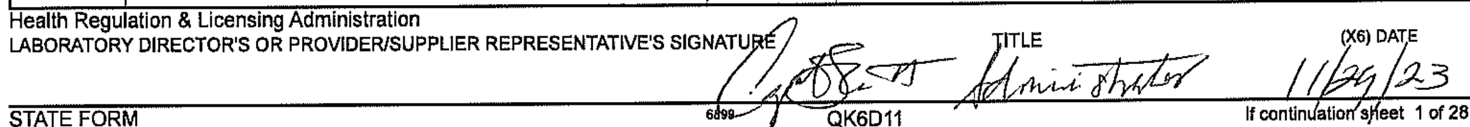
Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 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 DC~10563 DC~10309	L 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.	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 000	Continued From page 1	L 000		

After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 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
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 000	Continued From page 2 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 POS - physician's order sheet Prn - As needed Pt - Patient	L 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 000	Continued From page 3 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of	L 051	1. 4 residents were identified 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 051	Continued From page 4	L 051		

residents.
This Statute 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 2 (two) of 32 sampled residents. Residents #12, #41

The findings included:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 051	Continued From page 5	L 051		

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 .... 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 03/11/23@ 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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 051	Continued From page 6	L 051		

Continued From page 6

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 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 03/11/23 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 03/14/23 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 03/15/23 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: ... 03/11/23: [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

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 051	Continued From page 7 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 10:56 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no comments. 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	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 051	Continued From page 8 that facility staff revised Resident #41's nutritional care plan with the new diet order of mechanical 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.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities;	L 052	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 052	Continued From page 9	L 052		

(f)Encouragement and assistance to:

(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;

(2)Use the dining room if he or she is able; and

(3)Participate in meaningful social and recreational activities; with eating;

(g)Prompt, unhurried assistance if he or she requires or request help with eating;

(h)Prescribed adaptive self-help devices to assist him or her in eating
independently;

(i)Assistance, if needed, with daily hygiene, including oral acre; and

j)Prompt response to an activated call bell or call for help.

This Statute 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 052	Continued From page 10	L 052		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 052	Continued From page 11	L 052		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 052	Continued From page 12 [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 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	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 052	Continued From page 13 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. 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]	L 052		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:	L 099		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 099	Continued From page 14 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. 2. Food items such as five (5) of five (5)	L 099	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. a. 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 15 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.	L 099		
L 112	3220.6 Nursing Facilities Each change in a therapeutic diet order shall be authorized by the attending physician and shall be forwarded in writing to the Dietary Services This Statute is not met as evidenced by: Based on observations, record review, resident and staff interviews, for one (1) of 32 sampled	L 112		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 112	Continued From page 16 residents, facility staff failed to forward, in writing, Resident #41's new therapeutic diet order Dietary Services. 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 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,	L 112	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 112	Continued From page 17 "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 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.	L 112		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on	L 128		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 128	Continued From page 18	L 128		

the status of the pharmaceutical services and staff performances, at least quarterly;

(c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;

(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and

(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.
This Statute 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..."

1A. During an observation on 07/30/23 at 6:58 AM of the 2nd floor, medication cart 2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 128	Continued From page 19 "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 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."	L 128	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 20 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.	L 128		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute 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."	L 168	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE

L 534 Continued From page 21 (L 534)

L 534 3270.1 Nursing Facilities (L 534)

A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)).

This Statute 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 following the requirements of the DC 6-108..."

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.

Provider's Plan of Correction (L 534) — Complete date: 10/15/23

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 4 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 5 residents identified, 4 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534	Continued From page 22	L 534		

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 she fell ... MD (medical doctor) notified and order to transfer resident to the nearest ER (emergency room). POA (power of attorney) 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 notified and ordered to transfer resident to the nearest ER ... 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534	Continued From page 23 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 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.	L 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534	Continued From page 24	L 534		

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."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534	Continued From page 25	L 534		

staff provided the resident, or his daughter written notice of the bed hold policy to include the 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534		L 534		

Continued From page 26

"Resident transfer to ER for evaluation."

"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 ..."

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."

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.

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

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0004	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) COMPLETE DATE
L 534	Continued From page 27 days information for Resident #98."	L 534		