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	095031	A. BUILDING _____ B. WING _____	C 11/14/2023

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F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility from October 30, 2023 to November 14, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 167 and the survey sample included 47 residents. The following Complaints were investigated: DC~11545, DC~11871, DC~12392, DC~12341, DC12130, and DC ~11948. The following Facility Reported Incidents were investigated: DC~11464 DC~11116 DC~11992 DC~11144 DC~11357 DC~11434 DC~11664 DC~11597 DC~11456 DC~11326 DC~11081 DC~11845 DC~11306 DC~11789 DC~11647 DC~12273 DC~11180 DC~11505 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and	F 000	Inspire Rehab and Health LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Cheli	Administrator	12/8/2023

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Requirements for Long Term Care Facilities.

Citations are being cited for: DC~12341, DC~11326, DC~12130, DC11081, DC~11144, DC~11505, DC~11545, DC~11434, and DC~11597.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C - Discontinue
Dl - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube

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HR - Human Resources
Hrs - Hours
HS - hour of sleep
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)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO - by mouth
POA - Power of Attorney
POS - physician's order sheet
Prn - As needed
Pt - Patient
Q - Every
RD - Registered Dietitian
RN - Registered Nurse
ROM - Range of Motion

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F 000	Continued From page 3 RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 584 SS=D	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 in good condition; §483.10(i)(4) Private closet space in each	F 584	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The Housekeeping Director had an EVS employee come into resident 132's room to clean the unsanitary areas. This was completed on 11/2. Resident 113's walls were fixed the day of the findings by the maintenance department. No other residents were affected by these issues. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the Director of Housekeeping and Director of Maintenance for proper cleaning methods and areas as well as room observations pertaining to chipped paint and wall damage since 11/1/23. This audit will be completed by 12/8/23. Any negative findings will be corrected upon discovery and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/Designee in-serviced all Housekeeping and maintenance staff and	12/8/2023

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F 584	Continued From page 4 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, record review and staff interviews, for two (2) of 47 sampled residents, facility staff failed to provide a clean, homelike environment. Residents' #132 and #113. The findings included: 1. A Complaint, DC~12341, received by the State Agency on 10/04/23 from Resident #132's representative documented that: - Residents are in unsanitary living conditions - The facility failed to provide daily clean and safe living environment During an observation of Resident #1332's room, 515 bed A, on 10/30/23 at 10:50 AM, the air conditioning/heating unit was noted with thick layers of gray dust-like material. The resident's over-bed table was sticky to the touch, wet, and had with dark colored stains. During a face-to-face interview on 10/30/23 at 10:55 AM, Employee #6 (Director of Housekeeping and Laundry) acknowledged the findings, stated that cleaning the resident	F 584	leadership on the policy and procedures for room cleanliness and physical damage. This education was completed on 12/6/2023. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee for at least 10 rooms per unit to ensure the facility implements its policy on room cleanliness and physical damage in resident rooms. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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F 584	Continued From page 5 overhead tables and the grills of the air conditioning/heating unit is part of the housekeeping duties and would get someone from housekeeping to come to Resident #132's room. 2. A Complaint DC~12130 received by the State Agency on 07/26/23 from Resident #113's representative documented that: - The facility is unclean - I have to ask for the floor to be mopped During an observation on 10/30/23 at 11:28 AM of Resident #113's room, 510, upon entering the room, two large areas of chipping paint and a large whole were noted on the right wall. During a face-to-face interview on 10/30/23 at 12:01 PM Employee #12 (Director of Maintenance) acknowledged the findings and stated, "Our maintenance guy made written note of this on Thursday (10/26/23) during his daily rounds but it was never entered into the electronic system as a request for me to see. We'll take care of it now."	F 584		
F 607 SS=D	Cross Reference 22B DCMR Sec. 3256.1 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607		

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F 607	Continued From page 6 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's staff failed to follow it's Abuse Policy by not thoroughly investigating: an allegation of staff-to-resident sexual abuse (inappropriate touch), an allegation of staff-to-resident verbal abuse,a fall incident, an allegation of a verbal altercation between residents and an unusual occurance for five (5) of 47 sampled residents. (Residents #228, #229, #230, #331, and #332). A review of a policy titled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation with a revision dated of 06/23 instructed, "All allegations are thoroughly investigated."	F 607	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. Residents 228, 230, 231, and 332 suffered no negative outcomes from failure to obtain interviews or written statements from other staff members who were on duty during the time of incident that weren't included in interview packet. Resident 229 is no longer a resident at the facility. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the ADON for all incidents and accidents that occurred in the last 90 days to ensure statements were obtained from all pertinent staff. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee completed a house-wide in-service for staff and leadership on the Policy and procedures regarding the reporting and investigating requirements on any abuse. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, Falls, are discussed during the Risk meetings to ensure the facility	12/8/2023

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F 607	Continued From page 7 1.The facility's staff failed to thoroughly investigate Resident #228 allegation of staff-to-resident sexual abuse (inappropriate touch). Resident #228 was admitted to the facility on 01/23/23 with multiple diagnoses including Hemiplegia, Morbid Obesity, and Muscle Weakness. The staff assignment for the night shift on 01/29/23 revealed five (5) employees worked that shift. According to the facility's investigation packet, two (2) of the five (5) employees (the assigned nurse and assigned CNA) provided statements. There was no documented evidence that the facility interviewed the three other employees who may have had knowledge of the incident. A review of an Admission Minimum Data Set dated 01/30/23 revealed the resident had a Brief Interview of Mental Status summary score of "10" indicating the resident cognitive function was moderately impaired. The resident was code for requiring extensive assistance for staff for toilet use and being frequently incontinent of urine and bowel. A nursing note dated 01/30/23 at 4:41 PM documented, "Around 2:45 pm, unit manager received a call from [resident's daughter name] alleging that she got a phone call from her father saying he was inappropriately touched by [Employee #4, CNA] over the night Investigation started immediately. Head to toes assessment done, scrotal area observed with a scratch, Pain assessment-denies pain verbally and did not express pain nonverbally MD notification called to DC police staff suspended f pending	F 607	implements its policy on investigating incidents of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Negative findings, if any, will be corrected upon discovery. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on abuse investigations. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023	

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investigation. Investigation initiated. Resident reassured."

A psychiatric nursing note dated 01/30/23 at 10:10 PM documented the following but not limited to, "[Resident's name] explored his accusation made about a male staff touching him inappropriately. He explained that the staff was rough, pulling on his sore arms when personal care was provided (washing him). He said that he and the staff [Employee #4] enjoyed joking with each other and the staff did not take his complaints about being treated roughly while being bath seriously. He reported that the male staff told him his testicles were large and squeezed them while he was washing that area. [Resident's name] said he did not view this behavior as sexual stimulation but a joke."

A review of a State Survey Agency Facility Reported Incident Intake form #DC ~11597 dated 02/01/23 documented, "Around 2.45 pm, unit manager received a call from [Resident's daughter] alleging that she got a phone call from her father saying he was inappropriately touched by a CNA over the night. Investigation started immediately. Head to toe assessment done, scrotal area observed with a scratch. Pain assessment was done with denies pain verbally and did not express pain non verbally MD notification called to DC police staff suspended pending investigation. Investigation initiated Resident reassured."

During a face-to-face interview on 11/13/23 at 3:37 PM, Employee #2 (DON) stated that the facility obtains written statements or questionnaires from all staff who worked on the shift on which the allegation was made. The

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employee said that they had gotten statements from all five staff who worked on the nightshift of 01/29/23, but she could not explain why they were not in Resident #228's investigative packet."
2. The facility staff failed to thoroughly investigate Resident #230's allegation of staff-to-resident verbal abuse.

Resident #230 was admitted to the facility on 12/07/22 with multiple diagnoses including Chronic Pulmonary Disease.

A review of a nursing note on 12/11/22 at 4:30 PM documented but not limited to, "Note Text: At around 3:40 PM writer's attention was drawn to the presence of 911 in the lobby. Upon enquiry it was noted that resident had called 911.Writer and nursing supervisor went to resident about her reason of calling 911 and she said she just want to get out of here and not to come back. She refused assessment but allowed us to take vital signs which was 132/72 (blood pressure),80 (pulse),18 (respiration), 97% (oxygen saturation level), 97.4 (temperature). 911 crew also found resident to be stable but resident insist going so they call a private ambulance who came at 4:07[PM]. [Doctor's name] was notified and gave order to send patient to hospital per her request. Resident left the facility at 4:15 pm to [hospital's name]."

A nursing note dated 12/12/22 at 11:18 PM documented, "It was reported [resident representative's name] via email that her mother [resident's name] was mistreated by a male staff wearing a green uniform yesterday being Sunday, Dec. 11th, 2022, before going to the Hospital. Police has (sp) been called and they will be on their way for further investigation. Report was

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given to the incoming supervisor to look up for the police."

A nursing note dated 12/12/22 at 11:30 PM documented, "The police came and talked to her they said it is not a police matter, that it is something the management will handle internally."

A review of a 5-Day-Minimum Data Set dated 12/13/22 documented the resident did not have a Brief Interview for Mental Status summary score indicating that the resident was not tested. Additionally, the resident was coded for verbal behavioral symptoms directed towards others including threatening others, screaming at others, and cursing at others. The resident was also coded for rejection of care.

A State Agency Facility Reported Incident #DC~11357 date 12/13/22 documented, "Per resident's daughter she stated, "My mom, [resident's name] called at 4 pm to let me know a male dressed in all green uniform threatened her."

The staff assignment for the evening shift on 12/11/22 revealed six (6) employees worked that shift. According to the facility's investigation packet, three (3) of the six (6) employees provided statements. There was no documented evidence that the facility interviewed the three other employees who may have had knowledge of the incident.

During a face-to-face interview on 11/13/23 at 3:35 PM, Employee #2 (DON), reviewed the resident's investigation packet and stated that she did not see a statement or questionnaire for

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three staff members who worked the time of the incident with Resident #230.

3. The facility's staff failed to investigate Resident #229's fall incident that occurred on 12/31/22.

Resident #229 was admitted to the facility on 12/23/22 with multiple diagnosis including Lung Cancer and Legal Blindness.

An Admission Minimum Data Set dated 12/29/22 documented the resident had a Brief Interview for Mental Status summary score of "15" indicating that the resident had an intact cognitive status. In addition, the resident was coded for being independent with indoor ambulation and receiving Physical, Occupational, and Speech Therapy services.

A nursing note dated 12/31/22 at 11:30 PM showed, "Resident was observed by medication nurse at 11:00 PM and she was sleeping. Around 11:15 PM resident was observed on floor, unresponsive Resident was transferred back to bed. CPR was initiated. 911 was called and arrived around 11:43. [Doctor's name] was called and ordered to be transferred to nearest hospital for evaluation and treatment via EMS (Emergency Medical Center). Responsible Party was called."

A nursing note dated 01/01/23 at 2:10 AM documented, "EMS (Emergency Medical Service) team pronounced resident dead at approximately 12:35 am, CPR terminated, Dr. Allen made aware and he stated that cause of death is Malignant Neoplasm of Lower Lobe of Left Bronchus or Lung. RP could not be reached on phone immediately, but a call back message was left.

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Resident was given postmortem care with dignity. Writer will continue to follow up with RP (responsible party)."

A State Survey Agency Facility Reported Incident Intake Form # DC~11434 dated 01/01/23 at 4:39 AM documented the following but not limited to: "According to the charge nurse, resident was last seen lying on her bed with bed on lowest position and respiration un-labored at 11PM. By 11:15 pm, resident was observed on the floor unresponsive. Code called, resident was assisted back to the bed. MD was made aware and MD gave order to transfer resident to the nearest ER via 911 for treatment and further evaluation."

A review of the facility's investigation documents lacked documented evidence that the facility's staff investigated Resident #229's fall that occurred on 2/31/22.

During a face-to-face interview on 11/01/23 at 2:10 PM, Employee #3 (ADON) stated that the facility investigates all fall incidents to include gathering witness statements from staff who worked at the time of the resident's fall. However, Employee #3 could not explain why there was no documented evidence of the facility's investigation of Resident #229's fall incident that occurred on 12/31/22.

4. The facility staff failed to implement its policy to investigate Resident #331's allegation of a report of a verbal altercation with another resident.

Resident #331 was admitted to the facility 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and

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Cognitive Communication Deficit.

A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..."

A review of Resident #331's medical record revealed the following:

[Social Work Progress Note] 01/09/23 at 11:19 AM, documents " ...Writer received a call from residents sister ...because resident call her & (and) shared that she had some type of verbal altercation with another resident ..."

[Nursing Progress Note] 01/09/23 1:57 PM, documents ": In-House transfer from room 115D to Room 115A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated ..."

[Physician Orders] 01/09/23 " ...In-House transfer from room 115D to Room 115A for comfort and socialization ..."
Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was

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documented in the social work progress note.

During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.

5A. The facility staff failed to implement its policy to investigate an allegation of abuse concerning Resident #332.

Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia

A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: " ...Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time ...On 10/27/2022, resident called the Admission Director with the following concerns, "Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice" ..."

A review of Resident #332's medical record

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revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of "01" indicating severe cognitive impairment.

[Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents " ...Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware ..."

The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.

During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.

During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated "I don't remember that kind of report to me."

During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them.

5B. The facility staff failed to implement its policy to investigate an unusual occurrence concerning resident #332.

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Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.

A review of Resident #332's medical record revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of "01" indicating severe cognitive impairment.

[Nursing Progress Note] 10/12/22 at 2:18 PM, documents," ...At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) ...with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied "I'm trying to give my mom supplements, She is what I do even when she was in the hospital". On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 17 Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized "I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her. The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22 in the nursing progress note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

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F 609	Continued From page 18 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two (2) of 47 sampled residents, the facility staff failed to report allegations of abuse and an unusual incident to the State Agency. Resident #331 and #332. The findings included: A review of the facility's policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating" with a revision date of 06/2023 instructs the facility staff to do the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported... 1. If resident abuse, neglect, exploitation, misappropriation of resident property, unusual occurrences or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other	F 609	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. Residents 331 and 332 suffered no negative outcomes from failure to report to the state agency. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by ADON for all incidents and accidents that occurred in the last 90 days to ensure they are reported as per the regulatory guidelines. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided a house wide in-service for staff and leadership on the Policy and procedures regarding the reporting requirements to the state agency. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, falls etc are discussed during the Risk meetings to ensure the facility implements its policy on investigating incidents of alleged abuse and reporting incidents as per Federal and District guidelines in a timely manner. Negative findings, if any, will be corrected upon discovery.	12/8/2023

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F 609	Continued From page 19 officials according to state law." 1. The facility staff failed to report an allegation of a verbal altercation involving resident #331 and another resident to the State Agency. Resident #331 was admitted to the facility 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit. A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..." A review of Resident #331's medical record revealed the following: [Social Work Progress Note] 01/09/23 at 11:19 AM, documents " ...Writer received a call from residents' sister ...because resident call her & (and) shared that she had some type of verbal altercation with another resident ..." [Nursing Progress Note] 01/09/23 1:57 PM, documents ": In-House transfer from room 115D to Room 115A for comfort and socialization. Resident in stable condition. Family informed of	F 609	**MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on abuse investigations and reporting. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/08/2023

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the transfer. Skilled services in progress and well tolerated ..."

[Physician Orders] 01/09/23 " ...In-House transfer from room 115D to Room 115A for comfort and socialization ..."

Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note.

During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.

2A. The facility staff failed to report an allegation of abuse concerning Resident #332.

A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: " ...Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time ...On 10/27/2022, resident called the Admission Director with the following concerns, "Accused tall dark brown skin

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CNA (Certified Nurse Aide) of hitting her mother twice" ..."

Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.

A review of Resident #332's medical record revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental status (BIMS) summary score of "01" indicating severe cognitive impairment.

[Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents " ...Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware ..."

The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.

During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility did not report this to the State Agency.

During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated "I don't remember that kind of report to me."

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During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them.

2B. The facility staff failed to report an unusual occurrence concerning resident #332 to the State Agency.

Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.

A review of Resident #332's medical record revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of "01" indicating severe cognitive impairment.

[Nursing Progress Note] 10/12/22 at 2:18 PM, documents," ...At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) ...with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied "I'm trying to give my mom supplements, She is what I do even when she was in the hospital". On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2)

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F 609	Continued From page 23 Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized "I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her. The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22, in the nursing progress note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility did not report this to the State Agency.	F 609		
F 610 SS=D	Cross Reference22B DCMR Sec.3232.4 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		

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F 610	Continued From page 24 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for three (3) of of 47 sampled residents, facility staff failed to have documented evidence that they took corrective actions to protect and prevent further potential abuse of Resident #103 by Employee #13 (Smoke Aide), the alleged perpetrator, after an allegation of physical abuse; failed to show documented evidence that investigations were conducted into Resident #331's report to a social worker of a verbal altercation with another resident; and Resident #332's abuse allegation and unusual incident. Residents #103, #331 and #332. The findings included: Review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy documented: - The Administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the	F 610	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. Residents 103, 331, and 332 suffered no negative outcomes from the deficient practice. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the ADON for all incidents and accidents that occurred in the last 90 days to ensure that the Abuse protocol was followed with appropriate investigating, reporting and corrective actions. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided a house wide in-service for staff and leadership on the Policy and procedures regarding suspending staff, pending investigations. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, misappropriation of resident property or unusual occurrences are discussed during the Risk meetings to ensure the facility implements its policy on reporting and investigating incidents as per Federal and District guidelines. Negative findings, if any, will be corrected upon discovery.	12/8/2023

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F 610	Continued From page 25 alleged perpetrator, or by anyone associated with the facility. - If the investigation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to his/her/their former position and will be paid in full for the duration of the suspension. - The employee will obtain education for the incident prior to returning to work and will not be allowed to work with the suspected victim to prevent retaliation. - Corrective actions may include a full review of the incident(s) by the QAPI committee. 1. Facility staff failed to to have documented evidence that they took corrective actions to protect and prevent further potential abuse of Resident #10 for six months after an alleged incident. Resident #103 was admitted to the facility on 01/25/20 with diagnoses that included: Schizophrenia and Depressive Disorder. Review of Resident #103's medical record revealed the following: A care plan focus area last revised in March 2022 documented, "[Resident #103] wishes to smoke at the facility and is assessed as a Safe Smoker" A Quarterly Minimum Data Set (MDS) assessment dated 09/05/22 showed that facility staff coded: clear speech; understood others and able to make self understood; and a Brief Interview for Mental Status (BIMS) Summary Score of 10, indicating moderate impaired cognition. A schedule for calendar for September 2022	F 610	**MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on abuse and reportable incidents. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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documented that on 09/29/23 from 9:30 AM - 6:00 PM, Employee #13/alleged perpetrator was the assigned to the courtyard/smoking patio.

A Situation Background Assessment Request (SBAR) Communication Tool dated 09/29/22 at 11:00 AM documented:
- Situation - At 10:30AM Resident alleged smoke aide put his hands on his left shoulder, at the smoking area.
- Resident denies pain; head to toe assessment shows no bruises or any skin issue. Staff suspended pending investigation.
- Medical Doctor and representative made aware.

A care plan focus area initiated on 10/04/22 documented,
- [Resident #103] is at risk of feelings emptiness, anxiety, uneasiness, characterized by; ineffective coping, related to restricted physical activity (smoking) AEB (as evidenced by) reported that assigned smoke aide did not maintain his physical distance (finger on him shoulder) for redirection in the designated smoking area.

Review of Employee #13's human resources (HR) file on 11/01/23 at approximately 9:00 AM, showed a "Disciplinary Action Form" dated 09/29/22 that documented:
- It was alleged [Employee #13 tapped [Resident #103] on the shoulder with his finger and asked him to return inside.
- Corrective Action Taken - [Employee #13] will be suspended pending investigation.
- Employee #13 received abuse training and education on 10/05/22 and returned to work on 10/06/22.

It should be noted that there was no documented

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evidence in Employee #13's HR file to show that the employee was no longer working as a Smoke Aide upon returning from suspension.

Review of the facility's investigation documents on 11/01/23 at 9:30 AM showed a document dated 03/21/23 that documented:
- Per the facility policy, you [Employee #13] are not to come in contact with this resident [Resident #103] at any time.
- This means you will not provide direct care or services to this resident, or enter this resident's room for any reason (not even to provide care or services to their roommate.

A conference was conducted on 11/01/23 at 10:30 AM with Employee #1 (Administrator), Employee #2 (Director of Nursing/DON), Employee #3 (Assistant Director of Nursing/ADON), and Employee #14 (Human Resources Manager/HRM). During the conference, the employees were asked to explain why did take until 03/21/23, approximately six months after the alleged incident, for the facility administration to have documented evidence of the corrective actions that were taken to protect and prevent further potential abuse of Resident #103 from Employee #13. Employee #2 sated, "After the investigation and suspension, [Employee #13] was removed from that position (Smoke Aide) and worked as restorative aide." When asked to show/provide documented evidence of Employee #13's position change after allegation, Employee #14 reviewed Employee #13's HR file and acknowledged that there was no such documentation.

On 11/02/23 at 12:00 PM, Employee #1 and Employee #2 came to the State Surveyor with

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documents and Employee #1 stated, "We called the previous Administrator who was here at the time of this incident (09/29/22) and she directed us looked through some folders and we found these additional documents."

The additional documents showed:
- A "Personnel Action Notice" dated 03/21/23 with Employee #13's name; "Job/Department Change"; "Current Job/Department: Smoking Aide"; "New Job/Department CNA (Certified Nurse Aide)/Restorative".

Employee #1 stated, "The board held a meeting in March [2023] and reviewed all incidents that involved allegations of abuse. For this particular case, they felt it was warranted to take the steps of removing [Employee #13] from the position of a smoke aide to restorative aide out of abundance of caution." When asked prior to this personnel action, where was the employee working, Employee #2 stated, "[Employee #13] was working as the Smoke Aide and there were cameras out there that were being monitored at all times by the front desk staff."

The evidence showed that from 10/06/22 to 03/21/23, approximately six months, facility staff failed to have documented evidence that they took any corrective actions to protect and prevent further potential abuse of Resident #103 by Employee #13. During a face-to-face interview on 11/02/23 at 12:08 PM, Employees #1 and #2 acknowledged the finding.

Cross Reference 22B DCMR Sec. 3203.5

2. The facility staff failed to investigate Resident #331's report of a verbal altercation with another

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resident.

Resident #331 was admitted to the facility on 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit.

A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC (District of Columbia) really needs to do an inspection ..."

A review of Resident #331's medical record revealed the following:

[Social Work Progress Note] 01/09/23 at 11:19 AM, documents " ...Writer received a call from residents sister ...because resident call her & (and) shared that she had some type of verbal altercation with another resident ..."

[Nursing Progress Note] 01/09/23 1:57 PM, documents ": In-House transfer from room 115D to Room 115A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated ..."

[Physician Orders] 01/09/23 " ...In-House transfer

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from room 115D to Room 115A for comfort and socialization ..."

Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note.

During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.

3A. The facility staff failed to investigate an allegation of abuse concerning Resident #332.

A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: " ...Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time ...On 10/27/2022, resident called the Admission Director with the following concerns, "Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice" ..."

Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included

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the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.

A review of Resident #332's medical record revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of "01" indicating severe cognitive impairment.

[Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents " ...Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware ..."

The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.

During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility does not have an investigation into this incident.

During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse)
stated "I don't remember that kind of report to me."

During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no
allegation of abuse was reported to them.

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3B. The facility staff failed to investigate an unusual occurrence concerning resident #332.

Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.

A review of Resident #332's medical record revealed the following:

A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of "01" indicating severe cognitive impairment.

[Nursing Progress Note] 10/12/22 at 2:18 PM, documents," ...At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) ...with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied "I'm trying to give my mom supplements, She is what I do even when she was in the hospital". On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical

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F 610	Continued From page 33 Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized "I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her. The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22 in the nursing progress note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.	F 610		
F 625 SS=D	Cross Reference 22B DCMR Sec. 3232.1 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing	F 625		

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F 625	Continued From page 34 facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 47 sampled residents, facility staff failed to provide the residents or their representative with bed-hold notice upon transfer to the hospital. Residents' #87 and #278. The findings included: 1. Resident #87 was admitted to the facility on 04/11/19 with diagnoses that included: Benign Prostatic Hyperplasia, Cerebellar Ataxia and Degenerative Diseases of Basal Ganglia. Review of Resident #87's medical record revealed the following: A Modified Quarterly Minimum Data Set (MDS) assessment dated 08/04/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 15, indicating intact cognition.	F 625	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. The facility had self-identified the deficient practice and submitted the 6-108. Residents 87 and 278 suffered no negative outcomes from failure to notify them of the facility's bed hold policy and notice of transfer. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Social Services for all residents that were transferred or discharged over the last 90 days. Audit was completed on 12/06/2023. There were no negative findings from this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided a house wide education for nurses and social service department on the Policy and procedures regarding notice of transfer and bed hold policy. This education was completed on 12/6/23.	12/8/2023

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F 625	Continued From page 35 A physician's order on 08/30/23 directed, "Transfer patient to nearest ER (emergency room) for evaluation and treatment for worsening sacral stage 4 wound and possible infection." An Admission Note dated 09/13/23 at 11:45 PM documented that Resident #87 was re-admitted from [Hospital name] at 8:30 PM. Review of a Notice of Discharge, Transfer or Relocation Form showed: - Submitted on 09/06/23 at 5:52 PM - Resident #87s name - Proposed action - transfer - Transfer type - hospital - You are scheduled to be transferred on 08/31/23 The evidence showed that facility staff failed to must provide Resident #87 written notice which specifies the duration of the bed-hold policy upon transfer to the hospital on 08/30/23. During a face-to-face interview on 11/06/23 at 10:35 AM, Employee #16 (Social Worker) reviewed Resident #87's Notice of Discharge, Transfer or Relocation Form and stated, "It was an oversight. When we caught it the following week, it was submitted." 2. Resident #278 was admitted to the facility on 07/18/22 with diagnoses that included: Muscle Weakness, Adjustment Disorder with Disturbance of Conduct and Anemia. Review of Resident #278's medial record revealed the following: A face sheet that documented the resident's	F 625	**MONITORING CORRECTIVE ACTION** An audit will be done by the Social Worker/designee to ensure the facility implements its policy on transfers and the bed hold policy for the residents transferred to the hospital. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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daughter as the primary contact.

A Quarterly MDS assessment dated 10/22/22 showed that facility staff coded: BIMS Summary Score of 01, indicating severely impaired cognitive function.

A Situation Background Assessment Request dated 12/08/22 at 10:32 AM documented:
- Situation: Observed with a bump size of a quarter left side of head
- New orders: Transfer resident to the hospital for CT (computed tomography) Scan /evaluation and treatment

A Facility Reported Incident (FRI), DC~11326 submitted to the State Agency on 12/08/22 at 12:03 PM documented:
- Around 9:55 AM, assigned Certified Nursing Assistant (CNA) observed a bump on the left side of head the size of a quarter
- Medical Doctor assessed the resident ad order given to transfer resident to the emergency department for CT scan and evaluation

A Nurse's Note dated 12/08/22 at 11:03 PM documented, "Writer placed a follow up call to [Hospital name] on the status of the resident, spoke with ER nurse, stated resident is admitted."

An Admission Note dated 12/13/22 at 9:36 PM documented that the resident was readmitted from the hospital on that day to room 505 B.

Review of a "Notice of Discharge, Transfer and Relocation Form" in Resident #278's medical record showed that the form was completed by Employee #16 (Social Worker) and it documented:

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F 625	Continued From page 37 - Submitted on 12/23/22 at 6:34 AM - Resident #278's representatives name - Proposed action - transfer - Transfer type - hospital - You are scheduled to be transferred on 12/08/22. The evidence showed that facility staff provided Resident #278's representative notice of transfer to the hospital on 12/23/22, 15 days after the resident was initially transferred to the hospital and 10 days after the resident had already been readmitted back to the facility. During a face-to-face interview on 11/03/23 at 1:27 PM, Employee #16 stated that Notice of Discharge, Transfer and Relocation are to be provided immediately to the resident or the representative in person or via email. When asked about Resident #278's Notice of Discharge, Transfer and Relocation Form, Employee #16 reviewed the document, acknowledged the findings and stated," I don't know why this one was delayed."	F 625		
F 641 SS=D	Cross Reference 22B DCMR Sec. 3270.1 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 by: Based on record reviews and staff interviews for two (2) of 47 sampled residents facility staff failed to accurately code Resident #379's Quarterly Minimum Data Set (MDS) assessments to	F 641		

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F 641	Continued From page 38 accurately reflect the resident's history of falls and failed to accurately code Resident #174's Admission MDS to reflect the resident's surgical wound. The findings included: 1.Resident #379 was admitted to the facility on 12/01/22 with diagnoses that included: Cognitive Communication Deficit, Muscle Weakness, Unspecified, Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, History of Falls, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. A review of Resident #379's medical record revealed the following: A physician's order dated 12/01/2 at 11:0 PM documented: "Precautions: Fall every shift." A care plan initiated on 12/02/22 documented: "Focus: [Resident #379] has Fall Prevention in place ... Goal: [Resident Name] will have reduced incidents of falls through the next review period x 90..." An Admission Minimum Data Set (MDS) assessment dated 12/05/22 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "08," indicating the Resident had moderately impaired cognition and had a history of falls that included a fall within 2-6 months of the admission assessment. A Post Fall Assessment done on 12/26/22 at 1:15 PM documented: "Score 10.0 Moderate Risk for recent fall."	F 641	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 379 and 174 suffered no negative outcomes from failure of MDS to accurately code the residents quarterly MDS assessment. The MDS for these residents were corrected on 11/3. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by MDS department for all residents that had a surgical wound and/or fall within the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Regional Director of MDS completed an in-service all staff and leadership on the Policy and procedures regarding how to accurately code falls and surgical wounds for the resident's MDS assessments. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Regional MDS Director to ensure the facility implements its policy on MDS assessments for accurate coding for falls and surgical wounds. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will	12/8/2023

	be corrected upon discovery. Compliance date of 12/8/2023.	

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F 641	Continued From page 39 SBAR Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool on 12/26/22 at 1:52 PM documented: " ... "Reason: Fall ...Additional Comments: " ...Writer was alerted by OT (Occupational Therapist) that patient was on the floor. Observed [the] patient sitting on the floor leaning against the wall outside her room. When asked what happen(ed)? Pt (patient) stated, "I was going across the hall to my neighbor, and I fell." Pt was assessed head to toe, UL (upper and lower) ext (extremity) ROM (range of motion) within limits. Denies pain or discomfort. Pt (patient) was assisted up by [the] writer and therapist using [a] gait belt and rolling walker." A care plan initiated on 12/26/22 documented: "Focus: [Resident# 374] had an actual fall with no injury due to unsteady gait..... " The care plan was revised on 01/13/23 and documented: "Focus: [Resident] was observed on the floor on 01/13/23 with an abrasion 0.3 x 0.3 cm x 0 at the back of her head ... " SBAR Physician/NP/PA Communication Tool on 01/13/23 at 4:50 PM documented: "... Reason: Fall with an apparent head injury..... Additional Comments: Resident was observed on the floor on her back .. Upon assessment, a minor blood was noted at the back of her head, the area was cleaned with normal saline, an ice pack was applied to the area, no bleeding. Pressure dressing was applied to the site. Resident is alert. Resident was asked if she hurts anywhere, she said no .... Resident was assisted back to the bed by three nursing staff. [Physician's Name] was notified, ... gave an order to send Resident to the nearest ER (Emergency Room) for evaluation and treatment ... "	F 641		

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F 641	Continued From page 40	F 641		

A Department of Health Complaint /Incident Report submitted on 01/13/23 at 8:18 PM that documented: "Writer was informed that Resident was observed on the floor on her back at 4:50 PM. A nursing staff called the charge nurse to assess this Resident. Upon assessment, minor blood was noted at the back of her head ...area was cleaned with normal saline, ice pack was applied to the area ...Pressure dressing was applied to the site. Resident is alert, verbally responsive, but she could not recall how she got on the floor. Resident was asked if she hurts anywhere, she said no. She was able to move her extremities. The bed was on the lowest Position and the call bell was in the bed. Resident was assisted back to the bed by three nursing staff... [Name of Physician] was notified, she gave an order to send Resident to the nearest Emergency Room (ER) for evaluation and treatment ..."

A review of Resident #379's medical record revealed that the Resident had two falls; one fall with no injury on 12/26/22 and another fall with injury on 01/13/23.

A Quarterly MDS assessment dated 01/27/23 documented that Resident #379 had only one fall (with a minor injury) since the Resident's last assessment on 12/05/22, or since the resident's admission on 12/01/22.

During a face-to-face interview on 11/06/23 at 11:30 AM, Employee #15 (MDS Coordinator), acknowledged that the fall with no injury (on 12/26/222) was missed, and she stated that she would correct the resident's MDS assessment to include the Resident's fall.

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F 641	Continued From page 41	F 641		

[Cross-over DCMR 3231.2]

2. Facility staff failed to accurately code Resident #174's An Admission MDS assessment.

Resident #174 was admitted to the facility on 10/11/23 with diagnoses that included: Extradural and Subdural Abscess, Osteomyelitis of Vertebra, Lumbar Region and Urinary Tract Infection.

Review of Resident #174's medical record showed the following:

A Hospital Discharge Summary dated 10/11/23 at 2:45 PM documented that the resident had an L (lumbar) 4 - L5 laminectomy on 09/26/23.

An Admission Note dared 10/11/23 at 9:12 PM documented:
- Status post laminectomy and wound vac placement

A Skin/Wound Note dated 10/12/23 at 3:43 PM documented:
- Wound Nurse assessed patient
- Right lower posterior back, 4 (length) x 3.7 (width) x 5.7 (depth) cm (centimeter) with the PSAOS abscess (collection of pus in the iliopsoas muscle compartment)
- Wound vac in place

A Physician's Progress Note dated 10/15/23 at 10:08 AM documented:
- Status post laminectomy, wound vac placement PSOAS abscess

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F 641	Continued From page 42 An Admission /Medicare - 5 Day MDS assessment dated 10/16/2023 showed facility staff coded: a BIMS Summary Score of 15, indicating intact cognition and had no surgical wound(s). The evidence showed that facility staff failed to Resident #174's Admission MDS assessment to capture that he had a surgical wound on his right lower back. During a face-to-face interview on 11/06/23 at 2:39 PM, Employee #15 (MDS Coordinator), reviewed Resident #174's Admission MDS assessment, acknowledged the finding and stated, "The MDS will have to be modified to capture the surgical wound."	F 641		
F 656 SS=D	Cross Reference 22B DCMR Sec. 3231.11 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		

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F 656	Continued From page 43 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 47 sampled residents facility staff failed to implement a Resident's care plan for the use of carrot palm guards to bilateral hands to prevent skin integrity impairment and further immobility/contractures. Resident #25 The findings included:	F 656	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident t#25 was assessed by nursing on 11/3 and suffered no negative outcomes from failure to update the care plan for the refusal of palm guards. The care plan was updated on 11/3. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for all residents that have splint orders over the last 90 days and ensure they are accurately following the plan of care. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding updating care plans when new devices are introduced into resident’s plan of care, or refusals are documented and ensuring the plan of care is followed. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on updating care plans when refusal for splint is documented.	12/8/2023

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F 656	Continued From page 44 Resident #25 was admitted to the facility on 08/21/08 with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia. A review of Resident #25's medical record revealed the following: A Quarterly MDS dated 10/20/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "06," indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care. A physician's order dated 12/04/19 read: "Carrot palms to prevent further tightness on at 10:00 AM and off at 12:00 PM." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for skin integrity impairment related to immobility, incontinence ...Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of redness or skin breakdown ... Interventions: Apply pressure relief cushions and devices per order." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity ...Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) ...Interventions: ...splint application as recommended to right and left ext (extremity) ..."	F 656	This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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F 656	Continued From page 45	F 656		

A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands ...Goal: [Resident #25] will not have an increase of contracture by the next review in 90 days (initiated 06/14/16) ...Interventions: ...Apply carrot palm guards as ordered ..."

A physician's order dated 08/01/23 read: "Splinting order: Resident to wear bilateral palmer guard for 6 hours as tolerated to maintain skin integrity."

During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room.

During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand.

Based on three observations and a review of Resident #25's comprehensive care plan, the evidence showed that facility staff failed to implement the Resident's use of bilateral palm guards. In addition, the Resident's refusal for treatment (i.e. Resident #25's refusal to keep palmar guards on hands) was not included as

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F 656	Continued From page 46 part of the resident's comprehensive care plan. During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), when asked about the Resident's use of palm guards, stated that the resident takes them off and throws them down on the floor. When asked if she or any of the other facility staff made the physician aware that the resident was removing the palm guards, she stated that she had not, but would do so. The Employee then acknowledged that the Resident's refusal to keep the bilateral palm guards on should have been included as a focus of the resident's comprehensive care plan.	F 656		
F 688 SS=D	Cross Refrence 22B DCMR sect. 3210.4 (c) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		

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F 688	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews for one (1) of 47 sampled residents facility staff failed to ensure that a resident with a limited range of motion received the appropriate treatment and services to increase the resident's range of motion or prevent further decrease in range of motion. The findings included: Resident #25 was admitted to the facility on 08/21/08 with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia. A review of Resident #25's medical record revealed the following: A Quarterly MDS dated 10/20/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "06," indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care. A physician's order dated 12/04/19 read: "Carrot palms to prevent further tightness on at10:00 AM and off at 12:00 PM. A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has [a] risk for skin integrity impairment related to immobility, incontinence ...Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of	F 688	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #25 was assessed by nursing on 11/6 and suffered no negative outcomes from failure to update the care plan for the refusal of palm guards. The Physician was made aware on 11/6 and orders were to continue to encourage resident to wear splints. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for all residents that have refused splint orders over the last 8 days to ensure that the Physician is notified. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee in-serviced all Restorative Aides and nursing leadership on the Policy and procedures regarding carrying out Physicians orders for restorative care and contacting them when any changes or refusals occur. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on physician orders and contacting physicians for refusal of splints. This audit will be done weekly for four (4) weeks and	12/8/2023

	monthly for two (2) months. Findings to be	

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F 688	Continued From page 48 redness or skin breakdown ... Interventions: Apply pressure relief cushions and devices per order." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity ...Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) ...Interventions: ...splint application as recommended to right and left ext (extremity) ..." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands ...Goal: [Resident #25] will not have an increase of contracture by the next review in 90 days (initiated 06/14/16) ...Interventions: ...Apply carrot palm guards as ordered ..." A physician's order dated 08/01/23 read: "Splinting order: Resident to wear bilateral palmer guard for 6 hours as tolerated to maintain skin integrity." During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room.	F 688	reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand.

During a face-to-face interview on 11/03/23 at 1:48 PM, Employee #23 (Restorative Nursing Aide/RNA), stated that she had not applied the resident's palm guards to the resident's hands, because the resident removed them all the time. When asked if she had let the Restorative Nurse Manager know that Resident #25 was not keeping the splints (palm guards) on, Employee #23 said that everyone knew including the Restorative Nurse Manager (Employee #22).

On 11/03/23 review of the Splint Monitoring Form for 11/01/23 to 11/03/23, showed that the Restorative Nursing Aides documented that they were applying Resident #25's splints at 7:00 AM and were removing the splints at 3:00 PM.

During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), stated that the resident takes the palm guards off and throws them. When asked if she or any of the staff made the physician aware that the resident was removing the palm guards, she stated that she had not, but would do so.

During an observation on 11/06/23 at 12:25 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrist. The resident's fingers on her right hand were tightly bent into her right palm. There were no palm guards applied to either hand.

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F 688	Continued From page 50 During a face-to-face interview on 11/06/23 at 12:20 PM, when asked about the Resident's palm guards, Employee #24 (Licensed Practical Nurse) observed that the Resident was not wearing the palm guards and stated that the RNA applied them earlier, but the Resident took them off. When asked if she had docuemneted the resident's behavior or had mentioned the resident's behavior to the physician, she stated that she had not. The employee then opened the top drawer of the resident's nightstand, removed the resident's palm guards, and started to apply them to the resident's hands. When Employee # attempted to straighten the resident's contracted fingers on her right hand, to apply the right-hand palm guard, the resident grimaced and stated that it hurt. The Employee then stated that she would mention to the physician the resident's refusal to keep the palm guards on her hands. Based on three observations, record reviews and staff interviews, the evidence shows that the facility staff failed to provide appropriate treatment to increase Resident #25's range of motion or prevent the resident's further decrease in range of motion. In addition, facility staff failed to make the physician aware of the resident's refusal to wear her palm guards, so that alternative treatment for the resident's limited range of motion could be prescribed. Cross Refrence 22B DCMR sect. 3213.2(e)	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		

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F 689	Continued From page 51 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff failed to adequately supervise Resident #331, while toileting as required by the residents Minimum Data Set (MDS) assessment which staff coded as requiring supervision and a one person staff assist with toileting. (Resident #331.) The Findings Included: A review of the facility's policy titled "Fall and Fall Management" documents " ...If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...Staff will monitor if interventions have been successful in preventing falling ...If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions ..." Resident #331 was admitted to the facility on 01/05/23, with multiple diagnoses that included the following: Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit. A review of a complaint intake #DC00011545, that was submitted to the State Agency on 01/23/23, documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out	F 689	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #331 no longer resides at the facility. This deficiency cannot be retroactively corrected. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for residents that need assistance while toileting that they were assisted appropriately with no falls reported. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided in-service all nursing staff and leadership on the Policy and procedures regarding ADL coding and ADL execution. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on proper ADL assistance. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/8/2023

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F 689	Continued From page 52	F 689		

nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..."

Review of Resident #331's medical record revealed the following:

[Baseline Care Plan] dated 01/06/23, documents " ...Toilet use: support provided One-person physical assist ..."

Review of an Admission Minimum Data Set assessment (MDS) dated 01/11/23, showed that the facility staff coded Resident #331 as having a Brief Interview for Mental status (BIMS) summary score of "14" which indicates intact cognition. The facility staff coded that the resident required supervision and one-person physical assist with toileting.

[Nursing Progress Note] 01/11/23 at 2:00 AM, documents " ...At approximately 11:15 pm, a Night shift Staff answered a call bell light in Room 115 B, the Resident in Room 115 A was on the floor. She called another Staff to assist her with the Resident. Writer was called to assist and assess the Resident. She was on the floor in a sitting Position on her buttocks and leaning on the bed. Resident said that she was going to the bathroom, urinated on the floor and missed her step and sledded on the floor. Pain assessment was done, she denied Pain, Neurological assessment was done, she is alert, oriented, no

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injury noted, she can move all her extremities, she did not verbalize any Pain or discomfort. Three Staff assisted her to her bed, call bell was already within reach. She was encouraged to call for assistance any time she needs help ..."

[Post Fall Huddle] 01/11/23 at 1:12 AM, " ...Post-Fall Huddle Recommendations /New Intervention to prevent another fall (what could have been done differently-Encourage resident to use call bell and call for assistance ..."

[Nursing Progress Note] 01/20/2023 at 9:52 AM, documents " ...around 5:40 am, Resident was taken to the bathroom and placed on the commode, and was told to pull the call light when she is done, the CNA (Certified Nurse Aide) was cleaning Resident's room when she heard her call for help, on getting inside the bathroom, Resident was observed sitting on the bathroom floor, As per Resident, she said she fell on her back, but denied hitting her head on the floor, Head to toe assessment done, no injury noted, ROM (Range of Motion) tolerated and within Resident's baseline, ..."

[Post Fall Huddle] 01/20/23 at 6:57 AM, " ... Description of Fall- Resident was getting up from commode without calling for help ...Post- Fall Huddle Recommendations /New Intervention to prevent another fall what could have been done differently- Re educated to use call light ..."

[Release of Responsibility for Discharge] was signed by Resident #331 on 01/20/23 at 7:30PM.

The medical record lacked documented evidence that the facility staff provided supervision while toileting Resident #331.

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F 689	Continued From page 54 During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that supervision with toileting means that the staff should be in the bathroom with the resident and acknowledged the findings.	F 689		
F 755 SS=D	Cross Reference 22B DCMR Sec. 3211.1 (d) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		

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F 755	Continued From page 55 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed. The findings included: During an observation on 11/01/23 at 8:13 AM of the 3rd Floor narcotic book, it was noted that there was no signature in the section "Balance verified by nurse coming on duty" for the 7:00 AM - 3:00 PM shift on 11/01/23. The evidence showed that facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed as evidenced by failing to sign off that the narcotic count was correct with the off-going nurse. During a face-to-face interview done at the time of the observation, Employee #19 (Licensed Practical Nurse/LPN) stated that her shift started 7:00 AM. The employee further stated, "I had to run to the bathroom during the [narcotic] count and forgot to sign off." Cross Reference 22B DCMR Sec. 3224.3	F 755	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcome. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by all Unit Managers for all active residents on narcotics and a med pass was observed on each unit to ensure all procedures were followed. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided house wide in-service for licensed nurses on the Policy and procedures regarding narcotic reconciliation. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on narcotic reconciliation. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/8/2023
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		

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F 756	Continued From page 56 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff	F 756	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident 137 suffered no negative outcomes from failure to show documented evidence in the medical record that the Physician reviewed the Pharmacy Regimen Review. The completed Pharmacy review was uploaded in the resident's medical record on 12/8/2023. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the Nurse Educator for all Pharmacy Regimen Reviews over the last 90 days to ensure they were documented in the medical record. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided in-service all nursing leadership on the Policy and procedures regarding the process to complete Pharmacy Regimen Review. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Assistant Director of Nursing to ensure the facility implements its policy Pharmacy Regimen Reviews. This audit will be done for at least 5 residents per unit, weekly for four (4) weeks and monthly for two (2) months.	12/8/2023

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F 756	Continued From page 57 failed to show documented evidence in the medical record that the physician reviewed the pharmacy regimen review for Resident #137. The Findings included: A review of the facility's policy tilted "Medication Regimen Review" with a revision date of 06/2023 documents " ...The Consultant Pharmacist shall review the medication regimen of each resident at least monthly ...Routine reviews will be done monthly ...Copies of drug/medication regimen review reports including physician responses will be maintained as part of the permanent medical record ..." Resident #137 was admitted to the facility on 11/14/22, with multiple diagnoses that included the following: Dementia, Paranoid Schizophrenia, and Gastrostomy Status. Review of Resident #137's medical record revealed the following: A review of a Quarterly Minimum Data Set (MDS) assessment dated 09/18/23, shows that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 13 indicating intact cognition and as receiving antipsychotic medication. Pharmacy medication regimen reviews were reviewed in the medical record from 01/01/2023 to 10/02/2023. The pharmacist made recommendations on the following dates: 02/02/23, 03/01/23, 04/01/23, 04/28/23, 06/01/23, 09/01/23, and 10/02/23. The physician response to the medication	F 756	Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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F 756	Continued From page 58 regimen reviews were not present in Resident #137's medical record. During a face-to-face interview conducted on 11/06/23 at approximately 12:00 PM, Employee #10 (QA Quality Assurance) stated that the facility is in the process transitioning into 100% electronic health records and that the physician response to the pharmacist was in a binder in an office. Employee #10 acknowledged the findings.	F 756		
F 761 SS=D	Cross Reference 22B DCMR Sec. 3231.9 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

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F 761	Continued From page 59 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on two (2) of ten (10) observations and facility interviews, facility staff failed to store and label biologicals in accordance with currently accepted professional practices. The findings included: According to the Institute for Safe Medication Practices (ISMP) - Vials of insulin dispensed from the pharmacy should be labeled appropriately and include the patient's name. https://www.ismp.org/resources/clinical-reminder-about-safe-use-insulin-vials According to Healthline: - Insulin is effective for 28 days after opening - Users are supposed to mark the date they open a vial or began using a pen, and then keep track and discard it after 28 days https://www.healthline.com/diabetesmine/what-to-do-with-expired-insulin 1. During an observation of the 4th floor medication storage room on 10/31/23 at 2:10 PM, one opened Lantus (type of Insulin) vial stored for use that was not labeled with an open or expire date During a face-to-face interview at the time of the observation, Employee #21 (Licensed Practical Nurse/LPN), acknowledged the finding and	F 761	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcomes. The insulin pens were discarded on the day of the finding and new ones were ordered. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Unit Managers for all insulin stores on the medication carts and rooms. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided house wide in-service for Licensed Nursing staff on the Policy and procedures regarding storing and labeling biologicals in accordance with regulatory standards. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on biological labeling and storing in accordance with regulatory standards. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations.	12/8/2023

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F 761	Continued From page 60 appropriately discarded the Lantus vial. 2. During an observation of the 2nd floor, team 2 medication cart with Employee #20 (Licensed Practical Nurse/LPN) on 11/01/23 at 8:00 AM, one (1) Novolog (type of Insulin) pen stored for use that did not contain a resident label and one other Novolog pen that was not labeled with the date it was opened or the expire date. During a face-to-face interview at the time of the observation, Employee #20 acknowledged the findings and stated that she would discard the Novolog pens. Cross Reference 22B DCMR Dec. 3227.19	F 761	All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/8/2023
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcomes. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. Temperature logs were reviewed over the last 30 days to ensure that the wash cycle reached the proper temperature of 150-165 degrees Fahrenheit. The Maintenance Director has confirmed that as of 11/17, the dishwasher has been fixed in accordance with sanitary regulations.	

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F 812	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on two (2) observations of the dishwashing cycle and staff interview, facility staff failed to ensure that the dishwasher reached the required temperature (150 degrees to 165 degrees Fahrenheit) to clean dishes and utensils under sanitary conditions. The findings included: During an observation in the facility kitchen on 10/31/23 at 10:55 AM, it was noted that the high temperature dishwasher, during the wash cycle, reached a high of 130 degrees Fahrenheit. In a second observation on 10/31/23 at 11:00 AM, the wash cycle temperature reached a high of 132 degrees Fahrenheit. During a face-to-face interview at the time of the both observations, Employee #25 (Food Service Director) acknowledged the findings and stated that the Maintenance Director would be notified to address the issue. Cross Reference 22B DCMR Sec. 3219.1	F 812	**MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided an in-service all dietary staff on the Policy and procedures regarding dishwasher temps. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on dishwasher temps in accordance with regulatory standards. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/8/2023
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 229, 132, and 128 suffered no negative outcomes. This deficiency cannot be retroactively corrected. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice	

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F 842	Continued From page 62 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight 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	F 842	An audit was done by ADON for all incidents and accidents and the Nurse Educator completed an audit for all skin assessments over the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. An audit was done on 12/6/23 by the ADON to check for refusal documentation when resident refuses to get out of bed. This deficiency cannot be retroactively corrected An audit was done on 12/6/23 by the Unit Managers to ensure the post fall huddle and weekly skin assessments contains accurate information. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding accurately documenting in the medical record. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Assistant Director of Nursing/designee for 10 residents per unit to ensure the facility implements its policy on accurately documenting in the medical record by auditing documentation during resident transfers to the hospital, weekly skin assessments and post fall huddles. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for three (3) of 47 sampled residents, facility staff failed to ensure resident's records contained accurate information. Residents' #229, #132 and #128.

The findings included:

1A.The facility's staff failed to ensure Resident #229's Post Fall Huddle dated 12/31/22 contained accurate information as evidence by documenting the resident's fall as witnessed.

Resident #229 was admitted to the facility on 12/23/22 with multiple diagnoses including Stage 4 Malignant Neoplasm of Lower Lobe,

A nursing note dated 12/31/22 at 11:30 PM documented the following but not limited to:
"Resident was observed by medication nurse at

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11:00 pm and she was sleeping. Around 11:15 pm resident was observed on floor, unresponsive resident was transferred back to bed. CPR was initiated. 911 was called."

A review of a Post Fall Huddle dated 12/31/22 at 11:40 PM documented the following but not limited to: "Was fall witnessed? Yes."

1B. The facility's staff failed to ensure accurate information was included in the Facility Reported Incident. As evidenced by, not including the resident expired in the facility and discharged to a funeral home.

Resident #229 was admitted to the facility on 12/23/22 with multiple diagnoses including Stage 4 Malignant Neoplasm of Lower Lobe, Generalized Muscle Weakness, and Legally Blind.

A nursing note dated 12/31/22 at 11:30 PM showed, "Resident was observed by medication Nurse at 11:00 PM and she was sleeping. Around 11:15 PM resident was observed on floor, unresponsive resident was transferred back to bed. CPR was initiated. 911 was called and arrived around 11:43. Dr Allen was called and ordered to transferred to nearest Hospital for evaluation and treatment via EMS. Responsible Party was called."

A nursing note dated 01/01/23 at 2:10 AM documented, "EMS (Emergency Medical Services) team pronounced resident dead at approximately 12:35 am, CPR terminated, [doctor's name] made aware and he stated that cause of death is Malignant Neoplasm of Lower Lobe of Left Bronchus or Lung. RP (responsible

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party) could not be reached on phone immediately but a call back message was left. Resident was given postmortem care with dignity. Writer will continue to follow up with RP."

A State Survey Facility Reported Incident Intake form# DC~11434 dated 01/01/23 at 4:39 AM documented, "According to the charge nurse, resident was last seen lying on her bed with bed on lowest position and respiration un-labored at 11PM. By 11:15 PM, resident was observed on the floor unresponsive. Code called, resident was assisted back to the bed. MD was made aware and MD gave order to transfer resident to the nearest ER via 911 for treatment and further evaluation."

A nursing note dated 01/01/23 at 6:56 AM documented, "The remains of resident body was collected by two DC morgue personnel by 6:26am. RP could not be reached on [phone number]. Next shift will follow up."

During a telephone interview on 11/02/23 at 2:58 PM, Employee #5 (Nurse Supervisor) stated that she sent the Facility Report Incident to the State Survey Agency. However, she did not provide an explanation as to why she did not include that the resident had expired in the facility and discharged to the funeral home.

2. Facility staff failed to accurately document Resident b#132's refusal of care in the Treatment Administration Record (TAR).

Resident #132 was admitted to the facility on 07/23/22 with diagnoses that included: Muscle Weakness and Cognitive Communication Deficit.

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Review of Resident #132's medical record revealed the following:

A physician's order dated 02/21/23 directed, "Continue use of brace when sitting up or out of bed, every shift"

A physician's order dated 05/23/23 directed, "Resident needs to get out of bed to recliner daily, every day and evening shift"

A Quarterly Minimum Data Set (MDS) assessment dated 07/30/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition.

A Complaint, DC12341, received by the State Agency on 10/04/23 documented:
- [Resident #132] has been recommended by a chiropractor to wear her back brace. This recommendation request the use of the back brace when she's sitting in a chair. I have witnessed back brace not being used as directed

A care plan focus area: [Resident #132] is noncompliant with getting out of bed to the jerry chair, back brace was initiated on 10/11/23.

During an initial observation of Resident #132 on 10/30/23 at 10:50 AM, she was observed lying in bed in bed. While the surveyor was in the room, the resident's assigned Certified Nurse Aide (CNA), Employee #26 entered the room and told the resident that she would be getting ready to put on her back brace and then getting her up into the chair. Resident #132 refused, stating, "I'm not getting out of bed today." The CNA asked again with the resident still refusing.

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During a second observation of Resident #132, on 10/30/23 at 2:40 PM, the resident was noted in bed.

During a face-to-face interview on 10/30/23 at 2:43 PM, Employee #26 stated, "Resident refused to get out of bed today, I tried multiple times. I let the nurse know. She gets a shower tomorrow and usually on those days she'll sit up in the chair."

Review of the Treatment Administration Record (TAR) on 11/02/23 at approximately 11:30 AM showed that on 10/30/23, day shift (7:00 AM - 3:00 PM), facility staff documented a check mark and their initials to indicate that the following order was administered and or carried out, "Resident needs to get out of bed to recliner daily every day and evening shift".

The evidence showed that facility staff failed to accurately document that Resident #132 refused to get out of bed care on the TAR on 10/30/23.

During a face-to-face interview on 11/02/23 at 11:52 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, "We don't document things that weren't done or didn't happen."

Cross Reference 22B DCMR Sec 3231.11

3.The facility staff failed to accurately document the presence of open areas on Resident #128's weekly skin assessments.

Resident #128 was admitted to the facility 09/20/23 with multiple diagnoses that included the

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following: Cutaneous Abscess of Right Lower Limb, Pressure Ulcer left Buttock Unstageable, and Pressure Ulcer of Unspecified Heal Stage 3.

A review of the facility's policy titled "Clinical Documentation Record" revised on 05/2023 documents " ...It is the policy of this facility to ensure accurate documentation of important elements contributing to high quality care of our residents ...Documentation Entries into organization documents or the health record (including but not limited to provider orders) must be: Accurate, valid, and complete ..."

Review of Resident #128's medical record revealed the following:

[Admission Note] 09/20/2023 at 2:22 AM documents " ..., has altered skin issues on unstageable Sacral decubitus ulcer measuring 11 x 13 cm (centimeters), Left hip DTI (Deep Tissue Injury) 9 x 10 cm, Right heel 9 x6 cm, R (Right) /foot 4 x 5 cm, R/knee eschar 5 x 3 cm, Left foot dorsal 2 x 4 cm, and double lumen Picc (peripherally inserted central catheter) line on right upper arm ..."

A review of the Admission Minimum Data Set (MDS) assessment dated 09/25/23, revealed that the facility staff coded the following: Brief Interview for Mental Status (BIMS) summary score of "14" indicating intact cognition, the resident is at risk of developing pressure ulcers, the resident has one or more unhealed pressure ulcers, two (2) stage 3 pressure ulcers present on admission, one (1) stage 4 pressure ulcer present on admission, three (3) unstageable pressure ulcers present on admission and an infection of

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the foot. The facility staff coded that Resident #128 received the following skin and Ulcer/Injury treatments: Pressure reducing device for chair, turning /repositioning program, nutrition hydration intervention, pressure ulcer injury care, application of nonsurgical dressing, application of ointments/medications and application of dressing to feet.

[Skilled Documentation] 10/17/23 at 10:22 PM, documents " ...Skin issues: osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection Active Infection"

[Weekly Skin Assessment] 10/17/23, at 10:48 PM documents " ...Describe the skin impairment No new skin alteration" The interventions section was blank.

[Weekly Skin Assessment] 10/24/2023 at 9:06 AM, documents" ...Describe the skin impairment none.." The interventions section was blank.

[Skilled Documentation] 10/25/23 at 2:02 PM, documents " ...Wound location(s) ...osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection."

[Weekly Skin Assessment] 10/31/23 at 10:52 AM, documents " ...Describe the skin impairment none ..." The interventions section is left blank.

[Skilled Documentation] 10/31/23 at 11:17 AM, documents "......Wound location(s) ...osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection."

[Weekly Skin Assessment] 11/07/23 at 2:30 PM, documents "... Describe the skin impairment

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F 842	Continued From page 70 none ..." The interventions section is blank. [Skilled Documentation] 11/07/23 at 8:29 PM, documents " ...Wound locations: Osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection ..." The weekly skin assessments from 10/17/23 through 11/07/23 inaccurately document the condition of Resident #128's skin. During a face-to-face interview conducted on 11/13/23 at 10:20 AM, Employee #18 (Wound Nurse) stated that the weekly skin assessments are inaccurate and acknowledged the findings. During a face-to-face interview conducted on 11/13/23 at approximately 12:00 PM, Employee #9 (Licensed Practical Nurse) stated they do skin assessments every week and she thought she was only to document if there were new wounds.	F 842		
F 849	Cross Reference 22B DCMR Sec. 3231.11 Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident 15 suffered no negative outcomes. The care plan for hospice for Resident #15 was updated on 12/7/2023. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator on all active hospice residents to ensure that the hospice plan of care is updated and correlates to the facility's care plan for the	12/8/2023

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F 849	Continued From page 71 §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate	F 849	residents. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding compliance with hospice service regulations. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on hospice service regulations by updating Hospice plan of care. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the

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hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.

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(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility staff failed to ensure that one (1) of 47 sampled residents had a current written hospice care plan that included both the most recent hospice plan of care and a description of the care and services furnished by the long term care facility. Resident #15

The findings included:

A review of the facility's Hospice agreement documented, "...Hospice Plan of Care means a

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written plan which is established, maintained, reviewed and modified if necessary by an Interdisciplinary Hospice Team..."

"Nursing Home Plan of Care means a written care plan which is established, maintained, reviewed and modified if necessary by a Nursing Home Interdisciplinary Team ..."

"Design and Maintenance of Hospice Plan of Care ...Hospice shall furnish the Nursing Home with a copy of the following items: ...2) the most current Hospice Plan of Care ... The Hospice Plan of Care will identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care."

"Design and Maintenance of Nursing Home Plan of Care ...Nursing Home shall furnish Hospice with a copy of the Nursing Home Plan of Care. The Nursing Home will periodically review and modify the Nursing Home Plan of Care in coordination with Hospice ..."

"Compilation of Records ...Each medical record shall completely, promptly, and accurately document all services provided to, and events concerning, each Residential Hospice patient ..."

Resident #15 was admitted to the facility on 09/07/04 with the following diagnoses: Polyosteoarthritis, Age-Related Physical Debility, Parkinson's Disease, Legal Blindness, Schizophrenia, Dementia, and Encounter for Palliative Care.

A review of Resident #252's medical record

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revealed:

A Face Sheet documented that Resident #15 had an Court Appointed Guardian/Representative.

A Physician's Order dated 01/21/22 documented: "Resident readmitted to [Name of Hospice] with a diagnosis of Parkinson's Disease with a prognosis of six (6) months or less if the disease goes the normal course. Please call [Name of Hospice] at...when there is a change of care condition. Symptoms management concern, death of a patient, clinical changes prior to any test/hospitalizations."

An Informed Consent Form documented that Resident #15 was to receive hospice services from [Name of Hospice], signed by Resident #15's Representative on 04/21/21.

A Medicare Hospice Benefit Election Form that documented that the Resident was to receive hospice benefits and signed by Resident #15's Representative on 04/21/21.

A care plan initiated on 04/27/21 documented: "Focus: Advanced directive form has been completed and Resident is currently on hospice care with [Name of Hospice and Phone Number] with a diagnosis of Parkinson's Disease ...Care Plan Goals reviewed 05/17/23.

A care plan initiated on 06/29/23 documented: "Focus: [Resident #15] admitted with Hospice [Name of Hospice] with a diagnosis of Parkinson's Disease. Interventions: Allow/resident/family to discuss feelings, etc, Arrange visits with clergy, social worker, or psychological services prn (as needed), Assis

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with ADL care and pain management as needed, Encourage loved ones to keep in contact/visit, Evaluate for unmet needs such as toileting, hunger, thirst, fatigue, Hospice referral, Observe for and medicate for pain/discomfort as needed. Notify MD of unrelieved pain. Of note, the Nursing home care plans for Resident #15 had not been updated since 06/29/23 and did not include or specify the care and services that were to be provided by the Hospice agency.

A Hospice Plan of Care for Resident #15 from [Name of Hospice] dated 06/23/22 documented:: "DME/Supplies: DME: Oxygen concentrator; Safety Measures: Aspiration precautions, Equipment, Safety start, Fall precautions, ...Support during transfer and ambulation, Standard precautions/infection control, Use of assistive devices; Diet/Hydration: Pureed diet ...Goals/Interventions/Summary of Problems: Pain/Alteration in comfort ...Interventions: Administer pain medication as prescribed ... Respiratory: Alteration in Respiratory Status ... Interventions: Assess respiratory status...Patient/Caregiver will demonstrate safe use and maintenance of respiratory equipment ...GU/GI Nutritional/Endocrine: Alteration in Nutrition related to disease progression as evidenced by weight ...Interventions: Determine nutrition hydration needs and desires... Integumentary: Potential for skin breakdown due to immobility ...Medical Social Services Interventions: Assist family/caregiver with coping, ...Counseling for family/patient coping, Counseling for planning decision making, Facilitate problem-solving and decision making, and Financial counseling/linkage for additional resources ..."

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Of note the Hospice Plan of Care included in Resident 25's medical record, had not been updated since 06/23/22 and did not specifically identify which hospice provider was responsible for performing the respective functions that were agreed upon and included in Resident #25's Hospice Plan of Care.

A review of the Quarterly Minimum Data Set Assessment on 08/03/23 documented that the Resident had received hospice services within the last 14 days of the assessment.

Further review of Resident #15 medical record lacked documented evidence that facility staff updated the Resident's comprehensive person-centered care plan to include the hospice agency's care plan for the Resident.

During a face-to-face interview on 11/14/23 at 10:14 AM, Employee #28 (Hospice Nurse) stated Resident #15's Hospice Plan of Care had been updated since 06/29/23 and she was not aware that the facility did not have a copy of Resident #15's most recent Hospice Plan of Care. She then added that she would print the resident's most recent hospice plan of care and would leave it with the Resident's nurse.

During a face-to-face interview on 11/14/23 at 10:28 AM, Employee #27 (Registered Nurse) acknowledged that Resident #15's comprehensive care plan had not been updated and did not include the hospice plan of care for the resident.