STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility from July 30, 2023 to August 9, 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 43 and the survey sample included 32 residents. The following Complaints were investigated: DC~11004 and DC~11147. The following Facility Reported Incidents were investigated: DC~12085 DC~11929 DC~11758 DC~11663 DC~11613 DC~11439 DC~11166 DC~11435 DC~11409 DC~11384 DC~11272 DC~11372 DC~11267 DC~10985 DC~11197 DC~11202 DC~11312 DC~11151 DC~11118 DC~11084 DC~11034 DC~10858 DC~10687	F 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 11/29/23

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

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F 000	Continued From page 1	F 000		

DC~10563
DC~10309

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.

Citations are being cited for: DC~11929, DC~11758, DC~11439, DC~11166, DC~11409, DC~11372, DC~11202, DC~11151, DC~11118, DC~11034, DC~11004, DC~11147, and DC~10309.

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

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F 000	Continued From page 2 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube 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	F 000		

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F 000	Continued From page 3 POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 575 SS=D	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced	F 575	1. On 8/24/23, the facility Immediately posted the signage reflecting the accurate contact information of the state Survey Agency in a manner feasible, accessible, and understandable to residents and their representatives. 2. All residents have the potential to be impacted by this practice. There were no additional findings related to this citation on 8/24/2023. 3. On 8/24/23, the Social Service Director/Designee provided training for Social service staff responsible on the need to display accurate contact information of the state survey agency in a manner accessible and understandable to residents and their representatives. Designated staff will also ensure the accuracy of information posted through monthly audit x 6 months and report any issues to the Administrator and DON. 4. The Director of Social Service/ Designee will report the results of the audit at the quarterly QAPI meeting until 1/25/2024.	10/15/23

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F 575	Continued From page 4	F 575		

directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to visibly post signage of the accurate contact information for the State Survey Agency to ensure residents and resident representatives were able to file a complaint. The facility census was 43 on the first day of the survey.

The findings included:

A Complaint (DC~11004) received by the State Agency on 09/28/22 at 11:19 AM documented, "... She [resident's daughter] made her [resident 's daughter] complaint to the Ombudsman Office and had been leaving messages for [State Agency Program Manager's name] as posted around the facility. She [residents daughter] learned a few days later that [contact person name] was deceased, but the signage does not reflect an alternative person to contact."

During an observation on 08/04/23 at 10:30 AM, an 8x10 binder marked "Grievance Forms" sign posted on the First-Floor unit board at the elevator instructed the resident to "After completing a grievance form, please contact the Social Worker ... or Charge Nurses to collect the forms."

On 08/04/23 between 10:00 AM and 12:00 PM, additional observations were conducted on the second floor which showed the identical signage was posted in the same location.

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F 575	Continued From page 5 The evidence showed that the facility failed to post the accurate State Survey Agency information to ensure residents and resident representatives had the contact information needed to file a complaint. During a face-to-face interview conducted on 08/04/23 at 12:00 PM, Employee #1 (Administrator) acknowledged the findings and proceeded to get new signage with the accurate State Survey Agency information posted.	F 575		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		

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

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F 623	Continued From page 6 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623	1. The facility was informed that Resident #253 was affected by this deficiency on 8/9/2023. Corrective action could not be taken retrospectively as the resident has since returned to the facility. 2. The facility recognizes that all residents have the potential to be affected. The Director of Social Service/Designee completed review on 8/16/2023 on all residents who were transferred, relocated, or discharged, to ensure they received proper notification regarding discharge. Discharges and transfers done 30 days prior 8/9/23 were reviewed, a total of 19 residents required 6-108, 16 were completed. Corrective action could not be accomplished on the remaining 3 residents retrospectively. There is no report of harm to any resident resulting from this deficiency. 3. Director of Social Services provided in-service training to social service staff and License Nurses on 8/15/23 on corrective measures including proper notification of transfer, relocation, and discharge to the resident and or responsible party of transfer, relocation, and discharge. A Social Worker/ Designee will monitor compliance and audit monthly x 6 months and report findings to the Director of Social Services. Any issues found from the audit would be addressed by the DON. 4. Director of Social Services/Designee will report the audits to the QAPI Committee that meets quarterly until 1/25/2024.	10/15/23

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F 623	Continued From page 7 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 32 sampled residents, the facility staff failed to notify a resident, their representative, or the Ombudsman of the reason for the resident's transfer to the hospital in writing. Resident #253. The findings included:	F 623		

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F 623		F 623		

Continued From page 8

Resident #253 was admitted to the facility on 11/03/21 with the following diagnoses: Left Hip Arthroplasty, Thrombosis Distal Left Cephalic Vein, Bilateral Leg Swelling, Rheumatoid Arthritis, and Osteoporosis.

Resident #253's medical record revealed the following:

A Face Sheet that documented that the resident had a representative.

A Five (5)-Day Scheduled Minimum Data Set (MDS) Assessment dated 11/07/21 showed that facility staff did not complete Section C (cognitive patterns).

A Change in Condition Note dated 11/07/21 at 4:08 PM documented: "Situation: Resident reported that her left calf is hurting. Background: Resident ...admitted with a diagnosis of left hip replacement ... A quick assessment was done; she was noted with a swollen left leg calf filled with fluid, but skin remains intact. Recommendations: Md (Medical Director) notified, and new order given to send resident to the nearest ER (Emergency Room) for evaluation. Contact person notified."

A Health Status Progress Note dated 11/07/21 at 11:42 PM documented: "Resident was transferred to [Local Hospital] ... by ...[Local Medical Emergency Response Team] at 5:30 PM. Writer called ... E.R.(Emergency Room) the E.R. Nurse confirmed that [Resident #253] is being admitted for leg pain ..."

Further review of Resident #253's medical record lacked documented evidence that facility staff

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F 623	Continued From page 9 provided written notification to the resident's representative or the Ombudsman of the reason for transfer on 11/07/21. During a face-to-face interview on 08/08/23 at 11:38 AM, Employee #3 (Social Worker) acknowledged the findings and stated that notification was made via telephone to the Resident #253's representative.	F 623		
F 625 SS=E	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 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	F 625		

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F 625	Continued From page 10 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 review and staff interview, for four (4) of 32 sampled residents, facility staff failed to provide written notice of the bed hold policy to include the number of bed hold days to the resident or their responsible party upon transfer to the emergency room. Residents' #197, #253, #27 and #98. The findings included: The facility policy "Bed Hold" documented, "... At the time of transfer or leave of absence, the social worker will notify the resident/responsible party of the transfer and the number of bed-hold days remaining..." 1. Resident #197 was admitted to the facility on 10/18/22 with multiple diagnoses that included: Repeated Falls, Muscle Weakness, Unsteadiness on Feet and Abnormalities of Gait and Mobility. Review of Resident #197's medical record revealed: An Admission Minimum Data Set (MDS) dated 10/25/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A Health Status Note dated 11/03/22 at 8:20 AM documented: "On 11/3/22 around 7:30 AM during rounds resident reported to charge nurse that resident fell ... MD (medical doctor) notified and order to transfer resident to the nearest ER (emergency room). POA (power of attorney)	F 625	1. On 8/4/23 the facility was informed that bed hold policy was not provided to residents #197, #253, #27, and #98, and or responsible party upon transfer to the hospital. Retrospective corrective action could not be accomplished as the four residents had since returned to the facility. 2. All residents residing in the facility have the potential to be impacted. On 8/4/23 the Director of Social Service completed a facility audit of residents transferred within the last 30 days, to identify any failure to give written notice to the resident or their responsible party of the bed hold policy including the number of bed hold days upon transfer to the emergency room. Out of the five residents identified, four received timely notice of bed hold policy while 1 resident could not be completed retrospectively. No residents were harmed by this deficient practice. 3. The Director of Social Services provided in- service training to social service staff and license nurses on 8/4/23 on the need to prove written information on the facility's bed hold policy to the resident and or their responsible party upon transfer, relocation, and discharge. The Director of Social Service/Designee will monitor and audit for compliance monthly x 6 months to ensure compliance. Any issues found during the audit will be addressed. 4. Director of Social Services or designee will report the audit to the QAPI Committee that meets quarterly until 1/25/24.	10/15/23

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F 625	Continued From page 11 made aware..." A physician's order dated 11/03/22 directed, "Transfer resident to the nearest ER via 911 for further evaluation post fall." A Facility Reported Incident (FRI), DC~11151, received by the State Agency on 11/03/22 documented, "On 11/3/22 around 7:30AM during rounds resident reported to Charge Nurse that She fell...On assessment swelling with bruise noted to the right hip...MD[medical doctor] notified and ordered to transfer resident to the nearest ER [emergency room] ... Resident's emergency contact person notified ...Resident transferred as ordered." Further review of Resident #197's medical record showed no documented evidence that facility staff provided the resident or their POA written notice of the bed hold policy to include the number bed hold days upon transfer to the emergency room on 11/03/22. During a face-to-face interview conducted on 08/04/23 at 9:25 AM, Employee #3 (Director of Social Services) acknowledged the findings and stated, "We have identified holes in our process of informing residents and their family or responsible party of bed hold policy and days. It's been brought up to quality improvement and we are working on ways to make improvements." 2. Resident #253 was admitted to the facility on 11/03/21 with the following diagnoses: Left Hip Arthroplasty, Thrombosis Distal Left Cephalic Vein, Bilateral Leg Swelling, Rheumatoid Arthritis, and Osteoporosis.	F 625		

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F 625	Continued From page 12	F 625		

Continued From page 12

Resident #253's medical record revealed the following:

A Face Sheet that documented that the resident had a representative.

A Five (5)-Day Scheduled Minimum Data Set (MDS) Assessment dated 11/07/21 showed that facility staff did not complete Section C (cognitive patterns).

A Change in Condition Note dated 11/07/21 at 4:08 PM documented: "Situation: Resident reported that her left calf is hurting. Background: Resident ...admitted with a diagnosis of left hip replacement ... A quick assessment was done; she was noted with a swollen left leg calf filled with fluid, but skin remains intact. Recommendations: Md (Medical Director) notified, and new order given to send resident to the nearest ER (Emergency Room) for evaluation. Contact person notified."

A Health Status Progress Note dated 11/07/21 at 11:42 PM documented: "Resident was transferred to [Local Hospital] ... by ...[Local Medical Emergency Response Team] at 5:30 PM. Writer called ... E.R.(Emergency Room) the E.R. Nurse confirmed that [Resident #253] is being admitted for leg pain ..."

Further review of Resident #253's medical record lacked documented evidence that facility staff provided written notice of the bed hold policy to include the number bed hold days upon transfer to the emergency room on 11/07/21.

During a face-to-face interview conducted on 08/04/23 at 9:25 AM, Employee #3 (Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 13	F 625		

Social Services) acknowledged the findings and stated, "We have identified holes in our process of informing residents and their family or responsible party of bed hold policy and days. It's been brought up to quality improvement and we are working on ways to make improvements."

3. Resident #27 was admitted to the facility on 11/22/21 with multiple diagnoses that included: Alzheimer's Disease, Vascular Dementia, Muscle Weakness, Difficulty Walking and Heart Failure.

Review of Resident #27's medical record revealed:

An Annual Minimum Data Set (MDS) dated 11/20/22 documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "4," indicating the resident had severely impaired cognition.

A Change in Condition Note dated 01/01/23 at 11:32 AM documented: "At 10:35 AM resident called for help in the day room, upon arrival resident observed on the floor on his left side ... [doctor's name] notified and order given to send resident to ER (emergency room) for evaluation. [Daughter's name] made aware ..."

A Facility Reported Incident (FRI), DC~11435, received by the State Agency on 01/03/23 documented, "...At about 10:35 AM, staff heard resident called for help. Upon arrival, resident was observed on the floor on his left side ..."

Further review of Resident #27's medical record showed no documented evidence that the facility staff provided the resident, or resident daughter written notice of the bed hold policy to include the

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 625	Continued From page 14	F 625		

number of bed hold days upon transfer to the emergency room on 01/01/23.

During a face-to-face interview conducted on 08/04/23 at 9:25AM, Employee #3 (Director of Social Servies) acknowledged the findings and stated, "We have identified holes in our process of informing residents and their family or responsible party of bed hold policy and days. It's been brought up to quality improvement and we are working on ways to make improvements."

4. Resident #98 was admitted to the facility on 10/04/22 with multiple diagnoses that included: Diabetes Mellitus, Hypertension, Dementia, Deep Vein Thrombosis (DVT) and Open Reduction and Internal Fixation (ORIF) and Left hip Pain.

Review of Resident #98's medical record revealed:

A 5-day scheduled assessment Minimum Data Set (MDS) dated 10/11/22 showed facility staff coded: not able to do Brief Interview for Mental Status Interview, cognitive skills for daily decision making as modified independence- some difficulty in new situations only.

A Health Status Note dated 10/11/22 at 3:15 PM documented: "Resident was doing great , walking with a walker but today complaining of pain at the surgical site unable to walk...X-ray of the LT [left] surgical leg with Doppler to rule out fracture related to pain and DVT was ordered by [doctor's name] via telephone. Family members notified [daughter] Pls [please] monitor site."

A physician's order dated 10/13/22 directed, "Resident transfer to ER for evaluation."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 625 Continued From page 15 F 625

"A progress note dated 10/13/22 at 12:00 PM "... Resident had a decrease in mobility due to increased c/o [complaints of] pain to left surgical leg which[doctor name] was made aware of and ordered x-ray and Doppler study done. Resident's daughter was made aware ... Resident's son-in-law who was visiting this morning made charge nurse aware that [doctor name] who is a surgeon at [hospital name] for resident had requested resident to be transferred to [Hospital name] for further evaluation of the surgical leg...the attending physician was made aware of the surgeon's request and agreed. The resident was transferred to [Hospital name] at 10:30 AM via facility's transportation accompanied by daughter and son-in-law ."

Further review of Resident #98's medical record showed no documented evidence that facility staff provided the resident or their responsible party written notice of the bed hold policy to include the number bed hold days upon transfer to the emergency room on 10/13/22.

A Facility Reported Incident (FRI), DC~11034, received by the State Agency on 10/14/22 documented, "...The surgeon requested resident be transferred to the hospital and the attending physician [doctor name] agreed with the transfer. Resident was transferred to [hospital name] on 10/13/22 at 10:30 AM via the facilities transportation system accompanied by daughter and son-in-law."

During a face-to-face interview conducted on 08/08/23 at 10:50 AM, Employee #3 (Director of Social Services) acknowledged the findings and stated, "I do not have the bed hold policy and

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 625	Continued From page 16 days information for Resident #98." [Cross Reference - 22 B DCMR Sec. 3270.1]	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for three (3) of 32 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) for one who had a fall, one resident's Drug Regimen Review, and one resident's hospice services. Residents' #7, #35 and #252. 1. Facility staff failed to accurately code Resident #7's MDS for Drug Regimen Review. Resident #7 was admitted on 06/24/22 with multiple diagnoses including Alzheimer's Disease, Anxiety Disorder, Dementia and Generalized Muscle Weakness. Pharmacy drug regimen review dated 01/02/23 documented, "Recommend a psych consult for continued use of Sertraline, donepezil, and melatonin in context of fall on 01/02/23[doctors name] the psychiatrist. Physician response: Disagree continue for anxiety." The evidence showed the facility staff failed to accurately code the MDS for Resident #7 drug regimen review identify potential clinically significant medication issues that was	F 641	1. The MDS assessments for Residents #7, #35 and #252 were corrected to reflect accurate medication review, fall and hospice status and were resubmitted by 8/29/23. 2. All residents have the potential to be impacted. The MDS Coordinator/ Designee completed a review on 8/8/23 of all pharmacy recommendations, fall incidents and hospice caseload report for the past 30 days since findings. After review of the past 30 days, 6 drug regimen reviews were made, 0 issued was noted, 7 falls were reported, and 2 of the 7 falls on MDS records received corrective actions. 2 additional residents on hospice caseload were appropriately captured on the MDS record. 3. On 8/3023, the DON educated the MDS coordinator on the importance of ensuring that pharmacy review, fall incidents and residents on hospice caseload are correctly documented in the MDS. The MDS coordinator will be responsible for ensuring that resident's MDS is accurately coded. The MDS coordinator or designee will perform random weekly audit of 25%of the residents MDS to ensure accurate coding monthly x 6 months. Findings will be reported to the Director of Nursing. Any issues identified will be addressed. 4. The DON will report results of the audits to the QAPI Committee that meets quarterly until 1/25/24.	10/15/23

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F 641	Continued From page 17 recommende by the pharmacy on 01/02/23. A review of the follow-up note to the pharmacy review dated 01/20/23 documented, "[doctor name] the psychiatrist prefers resident to continue use for Sertraline, donepezil, and melatonin effective in managing residents Anxiety." Review of the Quarterly Minimum Data Set [MDS] dated 04/30/23 showed facility staff coded under Section N [Medications] the area "did the facility drug regimen review identify potential clinically significant medication issues" was left blank. A face-to-face interview was conducted on 08/08/23 at approximately 1:04 PM with Employee #3 (director of nursing). acknowledged the findings and stated MDS will review and make corrections. 2. Facility staff failed to accurately code Resident #35's MDS for falls. Resident #35 was admitted to the facility on 05/19/23, with diagnoses that included: Weakness, Vascular Dementia, Anxiety and Muscle Weakness. Review of Incident Note dated 05/24/23 at 10:40 PM documented, " ... resident observed sitting in front of a recliner chair with his leg stretched and the walker was in front of him. Assessed for any injury no apparent injury noted. Assisted to go to the bathroom and put him back to his chair. MD (medical doctor) and family were notified." The evidence showed that facility staff failed to accurately code the MDS for Resident #35 for	F 641		

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 641	Continued From page 18	F 641		

falls that occurred on 05/24/23.

A Quarterly Minimum Data Set (MDS) dated 05/26/23, showed that under under Section J [Health conditions] the fall indicator box was left blank, indicating "not coded for fall."

During a face-to-face interview conducted on 08/08/23 at approximately 1:04 PM with Employee #3 (Director of Nursing) acknowledged the findings and stated corrections will be made.

3. Facility staff failed to accurately code Resident #252's Quarterly MDS for hospice services.

Resident #252 was admitted to the facility on 05/08/20 with the following diagnoses: Cerebral Atherosclerosis, Encounter for Palliative Care, Cerebral Infarction and Dementia.

A review of Resident #252's medical record revealed:

A physician's order dated 01/21/22 that directed, "Admit (ted) to [Name of Hospice]. Dx (Diagnosis): Cerebral Atherosclerosis Please call [Name of Hospice] at ...for any change in condition."

A care plan initiated on 01/24/22 documented: "Focus: [Name of Resident] has a terminal prognosis r/t (related to) Cerebral Atherosclerosis 01/21/22 - admitted into [Name of Hospice] ..."

A Quarterly Minimum Data Set dated 10/30/22 showed facility staff coded that the Resident #252 had not received hospice services in the last 14 days.

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 641	Continued From page 19 Further review of Resident #252's medical record showed that the resident received hospice services until her death in January 2023. The evidence showed that facility staff failed to accurately code the MDS dated 10/30/22. During a face-to-face interview on 08/03/23 at 12:39 PM, Employee #2 (Director of Nursing) acknowledged that Resident #252's Quarterly Minimum Data Set Assessment on 10/30/22 was inaccurately coded.	F 641		
F 656 SS=D	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 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	F 656		

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 656	Continued From page 20 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 record review and staff interview, for two (2) of 32 sampled residents, facility staff failed to develop and implement a comprehensive resident centered care plan to address: Resident #199's right toe wound and Resident #7's use of antianxiety medications. Residents' #199 and #7. The findings included: The facility policy "care Plans, Comprehensive Person-Centered" documented, "...The care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment ...The comprehensive, person-centered care plan will: include measurable objectives...incorporate	F 656	1. Resident #7 comprehensive care plan was reviewed and updated to reflect anti-anxiety medication use on 8/27/23. Resident #199 no longer resides in the facility, discharged 2/21/23. 2. a. All residents on anti- anxiety medication have the potential to be impacted. The DON/Designee will review all comprehensive care plans for the last 30 days of all residents receiving anti-anxiety medications since findings to ensure that comprehensive care plan was reviewed and updated. From the review a total number of 4 residents were on anti-anxiety medications and all had care plans reflecting the use of anti-anxiety medications. 2. b. All residents with wounds have the potential to be impacted. The DON/ Designee will review all comprehensive care plan for the last 30 days since findings to ensure comprehensive care plan was reviewed and updated. 10 residents were seen by the wound practitioner and all the wounds were provided for in residents care plans. 3. The DON provided in-service to the Social Worker, Nurse Supervisor, ADON, and the MDS Coordinator on 8/31/2023 on the importance of ensuring that comprehensive care plans are created for each resident in a timely manner and updated as needed. The MDS Coordinator will be responsible for ensuring that all residents have comprehensive care plans. The MDS Coordinator will complete monthly audit of comprehensive care plans to ensure that all residents have comprehensive care plans. The result of the audit will be reported to the DON monthly x 6 months for review and recommendations. Any issues found from audit will be addressed. 4. The DON will report results of the audits to the QAPI Committee that meets quarterly until 1/25/24.	10/15/23

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F 656	Continued From page 21 identified problem areas ... identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident..." 1. Facility staff failed to develop and implement a comprehensive resident centered care plan to address Resident #199's right toe wound. Resident #199 was admitted to the facility on 07/26/22 with multiple diagnoses that included: Type 2 Diabetes Mellitus, Atrial Fibrillation, Muscle Weakness and Lack of Coordination. Review of Resident #199's medical revealed the following: A Quarterly Minimum Data Set (MDS) dated 10/26/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognition and one unhealed stage 2 pressure ulcer that was present on admission. A Skin Only Evaluation Note dated 11/11/22 at 1:54 PM documented, "...Skin Issue: #001: New. Issue type: Redness. Location: Right toe(s). Skin note: Resident noted with redness and swelling to right 2nd toe. skin prep applied." Physician's orders dated 11/11/22 directed, "Cleanse right second toe with normal saline, pat dry, apply skin prep, every shift, leave open to air"; "right second toe redness and swelling: monitor area every shift and report any abnormalities to MD (medical doctor." A Facility Reported Incident (FRI), DC~11202, received by the State Agency on 11/11/22	F 656		

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 656	Continued From page 22 documented, "on 11/11/22 during morning care resident was noted with blanchable [turns white when pressed then immediatley turns red again when presure is removed] redness and moderate swelling to right second toe. Resident denies any pain when area was palpated. MD made aware gave order for podiatry consult ..." A physician's order dated 11/20/22 directed, "Silver Sulfadiazine (topical antibiotic) 1% cream, apply sparingly to right second toenails and dress lightly with sterile roll gauze and paper tape every other day for 1 week." A Podiatry Consult Report dated 12/06/22 documented, "...There are no signs of infection to the wound on the tip of your [right] second toe, we applied Betadine (antiseptic) to the toe today. Wash with soap and water and apply Betadine daily..." Physician's orders dated 12/06/22 directed, "Wash right distal second toe wound with soap and water, pat dry gently and apply Betadine and band aid every day ... for wound care; return to clinic 3-4 weeks with [Doctor's name] at [Wound clinic name and address]; weight bearing as tolerated in comfortable supportive shoes." Review of Resident #199's comprehensive care plan revealed that facility staff failed to develop a care plan with goals and interventions to address the resident's right second toe wound. During a face-to-face interview conducted on 08/03/22 at 11:50 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated that care plans are developed by DON, the Assistant DON or the nursing supervisors and	F 656		

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 656	Continued From page 23 that one should've been implemented for Resident #199's right second toe wound. 2. Facility staff failed to develop and implement a comprehensive resident-centered care plan to address Resident #7's medication for diagnosis of Anxiety. Resident #7 was admitted on 06/24/22 with multiple diagnoses that included Anxiety Disorder, Alzheimer's Disease, Generalized Muscle Weakness, and Dementia. Review of Resident #7's medical record revealed the following: A physician's order dated 06/24/22 that directed, "Sertraline (antidepressant) 50mg (milligrams) tablet 1 tab (tablet) by mouth every day for Anxiety." A Quarterly Minimum Data Set (MDS) dated 04/30/23 showed facility staff coded: severely impaired cognitive skills for decision making. Further review lacked documented evidence that a care plan with person-centered goals and interventions to address Resident #7's diagnoses of Anxiety and the use of the medication Sertraline. During a face-to-face interview conducted on 08/08/22 at 1:50 PM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated that care plans are developed by DON, the Assistant DON, or the nursing supervisors and that one should have been implemented for Resident #7's.	F 656		

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 657	Continued From page 24	F 657		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility staff failed to revise and update person-centered care plans for 4 (four) of 32 sampled residents. Residents #12, #41, #17, and #23 The findings included:	F 657	1. 4 residents were impacted by this deficiency. The care plan for residents #12 was updated on 8/4/23 to reflect injury from fall incident of 3/11/23. The care plan for resident #41 was updated on 7/23/23 to reflect mechanical soft texture diet. The care plan for resident #23 was updated on 8/3/23 to reflect sacral ulcer. Also updated resident #17 care plan to include the fall of 7/4/23 and she was thereafter referred to PT/OT on 7/6/23 for proper sitting and positioning. 2. The DON/Designee conducted a review of care plan for the previous 30 days to determine whether residents have their comprehensive care plans reviewed and updated. The findings from the audit revealed 7 residents had fall incidents, all were care planned. One with minor injury was recorded on the care plan. A review of diet texture of the 40 residents present in the facility on 8/3/2023 was done by the Dietician, no other findings were noted. 10 residents were receiving wound care, there were no additional findings related to this citation. 3. On 8/7/23, the DON provided in-serviced training to the ADON, Social Worker. Life Enrichment, Nurse Supervisor, and MDS Coordinator on the need to update care plans whenever there is a change in condition. The MDS/ADON coordinator will be responsible for ensuring that residents care plans are updated/revised and to conduct monthly audits. The result of the audit will be reported to the DON monthly x 6 months for review and recommendations. Any issues found will be addressed by the DON 4. The DON will report the results of the audits to the QAPI Committee that meets quarterly until 1/25/24.	10/15/23

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	095038	A. BUILDING ____ B. WING ____	C 08/09/2023

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F 657	Continued From page 25	F 657		

The facility policy "Care Plans, Comprehensive Person-Centered" documented, "...Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change... The Interdisciplinary Team (IDT) must review and update care plan ... when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay..."

1. Facility staff failed to update Resident #12's care plan to show that the resident had sustained a fall with injuries.

Resident #12 was admitted to the facility on 10/13/22 with the following diagnoses: Unspecified Fall, Multiple Fractures of Pelvis without Disruption of Pelvic Ring, Displaced Intertrochanter Fracture of Right Femur, Osteoporosis, Unsteadiness on Feet, and Generalized Muscle Weakness.

Review of Resident #12's medical record revealed:

A Quarterly Minimum Data Set (MDS) dated 01/20/23 showed facility staff coded: moderately impaired cognitive skills for decision making; exhibited wandering behaviors 1-3 days; required extensive assistance with 2 persons for bed mobility, transfer limited assistance with 2 persons for transfers; had unsteady gait and only able to stabilize with staff assistance; and had one (1) fall with no injury.

An Incident Note dated 03/11/23 at 6:16 AM documented: "Around 4:30 AM during nursing rounds, resident noted sitting on left side of bed

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F 657	Continued From page 26	F 657		

.... Resident unable to explain. On assessment resident alert and verbally responsive, skin remain intact, no(t) any visible injuries noted...no c/o (complaint of) pain verbalized ..."

A Health Status Note dated 03/11/23 at 7:59 PM documented," Upon change of shift, Resident noted laying on ...bed with verbal report of moderate pain to right hip ...was unable to rate pain, kept saying it hurts. Writer assessed right hip, noted swollen, pain on touch and warm to touch. Resident is SP (status post) fall on 3/11/23@ 4:30am ....ROM (range of motion) to left leg adequately tolerated, not able to lift right leg... MD (Medical Director) notified, new order for STAT x-ray to rt (right) hip to r/o (rule out) fx (fracture). Order called in to radiation physics and awaiting x-ray ..."

A Radiology Results Report on 03/12/23 at 11:24 AM documented: " ...Findings: There is an old fracture of the right pelvic ring. There is a right hip fixation ...Impression: Right hip fixation 2. No evidence of acute fracture ..."

A physician's order dated 03/14/23 at 1:45 PM directed, "Transfer Resident to [Local Hospital] for further evaluation due to excruciating pain to right hip post fall day ...Stat x-ray to right hip to r/o (rule-out) fx (fracture) due to pain and swelling on rt (right) hip s/p (status-post) fall one time only until 03/12/23."

A Review of the Discharge Summary from [Local Hospital] on 03/14/23 documented: " ... Imaging /results: CT (computed tomography scan) Pelvis without Contrast.-Impression: 1. Acute right superior and inferior pubic rami fractures 2. Acute right sacral alar fracture ...XR (Xray) Hips

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F 657	Continued From page 27	F 657		

Bilateral with Pelvis 3-4 Views (Final Result) - Impression: Right superior pubic ramus mildly displaced fracture ...Findings: Mildly displaced fracture of the right superior ramus noted ...Patient is status post ORIF (open reduction and internal fixation) of the right hip with intramedullary rod and head and neck screw ..."

A Facility Reported Incident (FRI), DC~11758) received by the State Agency on 03/15/23 at 6:18 AM documented: "Resident had a(n) unwitnessed fall on 3/11/23 around 4:30 AM with no apparent injury noted. ... X-ray of right hip...done due complaint of pain. Result ...No evidence of acute fracture. On 3/14/23 Resident's right hip/leg noted swollen, and painful to touch. MD (Medical Director) notified and ordered to transfer Resident to the nearest ER (Emergency Room) for further evaluation of x-ray and Ultrasound ...Resident returned on 3/15/23 around 2:10 AM with new diagnosis of open fracture of multiple pubic rami (bones), right ..."

A Significant Change MDS dated 03/28/23 showed facility staff coded: one (1) fall with a major injury since the prior assessment.

A care plan revised on 04/18/23 documented: "Focus: ... 3/11/23: [Resident #12] has had an actual fall without any apparent injury..."

Further review of Resident #12's comprehensive person-centered care plan lacked documented evidence that facility staff updated the aforementioned care plan to reflect that the fall on 03/11/23 resulted in injuries (open fractures of multiple pubic bones).

During a face-to-face interview on 08/04/23 at

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F 657	Continued From page 28 10:56 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no comments. [Cross Reference 22B DCMR Sec. 3210.4] 2. Facility staff failed to revise Resident #41's nutritional care plan to reflect her new diet order. Resident #41 was admitted to the facility on 07/05/23 with multiple diagnoses that included: Dysphagia and Protein Calorie Malnutrition. Review of Resident #41's medical record showed the following: A care plan focus area: "[Resident #41] is at potential nutritional risk..." initiated on 07/11/23 had interventions that included, "...Provide regular diet/regular texture/thin liquids." An Admission Minimum Data Set (MDS) dated 07/12/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; required limited assistance for eating; and received a mechanically altered diet. A Speech Language Therapy Evaluation and Plan of Treatment Summary dated 07/20/23 recommended, "...Solids - mechanical soft textures ..." An active physician's order dated 07/27/23 directed, "Other diet, mechanical soft/chopped meats texture." Further review showed no documented evidence that facility staff revised Resident #41's nutritional care plan with the new diet order of mechanical	F 657		

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F 657	Continued From page 29 soft. During a face-to-face interview on 07/30/23 at 8:40 AM, Resident #41 stated, "I have Dysphagia and I get a puree diet. I've been seeing the Speech Therapist and I was supposed to get upgraded to a mechanical soft diet." During a face-to-face interview conducted on 08/03/23 at 1:58 PM, Employee #8 (Registered Dietician) acknowledged the findings, and stated that she would take care of it now. [Cross Reference 22B DCMR Sec. 3210.4] 3. Facility staff failed to update Resident #17's Fall care plan to reflect she fell. Resident #17 was admitted to the facility on 10/02/19 with multiple diagnoses that included: Diabetes Mellitus, Major Depressive Disorder, and Anxiety. A review of the care plan showed the focus area: "[Resident #17 name] had a fall without injury ..." initiated on 10/03/19 had interventions that included, ". Anticipate and meet [resident name] ..." A quarterly Minimum Data Set (MDS) dated 06/10/23 showed facility staff coded: Unable to complete Interview for Mental Status (BIMS) summary score, Cognitive skills for daily decisions making "3" indicating severely impaired (never rarely made decisions) Bed mobility, Transfer, toileting use, and personal hygiene need extensive assistant with two person's physical assist. The history of the fall box was left blank indicating No fall.	F 657		

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F 657	Continued From page 30	F 657		

A review of the Incident Note dated. 07/04/23 at 7:24 AM documented, "Private duty aide reported that the resident was shaking and shifting in her wheelchair and slid off the wheelchair. She was unable to stop her from sliding. Resident was observed on the floor in a sitting position in front of her wheelchair ... no apparent injury was noted."

A change in Condition Note dated 7/04/23 at 6:04 PM documented, " ...Resident was observed on the floor in front of her wheelchair. ...Head to toe assessment was done and no apparent injury was noted. Able to move all her extremities within her normal baseline. ...recommended close monitoring. MD and RP made aware."

Further review showed no documented evidence that facility staff updated Resident #17's fall care plan to reflect that the resident had a fall.

During a face-to-face interview conducted on 08/03/23 at 1:58 PM, Employee #2 (DON) acknowledged the findings and stated we will update Careplan.

4. Facility staff failed to update Resident #23's pressure ulcer care plan to reflect her sacrum ulcer.

Resident #23 was admitted to the facility on 07/14/23 with multiple diagnoses that included: Parkinson's Disease, Seizure, General Muscle Weakness, Protein Calorie Malnutrition, and unstageable sacrum ulcer.

A review of the care plan initiated on 7/21/22

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F 657	Continued From page 31 showed the focus area: "[Resident #23] has potential risk for developing pressure ulcer r/t ... bony prominence to pressure point areas. 12/15/22 [resident name] has actual pressure injury r/t open wound to left inner forearm, 4/19/23 [resident name] noted with open areas to the left wrist." A Quarterly Minimum Data Set (MDS) dated 5/13/23 showed facility staff coded: unable to complete a Brief Interview for Mental Status (BIMS), Daily decision-making skill coded for severely impaired (never /rarely made decision). Skin condition coded for "1" unstageable pressure ulcer. A review of a Change in Condition Note dated 7/03/2023 at 3:09 PM documented, "... 11 AM during AM care, resident noted with redness to coccyx area, New orders obtained for zinc oxide to coccyx area". A Wound care observation on 8/02/2023 at 9:50am with Employee#16 [wound nurse] showed a sacrum wound that was measured 1x 0.5 x 0cm without slough, drainage, and odor ..." There was no evidence that facility staff updated Resident #23's pressure ulcer care plan to reflect the resident had a sacrum ulcer. During a face-to-face interview conducted on 08/03/23 at 1:58 PM, Employee #2 (DON) acknowledged the findings and stated we will update Careplan.	F 657		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)	F 685		

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F 685	Continued From page 32 §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, for one (1) of 32 sampled residents, facility staff failed to ensure that the resident received proper treatment and assistive devices to maintain hearing abilities. Resident #299. The findings included: Resident #299 was admitted to the facility on 07/10/17 with multiple diagnoses that included: Hard of Hearing, Blindness and Parkinson's Disease. Review of Resident #299's medical record revealed: A physician's order dated 05/28/20 that directed, "Nursing staff to check/ensure resident has both hearing aids. Please document in progress notes every shift." A care plan focus area initiated on 12/03/20 documented, "Hearing Aides ...Goal: [resident's name] uses hearing aides r/t (related to) hard of	F 685	1. Resident #299 no longer resides in the facility, expired on 4/28/22. Resident #299 received a pocket talker on October 15, 2021. 2. All residents with hearing aids have the potential to be impacted. Review of all the missing hearing aids for the last 6 months was completed on 8/8/23. This was found to be an isolated finding during the period of review. There were no additional findings related to this citation. 3. On 8/10/23, the Social Works Director/ Designee provided in-serviced training to on the Charge Nurses/Nursing Supervisor, Social Workers, Life Enrichment, and Direct Care staff on the facility policy regarding missing items, to ensure that the any resident with missing hearing aide receives alternative hearing device while waiting for follow up appointment and to further ensure the missing devices are replaced. The Director of Social Works will be responsible for ensuring that missing items are replaced in a timely manner. The Director of Social Worker will conduct monthly audits and the result of the audit will be reported to the DON monthly x 6 months for review and recommendations. Any issues from the audit will be addressed the DON. 4. The Social Worker Director/Designee will report the results of the audit to the QAPI committee that meets every quarter until 1/25/24.	10/15/23

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F 685	Continued From page 33 hearing ...Interventions/Tasks: Change first hearing aid batteries routinely every Friday on 3-11 shift ...Change second hearing aid batteries routinely every Friday on 3-11 shift ...Check first and second hearing aid for functioning prior to use ...Place second hearing aids in each ear at bedtime, then remove in the morning." A care plan focus area initiated 06/22/21 documented, " ...is hard of hearing ... Interventions/Tasks: Assist [resident's name] to sit next to the speaker ..." A Quarterly Minimum Data Set (MDS) dated 09/05/21 showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "12," indicating the resident had a moderately impaired cognitive status and that the resident used a hearing aid for adequate hearing. An Incident Note dated 10/11/21 documented, "Late entry for 10/5/21 ...during change of shift rounds, hearing aid noted missing. Writer and outgoing nurse searched everywhere in resident's room, could not find. Laundry aware to search linen. Search in progress." A Facility Reported Incident (FRI), DC~10309, received by the State Agency on 10/15/21 documented, "During change of shift round with the outgoing charge nurse in the morning, the charge nurse noticed that the resident hearing aid was missing. The resident room and laundry room search[ed] but unable to locate the missing hearing aid." A care plan focus area initiated on 11/16/21 documented, "Hearing aids were reported missing in Oct 2021. [Resident #299] has an	F 685		

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F 685	Continued From page 34 audiology appointment on 12/3/21 ..." An Administration Note dated 01/02/22 documented: "... Right ear hearing aid is missing." An Alert Note dated 03/18/22 documented, "[Doctor's name] followed up on [resident's name] in reference to his hearing loss ...recommendations for resident to follow up with some hearing test at [hospital's name] cancelled ..." A physician's order dated 03/18/22 directed, "Consult [doctor's name] (Hearing Doctor) for in house eval-Hearing Aide Replacement." An Administration Note dated 04/18/22 documented, "... Hearing aid have not been found for months." Further review of the Resident #299's medical record showed that from 10/05/21 to 04/28/22 (date of death), over six months, there was no documented evidence that the resident was seen by an audiologist for the ordered hearing consult, nor any documented evidence that the facility found the resident's missing hearing aid, or replaced the missing hearing aid. During a face-to-face interview conducted on 08/08/23 at 1:00PM, Employee #1 (Administrator) acknowledged the findings and stated, "I was here, it was investigated. I don't think his hearing aid was ever found. We checked the laundry service, resident's room and wife's room and it was not found."	F 685		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 35 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains 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 32 sampled residents (#7), the facility staff failed to implement adequate supervision and assistance to prevent falls with injury for a cognitively impaired resident identified as a high risk for falls. These failures resulted in actual harm to Resident #7 on 1/2/23. The findings included: Resident #7 was admitted on 06/24/22 with multiple diagnoses including Generalized Muscle Weakness, Dementia, and Alzheimer's Disease. A review of Resident #7's medical record revealed a physician's order dated 06/25/22 that directed, "Maintain fall risk precaution at all times every shift." A Facility Reported Incident (DC~11166) received by the State Agency on 11/04/22 documented, "11/04/22 Resident taken to the bathroom at approximately 9:30 PM by a nursing assistant and placed on the toilet. The nursing assistant stepped out to get the resident a fresh gown and	F 689	1. The care plan for resident #7's for the falls on 11/4/22, 12/20/22, 1/2/23, and 4/21/23 were updated with new interventions at the time of each fall. On 1/2/2023 at 5:55 am resident #7 with impaired cognition fell from her bed and sustained an injury. Resident was promptly transferred to the emergency room for further evaluation, fall ezz mat was initiated upon arrival from the hospital, rehab referral post fall and on caseload for strengthening and balancing. Other interventions put in place include Toileting Hygiene, Ongoing Psych consultation, Ongoing communication with family agreed to be involved in speaking to resident via a phone call when agitated. Direct observation by nursing staff at the nursing station, offering favorite snacks , engaging resident in reading books of choice, watching legacy TV program. 2. All residents have the potential to be affected. A facility wide fall evaluation on all residents was conducted on 11/7/23 by the DON, there were 26 residents identified as high falls risk. These residents placed on hourly monitoring after the evaluation. 3. The ADON/designee or staff educator conducted in-service on 11/7/23 to all License Nurses, CNAs, and Nursing Assistants on monitoring tools to recognize residents at risks for Falls to include providing adequate supervision and assistance. Staff would be removed from the schedule if they did not complete the in-service. All License Nurses, CNAs, and Nursing Assistants shall be re-educated on documenting hourly rounding. ADON or designee will validate staff compliant by reviewing daily documentation every shift. DON/Designee will perform random audits monthly x 6 months. Any deficiency will be addressed and corrected. 4.The DON will report results of the audits to the QAPI committee that meets every quarter until 1//25/2024.	12/6/23

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F 689	Continued From page 36	F 689		

the resident was found lying on the floor on the staff's return. The resident had a laceration to the back of head left side ...transfer to the hospital ... for further evaluation."

A care plan focus area dated 11/04/22 documented, "[Resident #7] had a fall with injury" with interventions that included, "Resident should not be left in the wheelchair in the bathroom unattended."

A Transfer to Hospital Summary dated 11/04/22 at 10:20 PM documented, "Supervisor notified by the Charge Nurse that at approximately 9:30 PM the resident was found lying on the bathroom floor ... The nursing assistant placed the resident on the toilet and stepped away to get a fresh gown. The assistant returned to the resident lying on the bathroom floor... She had a laceration to the back left of her skull ... [Doctor's name] who was in the building came and evaluated the resident. The physician wrote a transfer order ... Resident taken to [hospital name]."

A Health Status Note dated 11/05/22 at 2:14 PM revealed Resident #7 returned from the hospital after a fall with a laceration to the left occipital (back of the head). The documentation indicated the resident was alert and oriented to name but confused about place and time. As a result of the fall the resident obtained three staples to the laceration. Resident #7's left elbow was bruised, but all extremities were movable, and neuro checks were ordered, fall precautions were in place with close monitoring and hourly rounding.

A progress note dated 12/20/22 at 7:59 PM noted an unwitnessed fall at 6:30 PM. The note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 689		F 689		

Continued From page 37

documented, "Fall occurred in resident's room ... Stated she was arranging her belongings whilst in the wheel chair, slid off unto the floor in a sitting position with back leaning on her wheel chair. Denied hitting her head. no apparent injury. New order for x-ray of the left post fall."

A Health Status Note dated 12/21/22 at 3:35 AM showed, "x-ray of the left hip to R/O (rule out) fracture due to s/p fall done result pending."

A Health Status note dated 12/21/22 at 7:03 PM: "Left hip x-ray result received and reviewed by [Doctor's name], NNO [no new order] obtained ..."

Resident #7's care plan was updated on 12/20/22 to reflect, "Resident on close monitoring every shift for fall risk."

An Incident Note dated 01/02/23 at 8:01 AM documented, "At about 5:55 AM assigned CNA [certified nurse aid] reported to the floor charge nurse, observed resident on the floor by the bedside in a supine position. Resident assessed and sustained two puncture wounds to the posterior left ear with minimal bright red blood. Neuro checks initiated. The resident was unable to state how it happens due to Dementia. [Doctor's name] and POA [power of attorney] were notified. Resident transferred to ER [emergency room] via 911 for evaluation."

A care plan focus area dated 1/2/23, documented, "at approx. 5:55 AM Resident falls and sustained puncture wounds to the posterior left ear and pelvic fracture which do not require surgery." The updated care plan intervention indicated, "ER Transfer for further evaluation secondary to fall," and "Fall EZZ mat on right side

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 689	Continued From page 38	F 689		

of resident bed floor every shift for fall risk precaution. Clean and fold when a resident is out of bed. Every shift while the resident is in bed."

A Progress Note dated 01/02/23 at 7:01 PM showed, "One of the doctors at [hospital name] called to update us on resident status ...The cut she sustained on the back of her left ear is superficial. The patient sustained a pelvic fracture which does not require surgery. Patient to follow up with orthopedic at the clinic in few weeks..."

A Facility Reported Incident (DC~11439) received on 01/03/23 documented, "01/02/23 10:42 AM ... at about 5:55 AM assign CNA (Certified Nurse Aide) reported to the charge nurse that resident was noted on the [floor]. upon assessment, the resident was observed lying on the floor in a supine position on the right side of her bed ...Two punctured wound measuring 0.1cm x 0.1cm was noted on the posterior left ear with minimal bleeding ...MD[medical doctor] notified with order to send the resident to the nearest ER[emergency room] for further evaluation, 911 called and the resident was transferred to [hospital name] ..."

A Health Status Note dated 04/21/23 at 10:17 PM showed, "Assigned CNA called the writer and notified [resident name] fall and resident observed on the floor. The writer assessed the resident for injury or pain. No apparent injury or sign of pain was noted. Two people assist the resident put back into her wheelchair safely."

A review of resident #7's care plan revealed a focus area revised on 4/21/23 which documented, "[Resident #7] deliberately placed herself on the day room floor expressed a preference to do so.

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 689 Continued From page 39 F 689

No injury noted at the time." Care plan interventions were updated to indicate, "Close observation on the resident by nursing staff every shift for fall risk."

A Quarterly Minimum Data Set (MDS) dated 04/30/23 showed facility staff coded: severely impaired cognitive skills for decision making, totally dependent on the physical assistance of one person for bed mobility, transfer, toilet use, and personal hygiene and sustained a fall with no injury since the prior assessment.

During a face-to-face interview conducted on 08/08/23 at 1:50 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated that the facility staff is aware of the need to frequently check on the resident with fall risk/fall precautions to ensure safety and prevent falls.

[Cross Reference 22B DCMR Sec. 3211.1]

F 755 SS=D Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) F 755

§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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 755	Continued From page 40 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on two (2) observations, record reviews and staff interviews, for one (1) of 32 sampled residents, facility staff failed to ensure that the system to account for the reconciliation, dispensing, and administration of controlled medications was followed. Resident #41. The findings included: The facility policy "Controlled Substances" documented, "The facility shall comply with all laws, regulations and other requirements related to to...documentation of schedule II and other controlled substances...an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance... This record must contain... time of administration... signature of nurse administering medication..."	F 755	1. Resident # 41 was not impacted by this deficient practice. 2.All residents have the potential to be impacted. The DON conducted a review of all narcotic counts on the 2 units in Health Care Center to confirm the accuracy of the narcotic count, no other findings were identified on 7/30/23. 3.The DON has provided in-serviced training Employee #5 and the licensed nursing staff on 8/7/23 on the facility policy regarding narcotic administration/control. Narcotic log must be signed off immediately upon withdrawal of medication. Narcotic book should be signed off by the incoming and outgoing nurse at the change of shift. This is an evidence-based practice for ensuring that there are no discrepancies in control substance count. The ADON/Designee will be responsible for conducting a weekly audit to ensure that all narcotic counts are accurate, and the incoming and outgoing charge nurses are signing off during change of shift. The ADON/ Designee will report the result of the audit to the DON monthly x 6 months for review and recommendations. Any issues found during the audit will be addressed. 4.The DON will report results of the audit to the OAPI committee that meets every quarter until 1/25/2024.	10/15/23

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 755	Continued From page 41	F 755		

1A. During an observation on 07/30/23 at 6:58 AM of the 2nd floor, medication cart 2's "Controlled Drug Shift Count Sheet", it was noted that Employee #5 (Registered Nurse) had signed her name in the area, "Nurse off" and documented "yes" in the area "drug count correct?". When asked why she had documented to doing the controlled substance count and that it was correct without another licensed nurse, Employee #5 stated, "I did that to get ahead and make it easier for when the other nurse comes in."

It should be noted that upon the surveyor performing the controlled substances count with Employee #5, it was found to be inaccurate.

1B. Resident #41 was admitted to the facility on 07/05/23 with diagnoses that included: History of Falls, Dysphagia and Hyperlipidemia.

A physician's order dated 07/25/23 directed, "Ambien oral tablet 10 MG (milligram) give 1 tablet by mouth at bedtime for Insomnia"

Review of Resident 41's Medication Administration Record (MAR) for July 2023 showed that on 07/29/23 at 9:00 PM, Employee #5 documented a check mark and her initials to indicate that she administered the Ambien 10 MG tablet to the resident.

During a controlled substances count on 07/30/23 at 7:00 AM of the 2nd floor, medication cart 2 with Employee #5, it was noted that the controlled medication inventory form for Resident #41's Ambien (narcotic sleep aide) 10 MG tablets documented, "28" tablets remaining however; the

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 755	Continued From page 42 blister packet had 27 remaining tablets. At the time of the observation, Employee #5 stated, "I gave this to her (Resident #41) last night. I forgot to sign it off." The evidence showed that facility staff failed to ensure that the system to account for the reconciliation, dispensing, and administration of controlled medications was followed. Cross Reference 22B DCMR Sec. 3224.3	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761	1.The medication was immediately discarded on 7/30/23. No resident was affected by this deficient practice. 2.All residents have the potential to be affected. The ADON pulled all medications requiring appending expiration dates, refrigeration, and resident names to determine if there are any undated medications. On all the units in the Health Care Center, no other findings were noted on 7/30/23. 3. On 8/7/23, the DON/Designee provided in-serviced to all nurses on the importance of ensuring medications are opened and resident names. The ADON will be responsible for conducting weekly audits to ensure that all multi dose medications are properly labeled and have resident names on the medication. The result of the audit will be reported to the DON monthly x 6 months for review and recommendations. Any issues found during the audit will be addressed. 4.The DON will report the results of the audits to the QAPI committee that meets every quarter until 1/25/24.	10/15/23

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F 761	Continued From page 43 be readily detected. This REQUIREMENT is not met as evidenced by: Based on one (1) observation, record review and staff interview, a multi-dose Humalog (type of Insulin) pen was stored for use that failed to have a resident label or an expiration date. The findings included: The facility policy "Administering Medications" directed, "...the expiration/beyond use date on the mediation label is checked ... When opening a multi-dose container, the date opened is recorded on the container... Insulin pens are clearly labeled with the resident's name ..." During an observation of the 1st floor medication storage room on 07/30/23 at 6:45 AM, it was noted that there was an open and used Humalog pen that failed to have a resident label or an expiration/beyond-use date. During a face-to-face interview conducted at the time of the observation, Employee #4 (Registered Nurse/RN) acknowledged the finding and stated, "It's a mistake." Cross Reference 22B DCMR Sec. 3227.19	F 761		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 803	Continued From page 44 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, for one (1) of 32 sampled residents, facility staff failed to ensure Resident #41 received the correct food consistency ordered by the physician. The findings included: Resident #41 was admitted to the facility on 07/05/23 with multiple diagnoses that included: Dysphagia and Protein Calorie Malnutrition. Review of Resident #41's medical record showed the following: An active physician's order dated 07/10/23 that directed, "Regular diet, pureed texture, thin	F 803	1.Resident #41 was immediately prescribed the correct diet on 8/3/2023 ordered by the Physician. There was no adverse effect on resident from this deficient practice. 2.All residents have the potential to be affected. On 8/3/23 the Rehab Director and Registered Dietician reviewed the chart of all 40 residents present in the facility for accuracy of information on diet type and consistency. There were no additional findings related to this citation. 3. On 8/11/23, the Director of Rehab and Registered Dietitian provided in- serviced training to the Charge Nurses and the SLP staff on the importance of notifying dining service department promptly whenever diet orders change and on updating the order in the EHR. The ADON/Designee will be responsible for ensuring that all new diet orders are communicated to nursing/dining services/ SLP and report to the DON. Audits will be conducted monthly x 6 months and reported to the DON. Any issues found during the audit will be addressed. 4.The DON will report results of this monitoring to the QAPI committee that meets every quarter until 1/25/24.	10/15/23

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F 803	Continued From page 45 consistency" An Admission Minimum Data Set (MDS) dated 07/12/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition and received a mechanically altered diet. A Speech Language Therapy Evaluation and Plan of Treatment Summary dated 07/20/23 recommended, "...Solids - mechanical soft textures ..." An active physician's order dated 07/27/23 directed, "Other diet, mechanical soft/chopped meats texture." During a face-to-face interview on 07/30/23 at 8:40 AM, Resident #41 stated, "I have Dysphagia and I get a puree diet. I've been seeing the Speech Therapist and I was supposed to get upgraded to a mechanical soft diet." During a follow-up observation and interview of Resident #41 on 08/03/23 at 1:00 PM, she stated, "I am still getting puree foods. It was supposed to be changed since last Thursday (07/27/23)." It should be noted that the resident's meal ticket had "Puree" handwritten on it and the food items on her meal tray were observed to be puree consistency. The evidence showed that from 07/27/23 to 08/03/23 (a total of 8 days); the resident had two active orders for different diet consistencies and as a result, continued to receive a puree diet instead of mechanical soft. During a face-to-face interview conducted on	F 803		

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F 803	Continued From page 46 08/03/23 at 1:07 PM, Employee #6 (Dietary Aide) stated that meal trays are served based off the diet order forms that are provided by the dietician. "If the diet order form says puree, that's what they get. Any changes would come from the dietician." The employee further stated that no new or change in diet form had been received for Resident #41. During a face-to-face interview conducted on 08/03/23 at 1:58 PM, Employee #8 (Registered Dietician) acknowledged the findings and stated that she would take care of it right now. Cross Reference 22B DCMR Sec. 3220.6	F 803		
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. This REQUIREMENT is not met as evidenced	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008

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F 812	Continued From page 47 by: Based on observations and interview, facility staff failed to store and distribute food under sanitary condition as evidenced by food items such as brown gravy, baked fish, bread chunks, a squash and zucchini dish, and two (2) liters of a white sauce, stored in various containers in one (1) of one (1) walk-in refrigerator that were not labeled, food items such as five (5) of five (5) containers with chopped and sliced carrots, one (1) of one (1) container of red onions, one (1) of one container of sliced celery, one (1) of one (1) container of chopped cabbage, one (1) of one (1) container of sliced yellow squash, one (1) of one container of sliced zucchini, one (1) of one (1) container of sliced cucumbers, and one (1) of one (1) container of sliced tomatoes, that were labeled with a use-by date of July 29, 2023, one (1) one (1) open pack of cheddar cheese that was labeled with a use-by date of 7/3/23, two (2) of two (2) bottles of eyewash solutions located in the kitchen on Healthcare Center 2 (HCC2) that expired as of 08/2022, and one (1) of one (1) bottle of eyewash solution located in the kitchen of Healthcare Center 1 (HCC1), that expired as of 06/2022. The findings include: During a tour of dietary services on July 30, 2023, at approximately 6:20 AM, the following were observed: 1. Food items such as brown gravy, baked fish, bread chunks, squash, and zucchini dish, two (2) liters of a white sauce, stored in various containers in one (1) of one (1) walk-in refrigerator were not labeled or dated.	F 812	1.All the expired food items, eye wash solution and incorrectly labeled food items were discarded upon discovery on 7/30/23. The employee was immediately issued a beard guard net on 7/30/23. 2. On 7/30/2023 the Director of Dining Services examined all stored food items to ensure that there are no expired or incorrectly labeled food items. There were no additional findings. b. On 7/30/2023 the Director of Dining Services identified 3 employees who required beard net and provided these before the start of shift. 3.The Dining Services Director in- serviced dining services staff on7/30/23 on proper food storage to include labeling and dating food items and discarding expired food. The Dining Service Supervisor/Designee will conduct weekly audits and be responsible for ensuring that all food items are stored and labeled correctly, and employees with beards are wearing the beard net. The result of the audits will be reported to the Dining Service Director monthly x 6 months for review and recommendations. Any issues found during the audit will be addressed. 4.The Dining Service Director will report result of the audits to QAPI committee that meets every quarter until 1/25/24.	10/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS OF DC	**4901 CONNECTICUT AVENUE, NW WASHINGTON, DC 20008**

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F 812	Continued From page 48 2. Food items such as five (5) of five (5) containers with chopped and sliced carrots, one (1) of one (1) container of red onions, one (1) of one container of sliced celery, one (1) of one (1) container of chopped cabbage, one (1) of one (1) container of sliced yellow squash, one (1) of one container of sliced zucchini, one (1) of one (1) container of sliced cucumbers, and one (1) of one (1) container of sliced tomatoes, were all stored beyond their use-by date of July 29, 2023. 3. One (1) one (1) open pack of cheddar cheese was labeled with a use-by date of 7/3/23. 4. Two (2) of two (2) bottles of eyewash solutions located in the kitchen on Healthcare Center 2 (HCC2) expired as of 08/2022, and one (1) of one (1) bottle of eyewash solution located in the kitchen on Healthcare Center 1 (HCC1), expired as of 06/2022. 5. An employee was observed with no beard net, serving food on the breakfast tray line on HCC1. Employee #10 acknowledged the findings during a face-to-face interview on August 2, 2023, at approximately 11:00 AM.	F 812		
F 849 SS=E	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:	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING _____ B. WING _____	C 08/09/2023

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F 849	Continued From page 49 (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. §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:	F 849	1.Resident #252 no longer resides in the facility. Resident #4 and #23 care plan was updated on 8/4/23 to include description of the care, services, and frequency of visit by the contracted hospice provider. 2. The DON/Designee reviewed all residents currently receiving hospice care, it was determined that one other resident was affected by this citation. Resident's care plan was updated to reflect description of care, services, and frequency of visit by the hospice provider. 3.. The hospice nurse was immediately brought into the facility and educated by DON on documenting in resident's health record on every visit. All required documentation was provided by the Hospice provider on 8/2/23. The hospice provider immediately provided the most recent POC and was placed in the Chart by 8/2/23. The Charge Nurses and Nursing supervisor was in-serviced by the DON on 8/11/23 on the facility policy in ensuring that care plans are updated to include description of care, services, and frequency of visit by the contracted hospice providers. The ADON/ Designee will audit all hospice residents to ensure the required care plans are in place every month x 6 months. The report of the audit will be provided to DON for review and recommendations. Any issues found from the audit will be addressed. 4.The DON will report results of the audit to the QAPI committee that meets every quarter until 1/25/24.	10/15/23

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F 849	Continued From page 50 (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 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.	F 849		

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F 849	Continued From page 51 (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 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	F 849		

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F 849	Continued From page 52 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. (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 three (3) of 32 sampled residents had hospice care plans that	F 849		

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F 849	Continued From page 53	F 849		

included: a description of the care, services, and frequency of visits to be provided by the contracted hospice provider. Residents' #252, #4, #23

The findings included:

Review of the facility's Hospice contract documented, "...Hospice plan of care means a written plan which is established, maintained, reviewed and modified if necessary... which includes... details concerning the scope of frequency of such hospice services... Nursing Home shall develop a nursing home plan of care.... in coordination with the hospice plan of care... Nursing home will periodically review and modify the nursing home plan of care in coordination with hospice...The Nursing Home shall prepare and maintain complete and detailed clinical records for each residential hospice patient receiving nursing home and hospice services... each medical record shall completely, promptly and accurately documents all services provided..."

Resident #252 was admitted to the facility on 05/08/20 with the following diagnoses: Cerebral Atherosclerosis, Encounter for Palliative Care, Cerebral Infarction, Dementia, Depression, Congestive Heart Failure, and Anemia.
A review of Resident #252's medical record revealed:

A Face Sheet documented that Resident #252 had a representative.

A Physician's Order dated 01/21/22 that documented: "Admit (ted) to [Name of Hospice]. Dx (Diagnosis): Cerebral Atherosclerosis Please

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 849	Continued From page 54 call [Name of Hospice] at ...for any change in condition." An Informed Consent Form documented that Resident #252 was to receive hospice services from [Name of Hospice], signed by Resident #252's Representative on 01/21/22 at 8:38 AM. A Medicare Hospice Benefit Election Form that documented that the Resident was to receive hospice benefits and signed by Resident #252's Representative on 01/21/22 at 8:38 AM. A care plan initiated on 01/24/22 that documented: "Focus: [Name of Resident] has a terminal prognosis r/t (related to) cerebral atherosclerosis *01/21/22 - admitted into [Name of Hospice] ...." A Significant Change in Status Minimum Data Set Assessment on 01/28/22 documented that the Resident was on hospice and had received hospice services in the last 14 days. A hospice visit frequency grid that documented visits for 01/22/22 and 02/09/22. A Plan of Care Review Form from [Name of Hospice] dated 02/09/22 documented the Hospice Agency's Plan of Care for Resident #252 in the following manner: "Response to Care and Updates to Comprehensive Assessment: Neurosensory - Manage agitation /confusion. Pt (patient) has indiscriminate words. Redirect patient. Give Ativan as needed; Respiratory - Manage SOB (shortness of breath). Elevate HOB (headed bed). Continuous O2 (oxygen) via NC (nasal cannula). Morphine on board; Gastrointestinal - Decrease oral intake. Pureed	F 849		

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F 849	Continued From page 55 diet with thickened liquids; Genitourinary - Patient incontinent, wears brief; Musculoskeletal - ...ADLs. Bed confined. Contracted in four (4) extr (extremities); ...Integumentary - Stage II on sacrum, cleanse, bacitracin; ...Physical Pain - Tylenol scheduled. Morphine as needed ..." A review of Hospice Aide/Homemaker /Volunteer Plan of Care Notes Files documented that between 02/01/22 to 07/18/22, the Resident received 26 hospice visits on the following days: 02/01/22 02/03/22 02/08/22 02/10/22 02/15/22 02/17/22 02/22/22 03/01/22 03/03/22 03/10/22 03/15/22 03/18/22 03/22/22 03/25/22 03/26/22 03/30/22 04/01/22 04/06/22 04/19/22 04/22/22 04/26/22 04/28/22 05/03/22 05/20/22 06/28/22, 07/18/22. A review of the Quarterly Minimum Data Set	F 849		

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 849	Continued From page 56 Assessment on 07/30/22 documented that the Resident had received hospice services within the last 14 days of the assessment. Further review of Resident #252's medical record lacked documented evidence that the Resident received hospice visits from the Hospice Aide after 07/18/22. In addition, there was no documented evidence that the facility staff updated the Resident's comprehensive person-centered care plan to include the hospice agency's care plan for the Resident. A review of a Health Status Note on 01/02/23 at 07:06 AM documented: "Writer called to Resident's room around 4 AM. Upon arrival Resident observed unresponsive to stimuli. On assessment no B/P, no pulse, no respiration, and no temperature. Resident pupils fixed, skin warm to touch. Resident pronounced dead at 4:08 AM and Verified by 2 RN (Registered Nurses), MD (Medical Director) notified and ordered to release Resident's body ....[Name of Funeral Home]. Postmortem care done. Writer notified [Name of Hospice] ..." During a face-to-face on 08/03/23 at 12:39 PM, Employees #2 (Director of Nursing) and #3 (Director of Social Services), stated that Resident # 252 started receiving hospice services from 02/02/22 until the Resident expired in the facility. Employee #2 said that the facility could not provide documented evidence of the frequency or number of hospice aide visits for Resident #252. In addition, the Employee acknowledged that the facility staff did not update the Resident's comprehensive care plan to include the hospice agency's most recent hospice care plan.	F 849		

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F 849	Continued From page 57	F 849		

2. Resident #4 was admitted to the facility on 02/03/22 with diagnoses that included: Dementia, Multiple Sclerosis, Malignant Neoplasm of the Left Kidney and Anemia.

Review of Resident #4's medical record revealed the following:

A physician's order dated 01/26/23 that directed, "Admitted to [Hospice provider name] for diagnoses of Intraparenchymal Hemorrhage"

A "Hospice Plan of Care" document dated 03/09/23.

A care plan focus area "[Resident #4] has a terminal prognosis and admitted to [Hospice provider] diagnoses of Intraparenchymal Hemorrhage" last revised on 05/02/23 had interventions of: "Adjust provision of ADLs (activities of daily living) to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate ...Observe resident closely for signs of pain, administer pain medications as ordered ...Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Work with nursing staff to provide maximum comfort for the resident."

A Modification Quarterly Minimum Data Set (MDS) dated 07/15/23 showed facility staff coded severely impaired cognitive skills for daily decision making and that hospice care was being received while a resident.

During a telephone interview conducted on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 849	Continued From page 58	F 849		

08/02/23 at 11:25 AM, Employee #9 (Hospice Clinical Manager) stated, "[Resident #4's] Hospice Plan of Care (POC) was last reviewed and updated on 07/13/23. It includes the services being provided and the frequency of visits for the hospice nurses and social services. The most recent POC should've been in the chart. I can email the most recent one to you."

An email correspondence from Employee #9 was received on 08/02/23 at 11:55 AM that documented, "[Resident #4] Hospice Plan of Care ... 07/13/2023 ... frequencies Hospice RN (Registered Nurse) 2 x month for 1 month starting 07/03/2023 ... Hospice Social Worker 1 x month for 1 month starting 07/05/2023 ..."

The evidence showed that facility staff failed to have a person centered hospice care plan for Resident #4 that included a description of the care, services and the frequency of visits to be provided by the contracted hospice provider and failed to have the most recent hospice plan of care in Resident #4's medical record.

During a face-to-face interview conducted on 08/02/23 at approximately 12:00 PM, Employees #2 (Director of Nursing/DON) and Employee #3 (Director of Social Services) acknowledged the findings with Employee #2 stating, "We will make sure that the hospice care plan is more detailed and that the most recent hospice plan care is in the chart and that aligns with our plan of care."
3.Resident #23 was admitted to the facility on 07/14/22 with multiple diagnoses that included: Parkinson's Disease, Seizure, General Muscle Weakness, and Protein Calorie Malnutrition.

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	095038	A. BUILDING ______ B. WING ______	C 08/09/2023

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F 849	Continued From page 59 Physician Order dated 07/20/2023 that directed, "Resident resides in-house under Hospice care for Parkinson's Disease." A review of the two "Hospice Plans of Care found in Resident#23 manual chart showed that one plan of care started on 02/07/23 and the other plan of care started on 3/09/23, the frequency of hospice treatment and care was no longer in existence indicating "plan of care were not updated". A review of the care plan initiated 08/12/22 focus area documented, "[Resident #23] has a terminal prognosis r/t Parkinson's Disease and severe malnutrition w/new admission to Hospice 08/15/22. Last revised on 02/14/23, had interventions of: "Encourage support system of family and friends, keep the environment quiet and calm, keep linens clean, dry and wrinkles free, keeps lightening low and familiar objects near, Observe resident closely for signs of pain, administer pain medications as ordered ...Work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Work with nursing staff to provide maximum comfort for the resident." A Quarterly Minimum Data Set (MDS) dated 05/13/23 showed facility staff coded: unable to complete a Brief Interview for Mental Status (BIMS), Daily decision-making skill coded for severely impaired (never /rarely made decision). Hospice care is being received while a resident. During a telephone interview conducted on 08/02/23 at 11:25 AM, Employee #9 (Hospice Clinical Manager) stated, "[Resident #23's]	F 849		

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 849	Continued From page 60 Hospice Plan of Care (POC) was last reviewed and updated on 07/27/23. It includes the services being provided and the frequency of visits for the hospice aide, nurses, and social services. The most recent POC should've been in the chart. I can email the most recent one to you." An email correspondence from Employee #9 was received on 08/02/23 at 11:55 AM that documented, "[Resident #23] Hospice Plan of Care ... 07/27/23 ... frequencies Hospice aide (CNA) 3x week for 4 weeks starting 07/13/23 ..., Hospice RN (Registered Nurse) 2 x month for 1 month starting 06/07/23 ... Hospice Social Worker 1 x month for 1 month starting 07/05/2023 ..." The evidence showed that facility staff failed to have a person-centered hospice care plan for Resident #23 that included a description of the care, services, and the frequency of visits to be provided by the contracted hospice provider and failed to have the most recent hospice plan of care in Resident #23's medical record. During a face-to-face interview conducted on 08/02/23 at approximately 12:00 PM, Employees #2 (Director of Nursing/DON) and Employee #3 (Director of Social Services) acknowledged the findings with Employee #2 stating, "We will make sure that the hospice care plan is more detailed, and that the most recent hospice plan of care is in the chart and that it collaborates with our plan of care."	F 849		