee #8 reported having COVID-19 symptoms, "chills and fatigue" on 12/28/2020 and the result of her COVID-19 test administered on 12/28/2020, was positive. During the interview conducted on 1/5/2021, with Employee #2, he also stated that Employee #8 came to the facility for COVID-19 testing and left immediately after the testing was completed. Employee #2 acknowledged the finding and further detailed that all employees are instructed to answer the screening questions truthfully. There was no evidence that Employee #8 disclosed his/her symptoms when answering the questions on the facility's COVID-19 screening system/form prior to entering the facility.	F 880		