STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 October 10, 2023, to October 20, 2023. Survey activities consisted of observations, record reviews, and resident, family and staff interviews. The facility's census on the day of the survey was 168 residents. The following Facility Reported Incidents (FRIs) were investigated: DC~11122, DC~11228 DC~12257, DC~12231, DC~12228, DC~12210, DC~12195, DC~12174, DC~12083, DC~12078, DC~12118, DC~12106, DC~12103, DC~11960, DC~11886, DC~11885, DC~11876, DC~11793, DC~11652, DC~11630, DC~11584, DC~11408, DC~11344, DC~11260, DC~11247, DC~11233, DC~11322, DC~11190, DC~11158, and DC~11677. 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~12257, DC~12228, DC~12083, DC~12106, DC~11886, DC~11885, DC~11584, and DC~11190. 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	F 000	**Serenity Rehabilitation and Health Center Disclaimer:** Serenity Rehab and Health LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	11.10.2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

LNHA | 11/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube 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)	F 000	**Serenity Rehabilitation and Health Center Disclaimer:** Serenity Rehab and Health LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion 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		11.10.2023
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident # 102 was immediately protected by pulling their privacy curtain. The certified nursing assistant assigned was educated on October 12, 2023 by the Staff Educator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, for one (1) of 57 sampled residents, the facility staff failed to treat Resident	F 550	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** The facility has determined that all residents have the potential to be affected. A house wide interview was conducted by the Administrative Assistant for all residents on 10.25.23 and 10.26.23 to ensure their privacy is maintained. All negative findings were addressed. The facility Staff Educator provided house wide education for all staff on Residents Rights. This education will be completed by 11.10.2023. **3. MEASURE TO PREVENT REOCURRENCE** Immediately on October 12, 2023, the Director of Nursing called a mandatory in-service for all CNA's. Staff were educated by the Director of Nursing on the facility policy regarding resident privacy and dignity. The DON/ designee checked each room on Oct 12th, 2023 to ensure a privacy curtain was in place. The Director of Nursing/ designee performed random audits to ensure privacy curtains were pulled while providing care. All staff will be in-serviced by November 10, 2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 #102 with respect and dignity and care for the resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, as evidenced by staff not closing the privacy curtain before opening the resident's door that opens to a public hallway. Resident #102. The findings included: Resident #102 was admitted to the facility on 02/27/21, with multiple diagnoses that included the following: Paraplegia, Complete, Pressure Ulcer of Sacral Region Stage 4, and Major Depressive Disorder Recurrent. A review of Resident #102's medical record revealed the following: [Quarterly Minimum Data Set Assessment] 09/28/23 revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) Score of 15 indicating intact cognition. Facility staff coded that the resident has an indwelling catheter. [Physicians Order] 09/23/33 "...Change Foley bag and tubing every 2 weeks and as needed ..." During an observation in Resident #102's room conducted on 10/12/23 at approximately 4:15PM, the Surveyor observed Employee #15 (Certified Nurse Aide) place Resident #102 into a Hoyer sling lift and transfer the resident from her motorized wheelchair onto her bed. After Employee #15 placed the resident in the bed she then opened the privacy curtain and opened the door that leads to the public hallway. The resident's urine collection bag was visible and uncovered on the bed and located between the	F 550	**4. MONITORING CORRECTIVE ACTION** The Unit Manager/designee will conduct random observations to ensure curtain is pulled while providing care. This audit will be done for five residents per day weekly x 4 and monthly x 2. Any staff found non-compliant will receive education as evidenced by remedial documentation in the individual's employee file. Any further non-compliance by the employee will result in progressive disciplinary action. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 resident's legs and the resident's clothing was disheveled with resident's bare shoulders and bare legs exposed. A face-to-face interview was conducted at the time of observation with Employee #15, and she stated, "I did not know I needed to pull the privacy curtain". During a face-to-face interview conducted on 10/19/23 at approximately 3:00 PM, Employee #4 (Unit Manager 1st floor) stated that the privacy curtain should have been pulled and re-education will be provided.	F 550		11.10.2023
F 584 SS=D	Cross Reference 22B DCMR Sec.3269.1 (d) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The chain on the window blind in room #128 was replaced on October 10, 2023 during the annual Survey. **2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** The facility has determined that all residents have the potential to be affected by this deficient practice. The Maintenance Director / Designee conducted a house wide inspection of all blinds/chain in each room to ensure they were operable. This inspection was conducted on October 26, 2023. All negative findings were resolved upon discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, comfortable environment as evidenced by a window blind in one (1) of 34 resident's rooms with a broken chain. The findings include: During a walkthrough of the facility on October 10, 2023, at approximately 1:15 PM, the window blind in one (1) of 34 residents' room (#128) would not open due to a broken pull chain. Employee #14 acknowledged the finding on October 11, 2023, at approximately 11:00 AM, and replaced the broken chain.	F 584	**3. MEASURE TO PREVENT REOCURRENCE** Education will be done by the Staff Educator for the Maintenance personnel to check for broken blinds/chain and replace them when found. This education was completed on October 26, 2023. All rooms will be monitored weekly, during grand rounds by the Director of Maintenance or Designee to ensure a safe and comfortable environment. Any negative findings will be addressed upon discovery. **4. MONITORING CORRECTIVE ACTION** The Director of Maintenance / designee will conduct weekly inspections of all rooms to ensure safe and comfortable environment. This inspection will be done weekly x 4 and monthly x 2. All negative findings will be addressed upon discovery. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, for eight (8) of 57 sampled residents, facility staff failed to report allegations abuse to the State Agency immediately (within 2 hours of the incident); and failed to send the results/follow-up of all investigations to the State Survey Agency within five (5) working days of the	F 609	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The resident-to-resident incident involving Resident #s 103, 46, 366, 91, 54, 99, 22, and Resident #63 final investigation report to the State Agency were forwarded late. This deficiency cannot be retroactively corrected. There were no adverse findings from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** No other residents were identified to have any current allegations that needed to be reported to the proper authorities. On October 13, 2023, the Compliance Officer/Designee completed an audit of reported abuse incidents from October 10, 2023, to present, to ensure all reported allegations of abuse completed investigations were reported timely and that the conclusive result of the investigation was sent to the State agency within the 5 working days timeframe. An audit of all documents relevant to the investigation was also conducted. No additional negative findings were discovered.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 8 incident. Residents' #103, #46, #366, #91, #54, #99, #22 and #63. The findings included: Review of the facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" documented: - All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported -If resident abuse is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law - "Immediately" is defined as within 2 hours of an allegation involving abuse. 1. Facility staff failed to report Resident #103's allegation of resident-to-resident physical abuse by Resident #46 to the State Agency immediately and failed to report the results of their investigation to the State Agency within five (5) working days. 1A. Resident #103 was admitted to the facility on 03/22/21 with diagnoses that included: Aphasia, Major Depressive Disorder and Muscle Weakness. Review of Resident #103's medical record revealed the following: A census tracking that documented Resident #103 resided in room 128, bed A. A Quarterly Minimum Data Set (MDS)	F 609	**3. MEASURE TO PREVENT REOCCURRENCE** The Staff Educator will conduct an In-service on expectation of reporting allegation of abuse/ results of the investigation in a timely manner to the state agency. This in-service will be completed by all Nurses, Nursing Supervisor, Clinical Manager. This in-service will be completed by November 10, 2023. On October 13, 2023, the current Administrator was educated by the Governing Body on the timely reporting of the final investigation findings of abuse allegations of 5 days to the state agency per facility Resident Abuse and Neglect policy and F 607 regulation as well as ensuring a thorough investigation is conducted. The Administrator is the designated Abuse Coordinator and will be responsible for the timely reporting to state agencies for all allegations of abuse. An audit was conducted for all incidents reported to the state agency on October 26, 2023 and no negative findings were discovered.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 9 assessment dated 08/13/23 showed facility staff coded: sometimes able to make self understood; a BIMS Summary Score of 9, indicating moderately impaired cognitive function; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; functional limitation in range of motion on one side for upper extremities; and used a walker and wheelchair for mobility. A Nurse Practitioner (NP) Progress Note dated 08/29/23 at 2:00 PM documented: - Reported resident had an altercation with another resident; [Resident #103] stated she was hit by [Resident #46]. 1B. Resident #46 was admitted to the facility on 01/06/14 with multiple diagnoses that included: Anxiety Disorder, Hyperlipidemia and Hypertension. Review of Resident #46's medical record revealed the following: A census tracking that documented Resident #46 resided in room 126, bed A. A MDS assessment dated 06/07/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 13, indicating intact cognitive response; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; had functional limitation in range of motion on one side for upper extremities; and used a wheelchair for mobility. A Situation Background Assessment and Request	F 609	**4. MONITORING CORRECTIVE ACTION** A member of the Governing Body will monitor final investigations findings of Abuse reportable to ensure a thorough investigation and timely reporting of the investigation conclusion within the 5-day requirement to the state agency. Monitoring will be completed weekly x 4 and monthly x 2. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 10	F 609		11.10.2023

(SBAR) Tool dated 08/29/23 at 3:04 PM documented:
- Situation: Resident-to-resident altercation
- Resident #103 of room 128A reported that she was hit on the face by Resident #46, room 126A, in the hall.

A Facility Reported Incident (FRI), DC~12257, received by the State Agency on 08/30/23 at 1:35 PM documented:
- Resident #103 reported to the NP that she was hit on the face by Resident #46.

The evidence showed that facility staff first documented that they had knowledge of the alleged incident of resident-to-resident physical abuse in Resident #46's medical record on 08/29/23 at 3:04 PM. However, the facility did not report the alleged incident to the State Agency until 08/30/23 at 1:35 PM, 22 hours later.

Review of the facility's investigation documents on 10/13/23 revealed that facility staff also failed to report the results of their investigation to the State Agency within five (5) working days.

During a face-to-face interview on 10/13/23 at 2:15 PM, Employee #3 (Assistant Director of Nursing/ADON) acknowledged that facility staff failed to report Resident #103's allegation of physical abuse by Resident #46 immediately (within 2 hours) and that they failed to report the results of their investigation to the State Agency and stated that the nurse assigned or Nursing Supervisor on shift when the allegation was first made, should've made the report to Department of Health.

2. Facility staff failed to report Resident #366's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 11	F 609		11.10.2023

allegation of resident-to-resident verbal and physical abuse by Resident #91 to the State Agency within the specified timeframe stipulated in their policy.

2A. Resident #366 was admitted to the facility on 08/16/22 with diagnoses that included: Anxiety Disorder, Cognitive Community Deficit, and Muscle Weakness.

Review of Resident #366's medical record showed the following:

A census tracking that documented Resident #366 resided in room 139, bed B.

A Quarterly MDS assessment dated 04/14/23 showed facility staff coded: BIMS Summary Score of 12, indicating moderate cognitive impairment; no physical, verbal or any other behavioral symptoms directed towards others.

A Nurses Note dated 04/15/23 at 2:24 PM documented:
- At about 12:15 PM, Resident #366's brother reported to the writer about a situation with his sister and roommate, Resident #91
- He stated, "Verbal threating language [by Resident #91]; throwing things that hit [Resident #366]".

A FRI, DC~11885, submitted to the State Agency on 04/16/23 at 4:56 PM documented:
- Alleged [Resident #91] verbally and physically abused Resident #366 by throwing things at her
- When asked, Resident #366 stated, "My roommate verbally threaten me and throws things like lotion bottle at me."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 12	F 609		11.10.2023

2B. Resident #91 was admitted to the facility on 06/12/2020 with diagnoses that included Dementia and Muscle Weakness.

Review of Resident #91's medical record showed the following:

A census tracking that documented Resident #46 resided in room 139, bed A.

A Quarterly MDS assessment dated 02/20/23 showed facility staff coded: a BIMS Summary Score of 7, indicating severe cognitive impairment; did not exhibit any physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); did not exhibit any verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); exhibited other behavioral symptoms that were not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred 1 to 3 days; and had wandering behavior that occurred 1 to 3 days.

A FRI, DC~11886, submitted to the State Agency on 04/16/23 at 5:27 PM documented:
- Resident #366 and her son alleged that Resident #91 verbally and physically abused Resident #366 by throwing things at her.

Review of the facility's investigation documents on 10/17/23 showed that facility staff first documented that they had knowledge of the alleged incident of resident-to-resident verbal and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 13	F 609		11.10.2023

physical on abuse in Resident #366's medical record on 04/15/23 at 12:15 PM. However, the facility did not report the alleged incident to the State Agency until 04/16/23 at 4:56 PM, over 28 hours later.

During a face-to-face interview on 10/17/23 at 3:01 PM, Employee #4 (1st floor Unit Manager) stated, "This was the weekend. I was called at home and made aware of the incident. The Nursing Supervisor or Charge Nurse working that shift was responsible for reporting the incident to the State Agency."

3. Resident #54 was admitted to the facility on 06/17/23 with multiple diagnoses including Generalized Muscle Weakness.

An Admission Fall Risk Assessment dated 06/17/23 at 6:28 PM revealed the resident had a score of "4" indicating the resident was low risk for falls.

A review of an Admission Minimum Data Set assessment dated 06/23/23 documented the following but not limited to the resident had a Brief Interview for Mental Status summary score of "05" indicating that the resident's cognitive status was severely impaired, the resident required set-up assistance from with walking in room, resident was receiving physical and occupational therapy services, and the resident did not have a history of falls prior to admission to the facility.

A physician order dated 07/11/23 at 11:27 AM instructed, "Transfer resident to ER for unwitnessed fall and open area on the occipital area one time only."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 14	F 609		11.10.2023

A review of a nursing note dated 07/11/23 at 11:45 AM documented the following but not limited to: "At about 7:15a.m, Writer receive [Resident #54] in bed lying on her left lateral side in no distress watching TV during safety rounds on the unit. Resident ate over 90% of her breakfast served, received and tolerated all due morning meds. At about 11:21a.m during wellness/safety rounds on the unit resident was observed by writer lying in a supine position on the floor in her room; her head towards the foot of the bed while her feet stretch forward towards the door entrance. Writer called for help and other nursing staffs on the unit came to the room to assist the resident. On assessment resident was observed with an open area on the occipital area of her head with bleeding. [NP's name] notified, order obtain to cleanse area with normal saline solution and apply light pressure with 4x4 gauze to halt the bleeding. [NP's name] also gave order to transfer resident to the ER via 911 due to unwitnessed fall with open area to the occipital area of the head. "

A review of a State Survey Agency Facility Reported Incident Intake Form DC ~12106 submitted on 07/11/23 at 3:37 PM documented the following but not limited to: "At about 11:21a.m during wellness/safety rounds on the unit [Resident #54] was observed by writer lying in a supine position on the floor in her room; her head towards the foot of the bed while her feet stretch forward towards the door entrance. On assessment resident was observed with an open area on the occipital area of her head with bleeding. [NP's name] gave order to transfer resident to the ER via 911 due to unwitnessed fall with open area to the occipital area of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 15 head. " A nursing progress note dated 07/11/23 at 8:40 PM documented the following but not limited to: "[Resident #54] returned from [hospital's name] at 7:30 PM on a stretcher via [transportation company's name]. During assessment alert and oriented x 1, normal baseline status. No distress noted from resident, denies any pain. Resident has 5 stiches on the occipital part of the head. No bleeding or drainage noted. Discharge Report stated that CT (computerized tomography) scan done at the hospital of the head and cervical spine did not show any acute fracture. There was no bleeding or hematoma in the brain according to the result." A review of the facility's investigative packet dated 07/11/23 revealed that there was no documented evidence the results of the investigation were sent to the State Survey Agency. An observation on 10/13/23 of Resident #54's room revealed Resident #5 ambulating around the room safely and independently. The resident was alert, oriented to name, and could not recall falling or having a head injury. During a face-to-face interview on 10/13/23 at approximately 2:00 PM, Employee #3 (ADON) stated the facility had not yet submitted the results of its investigation of Resident # 54's fall with injury (Laceration to Head) to the State Survey Agency. Cross reference 483.25 Quality of Care (F684). 4. Resident #99 was admitted to the facility on 03/04/23. The resident had a history of multiple	F 609		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 16 diagnoses including Traumatic Subdural Hemorrhage, Head Injury, Vascular Dementia, Muscle Weakness, Lack of Coordination, Seizures, Restlessness and Agitation. A review of a fall risk assessment dated 07/22/23 documented, the resident had a score of "17" indicating the resident was a "high risk" for falls. A review of a quarterly Minimum Data Set dated 08/11/23 documented the following but not limited to the resident had a Brief Interview for Mental Status summary score of "3" indicating that the resident's cognitive status was severely impaired, the required extensive assistance of two staff members when transferring from one surface to another, and the resident was receiving occupational therapy services. A review of a physician order dated 08/21/23 at 5:21 PM instructed, "Transfer resident via 911 for fall and injury to his head for further evaluation." A review of a nursing note dated 08/21/23 at 9:34 PM documented the following but not limited to: "During routine safety rounds at 3:10 PM ,writer received resident in bed lying on his lateral side in bed, no acute distress noted watching TV, resident tolerated all due medications at 4:30 PM, at about 4:50 PM during meds pass on the unit, resident was observed by writer lying in a supine position on the floor in his room, his head towards the foot of the bed. while his feet stretch forward towards the door entrance. Writer call for help and other nursing staffs on the unit came to the room and assist the resident back to his bed. On assessment resident was observed with open area on the right side of his head with bleeding, [NP's name] notified order obtain (sp) to transfer	F 609		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 17	F 609		11.10.2023

resident to ER via 911 due to unwitnessed fall with open area to right side of resident head. 911 was called and they arrived at the facility at 5:28pm bed side assessment done, then call AMR transportation service who pick up the resident from the facility at 6:15PM. Resident remained alert and oriented X 2-3, pleasantly confused with speech clear and coherent for his baseline, Resident is unable to explained what he was doing prior to his fall due to diagnosis of vascular dementia."

A review of the facility's investigative packet dated 08/21/23 revealed that there was no documented evidence the results of the investigation were sent to the State Survey Agency.

A review of a care plan with a review date of 08/21/23 documented the following but not limited to: Focus- [Resident #99] had actual falls on 06/04/23 and 07/22/23 with no injury. [Resident #99] had an actual fall (with injury) on 08/21/23. Interventions- Bilateral mats on the floor, bring resident in day room while awake, ensure bed is [in] lowest position for safety with call light with his reach, and redirect the resident."

A review of a State Survey Agency Facility Reported Incident Intake Form
DC ~ 12228 received on 08/22/23 at 5:04 PM documented but not limited to: "During routine safety rounds at 3:10 PM, writer received resident in bed lying on his lateral side in bed, no acute distress noted watching TV. Resident tolerated all due medications at 4:30 PM, at about 4:50 PM during meds (medication) pass on the unit, resident was observed by his assigned nurse lying in a supine position on the floor in his room. On assessment resident was observed with open

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 18	F 609		11.10.2023

area on the right side of his head with bleeding, [NP's name] order to transfer resident to ER via 911 due to unwitnessed fall with open area to right side of resident head."

A review of a re-admission nursing note dated 08/22/23 at 11:57 PM documented the following but not limited to: "[Resident #99] readmitted from [local hospital] on 8/22/23. Per resident's transfer note, on 8/21/23 at about 4:50pm during medication pass, [Resident #99] was observed on the floor in his room and on assessment he had an open area on the right side of his head with bleeding. MD order was also given to transfer out to nearest ER for further evaluation and treatment due to minor injury sustained during an unwitnessed fall. Imaging was performed at the hospital, and it revealed small subarachnoid hemorrhage and intraparenchymal hemorrhage and was treated for mild traumatic brain injury (concussion). Resident has [re]admitting diagnoses of head injury and subdural hematoma. Upon admission assessment, resident is alert, verbally responsive and oriented to self and place and is a poor historian. On further assessment, his head is round and has no swelling, and he did not verbalize any headache.

Multiple observations of Resident #99's room starting at approximately 10:00 AM on 10/17/23 to approximately 1:00 PM on 10/20/23 showed the resident sleeping or watching tv with bed in low position and black floor mats on the right and left side of bed. The resident answered to name but did not answer surveyor's questions.

During a face-to-face interview on 10/20/23 at approximately 1:00 PM, Employee #3 (ADON) stated the facility had not yet submitted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 19 results of its investigation of Resident # 99's fall with injury (Traumatic Subdural Hemorrhage without Loss of Consciousness) to the State Survey Agency. 5. Facility staff failed to report the results of their investigation of Resident #22's Facility reported allegation of Abuse to the State Survey Agency within 5 working days of the incident. Resident #22 was admitted to the facility on 01/17/20, with multiple diagnoses that included: Diabetes Mellitus 2, HIV, Hepatitis C, Paranoid Schizophrenia, Increased agitation with bizarre behavior, Bipolar Disorder, Mild Dementia, PCP, and Cocaine abuse. Review of a Facility Reported Incident (FRI) DC00011190 received on 11/14/22, documented, " On November 10, 2022, at about 12:15pm resident in room 246A [Resident #22] exhibited physical aggression behavior on the unit suddenly with no indication or prior signs went into room 245A and hit the [Resident#63], [Resident#63] yelled get out of my room and writer ran into the room and requested for [Resident #22] to step out of the room. While [Resident #22] was going out of [Resident #63]'s room, [Resident#22] hit writer on both shoulder area multiple times writer ran down in the hall way away from the resident. [Resident #22] was redirected by the ADON and other nursing staff. [Dr name] notified order given to transfer [Resident #22] to ER via 911 for physical aggressive behavior; hitting other resident/staff. [Resident #63] was offered Tylenol 650mg for pain of 4/10 scale. [Resident#63] refused pain medication and complained of difficulty using her left arm. [Dr name] notified; MD gave order for X-ray of the left shoulder, left	F 609		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 20 arm, and hand due to c/o pain. ... [Resident#63 son] was present at bed when police were called into the facility at 14:45pm. [Officer name], #2448 came to the facility 15:40 pm and spoke to both residents. No arrest was made. Police issued report CCN# 22164107. The police officers exit the building at 16:20 p.m. While Ms. Wilson was being transferred to UMC." Review of the facility's investigation documents showed there was no documented evidence that the facility staff reported the results of the alleged abuse investigation to the State Agency. During a face-to-face interview conducted on 10/18/23 at approximately 11:00 AM, Employee #3 (Assistant Director of Nursing) acknowledged the findings and stated "I did not send the investigation results to the State Agency. 6. Facility staff failed to report the results of their investigation of Resident #63's Facility reported allegation of Abuse to the State Survey Agency within 5 working days of the incident. Resident #63 was admitted to the facility on 09/02/16, with multiple diagnoses that included: Type 2 Diabetes Mellitus, Hypertension, Heart Failure, Paranoid Disorder, Anxiety Disorder, Major Depressive Disorder, and Post-traumatic stress disorder. Review of a Facility Reported Incident (FRI) DC00011584 received on 01/31/23, documented, "01/26/23 19:00 [8:00 PM] writer was informed of a verbal argument between 2 residents. Upon arrival, [Resident #63] was telling the roommate [Resident #215] " she should be removed out of	F 609		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 609	Continued From page 21 my room and stop staring at me in such an astonish manner. Writer tried to calm [Resident#63] in a quiet and calmly voice but she keeps on insisting of not wanting anybody in her room. Resident says that room belongs to her and no body is supposed to be in there. Writer intervened by proposing to [Resident#63] that she will be located to another room, but she declined the proposal. [Dr name] was made aware immediately of the verbal argument among both residents and the intervention put in place. An order to relocate the roommate [Resident #215] from room 245B to room 337A for safety precautions and was executed immediately .. " Review of the facility's investigation documents showed there was no documented evidence that the facility staff reported the results of the alleged abuse investigation to the State Agency. During a face-to-face interview conducted on 10/18/23 at approximately, 11:00 AM, Employee #3 (Assistant Director of Nursing) acknowledged the findings and stated "I did not send investigation results to the State Agency	F 609		11.10.2023
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The resident-to-resident incident involving Resident #s 103, 46, 366, & 391 final investigation reports sent to the State Agency were not thoroughly completed. This deficiency cannot be retroactively corrected. The residents did not receive any adverse reaction from this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 22 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for four (4) out of 57 sampled residents, facility staff failed to have documented evidence that they conducted thorough investigations of allegations of abuse by failing to have interviews or statements of all staff represent at the time of the alleged incidents. Residents' #103, #46, #366, and #91. The findings included: The facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" documented: -All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. 1A. Resident #103 was admitted to the facility on 03/22/21 with diagnoses that included: Aphasia, Major Depressive Disorder and Muscle Weakness. Review of Resident #103's medical record revealed the following: A census tracking that documented Resident #103 resided in room 128, bed A.	F 610	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** No other residents were identified to have any current allegations that needed to be investigated or reported to the proper authorities. On October 13, 2023, a member of the Governing body completed an audit of reported abuse incidents from October 10, 2023, to present, to ensure all reported allegations of abuse investigations were accurately and thoroughly done. An audit of all documents relevant to the investigation was also conducted. No additional negative findings were discovered.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 23 A Quarterly Minimum Data Set (MDS) assessment dated 08/13/23 showed facility staff coded: sometimes able to make self understood; a BIMS Summary Score of 9, indicating moderately impaired cognitive function; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; functional limitation in range of motion on one side for upper extremities; and used a walker and wheelchair for mobility. A Nurse Practitioner (NP) Progress Note dated 08/29/23 at 2:00 PM documented: -Reported resident had an altercation with another resident; [Resident #103] stated she was hit by [Resident #46]. 1B. Resident #46 was admitted to the facility on 01/06/14 with multiple diagnoses that included: Anxiety Disorder, Hyperlipidemia and Hypertension. Review of Resident #46's medical record revealed the following: A census tracking that documented Resident #46 resided in room 126, bed A. A MDS assessment dated 06/07/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 13, indicating intact cognitive response; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; had functional limitation in range of motion on one side for upper extremities; and used a wheelchair for mobility.	F 610	**3. MEASURE TO PREVENT REOCURRENCE** The Staff Educator will conduct an In-service on expectation of thoroughly investigating an allegation of abuse. This in-service will be completed by all Nurses, Nursing Supervisor, Clinical Manager. This in-service will be completed by November 10, 2023. On October 13, 2023, the current Administrator was educated by the Governing Body on the expectation and protocols for conducting a thorough investigation. The Administrator is the designated Abuse Coordinator and will be responsible for ensuring compliance with all allegations of abuse. An audit was conducted for all incidents reported to the state agency on October 26, 2023, and no negative findings were discovered.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 24 A Situation Background Assessment and Request (SBAR) Tool dated 08/29/23 at 3:04 PM documented: - Situation: Resident-to-resident altercation - Resident #103 of room 128A reported that she was hit on the face by Resident #46, room 126A, in the hall. A Facility Reported Incident (FRI), DC~12257, received by the State Agency on 08/30/23 at 1:35 PM documented: - Resident #103 reported to the NP that she was hit on the face by Resident #46. Review of the facility's investigation documents on 10/13/23 revealed that facility staff failed to have documented evidence that the Certified Nurse Aide (CNA) assigned to Resident #103 on 08/29/23, day shift, was interviewed and or provided a statement. The evidence showed that facility staff failed to conduct a thorough investigation as evidenced by no having an interview and or statement from all staff present at the time of the incident or who might have knowledge of the incident. During a face-to-face interview on 10/13/23 at 2:15 PM, Employee #3 (Assistant Director of Nursing/ADON) acknowledged the finding and stated that their investigation should have included a statement from all the staff present on the date and shift that the alleged incident occurred. 2A. Resident #366 was admitted to the facility on 08/16/22 with diagnoses that included: Anxiety Disorder, Cognitive Community Deficit, and	F 610	**4. MONITORING CORRECTIVE ACTION** A member of the Governing Body will monitor all paperwork / findings of Abuse reportable to ensure a thorough investigation was completed. On October 26, 2023, the Governing Body implemented a new audit compliance tool that will be used for all Facility Reported Incidents. This audit tool will be used to ensure compliance with reporting, data collection and thorough investigation with all incidents. Monitoring will be completed weekly x 4 and monthly x 3. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 25	F 610		11.10.2023

Muscle Weakness.

Review of Resident #366's medical record showed the following:

A census tracking that documented Resident #366 resided in room 139, bed B.

A Quarterly MDS assessment dated 04/14/23 showed facility staff coded: BIMS Summary Score of 12, indicating moderate cognitive impairment; no physical, verbal or any other behavioral symptoms directed towards others.

A Nurses Note dated 04/15/23 at 2:24 PM documented:
-At about 12:15 PM, Resident #366's brother reported to the writer about a situation with his sister and roommate, Resident #91
-He stated, "Verbal threating language [by Resident #91]; throwing things that hit [Resident #366]".

A FRI, DC~11885, submitted to the State Agency on 04/16/23 at 4:56 PM documented:
-Alleged [Resident #91] verbally and physically abused Resident #366 by throwing things at her
-When asked, Resident #366 stated, "My roommate verbally threaten me and throws things like lotion bottle at me."

2B. Resident #91 was admitted to the facility on 06/12/2020 with diagnoses that included Dementia and Muscle Weakness.

Review of Resident #91's medical record showed the following:

A census tracking that documented Resident #46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 26 resided in room 139, bed A. A Quarterly MDS assessment dated 02/20/23 showed facility staff coded: a BIMS Summary Score of 7, indicating severe cognitive impairment; did not exhibit any physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); did not exhibit any verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); exhibited other behavioral symptoms that were not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred 1 to 3 days; and had wandering behavior that occurred 1 to 3 days. A FRI, DC~11886, submitted to the State Agency on 04/16/23 at 5:27 PM documented: -Resident #366 and her son alleged that Resident #91 verbally and physically abused Resident #366 by throwing things at her. Review of the facility's investigation documents on 10/17/23 revealed that facility staff failed to have documented evidence that the Certified Nurse Aide (CNA) assigned to Residents' #366 and #91 on 04/15/23, day shift, was interviewed and or provided a statement. The evidence showed that facility staff failed to conduct a thorough investigation as evidenced by no having an interview and or statement from all staff present at the time of the incident or who might have knowledge of the incident.	F 610		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 610	Continued From page 27 During a face-to-face interview on 10/17/23 at 3:35 PM, Employee #3 (Assistant Director of Nursing/ADON) reviewed the investigation documents and stated, "We did not get a statement from her (assigned CNA on 04/15/23, day shift)." Cross Reference 22B DCMR Sec. 3232.2	F 610		11.10.2023
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 review and staff interview for one (1) of 57 sampled residents, facility staff failed to accurately code the residents Quarterly Minimum Data Set (MDS) assessment to accurately reflect the resident's fall that occurred on 08/17/23. Resident #415. The findings included: Resident #415 was admitted to the facility on 08/18/16, with multiple diagnoses that included the following: Diabetes Mellitus Type 2, Dementia in other Diseases Unspecified Severity With Behavioral Disturbance, and Insomnia. A Facility Reported Incident (FRI) DC00012210, was received by the State Agency on 08/17/23, and documented the following: " ...Writer notified by CNA (Certified Nurse Aide) that the resident was on the floor in his room. Writer immediately went to the resident room and observed the	F 641	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident 415 # was noted to have a fall on 08.17.2023. This was corrected on the quarterly MDS upon discovery. Resident was assessed head to toe post fall by the charge nurse on 08.17.2023 and no adverse findings resulted. MDS nurse was educated by MDS consultant upon discovery to ensure fall incidences are coded properly in the MDS. This in-service was conducted October 18, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 28 resident on the floor in a supine position beside his bed. Assigned CNA stated that the resident slid off his bed and got out of her grip while she tried to assist the resident with morning care ..." Review of Resident #415's medical record revealed the following: [Physician Order] 09/28/16 "Fall precautions Q (every) Shift ..." [Nurse Progress Note] 08/17/23 at 4:55 PM, " ...Writer notified by CNA (Certified Nurse Aide) that the resident was on the floor in his room. The writer immediately went to the resident room and observed the resident on the floor in a supine position beside his bed. Assigned CNA stated that the resident slid off his bed and got out of her grip while she tried to assist the resident with morning care. Resident was unable to explained (sp) what happened due to diagnosis of dementia. Upon assessment, resident is A (alert) & O (Oriented) x (times) 1(to person) associated to his baseline status. Resident was observed with swelling on his right forehead with small amount of blood. Pressure applied. Bleeding stopped immediately. Order given to transfer resident to hospital for further evaluation and treatment ..." A [Care Plan] initiated on 08/17/23 with a focus area of " ...(Resident #415) has a fall resident was observed on the floor in supine position" has interventions that included the following: "encouraged resident to change positions slowly, Bed in low position ..." [(Hospital facility name) Patient Visit Information] 08/17/23 " ...You were seen today for: Head injury	F 641	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. An audit of residents with falls was completed to ensure the MDS is accurate to reflect the fall incident by the MDS Director from 10.17.2023 to 10.21.2023. No other discrepancies on fall documentation and MDS coding were found on the audit. This is to ensure that residents with falls were coded correctly. This audit was completed on October 26, 2023, and no negative findings were discovered. **3. MEASURE TO PREVENT REOCURRENCE** Education was done on October 18, 2023, for the MDS coordinator by the Regional MDS Director to ensure that the MDS coding reflects the resident's Fall status correctly. Additionally, MDS will be informed through risk management meeting for all incidences of fall to ensure proper coding.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 29 Laceration of head ..." [Quarterly Minimum Data Set] 09/08/23, In Section J (Health Conditions) the facility staff coded that the resident did not have any falls since admission, entry or prior assessment. The facility left the section blank that documents number of falls since admission entry or prior assessment. The evidence showed that the facility staff failed to code the Quarterly Minimum Data Set assessment accurately to reflect Resident #415's fall with injury that occurred on 08/17/23. During a face-to-face interview conducted on 10/18/23 at approximately 1:00 PM, with Employee #16 (MDS Coordinator), stated that the facility staff usually has a clinical meeting and a risk meeting where the team informs us of falls, and this was an oversight. Cross Reference 22B DCMR Sec.3231.11	F 641	4. **MONITORING CORRECTIVE ACTION** An audit will be done by the MDS Director to ensure that Fall status is coded appropriately for the MDS section. This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: 11.10.2023	11.10.2023
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30 interview for (3) of 57 sampled residents, facility staff failed to do the following: follow an intervention included in a residents fall care plan, perform a weekly skin assessment as ordered by the physician for Resident #418, and use a 2 person physical assist when transferring Resident #102 from a wheelchair to the bed using a Hoyer lift. Resident #57, #418, and #102. The findings included: Resident #54 was admitted to the facility on 06/17/23 with multiple diagnoses including Generalized Muscle Weakness. A review of the policy titled, "Fall and Fall Management" with a review date of 05/23 instructed, "When a fall occurs, referral to rehabilitation or other disciplines depending on the reason for the fall. The staff, with the input of the interdisciplinary team will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the attending physician and interdisciplinary team, the staff will identify and implement relevant interventions to try to minimize serious consequences of falling." An Admission Fall Risk Assessment dated 06/17/23 at 6:28 PM revealed the resident had a score of "4" indicating the resident was "low risk" for falls. A review of an Admission Minimum Data Set assessment dated 06/23/23 documented the following but not limited to the resident had a Brief Interview for Mental Status summary score of "05" indicating that the resident's cognitive	F 684	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The Director of Rehabilitation and the Director of Nursing reviewed and revised Resident #54 comprehensive care plan on November 10, 2023, to ensure therapy services are provided by the facility to meet professional standards of quality. The resident had no negative outcome from this deficient practice. Resident #102 was assessed for required transfer assistance of two-person transfer assist when using mechanical lifts. A head-to-toe assessment was conducted by the DON/ Designee on October 16, 2023 and no adverse findings were resulted. Employee #15 was educated to ensure required transfer assistance is met for transferring resident while using a lift. This deficiency cannot be retroactively corrected. Resident#418 no longer resides in the facility.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 31 status was severely impaired, the resident required set-up assistance from staff with walking in room, resident was receiving physical and occupational therapy services, and the resident did not have a history of falls prior to admission to the facility. A physician order dated 07/11/23 at 11:27 AM instructed, "Transfer resident to ER (emergency room) for unwitnessed fall and open area on the occipital area one time only." A review of a nursing progress note dated 07/11/23 at 11:45 AM documented the following but not limited to: "At about 7:15a.m, Writer receive [Resident #54] in bed lying on her left lateral side in no distress watching TV during safety rounds on the unit. Resident ate over 90% of her breakfast served, received and tolerated all due morning meds. At about 11:21a.m during wellness/safety rounds on the unit resident was observed by writer lying in a supine position on the floor in her room; her head towards the foot of the bed while her feet stretch forward towards the door entrance. Writer called for help and other nursing staffs on the unit came to the room to assist the resident. On assessment resident was observed with an open area on the occipital area of her head with bleeding. [NP's name] notified, order obtain to cleanse area with normal saline solution and apply light pressure with 4x4 gauze to halt the bleeding. [NP's name] also gave order to transfer resident to the ER via 911 due to unwitnessed fall with open area to the occipital area of the head. " A Referral to Therapy form dated 07/11/23 at 12:15 PM documented, "PT (Physical Therapy) evaluation and treatment, post-fall evaluation."	F 684	**I DENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents with a therapy referral have the potential to be affected by this deficient practice. The Director of Rehab completed a 100% record review on therapy services orders and referrals for therapy from October 18, 2023, to present. All residents with an order and referral to therapy were addressed timely and appropriately. All residents residing in the facility who require 2-person assistance for transfers when using a lift have the potential to be affected by this deficient practice. The DON or designee completed 100% record review of residents requiring a 2 person assist on transfers when using a lift to ensure that staff are compliant with the transfer assistance. There were no negative findings. This audit was completed on November 3, 2023. All residents residing in the facility requiring a skin assessment has the potential to be affected by this deficient practice. A house wide audit was done for all skin assessment. This was conducted on November 03, 2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32 A review of a State Survey Agency Facility Reported Incident Intake form DC ~ 12106 submitted on 07/11/23 at 3:37 PM documented the following but not limited to: "At about 11:21a.m during wellness/safety rounds on the unit [Resident #54] was observed by writer lying in a supine position on the floor in her room; her head towards the foot of the bed while her feet stretch forward towards the door entrance. On assessment resident was observed with an open area on the occipital area of her head with bleeding. [NP's name] gave order to transfer resident to the ER via 911 due to unwitnessed fall with open area to the occipital area of the head. " A nursing progress note dated 07/11/23 at 8:40 PM documented the following but not limited to: "[Resident #54] returned from [hospital's name] at 7:30 PM on a stretcher via [transportation company's name]. During assessment alert and oriented x 1, normal baseline status. No distress noted from resident, denies any pain. Resident has 5 stiches on the occipital part of the head. No bleeding or drainage noted. Discharge Report stated that CT (computerized tomography) scan done at the hospital of the head and cervical spine did not show any acute fracture. There was no bleeding or hematoma in the brain according to the result." A review of a care plan dated 07/11/23 documented the following but not limited to: Focus - [Resident #54] has a fall on 07/11/23 with injury open area on occipital. Interventions: Hospital transfer for further evaluation and Physical Therapy consult for strength and mobility.	F 684	**3. MEASURE TO PREVENT REOCURRENCE** Staff Developer provided education to the Therapy Department, facility, and Licensed Nursing Staff. This In-service was initiated on October 20, 2023. This is to ensure that services provided or arranged by the facility as outlined by the comprehensive care plan, must-meet professional standards of quality. Education included implementation of a process to review physician orders and referrals for therapy services and to communicate therapy services orders to appropriate facility disciplines during the clinical morning meeting. The Director of Nursing or Designee will monitor newly admitted residents and residents with new therapy referrals to ensure orders are obtained, therapy services provided as indicated and comprehensive care plans reviewed and revised accordingly. All negative findings will be addressed upon discovery. Staff Developer/designee provided training and competency on proper transfer technique and always following the care plan on the required number of staff when transferring residents to ensure safety of resident and staff. This in-service will be completed by November 10, 2023. The Director of Nursing or Designee will monitor on a weekly basis that all residents weekly skin assessment is completed Negative findings, if any, will be addressed upon discovery.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 33 An observation on 10/13/23 at 11:00 AM of Resident #54 in her room showed the resident ambulating around the room safely and independently. The resident was alert, oriented to name, and could not recall falling or having a head injury. During a face-to-face interview on 10/16/23 at 11:00 AM, Employee #7 (Rehab. Area Manager/PT) stated that the Physical Therapy (PT) evaluation was an error, and an Occupational Therapy (OT) evaluation should have been done. In addition, the employee said she could not find documented evidence that an occupational therapy evaluation was conducted. Cross Reference DCMR 22B Sec. 3211.1 2) Facility staff failed to perform weekly skin assessments in December 2022, for Resident #418. Resident #418 was admitted to the facility on 12/09/2022 with multiple diagnoses that included the following: Diabetes Mellitus Type 2, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Benign Neoplasm of Parathyroid Gland. A Facility Reported Incident (FRI) DC00011344, was received by the State Agency on 12/13/2022 and documented the following, " ...readmitted with an open area 1 X 4 X 0.1cm on her sacrum. She also has rash excoriation on her groins and buttocks. The open area on her buttocks was cleansed with normal saline, pat dry ..."	F 684	**4. MONITORING CORRECTIVE ACTION** Monitoring of therapy orders and referrals will be completed weekly x 4 and monthly x 3 to ensure therapy services are provided timely and appropriately. This audit will be done by the Director of Rehab or Designee and will present results of audits to the QAPI Committee monthly and make changes to the plan as necessary to maintain compliance with services to meet professional standards of quality. All negative findings will be addressed upon discovery. An observation tool was developed to check at least three randomly selected residents, requiring a 2-person assist for transfers when using lifts weekly x 4 and monthly x 3 to ensure that staff are using required and proper assistance during transfers, based on plan of care. This will be conducted by Unit Manager or designee. All negative findings will be addressed upon discovery. Results of the audits will be reported to the QAPI committee. The Unit Manager or Designee will monitor all residents weekly skin assessment to ensure compliance. All negative findings will be addressed upon discovery. The review will be done weekly times 4 and monthly times 2. Results of the audit will be presented to the QAPI committee for review. Date of Compliance: 11.10.2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 34	F 684		11.10.2023

A review of the facility's policy titled "Wounds and Skin Assessments" with a revision date of 05/2023 documents " ...Upon admission, readmission, in conjunction with the Resident Assessment Instrument (RAI) and when a significant change in the resident status occurs, and on a weekly basis, the residents' s skin will be evaluated head-to-toe by licensed nurse and documentation will be maintained in the resident's Electronic Medical Record (EMR) ..."

A review of Resident #418's medical record revealed the following:

[Physicians Order] 12/09/22 "Weekly skin assessment by licensed nurse ..."

A [Care Plan] dated 12/09/22 with Focus area " ... (Resident #418) has a pressure ulcer on the sacrum upon admission 12/09/22 ...had interventions that included the following : Monitor/document/report PRN (as needed) any changes in skin status ...Administer treatments as ordered and monitor for effectiveness ..."

[Nurse Progress Note] 12/10/22 " ...Her skin warm to touch, discoloration observed on bilateral heels. She was admitted with an open area 1 X (times) 4 X (times) 0.1cm (centimeters) on her sacrum and rash/excoriation on her groins and buttocks ..."

[Tissue and Analytics] Wound evaluation 12/13/22 at 12:58 PM, documents "Location Perineum (Scattered) Length 16.80 cm Width 15.45 cm, L (Length) x (times) W (Width) 259.56 Depth - Total 185.48 ..."

[Tissue and Analytics] Wound Evaluation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 35 12/13/22 at 1:00 PM documents "Location Sacrum ...Length 1.94 cm Width 0.62 cm, L(length) x (times) W (width) 1.20 cm Depth-Total 0.50 ...Pressure Ulcer-Stage 3 ..." [Admission Minimum Data Set Assessment] 12/13/22 The facility staff coded that the resident has one or more unhealed pressure ulcer/injuries including one that is a stage 3 pressure ulcer. The facility staff also coded that the resident is at risk of developing pressure ulcers. [Weekly Skin Assessment] 12/19/22 documents "Date of Assessment 12/18/2022 Current Wound Orders No Wound Order ...Describe the Skin Impairment No Wound ..." It is noted that there were no weekly skin assessments documented in the medical record from December 11, 2022, through December 18, 2022, and none from December 20, 2022, until January 3, 2023. During a face-to-face interview conducted on 10/17/23 at 10:41 AM, Employee #5 (Wound Care Nurse) stated that the resident went to the hospital and came back with a wound on her sacrum and that the staff got orders for wound care. During a face-to-face interview conducted on 10/17/23 at approximately 10:50 AM, Employee #9 (Unit Manager 3rd floor) stated that the weekly assessments should have been done weekly and they were not documented. The nurse that documented that the resident did not have any wounds in December 2022 no longer works at the facility. Employee #9 acknowledged the findings.	F 684		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36 Cross Reference 22B DCMR Sec.3211.1(b)	F 684		11.10.2023

3) Facility staff failed to provide a 2 person assist when transferring Resident #102 from the Wheelchair to the bed with a Hoyer lift.

Resident #102 was admitted to the facility on 02/27/21 with multiple diagnoses that included the following: Paraplegia, Complete, Pressure Ulcer of Sacral Region Stage 4, and Major Depressive Disorder Recurrent.

A review of Resident #102's medical record revealed the following:

A care plan focus area " ... (Resident #102) has a ADL (activities of daily living) self-care performance deficit r/t (related to) paraplegia, muscle weakness and impaired visual function" was initiated on 02/28/21, had interventions that included the following: (Resident #102) requires mechanical aid sling for transfers, (Resident #102) requires total assistance with transfers ...2 person assist for ADL (activities of daily living).

[Quarterly Minimum Data Set Assessment] 09/28/23 revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of 15 indicating intact cognition. Facility staff coded the resident as requiring extensive assistance and a two-person physical assist for bed mobility, transfer and toilet use. Facility staff coded that the resident has an indwelling catheter.

During an observation in Resident #102's room conducted on 10/12/23 at approximately 4:15PM, the Surveyor observed Employee #15 (Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 37 Nurse Aide) place Resident #102 into a Hoyer sling lift and transfer the resident from her motorized wheelchair onto her bed. After Employee #15 placed the resident in the bed she then opened the privacy curtain and opened the door that leads to the public hallway. The resident's urine collection bag was visible on the bed between the resident's legs and the resident's clothing was disheveled with resident's bare shoulders and legs exposed. A face-to-face interview was conducted at the time of observation with Employee #15, and she stated, "I did not know I needed to pull the privacy curtain". During a face-to-face interview conducted on 10/12/23 at approximately 4:30 PM, Resident #102 stated that she is supposed to have 2 people assisting with care. During a face-to-face interview conducted on 10/19/23 at approximately 3:00 PM, Employee #4 (Unit Manager 1st floor) stated that it should be two (2) staff assisting when Resident #418 was transferred from the wheelchair to the bed using the Hoyer lift. Employee #4 stated that she will re-educate the staff. Cross Reference 22B DCMR Sec.3211.1	F 684	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #145 remains stable in the facility and an appointment for eye surgical evaluation was scheduled for 12/16/2023. A head-to-toe assessment was conducted by the DON / Designee on October 17, 2023, and no adverse findings were discovered.	11.10.2023
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §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-	F 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 685	Continued From page 38 §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 record review, resident interview and staff interviews for one of (1) of 57 sampled residents, facility staff failed to assist a resident in gaining access to vision services by failing to ensure that the resident was able to have an appointment with an ophthalmologist for evaluation for cataract surgery as recommended by the physician on 07/24/2023. Resident #145. The findings included: Resident #145 was admitted to the facility on 03/17/23 with multiple diagnoses that included the following: Hypertension, History of Falling and Heart Failure. A review of Resident #145's medical record revealed the following: [Physician Order] 03/17/23 "Ophthalmology consult as needed ..." [Admission Minimum Data Assessment (MDS)] 03/23/23 revealed that the facility staff coded the resident as having adequate vision and not requiring corrective lenses. The facility staff coded the resident as having severe cognitive impairment. [Quarterly Minimum Data Set assessment]	F 685	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents with vision impairment are at risk for this alleged deficient practice. An audit was conducted on October 18, 2023, for all in-house residents with vision impairment to ensure that all follow-up appointments are made timely. There were no negative findings.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 685	Continued From page 39 09/22/23 revealed that the facility staff coded the resident as having moderate cognitive impairment. [Consult Form] Visit Date 07/24/23 "...Recommendations ...Please refer patient to (Hospital Name) for a cataract surgery consult. Please have the patient see the next available Ophthalmologist who is available to perform cataract surgery. Please call. I t is noted that the bottom of the consult form has handwritten initials and dated on "08/08/23." [Nurse Practitioner Progress Note] 08/10/23 "...Continue current Tx (Treatment) ..." The medical record lacks any documented evidence that the resident was seen by an ophthalmologist or that the resident's attending physician was informed that the resident was not seen by the ophthalmologist. A face-to-face interview was conducted with Resident #145 on 10/11/23 at approximately 10:00 AM in which the resident stated that she cannot see well due to cataracts, and she is supposed to have cataract surgery, but the facility can't take her to her appointment. During a face-to-face interview conducted on 10/20/23 at 10:22 AM with Employee #10 (Unit Manager 2nd floor) stated that resident #145 was seen in the facility by an eye doctor who recommended that the resident be seen by an ophthalmologist to be evaluated for cataract surgery. The Nurse Practitioner signed off on the consult form.	F 685	**3. MEASURE TO PREVENT REOCURRENCE** Staff Developer/Designee provided training to all Clinical Managers on October 18, 2023, on the importance of following up on referrals on vision care to ensure they are coordinated an scheduled timely. Nursing Managers will be re-educated to review optometry consultations and make follow-up appointments as necessary. **4. MONITORING CORRECTIVE ACTION** Unit Managers/ designee will complete audits of in-house residents with optometry recommendations to ensure optometry follow-up appointments are made as necessary. This audit will be conducted weekly times 4 and monthly x 2. All negative findings will be corrected upon discovery. Results of audits will be reviewed monthly with the QAPI Committee.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 685	Continued From page 40 Employee #10 acknowledged that Resident #145's physician was never notified that the resident was not seen by an ophthalmologist. During a face-to-face interview conducted with Employee #11 (Medical Records Coordinator) stated that the appointment was not made because the resident did not have insurance to cover the transportation for the visit to the Ophthalmologist's office. It is noted that the facilities (POC) Plan of Correction with compliance date of 8/3/2023, documented the following " an audit was done by the Unit Managers on 07/25/2023 to ensure that all residents with orders for Ophthalmology consult have an appointment scheduled. The audit resulted in zero negative findings..."	F 685	Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: **11.10.2023**	11.10.2023
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#18 currently resides in the facility. The Licensed Nurse completed a head-to-toe assessment on October11, 2023, there were no adverse findings identified. The Customer Service aide was immediately educated on October 11, 2023 on job responsibilities and scope of practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 726	Continued From page 41 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on an observation, record review, staff interview and resident interview, for two (2) of 57 sampled residents, the facility's nursing staff failed to ensure a Customer Service Representative did not administer Vitamin C (supplement) to one resident; and failed to demonstrate competent nursing skills as evidenced by failing to ensure that one resident's medication orders were clarified to indicate specific administration times. Residents' #18 and #159. The findings included: 1. Facility nursing staff failed to ensure that a Customer Service Representative did not administer Vitamin C (supplement) to Resident #18. Resident #18 was admitted to the facility on 11/19/15. The resident had a history of multiple diagnoses including Hemiplegia, Muscle Weakness, and Contracture of Right Hand.	F 726	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. The Staff Educator conducted an in-service for all Customer Service Aide on the importance of complying with written instructions and adhering to the company's policy and their scope of practice. This In-service was conducted on October 11, 2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 726	Continued From page 42 A review of the policy titled, Administering Medications with a review date of 01/23 that instructed, "Only persons licensed or permitted by this state to prepare, administer of medications may do so." During a face-to-face interview with Resident #18's roommate on 10/11/23 at approximately 10:00 AM, Employee #8 (Customer Service Representative) could be heard talking with Resident #18 behind a privacy curtain. Employee #8 said to Resident #18, "I'm only given you one of these. They are not candy. Your family brought these in for your congestion." The surveyor went to the other side of the curtain and observed Resident #18 putting one orange gummie in her mouth. When asked what she was taken? The resident pointed to a large bottle of Vitamin C gummies sitting on her nightstand. The resident stated that her family family brought the Vitamin C two weeks prior. During a face-to-face interview on 10/11/23 at approximately 10:15 AM, Employee #8 stated that he gave the resident one gummie (Vitamin C) because she was congested. A review of Resident #18's medical record on 10/11/23 at approximately 10:30 AM revealed that she did not have a doctor's order for Vitamin C. Also, the resident did she have any known drug allergies. According to Employee #8's personnel record, the employee signed his job description titled "Customer Service Representative" on 02/13/23. Reviewing the employee's job description revealed no was documented evidence that the employee's duties and responsibilities included	F 726	**3. MEASURE TO PREVENT REOCURRENCE** The Staff Educator will conduct in-services for all Customer Service Aide with emphasis being placed on ensuring they are operating within their scope of duty. This was completed on October 18, 2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 726	Continued From page 43 administering vitamins (supplements). Further review of the employee's file showed an "Employee Discipline Report" dated 10/11/23 that documented, "Date of violation 10/11/23 - unintentional failure to observe written or oral instructions by evidence of [Employee #8's name] accidentally gave the resident OTC (over the counter) vitamins thinking it was candy. [Employee #8's name] will receive a verbal warning." It should be noted that Employee #8 didn't sign the discipline report and that the box titled "Employee declined to sign this form" was not checked. During a face-to-face interview on 10/11/23 at approximately 11:00 AM, Employee #9 (Unit Manager/RN) stated that per the facility's policy Employee #8 is not permitted to administer medications, including vitamins. Additionally, the employee said she would speak with Resident #18 and Employee #8. During a face-to-face interview on 10/16/23 at approximately 1:00 PM, Employee #2 (DON) stated that Employee #8 was not allowed to administer vitamins. In addition, the employee stated that when she spoke with Employee #8, he said he did not realize they were vitamins. He thought they were candy. 2. Facility staff failed to demonstrate competent nursing skills as evidenced by failing to ensure that Resident #159's medication orders were clarified to indicate specific administration times. According to the National Institute of Health (NIH):	F 726	**4. MONITORING CORRECTIVE ACTION** The Clinical Manger / Designee will conduct daily huddles with the Customer Service Aides to ensure they are carrying out their responsibilities based on the required standard of practice. All negative findings will be addressed upon discovery. The Clinical Managers will also have weekly meetings to reinforce compliance. The Clinical Mangers check all residents room weekly to ensure no medication is at the bedside. These meetings will be conducted weekly times 4 and monthly x 3. All negative findings will be corrected upon discovery. Results of audits will be reviewed monthly with the QAPI Committee. Compliance date is 11.10.2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 726	Continued From page 44 -One of the five traditional rights of medication administration is the right time -Certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. https://www.ncbi.nlm.nih.gov/books/NBK560654/ According to the Mayo Clinic: -Food in your stomach may change the amount of Methimazole (antithyroid) that is able to enter the bloodstream. To make sure that you always get the same effects, try to take Methimazole at the same time in relation to meals every day. That is, always take it with meals or always take it on an empty stomach. https://www.mayoclinic.org/drugs-supplements/antithyroid-agent-oral-route-rectal-route/proper-use/drg-20069661#:~:text=Food%20in%20your%20stomach%20may,it%20on%20an%20empty%20stomach. Resident #159 was admitted to the facility on 09/11/23 with diagnoses that included: Type 2 Diabetes Mellitus and Thyrotoxicosis. Review of Resident #159's medical record revealed the following: A hospital discharge summary dated 09/19/23 documented discharge medication instructions of: -Insulin Glargine 15 units subcutaneously nightly -Methimazole 10 mg (milligrams) by mouth daily A physician's order dated 09/19/23 directed, "Methimazole oral tablet 10 MG, give 1 tablet by mouth every night shift for Hyperthyroidism".	F 726	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#159 currently resides in the facility. The Licensed Nurse completed a head-to-toe assessment on October 13, 2023, there were no adverse findings identified. The physician was informed of the untimely administration of the medications. There were no new orders given. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** Residents currently residing in the facility who have orders for medications have the potential to be affected. An audit was completed by the DON/Designee on October 13, 2023 to identify any residents receiving insulin to ensure they have specific time and date for administration. No adverse findings were identified. **3. MEASURE TO PREVENT REOCURRENCE** The Director of Nursing has re-educated all licensed nurses on the Medication Administration Guideline with emphasis on ensuring medications are administered timely and signed in the Medication Administration Record. This was completed on October 26, 2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 726	Continued From page 45 A physician's order dated 09/20/23 directed, "Insulin Glargine subcutaneous solution 100 Units/ML (milliliters), inject 15 units subcutaneously every night shift, hold if FBS (fasting blood sugar) < (less than) 100". An Admission Minimum Data Set (MDS) assessment dated 09/25/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 14, indicating intact cognitive response and that the resident received Insulin injections every day during the last 7 days. Resident #149's Medication Administration Record (MAR) from 09/19/23 to 10/12/23, a total of 23 days, showed the administration time for Insulin Glargine and Methimazole as "11:00 PM - 7:00 AM" with no specific administration time. It should be noted that Resident #159's other ordered medications documented specific administration times. During a face-to-face interview on 10/12/23 at 4:47 PM, Employee #2 (Director of Nursing/DON) reviewed Resident #159's physician's orders and MAR, acknowledged the findings and stated that one of the rights of medication administration is the right time and that there should be specific administration times for all ordered medications. Cross Reference 22B DCMR Sec. 3210.4(b)	F 726	**4. MONITORING CORRECTIVE ACTION** The Unit Manager/designee will randomly audit 5 residents using the Medication Administration Record for timely completion weekly x 4 weeks and monthly x 2 to ensure timely administration of meds per physician orders. All negative findings will be corrected upon discovery. Results of audits will be reviewed monthly with the QAPI Committee. Compliance date is 11.10.2023	11.10.2023
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	F812: **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** 1.The ice machine in the kitchen was cleaned on October 13, 2023. This deficiency cannot be retroactively corrected but the Dietary Manager purchased a drying Rack on October 18, 2023. This rack will be used to ensure pots and pans are properly air dried after washing and stored in a clean dry location. The torn air curtain was replaced on October 10, 2023. The Dietary Manager immediately placed a scoop in the flour bin and the rice bin on October 10, 2023. On October 13, 2023, the Dietary Manager immediately placed a thermometer in the milk box/ refrigerator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 812	Continued From page 46 §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 by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by one (1) of one (1) ice machine that was soiled on the inside, eight (8) of eight (8) four-inch pans and ten (10) of ten (10) six-inch pans that were stacked wet, torn air curtains in one (1) of one (1) walk-in freezer, one (1) of one (1) flour bin and one (1) of one (1) sugar bin without scoops, and one (1) of one (1) milk box that lacked a thermometer. The findings include: 1. One (1) of one (1) ice machine was soiled on the inside. The ice machine was emptied and cleaned on the day of observation. 2. Eight (8) of eight (8) four-inch pans and ten	F 812	In-Service was provided on October 18, 2023 to all Dietary staff by the Dietary manager on the importance of ensuring accurate freezer temperatures and ensuring that thermometers are in all freezers and refrigerators. **3. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** 1.All residents have the potential to be affected by this deficient practice. A house wide audit was done by the Dietary Manager to ensure all Ice Machines are lean and maintained in a safe sanitary condition. This audit was conducted on October 13,2023. All negative findings were addressed. To ensure the changes are effective the Dietary Manager re-educated all dietary staff on the importance of properly storing and air drying all pots and pans to prevent cross contamination. This education was done on October 13, 2023. The Dietary Manager received in-service from the Staff Educator on the importance of maintaining a clean and sanitary environment to include the importance of maintaining safe temperatures in the freezers. This was conducted on October 12, 2023. Scoops were immediately placed in the flour and rice bins. The Dietary Manager was re-educated by the Staff Educator on Oct 18, 2023 on the importance of ensuring scoops are placed in each bins to prevent cross contamination.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 812	Continued From page 47 (10) of ten (10) six-inch pans were stored wet, one on top of the other, on a clean and ready-for-use shelf. 3. Air curtains located at the entrance of one (1) of one (1) walk-in freezer were torn throughout. 4. One (1) of one (1) flour bin and one (1) of one (1) rice bin were not equipped with a scoop. 5. One (1) of one (1) refrigerator box, used for milk storage, did not have a thermometer. Employee #13 acknowledged the findings during a face-to-face interview on October 10, 2023, at approximately 11:00 AM.	F 812	A house wide audit of all refrigerators and freezers in the kitchen, were done to ensure each unit has thermometer. This audit was conducted on October 23, 2023.No negative findings were discovered. **4. MONITORING CORRECTIVE ACTION** a. The Dietary manager will monitor the ice machine daily for four weeks to ensure the machine is always kept clean. b. The Dietary Manager will conduct weekly audits by observing and monitoring the proper storage of pans and pots. c. The Dietary Manager will conduct weekly audits by observing and monitoring the air curtains to ensure they're properly maintained and not damaged. This is to ensure freezer temperatures are accurately maintained. d. The Dietary department will monitor all flour and rice bins to ensure scoops are always present. e. The Dietary Manager will audit the freezers/refrigerators daily for two weeks., weekly for 4 weeks and monthly for 2 months. All of these mentioned audits (a.b.c.d.e) will be done weekly for four (4) weeks and monthly for two (2) months Any negative findings will be addressed immediately upon discovery. Findings to be reported to the monthly QAPI for further recommendations.	11.10.2023
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 48 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	F842: **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficient practice cannot be retroactively corrected. A head-to-toe assessment was completed for residents #418 and Resident#23 on 10/13/2023 and the resident did not suffer any negative outcome from this deficient practice. **2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who experience incidents resulting in the need for skin assessment are identified as having the potential to be affected by this deficient practice. The Director of Nursing / Designee will review all incident reports to ensure skin assessments are completed based on the professional standards and practices. This audit will be completed by November 10, 2023. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education will be conducted for all licensed clinical staff by Nursing Educator/ designee on accuracy in documentation. All Staff nurses will be trained on the facility's procedure for accurate documentation on skin assessment. This Education will be completed by 11.10.2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 49 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 57 sampled residents, facility staff failed to maintain accurate and complete medical records. Residents' #23 and 418. The findings included: Review of the facility policy "Clinical Documentation/Record" documented: - It is the policy of this facility to ensure accurate documentation of important elements contributing to high quality care of our residents - Clinical documentation is required to record pertinent facts, findings, and observations about resident's health history - Documentation entries into organization documents or the health record must be accurate and valid. 1. Resident #23 was admitted to the facility on 03/26/15 with diagnoses that included: Peripheral Vascular Disease, Anemia and Hypertension. Review of Resident #23's medical record revealed the following: A physician's order dated 09/05/23 that directed, "Gentamicin (antibiotic) Sulfate External Cream, apply to BLE (bilateral lower extremities) topically one time a day every Monday, Wednesday and Friday for antimicrobial protection"; Collagenase	F 842	**4. MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers /Designee to ensure accurate and proper documentation in resident's (medical record) on residents requiring skin assessments. This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: 11.10.2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 50	F 842		11.10.2023

(ointment to help the healing of burns and skin ulcers) external ointment, apply to bilateral heels topically one time a day for wound healing." It should be noted that both orders were discontinued 09/15/23.

A physician's order dated 09/08/23 that directed, "Weekly skin assessment by licensed nurse every night shift every Friday"

A Weekly Skin Assessment form dated 09/16/23 at 12:16 AM showed facility staff documented:
- Current wound orders - Bilateral heels - Collagenase external ointment to both heels daily
- Bilateral lower leg - Gentamicin

A Weekly Skin Assessment form dated 09/22/23 at 11:48 PM showed facility staff documented:
- Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily
- Bilateral lower leg - Gentamicin

A Weekly Skin Assessment form dated 09/29/23 at 2:53 PM showed facility staff documented:
- Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily
- Bilateral lower leg - Gentamicin

A physician's order dated 09/29/23 that directed, "Please wash wound every day with soap and water, then soak open wounds with Vashe (wound cleanser) soaked gauze for 10 minutes, prior to applying ACTi coat to the wounds, be sure to pack wounds so ACTi coat is touching all of the wound beds; reapply ACTi coat, Drawtex (hydroconductive wound dressing) and Allevyn (adhesive foam dressing) pad (5-layer silicone bordered foam dressing with Tubigrip [tubular bandage]); dressing can be changed more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 51 frequently if needed every day shift for wound care; Bilateral lower extremities, please wash wound every day with soap and water, then soak open wounds with Vashe soaked gauze for 10 minutes prior to applying Xeroform (occlusive dressing impregnated with petrolatum), SPD (subatmospheric pressure dressing), Kerlix (bandage roll), and Coban (self-adherent wrap used to secure dressings) every day shift for wound care" A Weekly Skin Assessment form dated 10/06/23 at 1:04 PM showed facility staff documented: - Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily - Bilateral lower leg - Gentamicin The evidence showed that facility staff inaccurately documented Resident #23's current wound care orders on the Weekly Skin Assessment form for four (4) consecutive weeks. During a face-to-face interview on 10/13/23 at 11:20 AM, Employee #2 (Director of Nursing/DON) reviewed the documents, acknowledged the findings and made no further comments. Cross Reference 22B DCMR Sec. 3231.11 2) Facility staff failed to accurately document Resident #418's weekly skin assessment in the medical record. Resident #418 was admitted to the facility on 12/09/2022 with multiple diagnoses that included the following: Diabetes Mellitus Type 2,	F 842		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 52 Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Benign Neoplasm of Parathyroid Gland. A Facility Reported Incident (FRI) DC00011344, was received by the State Agency on 12/13/2022, and documented the following, " ...readmitted with an open area 1 X (Times) 4 X 0.1cm (centimeters) on her sacrum. She also has rash excoriation on her groins and buttocks. The open area on her buttocks was cleansed with normal saline, pat dry ..." A review of Resident #418's medical record revealed the following: [Physicians Order] 12/09/22 "Weekly skin assessment by licensed nurse ..." A [Care Plan] dated 12/09/22 with Focus area " ... (Resident 418) has a pressure ulcer on the sacrum upon admission 12/09/22 ...had interventions that included the following : Monitor/document/report PRN (as needed) any changes in skin status ...Administer treatments as ordered and monitor for effectiveness ..." [Nurse Progress Note] 12/10/22 " ...Her skin warm to touch, discoloration observed on bilateral heels. She was admitted with an open area 1X(times) 4 X (times) 0.1cm on her sacrum and rash/excoriation on her groins and buttocks ..." [Physician Order] 12/13/22 "Calmoseptine (Miscellaneous topical agents) Ointment 0.44-20.6% (Menthol-Zinc Oxide) (medicated cream, ointment or paste) Apply to perineum scattered topically every shift for wound care ..."	F 842		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 53	F 842		11.10.2023

[Physician Order] 12/13/22 "Calmoseptine (Miscellaneous topical agents) Ointment 0.44-20.6% (Menthol-Zinc Oxide) Apply to Sacrum topically every shift for wound care."

[Tissue and Analytics] Wound evaluation 12/13/22 at 12:58 PM, documents "Location Perineum (Scattered) Length 16.80 cm Width 15.45 cm, L (Length) x (times) W (Width) 259.56 Depth - Total 185.48 ..."

[Tissue and Analytics] Wound Evaluation 12/13/22 at 1:00 PM documents "Location Sacrum ...Length 1.94 cm Width 0.62 cm, L(Length) x (Times) W (Width) 1.20 cm Depth-Total 0.50 ...Pressure Ulcer-Stage 3 ..."

[Admission Minimum Data Set Assessment] 12/13/22 The facility staff coded that the resident has one or more unhealed pressure ulcer/injuries including one that is a stage 3 pressure ulcer. The facility staff also coded that the resident is at risk of developing pressure ulcers.

[Weekly Skin Assessment] 12/19/22 documents "Date of Assessment 12/18/2022 Current Wound Orders No Wound Order ...Describe the Skin Impairment No Wound ..."

It is noted that the weekly skin assessment documents "No wounds" and no wound orders" on 12/19/22 which was 10 days after the resident's wounds were documented by the facility staff in the care plan and progress notes.

During a face-to-face interview conducted on 10/17/23, at approximately 10:50 AM, Employee #9 (Unit Manager 3rd floor) stated that the nurse that documented the resident has no wounds no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 54 longer works at the facility and acknowledged the findings. Cross Reference 22B DCMR Sec.3231.11	F 842		11.10.2023
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §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	F 849	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficient practice cannot be retroactively corrected. A head-to-toe assessment was completed for resident#132 on 10/13/2023 and the resident did not suffer any negative outcome from this deficient practice. The clinical team has reviewed Resident #102's medical record for accuracy for pertinent information to care for the resident. The most current hospice documentation including nursing progress notes and plan of care are properly entered into resident #102's electronic medical record. Hospice care nurses were educated on proper coordination of care with the charge nurses to ensure resident safety. This in-service was conducted on October 26, 2023. The facility has appointed The assistant Director of Nursing as the point of contact for all hospice services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 55 in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate 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	F 849	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who receives Hospice services are identified as having the potential to be affected by this deficient practice. The Director of Nursing / Designee reviewed all resident medical records to ensure coordination of care with facility and hospice providers. This review was conducted on October 27, 2023 and there were no negative findings **3. MEASURE TO PREVENT REOCURRENCE** Education will be conducted for all licensed clinical staff by Nursing Educator/ designee on the importance of coordination of care with external providers (hospice) and the facility. This education will be completed by November 10, 2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 56 necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the 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	F 849	**4.MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers /Designee to ensure timely and accurate documentation is recorded by the Hospice provider for each visit / assessment. This will ensure coordination of resident care. Any negative findings will be addressed upon discovery. This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: 11.10.2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 57 and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (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	F 849		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 58	F 849		11.10.2023

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, for one (1) out of 57 sampled residents, facility staff failed to have evidence in Resident #132's medical record of an established communication process between the hospice provider and the nursing home; and failed to have in writing, a designated member of the nursing home's interdisciplinary team who is responsible for working with hospice to coordinate care for its residents.

The findings included:

1A. Facility staff failed to have evidence in Resident #132's medical record of an established communication process between the hospice provider and the nursing home.

Resident #132 was Admitted to the facility on 08/23/22 with diagnoses that included: Metabolic Encephalopathy; Vascular Dementia and Adult Failure to Thrive.

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

A physician's order dated 05/23/23 that directed, "Admit resident to [Facility name] Hospice"

An Annual Minimum Data Set (MDS) assessment dated 08/30/23 showed that facility staff coded: a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 59 Brief Interview for Mental Status (BIMS) Summary Score of 10, indicating moderate cognitive impairment and received hospice care services while a resident. During a face-to-face interview on 10/18/23 at 10:28 AM, Employee #4 (1st Floor Unit Manager) stated, "The hospice people document on paper and we scan it into the computer, under the miscellaneous tab. The hospice documentation and communication are reviewed daily during our clinical rounds. Hospice providers are included in the care plan meetings if they are available. If they are not available, they call us for an update. I will get back to you on where the documentation of the visits is." Review of Resident #132's hospice communication documents provided to the surveyor on 10/18/23 at 11:20 AM showed that the last time the hospice nurse provider documented an assessment on the resident was 08/04/23, a total of 75 days. During a face-to-face interview on 10/18/23 at 12:10 PM, Employee #2 (Director of Nursing/ DON) was asked where the hospice providers are supposed to document when they conduct visits at the facility. Employee #2 stated, "They have and use their own portal for documentation. That documentation then comes to us (nursing) from medical records." When asked if she was aware that the facility does not have any hospice nursing provider assessment or documentation of the visits of Resident #132 since 08/04/23, over two months, Employee #2 stated, "No. I will be in contact with them to see what's going on with the documentation of services." Employee #2 was further asked what then is the facility's	F 849		11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 849	Continued From page 60 established communication process with Resident 132's hospice provider, Employee #2 stated that there is not an established communication process. 1B. Facility staff failed to have in writing, a designated member of the nursing home's interdisciplinary team who is responsible for working with hospice to coordinate care for its residents. During a face-to-face interview on 10/18/23 at 12:10 PM, Employee #1 (Administrator) was asked to provide the name of the facility's hospice coordinator. Employee #1 stated, "We do not have a designated hospice coordinator. Anything clinical is done and reviewed by the Director of Nursing and or the Assistant Director of Nursing."	F 849		11.10.2023
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficient practice cannot be retroactively corrected. Resident# 5 did not receive any negative outcome from this deficient practice. Employee #5 was re-educated by the staff educator on the importance of maintaining proper infection control prevention procedures when providing wound care. .This In-service was done on October 16, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who experience wound care are identified as having the potential to be affected by this deficient practice. The Director of Nursing / Designee will participate in wound care rounds x 1 week with the wound nurse to ensure the proper protocols are being adhered to. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education will be conducted for all licensed clinical staff who participate in wound care services on the importance of adhering to the standards of practices of infection control prevention. This Education will be conducted by the Staff Educator. This education will be completed by 11.10.2023.	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 62 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on an observation, record review and staff interview, the facility's staff failed to maintain Infection Control and Prevention Practices during wound care for one (1) of 57 sampled residents. (Resident #5). The findings included: Resident #5 was admitted to the facility on 07/02/21 with multiple diagnoses including Lower Back Stage 4 Pressure Ulcer and Paraplegia. A physician's order dated 06/08/23 at 5:37 PM instructed, "Cleanse lower back with normal saline pat dry apply collagen with silver and cover with bordered foam dressing daily every day shift for wound care." A care plan with a review date of 07/19/23 documented the following but not limited to: Focus- [Resident #5] has a pressure ulcer to lower back. Interventions-administer treatments as ordered and monitor effectiveness. A Quarterly Minimum Data Set assessment dated 09/25/23 documented the following but not limited to the resident had a Brief Interview for Mental Status summary score of "14", indicating the	F 880	**4.MONITORING CORRECTIVE ACTION** An audit will be done by the Quality Assurance / Infection Preventionist to ensure proper infection control protocols are being carried out during wound care services and that a clean field is always provided. This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: 11.10.2023	11.10.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 63	F 880		

resident's cognitive status was intact, the resident required extensive assistance from staff with toileting and bed mobility, the resident was frequently incontinent of stool and occasionally incontinent of urine, and the resident had one Stage 4 Pressure Ulcer.

A weekly wound/pressure ulcer progress note dated 10/13/23 at 2:25 PM documented the following but not limited to: " Type of Break in Skin Integrity: Pressure Ulcer /Stage 4 Location: Lower back, Length: 2.5cm (centimeters), Width: 1cm, Depth: 0.1cm, Drainage: Moderate Serosanguinous, Color: 100% granulation, Odor: No odor, Type of Dressing: Collagen Ag.(silver), Community acquired. Improving."

During an observation on 10/16/23 starting at approximately 10:00 AM, Employee #5 (Wound Care Nurse/LPN) was noted performing the following actions:
- Gathered supplies at the bedside to provide lower back wound care.
- Performed hygiene.
- Put on Gloves.
- Assisted Employee #6 (CNA) with repositioning the resident on his left side.
- When the resident was repositioned, his incontinent pad appeared soiled with stool and the sheet directly beneath him had brown stains. However, Employee #5 failed to maintain Infection Control Prevention and Practices. As evidenced by, not ensuring the resident's incontinent brief was changed and not putting a clean field underneath the resident before she provided wound care.

During a face-to-face interview on 10/16/23 at approximately 10:15 AM, Employee #5 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 64 to maintain Infection Control Practices. Incontinent care should have been provided by the staff. In addition, a clean field should have been placed underneath the resident before wound care was provided. The employee said, "I'll have staff change him now."	F 880		