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L 000	at this facility on Jun- activities consisted or reviews, and residen facility's census durin the survey sample in The following complet this survey: DC0001 DC00010280, and D The following Facility investigated during the DC00010195, DC00 DC00010403, DC00 DC00010403, DC00 DC00010486, DC00 DC00010846, DC00 DC00010825. Federal and/or Local related to the investin DC00010486, DC00 DC00010486, DC00 DC00010486, DC00 DC00010486, DC00 DC00010486, DC00 DC00010485, DC00 DC00010802, DC00 After analysis of the that the facility was r requirements of 22E Municipal Regulatio Facilities.	aints were investigated during 0161, DC00010279, C00010578. y Reported Incidents were his survey: DC00010151, 010264, DC00010280, 010379, DC00010402, 010416, DC00010439, 010609, DC00010680, 010685, DC00010821, and I deficiencies were cited gation(s) of: DC00010151, 010264, DC00010316, 010402, DC00010403, 010578, DC00010680, 010735, DC00010680, 010735, DC00010774, 010821, and DC00010825. findings, it was determined not in compliance with the 3 District of Columbia ns Chapter 32 for Nursing d actual harm at F600 for #145.	L 000	Serenity Rehabilitation and Health Center Disclaimer: The facility submits this plan of correction under procedures established by the department of Health in order to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of th facility's right to appeal or to challenge the accura or severity of alleged deficiencies admission of any wrongdoing.	09/23/2 e cy

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L 000	Continued From page	e 1	L 000			
	and/or acronyms that report:	may be utilized in the				
	AMS - Altered Me	ntal Status				
		t Reference Date				
	AV- Arteriovenous					
	BID - Twice- a-da	-				
	B/P - Blood Pres					
	cm - Centimet CFR- Code of I					
		Federal Regulations r Medicare and Medicaid				
	Services					
		Nurse Aide				
		/ Residential Facility				
		egistered Nurse Practitioner				
	D.C District of					
		Columbia Municipal				
	Regulations D/C- Disconti					
	DI- Deciliter	lide				
	DMH - Department	of Mental Health				
	DOH- Department					
	EKG - 12 lead Elec					
	EMS - Emergency	Medical Services (911)				
	F - Fahrenheit					
	FR French					
	G-tube- Gastrostor	ny tube				
	HR- Hour HSC - Health Se	rvice Center				
		ntilation/Air conditioning				
	ID - Intellectual	-				
	IDT - Interdiscipli					
		revention and Control				
	Program					
		ractical Nurse				
	L- Liter					
		nit of mass)				
		Administration Record				
	MD- Medical Do MDS - Minimum D					
	tion & Licensing Administrati					

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		(metric system unit of mass)				
	M- minute					
	mL - milliliters (i volume)	metric system measure of				
		s per deciliter				
	mm/Hg - millimeters					
	MN midnight	-				
	N/C- nasal ca					
	Neuro - Neurologio					
		e Protection Association				
	NP - Nurse Practitioner O2- Oxygen					
	,,,	ion screen and Resident				
	Review					
	Peg tube - Percutane	ous Endoscopic				
	Gastrostomy					
	PO- by mouth					
	POA - Power of					
		's order sheet				
	Prn - As needed	d				
	Pt - Patient					
	Q- Every RD- Registered	Distition				
	RN- Registered					
	ROM Range o					
	RP R/P - Responsil					
		Background, Assessment,				
	Recommendation					
		are Center				
	Sol- Solution					
		Administration Record				
	Ug - Microgram	1				
L 051	3210.4 Nursing Facili	ties	L 051			
	A charge nurse shall following:	be responsible for the				
	(a)Making daily reside	ent visits to assess physical				
th Regulat ⁻E FORM	(a)Making daily reside		6899 FZ			nuation she

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 051	Continued From page	e 3	L 051	CARE PLAN F656 and F657	09/23/22
	required nursing inter (b)Reviewing medica completeness, accura physician orders, and policies; (c)Reviewing residem	tion records for acy in the transcription of I adherences to stop-order		L051 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency Resident #124 was discharged from t facility 07/1/2022. Resident suffered no negative outcon Resident #354 PICC line dressing wa changed immediately on 6/14/22. Res	he ne
	them as needed; (d)Delegating respon	sibility to the nursing staff for g care of specific residents;		was reassessed from head to toe on 08/17/22 by licensed burse and suffer negative outcomes.	
	employee on the unit (f)Keeping the Director or her designee information residents. This Statute is not m Based on record revie two (2) of 67 sampled failed to revise Reside	or of Nursing Services or his med about the status of		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	
	be discharged and im	plement the care plan jing Resident #354's central			
	Team Meeting (IDT) ( 02/22 documented, "I Name] to develop and person-centered care includes the instruction	e plan for each resident that ons needed to provide centered care that meet ls of quality care"			

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L 051	Continued From page	e 4	L 051			09/23/2
	comprehensive care preference to not be of Resident #124 was at 04/21/21 with diagnos Walking, Hypothyroid and Dysphagia. Review of Resident # revealed the following Care Plan focus area expectation for discha community" initiated of " 05/2/22 IDT meeti reviewed and updated of care)" 02/01/22 at 3:27 PM   "Care Plan Note: IDT Meeting was held on are no plans for disch will continue to be a lo facility" 05/03/22 at 11:27 AM Note] "The clinical/ID resident's care plan. S Nursing, Dietitian, Re	dmitted to the facility on ses that included: Difficulty ism, Hypertension, Anemia "124's medical record g: "[Resident #124's] goal and arge is to return back to the on 04/22/21, documented, ng held today. Care plan d. Continue with POC (plan [Social Work Progress Note] (interdisciplinary team) behalf of residentThere harge at this time, resident ong term care resident in the [Social Work Progress T team met to review Social worker, Activity,				
	meetingThere were update, this worker w resident to assist with are no plans for disch	no changes since the last ill continue to work with the any needs or issues. There harge at this time, resident ong term care resident in the				
	05/14/22 Quarterly M ion & Licensing Administrati	inimum Data Set (MDS)				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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L 051	Continued From page	5	L 051	MEASURE TO PREVENT RECURRENCE:		09/23/2
	Mental Status (BIMS) indicating intact cogni psychosis, no verbal of symptoms directed to for locomotion on and	oded: a Brief Interview for summary score of 15, tion, no potential for or physical behavioral wards others, independent I off the unit and no active r the resident to return to		The facility Staff Development w provide education/in-services to social worker on the importance of ensuring resident comprehensive care plan is revis resident preferences not to be discharged and to remain in Lon This will be completed by 9/23/2	the facility sed to reflect g Term Care.	
	revise Resident #124 she was to remain in During a face-to-face 10:31 AM, Employee stated, "Discharge wa resident never verbali facility. That was the o	zed a desire to leave the original goal (discharge) Imitted here, it (care plan) anged to say that she		The facility Staff Development w provide education/in-services to facility licensed nurses on the importance of Implementing the care plan intervention for changing Resident intravenous I insertion site dressing by 9/23/22	the	
		to implement the care plan ging Resident #354's central even (7) days.				
	(CDC), " Replace di	ters for Disease Control ressings used on short-term catheter) sites at least every				
	https://www.cdc.gov/i i/index.html#rec6	nfectioncontrol/guidelines/bs				
	Resident #354 was of intravenous (IV) antib inserted central cathe stated, "I told the staff	iotics via a peripherally ter (PICC). The resident f they needed to change the een changed since it was				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 051	<ul> <li>put in in the hospital.' the dressing was note in bold, black ink.</li> <li>Review of Resident # revealed the following</li> <li>Resident #354 was a 06/10/22 with diagnosi and Inflammatory Re- Joint Prosthesis.</li> <li>Care Plan focus arearight upper line picc lid documented " Intern transparent dressing days Monitor right shift"</li> <li>06/11/22 at 10:43 AM "Late EntryAdmitted and left shoulder surge 06/11/22 [Physician's arm and call MD (me Practitioner) for bleed symptoms) of infection complications every set The evidence showed change the transpare #354's insertion site of the care plan.</li> <li>During a face-to-face 06/14/22 at 11:10 AM Nurse) acknowledged</li> </ul>	"Upon closer observatio ed to have the date "6/6/ 354's medical record g: dmitted to the facility on ses that included: Infecti- action Due to Other Inter "[Resident #354] has an ne" initiated on 06/10/22 ventions: Change on insertion site every 7 upper line picc line q (ev [Nurses Progress Note] d with right upper picc line gical wound" Order] "Observe right up dical doctor)/NP (Nurse ling, swelling s/s (signs a n or any IV related shift" d that facility staff failed to nt dressing to Resident every 7 days as specified interview conducted on b Employee #5 (Register d the finding and stated, dressing was due to be	red	L 051	MONITORING CORRECTIVE ACTION: The Director of Social Service/ Design complete house wide review/audit of a residents to identify any residents with preference not to be discharged, and e that the comprehensive care plan refle resident's preference to remain in long care. Any issue found during this audit corrected by 9/23/22. The audit will be conducted weekly times 4, then, month times 3 months. The findings of these audits will be pre monthly for 3 months to the Quality As Performance Improvement (QAPI) con The Unit Manager/ Designee will complete house wide review/audit residents to identify residents with Intravenous line to ensure that care pla interventions are properly implemented including care of the intravenous line ir site dressing. This audit will be conduc weekly times 4, then monthly times 3 m All findings will be corrected.	Il the the cts the term will be hly sented surance hmittee. of all ans and d sertion ted	09/23/22

Health Regulation & Licensing Administration

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L 052	<sup>2</sup> Continued From page 7		L 052			09/23/22
L 052	3211.1 Nursing Facili	ties	L 052			
	Sufficient nursing time resident to ensure that receives the following					
	(a)Treatment, medica supplements and fluid rehabilitative nursing			L052		
		imize pressure ulcers and romote the healing of ulcers:		CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident#126 was reassessed head to toe by the Unit Manager/Designee on 8/17/22. Resident#126 was last seen by Psychiatry Nurse Practitioner on		
	the resident is comfor	personal grooming so that rtable, clean, and neat as n from body odor, cleaned		8/10/2022. Resident remains on 1 on 1 m 24 hrs/ daily for safety precautions.	onitoring	
	and trimmed nails, ar well-groomed hair;	nd clean, neat and		This intervention for Resident #126 will re until cleared by the Attending Physician/I and the Psychiatrist/ Designee. Resident was assessed by	Designee	
	(d) Protection from ac	ccident, injury, and infection;		Psychiatrist, Psych NP, and FNP, medica review and behavioral management on 06	6/17/22.	
	(e)Encouragement, a self-care and group a	ssistance, and training in ctivities;		Medical treatment was updated on 6/17/2 Resident will remain on 1 on 1 supervision hours.		
	(f)Encouragement an	d assistance to:		Resident #133 was reassessed from head to toe on 08/17/22 by the licensed		
		and dress or be dressed in ig; and shoes or slippers, and in good repair;		nurse, Resident medications is administered as ordered by the physician. Resident did not suffer any negative outcome.		
	(2)Use the dining roo	m if he or she is able; and		Resident #133 was immediately given pai medication per physician orders. This in c	in ongoing.	
	(3)Participate in mean recreational activities	; with eating;		Licensed nurse was educated on proper administration of medication and accurate documentation. Resident was reassesse head to toe on 08/17/22 by licensed nurse	e d from	
	(g)Prompt, unhurried requires or request he	assistance if he or she elp with eating;		Resident suffered no negative outcome.		
	(h)Prescribed adaptiv	ve self-help devices to assist				
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hi in (() in j)) fo TBni top# bo rc mRpp R fr o ac pR 2(tc R # T 1. pr c ()	According oral acre; an Prompt response to or help. This Statute is not me based on record revie ine (9) of 67 sampled of allow sufficeint nurs ractitioner's recomment (126's psychiatric cor- ehavioral disturbance) coms]; administer Re- nedication as ordered Resident #257 receive rofessional standard ressure ulcer (Stage Resident #35 who use form an avoidable accor- rders for oxygen their dministered opioid pa- rescribed for Resider Residents' #84 and #4 022 and June 2022; o document care pro- Resident #102. Resid 35, #54, #104, #84, and the findings included: . Facility's staff failed ractitioner's recomm- onsult [treatment] for wandering in resident	ed, with daily hygiene, an activated call bell or call et as evidenced by: ews and staff interviews, for d residents, the facility failed sing time to: follow the nurse endations for Resident hsult [treatment] for es [wandering in residents' esident #133's narcotic pain d by the physician; ensure ed care consistent with s of practice to minimize 3) development; protect es a wheelchair for mobility, cident (fall); follow physcian rapy for Resident #54; ain medication as nt #104; provide baths for 4 for several days in May and follow a physician order vided on a sign-in sheet for ents' #126, #133, #257, #4 and #102.	L 052	Resident #257 skin sweep observ was implemented immediately. Th nurse completed head to toe reas including skin assessment on 08 no new skin issue observed. The completes and sign Resident wee assessment by licensed nurses is completed and skin sweep observ ongoing. Resident suffered no neg Resident #35 was assessed from head to toe on 05 by the licensed nurse post fall . No complaint of pain or apparent injury sustained. The resident is n with adequate supervision when r dialysis. Resident #35 was reass to toe on 08/17/22 by the licensed Resident did not suffered any neg Education was immediately provid assigned staff with regards to pro- assistance during care transfer. The affected Resident #54 oxyger was administered in accordance with physician order and paramete on 6/23/22 Resident was reassessed from he to toe on 08/17/22 by Unit Manager/Designee, Resident #54 did not suffer any negative outcome. Resident #104 pain medication was immediately according to the phys assigned licensed nurse was imm on medication administration proc reconciliation process. Resident w head to toe on 8/17/22. Resident w	ne licensed sessment /17/22 licensed nurse kly skin being ration sheet gative outcome. /20/22 ow provided eturned from essed from head in urse ative outcome. Hed to the viding proper in therapy ers rad	09/23/2

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L 052	05/07/21 with multiple Depressive Disorder Behavioral Disturband Review of the medica 06/13/22 at 1:47 PM [ [12:00 PM] resident w pacing the hallway wi other resident's room all times by staff. NP monitor and redirect a consult for behavioral be noted that on 06/1 #126 wandered in Re on top of her naked [r contact]. Review of progress n administration record lacked documented e evaluated by a psych of wandering in other During a face-to-face starting at approxima (RN/Unit Manager) st evaluation was not do Cross Reference 42 0 2. Facility staff failed # 133's narcotic pain r physician. Resident #133 was a	e diagnoses including Major and Dementia without ces. Il record [Nursing Note] - "at 1200 vas observed wandering and th his wheelchair, entering , resident was redirected at notified, recommends to as required and psych disturbances "It should 7/22 (4 days later) Resident esident #145 room and laid non-consenual sexual otes, consults, medication , and treatment s from 06/13/22 to 06/17/22 evidence Resident #126 was for behavioral disturbance resident's room [uninvited]. interview on 06/21/22 tely 1:30 PM, Employee #21 ated that the psychiatric one. CFR 483.12, F600 to administer Resident medication as ordered by the	L 052	Resident#84 reassessed from hea including skin assessment on 08/ licensed nurse, no new skin issue of Resident weekly skin assessment licensed nurses is being completed ongoing. The affected Resident #4 was reas from head to toe including skin assessment on 08/17/22 by licens no new skin issue observed. Resident suffered no negative outo Resident weekly skin assessment licensed nurses is being completed ongoing. Resident #102 was reassessed fro on 08/17/22 by licensed nurse. Re- no negative outcome. The resident care sign-in sheet wa implemented after being notified. S when care is rendered.	17/22 by observed. come. by d and seessed sed nurse, come. by d and om head to toe sident suffered s immediately	09/23/22

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L 052	Continued From page	e 10	L 052			09/23/22
	During a medication a on 06/15/22 at 8:46 A that his pain level was Employee #11 (Regis proceeded to adminis pain reliever) - APAP (milligram) 1 tablet by Review of Resident # revealed the following 05/27/22 [Physician's pan reliever) Patch 72 (micrograms)/HR (hot transdermally one tim pain management an 05/28/22 [Physician's (pain reliever) Tablet mouth one time a day wound care" 05/30/22 [Physician's "Oxycodone-Acetamii (Percocet) (Give 1 tak day for Pain [level of A Significant Change dated 06/06/22 show Brief Interview for Me score of 15, indicating intact cognitive respo	administration observation M, Resident #133 stated s "6" on a scale of 1 to 10. stered Nurse) then ster Oxycodone (narcotic (Acetaminophen) 5-325 MG y mouth to Resident #133. e133's medical record g: Order] "Fentanyl (narcotic 2 Hour 25 MCG ur) Apply 1 patch he a day every 3 day(s) for d remove per schedule" Order] "Acetaminophen 500 MG Give 2 tablet by y for Pain 30 minutes prior to Order] nophen Tablet 5-325 MG blet by mouth two times a				
	-	asionally. 06/14/22 "[Resident #133] is erapy (Percocet) r/t right leg				
	pain Administer an	algesic medications as Review for pain medication				

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L 052	Continued From page	e 11	L 052			09/23/
	Review of the June 2	022 Medication				
	Administration Record	d (MAR) showed that facility				
	staff administered Ox	ycodone-Acetaminophen				
	Tablet 5-325 MG 1 tablet as followed:					
	06/01/22 at 9:00 AM a	and 6:00 PM - Pain level =5				
	06/02/22 at 9:00 AM a	and 6:00 PM Pain level =0				
		Pain level =6 and 06/04/22				
	at 6:00 PM Pain level					
		and 6:00 PM Pain level =0 Pain level =2 and 06/06/22				
	at 6:00 PM Pain level					
		and 6:00 PM Pain level =3				
		and 6:00 PM Pain level =0				
		and 6:00 PM Pain level =0				
	06/10/22 at 9:00 AM I	Pain level =2 and 06/10/22				
	at 6:00 PM Pain level	= 0				
	06/11/22 at 9:00 AM a	and 6:00 PM Pain level =0				
		and 6:00 PM Pain level =0				
		and 6:00 PM Pain level =0				
		Pain level =2 and 06/14/22				
	at 6:00 PM Pain level	•				
	at 6:00 PM Pain level	Pain level =6 and 06/15/22				
	06/16/22 at 9:00 AM I					
		internition of the design				
	06/16/22 at 9:45 AM,	interview conducted on				
	acknowledged the fin					
		sk, he (Resident #133) says				
		er but I know it's not possible				
		ng on medically. He has a lot				
	of wounds. I know the	e pain level he's saying is not				
	possible."					
	The evidence showed	d that facility staff failed to				
		order for administering				
	Resident #133's narc	otic pain medication				
	evidenced by licensed	d staff administering				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY IPLETED
		HFD02-0011	B. WING		C 06/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STA	ATE, ZIP CODE		0/20/2022
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SERENIII		WASHIN	IGTON, DC 2003	2		
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L 052	Continued From page	e 12	L 052			
	than 7 on the pain sc	esident's pain level was less ale. to ensure Resident #257		IDENTIFICATION OF OTHER WITH THE POTENTIAL TO BI AFFECTED: All residents residing in the fac potential to be affected.	E	09/23/2
	received care consistent with professional standards of practice to minimize pressure ulcer (Stage 3) development. Resident #257 was admitted to facility on 11/19/21 with diagnoses that included: Acute Osteomyelitis of Left Ankle and Foot, Type 2 Diabetes Mellitus with Foot Ulcer and Peripheral Vascular Disease.			potential to be affected.		
	Review of Resident # revealed the following					
	04/06/22 with left food left toe, right lateral fo 2.95cm (centimeter)	t diabetic ulcer, absence of oot necrotic tissue measured X 1.71cm, left second toe X 1.29cm, right great toe				
	Physician's orders:					
	nurse. Document and doctor)/NP (Nurse Pr	n assessment by licensed I notify MD (medical actitioner) for abnormal ift every Wed (Wednesday)"				
	04/06/22 "Apply mois lubrication every day	turizing lotion daily for skin shift"				
	has potential for pres (related to) decreased incontinence Monit	n 04/13/22 [Resident #257] sure ulcer development r/t d mobility, fragile skin and tor/document/report PRN status Skin assessment				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
L 052	Continued From page	e 13	L 052			09/23/22
		d by licensed nurse"				
	Care Plan updated or has an ADL (activities performance deficit r/ totally dependent on s twice weekly and as r bath when a full bath tolerated totally dep repositioning and turn Reposition q 2 hou avoid injury require for redness, open are and report changes 06/01/22 [Weekly Ski skin impairment: none A Quarterly MDS date staff coded: moderate potential indicators of care, extensive assist assist for bed mobility impairment on both si always incontinent for unstageable pressure upon admission/entry ulcers. 06/06/22 at 2:51 PM [ Assessment Request on coccyx During in writer was notified by staff assigned to resic on coccyx which mea	<ul> <li>o 04/13/22 [Resident #257]</li> <li>o f daily living) self-care</li> <li>t generalized weakness</li> <li>staff to provide bath/shower</li> <li>necessary Provide sponge</li> <li>or shower cannot be</li> <li>pendent on staff for</li> <li>ing in bed and as necessary</li> <li>rs and as necessary to</li> <li>s skin inspection. Observe</li> <li>as, scratches, cuts, bruises</li> <li></li> <li>ad 06/03/22 where facility</li> <li>and personal hygiene,</li> <li>ides for lower extremities,</li> <li>bowel and bladder, 2</li> <li>a ulcers that were present</li> <li>or reentry and diabetic foot</li> </ul> Situation Background ["Situation: Observe wound icontinent care at 2:45 pm, CNA (Certified Nurse Aide) dent of an opening area				
	06/06/22 at 2:51 PM [ Coccyx wound 0.87	[Skin Observation Tool] " cm 0.55cm"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
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L 052	Continued From page	e 14	L 052			
	Comprehensive skin s sacrum stage 3 press					09/23/2
	Note] " Pressure ul	Wound/Pressure Ulcer cer/Stage 3 sacrum length n depth 0.1 cm in house				
	List" (not dated) provi 06/23/22 showed that	Init 3 Resident Bath/Shower ded to the surveyor on Resident #257 was on the nower every Monday and				
	11:05 AM, Employee stated, "Skin sweep a scheduled shower da completed by the CN.	interview on 06/23/22 at #12 (Registered Nurse) issessments are done on ys. A skin sweep form is A and nurse. If there's no reep assessment) wasn't				
	documented evidence Observation Sheet" w	257's medical record lacked e that a "Skin Sweep vas completed on 06/02/22 Resident #257's scheduled				
	-	ocumentation showed that ed a bed bath (BB) every 06/05/22.				
	(TAR) showed that fa area that directed, "A for skin lubrication ev	ent Administration Record cility staff initialed in the pply moisturizing lotion daily ery day shift" from 06/02/22 ndicating that the task was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
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L 052	Continued From page	e 15	L 052			09/23/22
	(06/02/22 to 06/05/22 failed to document an Resident #257's skin. #257 was observed w on his sacrum on 06/0 During a face-to-face 11:39 AM, Employee acknowledged the fine should not be found w stages. The CNA's ar and report any chang have been educated of Sweep Sheet on show refuses the bath, show should be documente [nurse's] note." 4. The facility failed to time to protect Reside	interview on 06/23/22 at #13 (Educator) ding and stated, "Resident's with wounds at advanced nd nurses know to document es to the skin. Nursing staff on documenting on the Skin wer days. If the resident wer or the skin sweep, it ed on the form and in a				
	facility' Resident #35 was re- 03/15/22 with diagnos Type 2 Diabetes Melli Dialysis, Personal His Attack (TIA), and Cer Residual Deficits, and					
	04/11/22 showed in S Patterns) that facility resident as having a B Status Summary Sco intact cognition. Secti facility staff document a wheelchair for mobi	ection C (Cognitive staff documented the Brief Interview For Mental re (BIMS) of "15," indicating on G (Functional Status), ted that Resident #54: used lity, required extensive verson physical assistance				

Health Regulation	& Licensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
L 052	Continued From page	e 16	L 052		
	for transfers, and required for locomotion on and A review of Resident revealed:			MEASURE TO PREVENT RECURRENCE: In-service will be provided by Staff Development /designee to all facility staff on abuse prohibition by 9/23/22 In-service will be provided by Staff Development /designee to all facility staff	09/23/2
	06/21/21 at 3:00 PM [Custom Mobility Evaluation Note] "Reasons for new wheelchair and/or seating system: Need custom fitted appropriate wheelchair with optimal support seating system Prescribed seating system:manual wheelchair Seat to back angle: manual adjustable, seat belt: standardrecline. Wheel lock: push -to-lock Tilt/recline access manually:Notes: Resident had major stroke 3 years ago. Pt(patient) has R (right) hemiplegiaPatient cannot stand by herself and transfer on the wheelchair she need [max (maximum aid)] to be transfer[red]Patient uses an ostomy bagPt can sit at 90 degrees Pt has curvature of the spine. Therapist feels that patient should not use powered wheelchair . Other best option is to have custom-fitted manual			Development /designee to all facility staff about care plan intervention in place for residents with sexual behavior, behavior with the potential to abuse others, and wandering behavior. In-service will be provided by Staff Development /designee to all Licensed Nursing staff on the importance of ensurin that residents identified with sexual behavior have a person-centered care plan that clearly state the type of behavior they are exhibiting and that the are always provided supervision to prevent such behavior. Repeat in-service will be provided as needed. Charge nurses will ensure that residents identified with sexual behavior, or behavior	y
	slid out of the wheelc the floorGoal: Red minimize[the] risk for assistance to transfer 05/20/22 at 5:00 PM returnedat 1600 (4 dialysis. CNA (Certific informed writer, that s resident from the tran facility. CNA stated , t	[Nurses Notes]: "Resident :00 PM) via wheelchair from		with the potential to abuse others, and wandering behavior have adequate supervision and monitored during all shifts, and that there is documentation in place fo any behavior observed. Any issues found will be corrected by 09/23/22.	
	[the] resident slid out	esident into the building, of her w/c (wheelchair) to position. CNA stated that			

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If continuation sheet 17 of 92

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE S COMPL	
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L 052	resident did not hit he assisted back into her and brought to the un bed and assessed no Resident denied havin MD [Medical Doctor] v given. Resident RP 05/20/22 at 5:25 PM [ documented: " Incir Reception/LobbyPe Employee #3 (Assista Incident Description: ' that when she went to assisted her in the but the facility at 1600p.m CNA stated, when sh around to enter the but of the wheelchair in a with her wheelchair o 05/20/22 Witness Sta 35 read: "Resident we 05/20/2022. Upon arr Nurse and writer[Emp slipped out of the whe while transferring her was assessed in her u and no apparent injur monitored throughout 05/20/22 Witness Sta 36 read: "[Resident # when another staff we wheelchair to the built	r head. Resident was r w/c with 2-person assist it, Resident was assisted to apparent injury noted. Ing any pain or discomfort. was notified no new orders . was also notified." [Incident Report] dent Location: erson Preparing Report: ant Director of Nursing) Writer was informed by CNA to the van to pick up resident ilding when she returned to a from her dialysis session. the turned the wheelchair uilding, the resident slid out sitting position on the floor in her back" tement from Employee # ent for dialysis treatment on ival, escort notified Charge ployee #] that resident eelchair into a sitting position into the facility. Resident room, she denied discomfort y observed Resident was the shift." tement from Employee # 35] was back from dialysis ent to assist her on the d. [Resident #35] slide off sted to reposition [Resident	L 052	Unit Mangers and Shift Superv conduct rounds during their sh that resident with sexual behavior, behavior with abuse others, and wandering behavio and adequate supervision is pr Any issues found will be correct The facility Staff Development a PharmScript Pharmacy Consul provide education to the facility nurses to ensure that medication administration meet professional standard of practi that licensed nurses administer and treatments following physic 9/23/22. The facility Staff Development a education to the facility licensed nursing assistants to ensure that received treatment and care pe comprehensive care plan or in accordance with professional standards of practice.	ift to ensure the potential to r are monitored ovided. ted by 9/23/22 . and tants will f licensed t ce, by ensuring medications cian orders by and will provide d nurses and at residents	09/23/22

Health Regulation & L	icensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			TE SURVEY MPLETED
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L 052	Continued From page	e 18	L 052			09/23/22
	10:42 AM, Resident # back from dialysis between off the van. Three curb when I got off. C pushing me back to b escort when I slid out ground. The escort we wasn't hurt. Two escor my chair, and one broce During a face-to-face 11:17 AM Employee # Nursing, stated. "The responsible for getting and putting resident of responsible for getting lobby. In some cases security pages the un resident's unit will escor the building." When a training was provided employee responded physical therapy usua During a face-to-face 10:37 AM Employee Resident #35 on 05/2 was coming back from were two other reside two CNAs and me to into the building. There van parks to come back [Resident #35] got of	k35 reported, "I was coming fore I fell. The van driver got e escorts were waiting at the one of the escorts was uilding, talking to another of the chair onto the as not paying attention. I orts helped me get back into ought me back upstairs." interview on 06/28/22 at k3 Assistant Director of transportation driver is g resident from the lobby on the van. The driver is also g the resident off van to the , when the van comes, it and the staff from the cort the resident back into sked if wheelchair safety to facility staff, the only when needed and if so, ally does the training. interview on 06/29/22 at #34 (Unit Clerk/ Escort for t0/22), stated [Resident #35] m dialysis on the van. There ents on the van. There were escort the residents back re is an incline where the tock into the building. When ff the van, I was helping the				
	When I turned the res building, she slid out (Social Worker for Un resident back in the c	h the building at the incline. sident in her chair to face the the chair. Employee # 6 hit 1) helped us put the hair. I told Employee #37 to Resident #35] had fallen."				

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Health Regulation	n & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMPI	
		B. WING			C 29/2022	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
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L 052	11:30 AM Employee stated that, "We (Reh Department) do provi to staff and residents didn't train the staff or because [Resident #3 # 35] also has a custo cushion like a donut t seated to the back of 5. Facility staff failed to time to ensure that ox administered as prese Resident #54. Resident #54 was re- 01/08/21 with diagno Chronic Obstructive F Congestive Heart Fa Diabetes Mellitus, De Oxygen, and Dement Classified Elsewhere Disturbance. A Quarterly Minimum 04/25/22 showed in S Patterns) that facility resident as having a Status Summary Sco that the resident had In Section G (Functio documented that Res assistance with one p for bed mobility and w	interview on 06/28/22 at #10, Rehabilitation Manager abilitation Therapy de wheelchair safety training on an as-needed basis. We the resident this time 55] is independent. [Resident or chair with a special o ensure the resident is the chair to prevent falls." to provide sufficient nursing tygen therapy was cribed by the physician to admitted to the facility on ses including, Pneumonia, Pulmonary Disease (COPD), ilure (CHF), Type 2 pendence on Supplemental ia in Other Diseases Without Behavioral Data Set (MDS) dated tection C (Cognitive staff documented the Brief Interview for Mental re (BIMS) of "00," indicating severely impaired cognition. nal Status), facility staff ident #54 required extensive erson physical assistance vas totally dependent and om one staff person for	L 052	The facility Staff Develop provide education/in-sem facility licensed nurses a assistants on the importa assisting and providing <i>A</i> of Daily Living (ADL) to r are unable to independe activities of daily living ( <i>A</i> importance of documentation of care p the residents by 09/23/23 Charge nurses will ensur- nursing assistants are p ADL's which include but shower, bath, shaving, g personal hygiene to the indicated during their shi frequent rounds on their issues found will be addr 09/23/22.	vices to the nd nursing ance of Activity esidents who ntly carryout ADLs) and rovided for 2 re the roviding not limited to grooming and residents as ft by making units . Any	09/23/2
	revealed:					

Health Re	egulation &	Licensina	Administration

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		HFD02-0011	B. WING			C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
L 052	Continued From page	≥ 20	L 052	MONITORING CORRECTIVE ACTION:		09/23/2
	· · · ·			House wide audit will be conducted Assistant Director of Nursing (ADC Designee to ensure that residents assessed for sexual behavior, with potential to abuse others, and wan	N)/ have been the dering	
	diagnosis of COPD ex bronchopneumonia;	xacerbation, acute		behavior, that care plans for reside behavioral issues clearly indicate the behavior the resident is exhibiting. Also that residents with sexual behavior with the potential to abuse and wandering behavior have adec	ne kind of avior, and e others,	
	documented the follow levels from 06/23/22:	54's Vital Signs Report wing oxygen saturation at 2:06 AM, 98% room air; air; 10:42 AM, 97% oxygen		supervision, and that staff members are fully trained on how to care for residents with with sexual behavior problems, behavior with potential to abuse oth wandering behavior weekly times four, then monthly times 3 months.	ners and	
	Resident #54 was aw with non-labored brea receiving supplement	n on 06/23/22 at 12:12 PM, ake, resting comfortably, athing. The resident was al humidified oxygen via te of 5 liters per minute.		Residents with wandering behavior will be redirected, supervised, and every shift by charge nurses and C	monitored	
	approximately 12:15 I Manager) acknowledg receiving 5 liters of op employee then stated too high," and the em	interview on 06/23/22 at PM, Employee #33 (Unit ged that Resident #54 was kygen per minute. The I, "Oh, the oxygen level is ployee turned down the				
	asked who was responses resident's oxygen rate commented that it is the responsibility to ensure administered oxygen					
	time to ensure that ar	to provide sufficient nursing n opioid pain medication was cribed by the physician to				

The         RESULATORY OR LSC DENTIFYING INFORMATION)         The         Cricoss-REFERENCED to THE APPROPRIATE DEFICIENCY)         DATE           L 052         Continued From page 21         L 052         L 052         Og/23/ Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents that facility potential residents to identify potential resident analysis and for that the resident facility staff documented that Resident fact required extensive assistance with one person physical assistance for transfers, dressing, toliet use and personal hygiene. In Section N (Medications) facility documented that resident received apicids for 3 days during the last 7 days or since admission/entry or reentry. A review of Resident #104's medical record revealed: 05/05/2022 at 11:00 PM [Physician's Orders] directed: "Pencoed (narcotic pain medication) Reviewed (accord (narcotic pain medication) Reviewed (accord (narcotic pain medication) Reviewed (accord (narcotic pain medication) Table F-325 mg (Dxycodone-Acetaminophen ). Give 2 table(5) by muth four times a day for         Date that facility Staff Developer/designee will provide education of physician. This will be completed by 9/23/22.         Date that facility staff and facility assessment as ordered by physician. This will be completed by 9/23/22.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
SERENTY REHABILITATION AND HEALTH CENTER         1380 SOUTHERN AVE SE WASHINGTON, DC 2032           MID PHERX TAG         SUMMARY STATEMENT OF DEFICIENCIES RESULTORY OR LSC IDENTIFYING INFORMATION         D PLEAC DEFICIENCY         PROVIDER'S PLAN OF CORRECTION (EACH ODERCIENCY MUST BE PRECEDED BY FULL TAG         D PLEAC PROVIDER'S PLAN OF CORRECTION (EACH ODERCIENCY OR LSC IDENTIFYING INFORMATION)         D PLEAC DEFICIENCY         D PLEAC CONSTRUENCE TO THE APPROPRIATE DEFICIENCY         D D COMPETING CONSTRUENCE TO THE APPROPRIATE DEFICIENCY         D D COMPETING CONSTRUENCE DEFICIENCY         D D D COMPETING CONSTRUENCE DEFICIENCY         D D D COMPETING CONSTRUENCE DEFICIENCY         D D D COMPETING CONSTRUENCE D CONSTRUENCE DEFICIENCY         D D D D D COMPETING CONSTRUENCE D D D D D D D D D D D D D D D D D D D			HFD02-0011	B. WING		-	
Statustical control of the c	NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
WASHINGTON, DC 2032           PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL Residuation of the provide and the provide of the provide and the provide andequate anoninoring and supervision to prevent avoidable accolember			1380 SO	UTHERN AVE S	E		
PREFX TAG         IEAH DEFICIENCY MUST BE PRECEDED BY FULL RESULTION OF OR LSC DENTIFYING INFORMATION)         PREFX TAG         CAN CORREPTENDED TO THE APPROPRIATE DEFICIENCY         Coding and DEFICIENCY           L052         Continued From page 21         L052         L052         Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents that facility increased and the facility on 05/05/222 with multiple diagnoses, including, Malignant Neoplasm of Prostate, Moderate Protein - Calorie Mainutrition, Acidosis, Vitamin D Deficiency, Pressure Ulcer of Sacral Region , Unstageable, and Pressure Ulcer of Left Buttock, Unstageable.         L052         Note and the facility potential residents that facility bidentify documented the resident as having a Brief Interview for Mental Status Summary Score (BIMS) of "15," indicating that the resident had intact cognition. In Section G (Functional Status, facility staff documented that Resident #104 required extensive assistance with no person physical assistance for bed mobility and eating, was totally dependent requiring one person physical assistance for transfers, dressing, lotel use and personal hygiene. In Section N (Medications) facility documented that resident #104's medical record revealed:         The facility Staff Device provide signee will provide education' in-services to the facility icensed nurses to ensure resident sective admission/entry or reentry.           A review of Resident #104's medical record revealed:         05/05/2022 at 11:00 PM [Physician's Orders] directed: "Pain assessment every shift."           05/17/222 at 6:00 PM [Physician's Orders] directed: "Percocet (narcotic pain medication) Table 5-232 m (Dxycodone-Acetaminophen ). Give 2 tabable(s) by muth four times a day for	SERENIIY	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 2003	32		
Resident #104.       Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify thouse wide audit to identify poletical residents that facility poletical residents that facility poletical residents that facility poletical residents that facility staff facility tates of the facility staff facility tates of the facility staff facility tates of the facility staff facility	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
chronic pain." D/C (Discontinue) date: 06/04/22." On 06/20/22 at 6:00 PM the physician changed	L 052	Resident #104. Resident #104 was re 05/05/22 with multiple Malignant Neoplasm Protein -Calorie Maln Deficiency, Pressure Unstageable, and Pre Unstageable, and Pre Unstageable. Quarterly Minimum D 05/12/22 showed in S Patterns) that facility resident as having a Status Summary Sco that the resident had G (Functional Status) that Resident #104 re with one person phys mobility and eating, w requiring one person transfers, dressing, to hygiene. In Section N documented that resi days during the last 7 admission/entry or re A review of Resident revealed: 05/05/2022 at 11:00 F directed: "Pain asses 05/17/22 at 6:00 PM directed: "Percocet (r Tablet 5-325 mg (Oxy Give 2 tablet(s) by me chronic pain." D/C (D	e-admitted to the facility on a diagnoses, including, of Prostate, Moderate utrition, Acidosis, Vitamin D Ulcer of Sacral Region, assure Ulcer of Left Buttock, ata Set (MDS) dated Section C (Cognitive staff documented the Brief Interview for Mental re (BIMS) of "15," indicating intact cognition. In Section , facility staff documented equired extensive assistance ical assistance for bed vas totally dependent physical assistance for bilet use and personal (Medications) facility dent received opioids for 3 days or since entry. #104's medical record PM [Physician's Orders] sment every shift." (Physician's Orders] harcotic pain medication) vcodone-Acetaminophen ). buth four times a day for iscontinue) date: 06/04/22."	L 052	Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents that facility licensed nurses failed to provi- management in accordance orders weekly times four, their months. The facility Assistant Director Nursing/Designee will conduct house wide visual audit of all identify potential resident that the facility staff f received adequate monitoring and sup prevent avoidable accidents of then monthly times 3 months. The facility Staff Developer/de provide education/ in-services licensed nurses to ensure resident with profession practice and importance of con assessments and implementi assessment as ordered by ph	ct vide pain with physician n monthly times 3 of ct residents to cailed to ensure ervision to weekly times four, esignee will s to the facility sidents receive onal standards of ompleting skin ng ongoing skin	09/23/2

ND I LAN OF CO	RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COMPL	ETED
		HFD02-0011	B. WING			) 29/2022
AME OF PROVID	DER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
		1380 SC	OUTHERN AVE SE	Ξ		
ERENITY REF	HABILITATION AND	HEALTH CENTER L WASHI	NGTON, DC 2003	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 052 Con the adr "Pe (Ox mo cor Jur doc 06/ PM 06/ AM 06/ AM 06/ 11:: 06/ AM 06/ 11:: 06/ AM AM 06/ AM AM 06/ AM AM 06/ AM AM 06/ AM AM 06/ AM AM 06/ AM AM AM AM AM AM AM AM AM AM AM AM AM	minister Percocet ti el of 7-10; [Physic ercocet Tablet 5-32 (ycodone-Acetamin uth four times a da fusing) ne 2022 Pain Ratin cumented: 20/22 - 5:44 AM 1-0/10; 5:45 PM- 0/ 21/22 - 12:55 AM 1-4/10, 2:15 PM-1/ 22/22 - 9:36 AM-0, 51 PM- 0/10 23/22 - 12:58 AM-0, 1-0/10; 12:14 PM-0 24/22 - 12:00 AM dication Administra 22 revealed that they olet 5-325 mg (Oxy sident #104 from 0 eview of Resident's ealed that from 06 ff failed to administra cordance with the ecified to administra ident for a pain rat ring a face-to-face iployee #3, Assista DON), after reviewi	aat facility staff should o Resident #104 for a pain ian's Orders] directed: 5 mg nophen ). Give 2 tablet(s) by ay for pain 7-10." (this is g Report (Numeric Scale) 4/10; 8:08 AM-0/10; 1:16 10 4/10, 1:55-0/10 AM, 6:11 10, and 6:25 PM- 0/10 /10, 5:36 PM-0/10, 10:59 /10, 5:36 PM-0/10, 10:59 /10, 5:23 PM-0/10 6/10 and 6:00 AM 6/10 ation Record (MAR) for June e facility's licensed nursing r administered Percocet roodone-Acetaminophen), to 6/21/22 to 06/24/22. s #104's medical record /21/22 to 06/24/22, facility tered Percocet in physician's order, which er the medication to the	L 052	DEFICIENCY Assistant Director of Nursin (ADON)/Designee will cond house wide audit of resider documentation to identify pot that facility staff failed to pro consistent with professional practice to prevent the deve wound weekly times four, th 3 months. The Unit Manager/ Designe will complete house wide re residents to identify potentia facility staff failed to ensure received treatment and care comprehensive care plan or with professional standard of practice weekly times 4 then, monthly times 3 month	ng uct at skin sweep and otential residents ovide care standards of elopment of ten monthly times e eview/audit of all al residents that residents e per the in accordance	09/23/

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		HFD02-0011	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER ( REHABILITATION AND SUMMARY ST/	HEALTH CENTER L	DDRESS, CITY, ST. DUTHERN AVE S IGTON, DC 2003	E	DN (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
L 052	evidence of bathing F #4 on multiple days d 2022 and June 2022. 7a. Resident #84 was 05/20/21, with multiple Type 2 Diabetes Melli Hemiplegia and Hemi Infarction Affecting Ri Following Cerebral In Organism, Unspecifie Sclerosis, Gastrostom Review of the Quarter (MDS) dated 02/18/22 staff coded the follow Section C (Cognitive Interview for Mental S Section G (Functional "Extensive assistance physical assist" Trans requiring "Two-persor Toilet use, "Extensive "One-person physical Personal hygiene, "Ex requiring "One-persor Bathing "Total depend Upper extremity "Imp Lower extremity "Imp Review of the physical following: 04/06/22 "A placement; Promote g skin care; &/or Improv	to provide documented Residents' #84 and Resident uring the months of May a admitted to the facility on e diagnoses that included: itus Without Complications, iparesis following Cerebral ght Dominant Side, Aphasia farction, Sepsis Unspecified ed Convulsions, Multiple my Status and Dysphagia. rly Minimum Data Set 2, revealed that the facility ing: Patterns): "Should a Brief Status be Conducted? "NO" I Status): Bed Mobility, e" requiring "One-person sfer, "Extensive assistance" in physical assist" e assistance" requiring I assist" xtensive assistance" in physical assist" dence" airment on one side"	L 052	<ul> <li>The Unit Manager/Designee will conduct wide review/audit to identify potential reswere unable to independently carry out activitiliving (ADLs) that facility staff failed proviservices necessary to maintain personal weekly times 4 then, monthly times 3 mother Unit Manager/ Designee will completerview/audit of ADL care signing sheet in room to ensure ADL is provided on ever according to physician order and the sign is visible in the resident room and signed nursing assistant and licensed nurses. The Unit Manager/Designee will conduct wide review/audit to identify potential resthat</li> <li>Activity of Daily Living (ADL) care provided are not documented in the in the resident medical records weekly times 4 then, monthly times 3 months.</li> <li>The Unit Manager/Designee will complete wide review/audit of all incontinent resider ensure that residents are provided with of incontinent brief as standard of care. This be conducted weekly times 4, then month s.</li> <li>Assistant Director of Nursing (ADON)/Deconduct house wide audit to identify poter or administered to residents in accordance Physician's order and parameters. This a be conducted weekly times 4, then month months. All findings will be corrected.</li> <li>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.</li> </ul>	idents who es of daily de hygiene nths. ete a resident y shift by is audit onthly house idents resident resident resident te house ne audit will nly times 3 signee will ntial xygen is with the uudit will

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Health Regulation	& Licensing Administration
	a Licensing Authinistration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HFD02-0011	B. WING		06	C 6/ <b>29/2022</b>
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE		
			UTHERN AVE SE	,		
SERENITY	REHABILITATION AND	HEALTH CENTER I	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
L 052	Continued From page	e 24	L 052			
		an with a focus area of				
	"[Resident #84] has a	t (related to) Hemiplegia and				
		g cerebral infarction affecting				
	right dominant side, a					
	-	included the following				
		lent #84) requires 2 staff				
	-	sfers the resident is totally				
	dependent on staff to					
	necessary[Reside	•				
		onal hygiene care The				
		endent on staff for dressing				
	"	5				
	Review of the docum	ent titled "Documentation				
	Survey Report v2" wh	nich is part of the electronic				
		he CNA's (Certified Nurse				
		_ and other care that they				
	•	5/01/22 to 05/31/22, shows				
		cumented evidence of				
	-	athed on the following				
	dates:					
	05/11/22					
	05/14/22					
	05/15/22					
	05/16/22					
	05/17/22					
	05/29/22					
	During a face-to face	interview conducted on				
		I, Employee #33 (Unit				
		stated "Its not documented"				
	<b>u</b> ,	wledged the findings and				
	made no further com	<b>v</b>				
	7b. Resident #4 was	admitted to the facility on				
		e diagnoses that included:				
		al Region Stage 4, Type 2				
	Diabetes Mellitus with	n Unspecified Complications,				

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PREFIX TVG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TVG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMMENTIFYING INFORMATION)     COMMENTIFYING INFORMATION     COMMENTIFYING INFORMATION)     COMMENTIFYING INFORMATION     COMMENTIFYI	Health Re	egulation & Licensing A	Administration				RM APPROVEI
HFD02-0011         B. WING         O6/29/2022           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE         1388 SOUTHERN AVE SE         SUMAINARY STATEMENT OF DEFICIENCIES         1388 SOUTHERN AVE SE         ISSUMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE         UMAININGTON, DC 20032         ID         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE         UMAININGTON, DC 20052         ID         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE         UMAINING TO ADD CORRECTIVE ACTION SHOULD BE         UMAININGTON, DC 20052           L 052         Continued From page 25         L 052         L 052         CROSS-REPERCENT IO THE AMPROPRIATE         DEFICIENCY         ID           L 052         Continued From page 25         L 052         L 052         ID         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE         UMAINS STATEMENT OF CORRECTIVE ACTION SHOULD BE         ID           Section G (Congritive Action Minimum Data Set (MDS) dated 05/7/22, revealed that the facility staff coded the following:         Section G (Congritive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02"         Indicata sasist"         ID         Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist"         ID         Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist"         ID         ID         ID         ID         ID <t< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th></th></t<>							
BERENTLY REHABILITATION AND HEALTH CENTER 1         1308 SOUTHERN VC 52 2032           OWNID PRETX TAG         SUMMARY STATEMENT OF DEFICIENCES         D PRETX RESOLATORY OR LSG DEMTIFYING INFORMATION)         D PRETX TAG         PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         Ossa           L052         Continued From page 25         L 052         L 052         L         Eggle Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness.         L 052         L         Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02"         L 052         L         Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02"         L 052         L         Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02"         L 052         L           Transfer, "Activity did not occur" Dressing. "Total dependence" requiring "One-person physical assist"         Transfer, "Activity did not occur" Dressing. "Total dependence" requiring "One-person physical assist"         Lower extremity "Impairment obth sides" Lower extremity "Impairment obth sides" Section H (Bladder present on admission, one (1) unstageable pressure ulcer present on admission, one (1) unstageable pressure ulcer present on admission and molSture associated skin damage. Review of the physical" or order present on admission and molSture associated skin damage. Review of the physical assilt"         L         L         L         L         L         L         L			HFD02-0011	B. WING		-	
(X4) ID PREFIX TAC     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES RECOLLICATORY OR LSC DENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTION PREFIX TAC     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCIES MIST BE PRECEDED BY FULL PREFIX RECOLLICATORY OR LSC DENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)     OW CROSS-REFERENCED TO THE APPROPRIATE     OW CROSS-REFERENCE TO THE APPROPRA	NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WASHINGTON, DC 20032           PRETIX         SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECULATORY OR LSCIDENTFYING INFORMATION)         ID PRETIX         PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE AND ID BENCIFICATION)         ID PRETIX           L052         Continued From page 25         L052         L052         L052           Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness.         L052         L052           Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition.         Section C (Cognitive Patterns): Brief Interview for Mental Status; Ced Mobility, "Extensive assistance" requiring "Two-person physical assist"         Transfer, "Activity did not occur" Dressing, "Total dependence" requiring "Two-person physical assist"         Total dependence" requiring "Two-person physical assist"           Pare extremity "Impairment both sides" Lower continence "Not rated" Breaded conflicons): The facility stafff coded that resident has two (2) stage three pressure ulcers that were present on admission, on (61) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physical scial"         Extension admission admission, on (61) unstageable pressure ulcer present on admission admoisture associated skin damage.			1380 SO				
Prefersy TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED)     Colded       L 052     Continued From page 25     L 052     L 052     L 052     L 052       L 053     Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness.     L 052     L 052     L 052       Review of the Admission Minimum Data Set (MDS) dated 052/722, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score *02° Indicating severely impaired cognition. Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist" Tailet Use, "Total dependence" requiring "One-person physical assist" Personal hygiene, "Total dependence" requiring "Two-person physical assist" Euwer extremity "Impairment both sides" Lower extremity "Impairment both sides" Lower extremity "Impairment both sides" Section H (Bladder and Bowel): Indwelling Catheter Urinary Continence "Not rated" Bowel Continence revealed the following: 05/21/22, "Meet ADL (Activities of Daily Living) needs daily"     Image: Review of the physical assist"	SERENITY	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition. Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist" Transfer, "Activity did not occur" Dressing, "Total dependence" requiring "One-person physical assist" Toilet Use, "Total dependence" requiring "One-person physical assist" Person physical assist" Bathling, "Total dependence" requiring "One-person physical assist" Duper extremity "Impairment both sides" Lower extremity "Impairment both sides" Section H (Bladder and Bowel): Indwelling Catheter Urinary Continence "Not rated" Bowel Continence "Not rated" Bowel Continence "Nater and Envelopment on admission, one (1) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physicians' revealed the following: 05/21/22, "Meet ADL (Activities of Daily Living) needs daily"	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	(X5) COMPLETE DATE
Glaucoma, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition. Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist" Transfer, "Activity did not occur" Dressing, "Total dependence" requiring "One-person physical assist" Toilet Use, "Total dependence" requiring "Two-person physical assist" Personal hygiene, "Total dependence" requiring "One-person physical assist" Bathing, "Total dependence" requiring "One-person physical assist" Euwer extremity "Impairment both sides" Lower extremity "Impairment both sides" Section H (Bladder and Bowel): Indwelling Catheter Urinary Continence "Not rated" Bowel Continence "Not rated" Bowel Continence associated skin damage. Review of the physicianel solity and maission, one (1) unstageable pressure ulcer present on admission and moisture associated skin damage. Review of the physicianel solity asff following: 05/21/22, "Meet ADL (Activities of Daily Living) needs daily"	L 052	Continued From page	e 25	L 052			
(MDS) dated 05/27/22, revealed that the facility         staff coded the following:         Section C (Cognitive Patterns): Brief Interview for         Mental Status (BIMS) Summery Score "02"         Indicating severely impaired cognition.         Section G (Functional Status): Bed Mobility,         "Extensive assistance" requiring "Two-person         physical assist"         Transfer, "Activity did not occur"         Dressing, "Total dependence" requiring         "One-person physical assist"         Toilet Use, "Total dependence" requiring         "One-person physical assist"         Personal hygiene, "Total dependence" requiring         "One-person physical assist"         Personal hygiene, "Total dependence" requiring         "One-person physical assist"         Personal hygiene, "Total dependence" requiring         "One-person physical assist"         Upper extremity "Impairment both sides"         Lower extremity "Impairment obth sides"         Lower extremity "Impairment on both sides"         Section M (Skin Conditions): The facility staff         coded that resident has two (2) stage three         pressure ulcers that were present on admission, one (1) unstageable presure ulcer present on admission, one (1) unstageable presure ulcer present on admission and moisture associated skin damage.         Review of the physicians' orders revea							
Review of the care plan with a focus area of: "[Resident #4] ADL self-care deficit related to physical limitations, visual impairment, change in		(MDS) dated 05/27/23 staff coded the follow Section C (Cognitive Mental Status (BIMS) Indicating severely im Section G (Functiona "Extensive assistance physical assist" Transfer, "Activity did Dressing, "Total deper "One-person physical Personal hygiene, "To "One-person physical Bathing, "Total depen Upper extremity "Imp Lower extremity "Imp Section H (Bladder an Catheter Urinary Continence "A Section M (Skin Cond coded that resident h pressure ulcers that w one (1) unstageable p admission and moistu Review of the physici following: 05/21/22, " Daily Living) needs da Review of the care pl "[Resident #4] ADL so	2, revealed that the facility ing: Patterns): Brief Interview for ) Summery Score "02" paired cognition. I Status): Bed Mobility, e" requiring "Two-person not occur" endence" requiring I assist" otal dependence" requiring I assist" otal dependence" requiring I assist" otal dependence" requiring I assist" airment both sides" airment on both sides" airment on both sides" nd Bowel): Indwelling Not rated" Iways Incontinent" ditions): The facility staff as two (2) stage three were present on admission, pressure ulcer present on ure associated skin damage. ans' orders revealed the Meet ADL (Activities of aily"				

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If continuation sheet 26 of 92

TATEMENT	OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		DENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		
		HFD02-0011	B. WING			C 5/29/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SE GTON, DC 20032			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (	OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLE DATE
L 052	Continued From page	e 26	L 052			
		ededAssist with daily ressing, oral care and eating				
	Survey Report v2" wi health record where t Aides) document ADI provide dated 05/21/2	ent titled "Documentation hich is part of the electronic the CNA's (Certified Nurse L and other care that they 22 to 6/28/2022, shows that ented evidence of Resident he following dates:				
	05/22/22 05/24/22 05/29/22 06/07/22 06/25/22 06/26/22 06/28/22					
		staff documented NA (Not esident Not Available).				
	conducted on 06/27/2	ace-to-face interview were 22 at 1:15 PM, Resident #4 rt, and they do not always ath."				
	06/28/22 at 10:37 AM	interview conducted on 1, Employee #3 (Assistant stated "She (Resident #4) ff failed to document				
		vledged that there was no e that staff bathed resident lay and June 2022.				
		to follow a physician's order				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HFD02-0011		B. WING		00	C 06/29/2022	
					00	0/29/2022
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
ERENITY	(REHABILITATION AND	HEALTH CENTER L	GTON, DC 20032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	D THE APPROPRIATE	COMPLET DATE
L 052	Continued From page	e 27	L 052			
		sheet in residents' room idered for Resident #102.				
		dmitted to the facility on e diagnoses that included				
	-	ailure to Thrive, Pressure				
		n, Stage 3, Contracture				
	Unspecified Joint, Co	<b>U</b>				
	Contracture Left Knee Malnutrition and Muse	e, Moderate Protein Calorie cle Weakness.				
	Review of a Complair	nt received by DOH				
	(Department of Healt					
	•	#102, documented "says howers and been out of bed				
	•	s been there. Some of this				
	issues were addresse "	ed during a careplan meeting				
		rly Minimum Data Set 2, revealed facility staff				
	coded the following:	z, revealed facility stall				
		Patterns): Brief Interview for				
	intact cognition.	ary Score "15" indicating				
	Section E (Behavior):	Rejection of Care				
	-Presence & Frequen exhibited	icy "0" Behavior not				
		I Status): Bed mobility				
	"Extensive Assistance physical assist"	e" requiring "Two-person				
	Transfer "extensive a					
	"Two-person physical					
	Dressing "Extensive a "Two-person physical					
		assistance" requiring "One				
	-person physical assis	· -				
	Personal Hygiene "Ex					
	requiring "One-persor tion & Licensing Administrati					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
HFI		HFD02-0011	B. WING		C 06/29/2022
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE	
			UTHERN AVE SI	Ε	
SERENITY	REHABILITATION AND	HEALTH CENTER L WASHIN	IGTON, DC 2003	32	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
L 052	Continued From page	e 28	L 052		
L 065	Bathing "Total depend Balance during transi surface transfer "Not with staff assistance" Upper extremity "Imp Section K (Swallowin Swallowing Disorder Review of the physici 08/21/21 "Please sign room each time care Observation of reside 06/24/22 at approxim did not observe a sign During a face-to-face 06/24/22 at approxim (Assistant Director of surveyor where was t fill in after care is rend "I cannot find it at the	dence" tions and walking Surface to steady only able to stabilize mpairment" airment on both sides" g/Nutritional status): "None of the above" ans' orders revealed: n signing sheet in residents' is rendered" ent's room was conducted on ately 12:30 PM, the surveyor in in sheet for ADL care. interview conducted on ately 1:00 PM, Employee #3 Nursing) when asked by the he sign in sheet for staff to dered? Employee #3 stated bedside"	L 065	The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #95 clinically stable. Resident #95 curre on Occupation Therapy started 08/11/22. Resident #95 did not suffer any negative outcome L065 THE CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident#28 was reassessed by th Unit Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's right resting has splint was applied immediately and psychiatric consult was completed after being notified on 7/19/22.The	e and
L 065	nursing in his or her of of residents, which sh	ee shall provide restorative	L 065	Unit manager will ensure that Resid #28 receives right resting hand spli as ordered by the physician.	
	or those residents that change position at lea more often as the residay and night, to stim	assisting bedridden residents at are confined to a chair to ast every two (2) hours or ident's condition warrants, ulate circulation; prevent ulcers and deformities; and			

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STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
HFD02-001		HFD02-0011	HFD02-0011 B. WING			C 5/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
		1380 SO	UTHERN AVE S	E			
SERENTI	REHABILITATION AND	WASHIN	GTON, DC 2003	32			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE	
L 065	Continued From page	29	L 065			09/23/22	
	bed for reasonable per contraindicated by ph (d)Encouraging reside activities of daily living the importance of self assisting with transfer by allowing sufficient the residents, and by resident's choices; (e)Assisting residents and to their use of pro- (f)Achieving good boo residents who use me are properly designed supervision of a licents (g)Identifying resident	ents to be independent in g by teaching and explaining f-care, ensuring and r and ambulating activities, time for task completion by encouraging and honoring a to adjust to their condition osthetic devices; dy alignment and balance for echanical supports, which d and applied under the sed nurse; ts who would benefit from a aining program and initiating crease incontinence and		The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #95 clinically stable. Resident #95 co on Occupation Therapy started of The affected Resident #95 right resting hand splint was applied immediately after being notified. Resident was re-evaluated by Occupational therapy on 8/11/22 assessed from head. Resident #9 received Right resti splint as ordered by the physicia as outline in the comprehensive care plan by 09/23/22	urrently 08/11/22. 2 ng hand in and		
	(h)Assessing the natu behavioral disorientat implementing approp practices to improve t	riate strategies and					
lealth Regula	This Statute is not met as evidenced by: Based on observations, record review, and staff interview, for three (3) of 67 sampled residents, the facility's staff failed to: assist Resident #28 with his left hand splint as outlined in his comprehensive care plan; assist Resident #95 with her prescribed prosthetic devices (right hand						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
	HFD02-0011		B. WING		C 06/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
		1380 SC	OUTHERN AVE S	E		
SERENII	( REHABILITATION AND	WASHIN	NGTON, DC 2003	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L 065	Continued From page	e 30	L 065			00/00/00
	splint); and provide Resident #102 with their prescribed orthotics and multi-podus boots as ordered by the physician. Residents' #28, #95 and #102. The findings included:			Resident #102 was applied prescribed orthotics, multi-po boots immediately after being and is ongoing per physician Resident was reassessed fro to toe on 08/17/22 by licensed nurse R	notified orders. m head esident	09/23/22
	1. Facility staff failed this left hand splint as comprehensive care			did not suffer any negative outcome.		
		g Cerebral Infarction ominant Side, Lack of				
	Review of the medica following:	Review of the medical record revealed the following: MDS 04/05/22 - Quarterly restorative services not listed because the order came the day after.				
	OT (occupation thera achieved the highest	practical level. Patient will tive nursing program) 3-5 x				
	Review of the compre the following.	of the comprehensive care plan showed ving.				
		it on restorative nursing for /palmar guard to the left event further left-hand				
lealth Regula		inue and refer back to OT /) if redness, swelling, or on				

neaith Re	equiation & Licensing A	aministration				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	) 29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER I	THERN AVE SE	E		
		WASHING	TON, DC 2003	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
L 065	Continued From page	e 31	L 065			09/23/22
	bruising notedresto daily exercise as per Observation on 06/17 approximately 10:00 / showed Resident #28 splint or receiving res Contined observation	orative staff will assist with order.		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facilit have potential to be affected.	ty	
	approximately 4:30 P stated that the resident restorative nursing se was accidentally omit residents on the restor employee was asked applied splints? He sa then asked if licensed splint? He said. "Yes" provide an answer wh failed to apply Reside	ervices because his name ted from the facility's list of prative nursing program. The if restorative nursing aid "Yes". The employee was I nursing staff can apply however, he failed to hy licensing nursing staff ent #28's left hand splint from pproximately 10:00 AM to				
Hoolth Dory in	her prescribed prosth splint) as specified in comprehensive care p During an observation Resident #95 was obs the head of her bed th hand splint for 6-8 ho	olan. n on 06/14/22 at 10:31 AM, served in bed with a sign at nat directed "Apply right urs daily" At the time of ht hand splint was noted ear, plastic bag.				

Health Regulation & Licensing Administration

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
HFD02-0011		B. WING		C 06/29/202	
	1380 SO	UTHERN AVE S	E		
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL	JLD BE	(X5) COMPLET DATE
Continued From page 32 During a face-to-face interview conducted at the time of the observation, Employee #9 (Certified		L 065		cility nursing	09/23/2
restorative aide applie During observations of 06/24/22 at 3:54 PM, be not wearing the rig observation, the right	es and removes the splint." on 06/21/22 at 12:16 PM and Resident #95 was noted to ht hand splint. At each hand splint was observed at		residents with limited range of motion rec appropriate treatment and services to pre decrease in range of motion and educate importance of providing restorative nursin	eived vent further staff on the g services as	
Resident #95 was ad 11/16/18 with multiple Muscle Weakness, C	mitted to the facility on diagnoses that included: erebral Vascular Disease,		In-service will be provided by Staff Development /designee to all facility staff about care plan intervention in place for residents with sexual behavior, behavior with the potential to abuse others, and wandering behavior.		
revealed the following 06/02/21 [Physician's splint"	y: Order] "Right resting hand		conduct house wide audit to identify poter with sexual behavior to ensure that the pr comprehensive care plan and intervention place in accordance with professional sta	ntial residents oper ns are in andards of	
restorative nursing for motion) to bilateral ex hand splint for 6-8hrs contractures Restor	r PROM (passive range of tremities right resting to prevent right hand rative staff will assist with		review/audit of all facility residents to ider residents with limited range of motion to e residents receive appropriate treatment a to prevent further decrease in range of mo	ntify potential ensure nd services otion. This	
facility staff coded the cognitive impaired, to two persons physical use and personal hyg impairment on both si	Resident #95 as severe tally dependent on staff with assist for bed mobility, toilet iene; range of motion des for upper and lower				
	Review of Resident # Review of Resident # revealed the following 06/02/21 [Physician's splint" 04/12/22 [Revised Ca restorative nursing for motion) to bilateral ex hand splint for 6-8hrs contractures Restor daily exercises as per A Quarterly MDS date facility staff coded the cognitive impaired, to two persons physical use and personal hyg impairment on both si extremities and receivant recomment content contractures and receivant contractures and	IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         INFORMATION         REHABILITATION AND HEALTH CENTER L         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 32         During a face-to-face interview conducted at the time of the observation, Employee #9 (Certified Nurse Aide) stated, "The therapist or the restorative aide applies and removes the splint."         During observations on 06/21/22 at 12:16 PM and 06/24/22 at 3:54 PM, Resident #95 was noted to be not wearing the right hand splint. At each observation, the right hand splint was observed at the head of her bed, in a clear, plastic bag.         Resident #95 was admitted to the facility on 11/16/18 with multiple diagnoses that included: Muscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension.         Review of Resident #95's medical record revealed the following:         06/02/21 [Physician's Order] "Right resting hand splint"         04/12/22 [Revised Care Plan] "[Resident #95] on restorative nursing for PROM (passive range of motion) to bilateral extremities right resting hand splint for 6-8hrs to prevent right hand contractures Restorative staff will assist with daily exercises as per order"         A Quarterly MDS dated 05/31/2022 showed facility staff coded the Resident #95 as severe cognitive impaired, totally dependent on staff with two personal hygiene; range of motion impairment on both sides for upper and lower extremities and received OT services from	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         HFD02-0011       B. WING	FCORRECTION         IDENTIFICATION NUMBER         A. BUILDING:           NOVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           STREADDRESS, CITY, STATE, ZIP CODE         1380 SOUTHERN AVE SE WASHINGTON, DC 20032           REHABILITATION AND HEALTH CENTER L         1380 SOUTHERN AVE SE WASHINGTON, DC 20032           REHABILITATION AND HEALTH CENTER L         1380 SOUTHERN AVE SE WASHINGTON, DC 20032           Continued From page 32         L 065           During a face-to-face Interview conducted at the time of the observation, Employee #9 (Certified Nurse Aide) stated, "The therapist or the papropriate treatment and services to pre decrease in range of motion reduction to the head of the bed, in a clear, plastic bag.           During observations on 06/21/22 at 12:16 PM and observation, the right hand splint, At each observation, the right hand splint was observed at the head of the bed, in a clear, plastic bag.           Resident #95 was admitted to the facility on 11/16/18 with multiple diagnoses that included: Wuscle Weakness, Cerebral Vascular Disease, Type 2 Diabetes Mellitus and Hypertension.           Review of Resident #95's medical record revaled the following:         MONITORING CORRECTIVE ACUTON: Assistant Jourt of Austing to ProMid passive range of mothaleral extremitiesinght resting hand splint"           04/12/22 [Revised Care Plan] "[Resident #95] on restorative nursing for PROM (passive range of mothaleral extremitiesfort the resting hand splint for 6-8hrs to prevent right hand splint"           04/12/22 [Revised Care Plan] "[Resident #95 as severe cognitive impaired, totally dependent on s	F CORRECTION         IDENTIFICATION NUMBER:         A BUILDING:         COMPLE           NUMC         B. WING         C           ADVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         1338 SOUTHERN AVE SE           YREHABILITATION AND HEALTH CENTERL         1338 SOUTHERN AVE SE         PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATION ON LIS DENTIFINING INFORMATION)         D         PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATION ON USE DENTIFINING INFORMATION)         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE CONSINCE AVER SE TO PREVENT RECOUNTING A factor on LIS DENTIFINING INFORMATION)         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE CROSSHEPTENED TO THE APPROPRIATE DEFICIENCY         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE CROSSHEPTENED TO THE APPROPRIATE DEFICIENCY         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE CROSSHEPTENED TO THE APPROPRIATE DEFICIENCY         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE CROSSHEPTENED TO THE APPROPRIATE DEFICIENCY         D         D         D         PROFINE         CORSSHEPTENED TO THE APPROPRIATE DEFICIENCY         D

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Health	Regulation	&	Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	C 29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
			OUTHERN AVE S			
SERENIT	Y REHABILITATION AND	HEALTH CENTER L	NGTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L 065	Summary] " Discha RNP to facilitate pa level of performance decline, development following RNPs has b bed mobility and R (ri care" Review of the "Restor document provided to 9:20 AM, did not list F RNP for the right han Review of Resident # no documented evide was applying the righ the physician's order During a face-to-face 06/24/22 at approxim acknowledged the fin comments. 3. Facility staff failed with their prescribed of boots as ordered by t Resident #102 was a 07/30/20, with multipl the following: Adult F Ulcer of Sacral Regio Unspecified Joint, Co Contracture Left Knee Malnutrition and Muse Review of the Quarte (MDS) dated 06/02/22 coded the following:	rge recommendations: tient maintaining current and in order to prevent of and instruction in the been completed with the IDT: ight) H (hand) splint or brace rative Nursing Program" of the surveyor on 06/21/22 at Resident #95 as receiving d resting hand splint. 95's medical record showed ence to show that facility staff t hand splint as specified by and care plan. interview conducted on ately 4:00 PM, Employee #2 dings and made no further to provide Resident #102 orthotics and multi-podus he physician. dmitted to the facility on e diagnoses that included ailure to Thrive, Pressure in, Stage 3, Contracture intracture Right Knee, e, Moderate Protein Calorie cle Weakness. rly Minimum Data Set 2, revealed facility staff	L 065	L091 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #38 was assessed was to toe on 08/17/22 by Unit Manager/Designee Resident suffered no negative out Resident #66 was assessed and monitored closely x 3 day for sign symptoms of Covid-19 by licensed post exposure to an employee wh vaccinated with Covid-19 vaccine not wearing recommended Face s N95 06/29/22. Resident #66 rema clinically without any symptoms of Resident suffered no negative out Employee #6 was verbally educat importance of the of wearing PPE marinating a minimum of 6 feet w working with resident or in the car Employee #6 was written up and suspended pending terminatii Employee resigned during susper	come s and d nurses o was not e and was shield and ained f Covid-19. come. ed on E and thile e area. on.	09/23/22

(X3) DATE SURVEY

COMPLETED

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06/29/2022

#### Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A. BUILDING: B. WING \_\_\_\_ HFD02-0011 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE

SERENIT	Y REHABILITATION AND HEALTH CENTER L	UTHERN AVE SI GTON, DC 2003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 065	Continued From page 34	L 065		09/23/22
	Mental Status Summary Score "15" indicating intact cognition. Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	
	Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"; Upper extremity "no impairment"; Lower extremity "Impairment on both sides"			
	Section O (Special Treatments, Procedures, and programs): Physical Therapy start date was coded "05/27/2022" no end date was coded. The number of minutes in physical therapy was coded "0168" minutes			
	Review of the physicians' orders revealed the following:			
	11/23/21 "LE (Left Extremity) orthotics: R (Right) knee extensor brace and ankle multi-podus boots to be worn up to 6 hours or to patients' tolerance with skin assessments completed pre and post use D/C (discontinue) use if patient reports pain or changes in skin integrity occur."			
	Review of the care plan with a focus area of "[Resident #102] has alteration in musculoskeletal status r/t (related to) contracture of the bilateral knees." date revised 06/02/2022 had the following interventions: "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance."			
	Review of a document titled "Physical Therapy progress report" in the section titled "Summary /Justification to continue service dated signed 06/21/22 at 3:04 PM showed, "Reason to			
Health Regula STATE FORM	tion & Licensing Administration	6899	FZSW11 If	continuation sheet 35 of 92

STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			A. BOILDING.		с		
		HFD02-0011	B. WING		06/2	9/2022	
VAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SI GTON, DC 2003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETE DATE	
L 065	Continued From page	e 35	L 065			09/23/2	
	Continued From page 35 continue services : Continue PT (physical therapy) services are necessary in order to evaluate need for assistive device, develop and instruct in RNP (restorative nursing program) promote safety awareness, enhance rehab potential, increase coordination , improve dynamic balance, increase functional activity tolerance, increase LE (lower extremity) ROM (range of motion) and strength" Review of the document titled "Documentation survey report v2" from June 1, 2022, through June 23, 2022, documents care provided to residents revealed in the section titled "Resident on Restorative Nursing for splinting to right knee with knee brace and multi pods boot. Don after morning care and Duff at bedtime" showed that this task was not performed on the following days:			MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to all facility staff infection control and prevention which include: Hand hygiene, Donning and doffing of Personal Protective Equipment (PPE), Maintaining social distancing of at least 6 fee while interacting with others. Importance of minimizing or prevent the potential spread infection (COVID-19) and other infectious diseases by 09/23/22.			
	06/01/22 06/02/22 06/03/22 06/06/22 06/07/22 06/16/22 06/16/22 06/17/22 06/20/22 06/23/22						
	For all the above-mentioned section, facility staff either left the space blank or documented "NA" which means "Not Applicable" according to the documentation. A face-to-face interview was conducted on 06/24/22, at 2:40 PM with Employee #3 (Assistant						
		The restorative aide does g program and applies the					

# Health Regulation & Licensing Administration

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		HFD02-0011	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER	1380 SO	NDDRESS, CITY, ST NUTHERN AVE S NGTON, DC 2003	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 065 L 091	.065       Continued From page 36       L 065         orthotics, I know we have some challenges sometimes they assist the unit."       L 065         MONITORING CORRECTIVE ACTION:       The Assistant Director of Nursing (ADON)/Designee will conduct house wide		MONITORING CORRECTIVE ACTION: The Assistant Director of Nursing (ADON)/Designee will conduct house wide visu audit to identify potential residents that employ failed to properly minimize or prevent	es	
	that infection control p implemented and sha services, including ho laundry, and linen sup the requirements of th This Statute is not m Based on observation interviews, the Infection to ensure an unvaccin	et as evidenced by: h, record review, and staff on Control Committee failed hated employee followed the re Staff Vaccination" policy t the potential spread		the potential spread infection (COVID-19) by no properly wearing Personal Protective Equipmer (PPE) when interacting with Resident less than six (6) feet away weekly times 4, ther monthly times 3 months. The findings of these audits will be presented monthly for 3 months t Quality Assurance Performance Improvement (QAPI) committee. L091 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #66 was assessed and monitored closely x 3 days for signs and symptoms of Covid-19. by licensed nurses post exposure to an employ who was not vaccinated with Covid-19 vaccine, and was not wearing recommended face shield and N95 on 06/29/22. Resident #66 remained clinically stable without any symptoms of Covid	ee
	<ul> <li>Review of the facility's policy entitled, "COVID-19 Healthcare Staff Vaccination", instructed unvaccinated staff to wear a N95 mask and face shield in the facility and continue to follow infection prevention guidelines.</li> <li>On 06/29/22 at approximately 2:00 PM, Employee #6 (Social Worker) was observed in his office sitting at his desk talking to a resident who was approximately less than 2 feet away. The employee was not wearing a face shield or N95 mask. Resident #66 was observed wearing a face mask that was under his chin not covering his mouth or nose.</li> </ul>			IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected .	-13.
	Review of the facility's Vaccination Status for	s COVID-19 Staff r Provider form showed			

STATEMENT	egulation & Licensing A OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		HFD02-0011	B. WING		06/2	29/2022
	(EACH DEFICIENC	HEALTH CENTER L 1380 SOU WASHING ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DDRESS, CITY, ST UTHERN AVE S GTON, DC 200 ID PREFIX TAG L 091	E	HOULD BE	(X5) COMPLETE DATE 09/23/2
	Employee #6 (Social for COVID-19. Review of Resident # the resident was adm with multiple diagnose Pacemaker, Hyperter Continued review of t resident received Moo vaccinations on the fo 02/09/21, 2nd dose -0 02/08/22. During a face-to-face approximately 2:10 P receptive to speaking During a face-to-face and Employee #2 (Do approximately 2:15 P he did not have on a he only spoke with Re minutes. When asked policy for wearing PP	Worker) was not vaccinated 66 medical record revealed itted to the facility 08/08/15 es including Brady Cardia, nsion, and Obesity. he record showed the derna (COVID-19) ollowing dates: 1st dose - 03/08/21, and 1st Booster - interview on 06/29/22 at M, Employee #6 was not with the surveyor. interview with Employee #6 DN) on 06/29/22 at M, Employee #6 stated that face shield or N95 because		L 091 MEASURE TO PREVENT RECURRE The facility Staff Development will prove ducation/in-services to all facility staff and prevention which include: Hand hy and doffing of Personal Protective Equ (PPE), Maintaining social distancing o while interacting with others. Important or prevent the potential spread infection (COVID-19) and other infectious diseases and the importance of proper sanitizing resident rooms and shared of MONITORING OF CORRECTIVE ACTION: The Assistant Director of Nursing (ADON)/Designee will conduct house wide visual audit to identify potential residents that employees failed to properly minimize or prevent t spread infection (COVID-19) by not properly wearing Personal Protective Equipmer interacting with Resident less than six weekly times 4, then, monthly times 3 The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	vide infection control rgiene, Donning ipment of at least 6 feet ce of minimizing cleaning and aquipment. he potential ht (PPE) when (6) feet away	
L 099	from spoilage, safe for served in accordance forth in Title 23, Subti Regulations (DCMR), This Statute is not m Based on observation staff failed to prepare sanitary conditions as	be clean, wholesome, free or human consumption, and with the requirements set tle B, D. C. Municipal Chapter 24 through 40.	L 099			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
HFD02-0011		B. WING		C 06/29/2022		
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		1380 SO	UTHERN AVE S	E		
ERENIT	REHABILITATION AND	HEALTH CENTER L	GTON, DC 2003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
L 099	<ul> <li>damaged wall behind failure to follow food s practice.</li> <li>The findings include:</li> <li>During a walkthrough 14, 2022, at approxim following were observed</li> <li>1. A ceiling light locate kitchen was cracked at</li> <li>2. The wall behind the with holes.</li> <li>3. Staff failed to conn- warmer to help maints on the tray line on June 21, 2022, at a Subsequently, three ( tested below required temperature assessment on June 2:00 PM.</li> <li>These observations w Employee #38 and/or face-to-face interview approximately 3:00 P</li> <li>3220.2 Nursing Facilit The temperature for of forty-five degrees (45)</li> </ul>	the grease fryer, and staff service standards of of dietary services on June hately 10:00 AM, the red: ed in a common area of the and loose. e grease fryer was damaged ect one (1) of one (1) plate ain hot food temperatures pproximately 12:45 PM. 3) of four (4) hot food items res during a test tray 21, 2022, at approximately vere acknowledged by Employee #42 during a on June 27, 2022, at M. ties cold foods shall not exceed °F) Fahrenheit, and for hot one hundred and forty renheit at the point of	L 099	L 099 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No resident was affected by this deficie IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the affected . MEASURES TO PREVENT REOCCUP The facility Staff Development will provide education/in-services to the maintenance staff on importance of : 1.maintaining and ensuring no ceiling light are cracked and loose around the facility. 2.maintaining and ensuring that the facility walls are not damaged with hol by 9/23/22. The facility Staff Development will provide education/in-services to the facility kitchen staff on importance of ensuring that food is distributed and served in accordance with professional practice and ensuring that the food plat connected to electricity to help maintai temperatures on the tray line by 9/23/22 MONITORING OF CORRECTIVE ACTION: Food and Nutrition Services Director/ Designee will conduct rounds in the kitchen to ensure that food is distributed in accordance with professional standards of practice; and will conduct test trays assessment to ensure that t residents get their food within the stand temperature weekly times 4, then montt times 3 months. Director of Maintenance /Designee will conduct house wide round/audit o common areas within the facility and tf residents rooms to ensure no ceiling lig are cracked and loose, and walls do no damage, weekly times 4, then months.	potential to be RENCE: les. standards of e warmer are n hot food 2. d he lard nly f ne ht	09/23/2

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# Health Regulation & Licensing Administration

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
HFD02-0011		B. WING		C 06/29/2022		
	ROVIDER OR SUPPLIER	1380 SO	DDRESS, CITY, ST UTHERN AVE S GTON, DC 200	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L 108	staff failed to serve for conditions as evidend temperatures that we Fahrenheit on three ( The findings include: During a food test tra 2022, at approximate as ham (117 degrees (105.7 degrees Fahre minimum required ter Fahrenheit (F). These observations w Employee #38 and/or	et as evidenced by: ns and staff interview, facility ods under sanitary eed by hot foods re below 140 degrees 3) of four (4) observations. y assessment on June 21, ly 2:00 PM, hot foods such Fahrenheit), cabbage enheit), and mechanical ham nheit), tested below the mperature of 140 degrees	L 108	L108 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No resident was affected by this deficient pract IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potentia affected . MEASURES TO PREVENT REOCCURENCE: The facility Staff Development will provide education/in-services to the facility kitchen staff on importance of ensuring that food is distributed and served in accordance with professional standa food served is warm at the required temperatu ensuring that the food plate warmer are conne- electricity to help maintain hot food temperatu line by 9/23/22. MONITORING OF CORRECTIVE ACTION: Food and Nutrition Services Director/ Designee will conduct rounds in the kitchen to ensure that food is distributed in accordance with professional standards of practice; and will conduct test trays assessment to ensure that the residents get their food within the standard temperature weekly times 4, then monthly times 3 months.	I to be rds of practice, ire and cted to	09/23/2
L 109	be offered at the sam This Statute is not m Based on observation resident interview for residents, facility staf appropriate food subs nutritive value and off to residents as eviden to provide menu option	ood, appropriate arable nutritive value shall e mealtime. et as evidenced by: n, record review, staff and two (2) of 67 sampled f failed to provide stitutions of comparable fered at the same mealtime need by the facility's failure ons so that residents could Residents' #102 and #82.	L 109			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		HFD02-0011	B. WING	(	C 06/29/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	
		1380 SC	OUTHERN AVE SI	E	
SERENITY	REHABILITATION AND	HEALTH CENTER L WASHIN	NGTON, DC 2003	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 109	Continued From page	e 40	L 109	L109	09/23/22
	<ul> <li>1) Resident #102 was admitted to the facility on 07/30/20, with multiple diagnoses that included the following: Adult Failure to Thrive, Pressure Ulcer of Sacral Region, Stage 3, Contracture Unspecified Joint, Contracture Right Knee, Contracture Left Knee, Moderate Protein Calorie Malnutrition and Muscle Weakness.</li> <li>Review of the Quarterly Minimum Data Set</li> <li>L109 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident #102 was immediate provided with the menu and alternative menu after negative outcomes noted.</li> <li>The affected Resident #82 was immediate with the menu and alternative menu after notified and is ongoing so that resident care</li> </ul>		CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident #102 was immediately provided with the menu and alternative menu after being notified and is ongoing so that resident can make food choices Resident reassessed was from head to toe on 08/17/22 by the licensed nurse. No	ed	
	coded the following: Section C (Cognitive	Patterns): Brief Interview for ary Score "15" indicating		to toe on 08/17/22 by the licensed nurse. No negative outcomes noted. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.	
	Section E (Behavior): -Presence & Frequen exhibited Section G (Functional "Extensive Assistance physical assist" Transfer "extensive as "Two-person physical Dressing "Extensive a "Two-person physical	I Status): Bed mobility e" requiring "Two-person ssistance" requiring assist" assistance" requiring assistance" requiring		All the residents in the facility have the potential to be affected . MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to the facility kitchen staff on importance of ensuring that menus are provided to all the facilities residents so that they could make food choices and to update menus periodically and have them reviewed by the facilities Dietitian/ Nutritionist by 9/23/22. The Director of Food and Nutrition Services/Designee will conduct house wide audit to	
	Toilet use "Extensive -person physical assis Personal Hygiene "Ex requiring "One-person Section K (Swallowing Swallowing Disorder "	xtensive assistance" n physical assist" g/Nutritional status):		to identify potential residents that facility staff failed to provide menus so that they could make food choices. This audit will be completed weekly times 4,then monthly times 3 months. The Director/Designee of Food and Nutrition Services will ensure that the menus are reviewed by facilities Dietician/ Nutritionist. This audit will be completed weekly time 4, then monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance	
	following:			Performance Improvement (QAPI) committee.	

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STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HFD02-0011	B. WING		06	C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	REHABILITATION AND	HEALTH CENTER I	UTHERN AVE SE			
JERENIT		WASHIN	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
L 109	Continued From page	e 41	L 109			09/23/22
	08/07/20 "Regular die Liquids consistency (l preference"	et Regular texture, Thin Double portion) per				
	"(Resident #102) is at to) Clinical DX (Diagn Protein Calories Maln Sickle Cell Trait, Calc (Hypertension) Requi nutritional supplement had multiple intervent "Continue providing et adherence to facility of outside facility Fo check on resident's for During an observation conducted on 06/24/2	an with a focus area of t nutritional risk r/t (related hosis) Adult Failure to Thrive, nutrition, Type 1 Diabetes, sulus of Kidney, GERD, HTN ring liberalized diet and oral ts" initiated on 07/31/20, tions including the following: education on importance of diet order/limiting food from od service staff to regularly bod preference changes" n and face-to-face interview 22 at approximately 1:00PM,				
	there is not enough mac and cheese for a water." The surveyor	"The food is terrible and One time they gave me a meatI can't get cold ice asked the resident about the these issues with staff? I do not get a menu"				
	06/24/22 at approxim #30 (Registered Dieti #102) complains he h	interview conducted on ately 2:23 PM, Employee cian) stated "He (Resident has been seen by the tes and she follows up.				
	menus are and how r replacement. The die surveyor a menu that May 2022 (The curren survey was June 202 wall by the nursing st	he dietician where the esident could get a meal tician then showed the was posted for the month of nt month at the time of 2), on a bulletin board on a ation. The menu was noted of font and in area not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD02-0011			(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		B. WING		06	C 06/29/2022	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1380 SO	UTHERN AVE SE			
ERENII	( REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
L 109	Continued From page	e 42	L 109			
<ul> <li>L 109 Continued From page 42</li> <li>assessable by all residents. Behind the menu was a form labeled "Next level Hospitality services that had food choices for breakfast lunch and dinner. Employee #30 stated the form was the alternative menu for residents. Employee #30 acknowledged that Resident #102 had no access to the form she identified as an alternative menu.</li> <li>2) Resident #82 was admitted to the facility on 06/13/17, with multiple diagnoses that included the following: Age-Related Nuclear Cataract, Bilateral, Vitamin B12 Deficiency Anemia Unspecified, Vitamin D Deficiency Unspecified, and Unspecified Dementia Without Behavioral Disturbance.</li> </ul>						
	conducted on 06/22/2 #82, the surveyor obs and noticed his break untouched and cover resident if he had eat which Resident # 82 s can't eat those power asked the resident if h	ed. The surveyor asked the en and how was the food to stated "It was disgusting I ed eggs" The surveyor ne told staff to which ded "That ain't going to do				
		Minimum Data Set (MDS) aled that facility staff coded				
	"Impaired"	peech, and Vision) Vision				
	Corrective Lenses "Ye	es"				
		Patterns) Brief Interview for ary Score "14" indicating				

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# Health Regulation & Licensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		HFD02-0011	B. WING		0	C 6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	. ZIP CODE		
			UTHERN AVE SE	, • • •		
SERENITY	REHABILITATION AND	HEALTH CENTER L	IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
L 109	Continued From page	9 43	L 109			09/23/2
	Section G (Functiona "Independent" requiri help from staff"	l status) Eating ng "No set up or physical				
	Section K (Swallowing Swallowing Disorder					
	following: 06/01/22 "F	ans orders revealed the Regular diet Regular texture, Icy, Double Portion per				
	"(Resident #82) is at a Dementia, Heart Failu Disorder-requiring Re nutritional supplemen had interventions whi "Regular Diet, Regular	gular diet and oral ts" date revised 06/02/22, ch included the following				
	06/22/22 at 10:55 AM Floor Unit Manager) " they have to say som them something else" is a menu where resid how would a resident tray replaced. Employ	interview conducted on I with Employee #33 (2nd If they don't like the meal, ething then we can give The surveyor asked if there dents can make choices and get a meal or item on the yee #33 stated she would eak with the surveyor.				
	06/22/22 at 12:07 PM (Registered Dietitian) residents choose alte they do not like a food	The surveyor asked how rnatives or replacements if d item that is being served. she was not sure and that then director.				

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STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			TE SURVEY MPLETED
		HFD02-0011	B. WING		0	C 6/29/2022
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		1380 SC	OUTHERN AVE SE			
DERENII	REHABILITATION AND	HEALTH CENTER L WASHIN	NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 109	Continued From page	2 44	L 109			09/23/2
	wall right here." The form that Employ menu is labeled "Nex	ately 12:15 PM with				
		being behind other papers				
L 204	3232.2 Nursing Facili	ties	L 204			
	completed immediate forty-eight (48) hours	e Director of Nursing and				
	(a)The date, time, and	d description of the incident;				
	(b)The name of the w	itnesses;				
	(c)The statement of the	ne victim;				
	(d)A statement indica pattern of occurrence	ting whether there is a ; and				
	(e)A description of the	e corrective action taken.				
	six (6) of 67 sampled failed to follow their "I by not interviewing or all potential witnesses	ew and staff interviews, for residents, the facility's staff nvestigation Process" policy obtaining statements from				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	C 29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		1380 SO	UTHERN AVE S			
SERENIT	Y REHABILITATION AND	HEALTH CENTER L	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L 204	non-consensual sexu Resident #108; resid for Resident #86, sex resident-to-resident in #121, staff physical a staff neglect of Reside #86, #112, #121, #30 The findings included Review of the facility's Process', with a revis documented, interview from potential witness scope of the investiga 1. Facility staff failed f statements/interviews who might have know resident-to-resident in sexual touch [sexual a Resident #108 was an 12/10/19 with multiple Alzheimer's Disease a 05/25/22 at 8:59 PM [ Assessment, Result F shift at about 8:30pm the nurse that activity #126]sitting at the I his wheelchair and ha [Resident #108] was in happened due to diag communication deficii assessed from head fo of pain/discomfort not No physical signs of t	al touch [sexual abuse] for ent-to-resident altercation ual abuse of Resident #112, ncident involving Resident buse of Resident #303's and ent #304. Residents' #108, 3 and #304. s policy titled, "Investigation ion date of 06/22, w and/or obtain statements ses as determined by the ation" to obtain a from all potential witnesses /ledge of the nappropriate non-consensual abuse] for Resident #108. dmitted to the facility on e diagnoses including and Major Depression. [Situation, Background, Form]- "During the evening writer was made aware by director saw [Resident bedside [of Resident 108] in ad feces on his left hand. unable to explain what gnosis of cognitive t. [Resident #108] was to toe by the nurse, no sign r facial grimace expressed.	L 204	DEFICIENCY) L204 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT : The facility cannot retroactively correct this deficiency. Resident #108 was assessed head to toe on 5/26/22, for pain and trau apparent injury observed. Resident was the hospital emergency room on 5/26/22 evaluation for possible sexual abuse. Re returned to the facility from ER/ hospital ' 05/27/22. Licensed nurse performed a hr assessment on the resident and no nega were found on 5/27/22. Resident #108 w reassessed head to toe on 8/17/22 by th licensed nurse no evidence of physical a observed.	transferred to for further sident visit on ead to toe tive outcomes as e facility	09/23/22

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		HFD02-0011	B. WING		06	/29/2022
	ROVIDER OR SUPPLIER	1380 S	ADDRESS, CITY, ST/ OUTHERN AVE SI NGTON, DC 2003	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
L 204	was given to Transfer room) via 911 for furth physical abuse." It sh to transfer Resident # until 05/26/22 at 4:41 facility after receiving abuse for Resident # 05/26/22 at 4:41 PM [ resident to ER via 912 possible physical abu 05/26/22 at 3:30 PM [ 3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re [Resident #126 who r was observed sitting i bedside of [Resident # 8:30pm on 5/25/22. It #126] was observed v front, back, and under also reported that [Re with feces on her thig [Resident #126] was is the scene and [MD's is given to transfer [Res 310-B. Also, [Detective number] was called to After meeting with the staff members the der arrest was made. How gave order to transfer (emergency room) via for possible physical a	resident to ER (emergency her evaluation for possible ould be noted that the order 108 to ER was not written PM after police came to a call for a call of physical 108 Physician Order] transfer I for further evaluation for se. ADON Note] - "At about d [two police officers names in the facility who said they abuse for [Resident #108] in ceived report from staff that esided in room 147 bed A n his wheelchair at the #108] room 112-A at about was reported that [Resident vith feces on his left-hand rneath his fingernails. It was isident #108] was observed h and her bed spread. mmediately removed from name] notified and order ident #126] to Unit 3 - Room	L 204	L204 Resident #108, Resident #86 ,Resident #112, Resident #303, Resident #304, and Resident #121 did not suffer any negative outcome for not reporting incidences within required time as stipulated by CMS regulation & requirement to St Agency or for not conducting interviews and obtaining statements from potential witness of allegation of abuse. No new incident or occurrences of allegation of abuse observed. Resident #108, Resident #86, Resident #112, Resident #303, Resident #304, and Resident #121 did not suffer any negative outcome for not reporting incidences timely to State Agency or for not conducting interviews and obtaining statements from potential witness of allegation of abuse. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has potential to be affected.	e the ate	

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	; 9/2022
	ROVIDER OR SUPPLIER				1	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
SERENIT	Y REHABILITATION AND	HEALTH CENTER L	OUTHERN AVE S			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
L 204	Continued From page	e 47	L 204			09/23/22
L 204	and left the facility at hospital]" Review of the staff as had two licensed staff on evening shift (3:00 05/25/22. However, reinvestigative report la of the four (4) CNAs [ interviews or statemed buring a face-to-face starting at approximat (ADON) stated that the process of investigatile Cross Reference 42 C 2. Facility staff failed the statements/interviews who might have know resident-to-resident a Resident #86 was add 08/28/18 with multiple Dementia without Bel Generalized Muscle V Review of a Facility R [DC00010685] dated documented, "Around informed by the smok [Resident #86] was hi #120][Resident #86] was hi #120] approached hir face and promised to himwriter called 91	17:28pm [5:28 PM] to [local asignment revealed Unit 1 f and four (4) CNAs working PM to 11:00 PM) on eview of the facility's cked documented evidence potential witnesses] nts. interview on 06/28/22 tely 4:00 PM, Employee #3 ney are working on their ng incidents. CFR 483.12, F600 to obtain a from all potential witnesses vedge of the ltercation for Resident #86. mitted to the facility on e diagnoses including: navioral Disturbances and Weakness. Reported Incident 04/14/22 at 9:09 PM a 11:00 AM writer was	L 204	MEASURES TO PREVENT RECURRENCE: The facility Staff Development/ Desi provide an education /In-service to facility Director of Nur ADON, Unit Managers and Supervisors on the process of repor incident of unusual occurrences to L the State Agency on timely. The in-service/education will explain the importance of reporting incidences of The compliance date for this intervention 9/23/22. The facility Staff Development/Desig provide education to the facility Unit and Supervisors on the importance facility protocol of conducting interv obtaining statement from potential v during an investigation of all inciden unusual occurrences. The compliant this intervention 9/23/22.	rsing, ting of 204 timely. gnee will Managers of following riews and vitnesses ices of	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HFD02-0011	B. WING			C 29/2022
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
ERENITY	REHABILITATION AND	HEALTH CENTER L	OUTHERN AVE S			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	· ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET
L 204	Continued From page	e 48	L 204			09/23/2
		0] to the ER for evaluation		MONITORING CORRECTIN ACTION: The Assistant Director of Nu (ADON)/ Designed will come	ursing	
	Review of the medica following:	al record showed the		(ADON)/ Designee will comp review/audit of all incidences unusual occurrences vial State Agency reporting syste	s of incidence of em timely	
	complained another r who was unprovoked of the neck two days	-		and within 2 hours if serious injury occurred. weekly time monthly times 3 months.		
	of the neck two days agoPlan continue admission to skilled NH (nursing home)" 04/20/22 at 1:47 PM [Social Work Note] - "The writer and recreation director was informed of a physical altercation between [Resident #86] an [Resident #120] on 04/14/22[Resident #86] expressed that he does not feel safe if [Residen #120] returns to the facilityI want to press chargesThis writer and activities director accompanied [Resident #86] to the 7th District Police Prescient to report incident and press charges "	director was informed of a between [Resident #86] and 4/14/22[Resident #86] bes not feel safe if [Resident acilityI want to press and activities director ent #86] to the 7th District				
	Review of facility's in the following:	vestigative report showed				
	04/18/22 [Employee's #27's statement - smoke monitor]- documented, "I was on the smoke patio with [Resident #86] and [another resident] when [Resident # 120] entered the patio cussing [cursing] and making verbal treats [threats] to					
	[Resident #86][Resident #8	sident #120] stated nobody etting to youI better not because I got something				
	Further review of the evidence of an interv	lacked documented iew of statement from the				
	other resident that wa	as present on the smoking				

6899

If continuation sheet 49 of 92

# Health Regulation & Licensing Administration

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		SURVEY PLETED
		HFD02-0011	B. WING		06	C / <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
			OUTHERN AVE S	E		
SERENIT	Y REHABILITATION AND	HEALTH CENTER L WASHIN	NGTON, DC 2003	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 204	During a face-to-face starting at approxima (ADON) stated that the process of investigati 3. Facility staff failed statements/interviews who might have know allegation made by R Resident #112 was at 08/03/20 with diagnes Schizophrenia, Psych Disorder. Review of a Facility F received on 07/19/21 informed by the charg PM) that [Resident #7 (physical therapist) st night, that she is feeli place that if she sees herself" Review of Resident # revealed the following 02/09/21 [Physician's (antidepressant) HCI MG (milligram) give 1 morning for Depression 03/20/21 [Physician's Fumarate (antipsychol tablet by mouth at be A Quarterly Minimum 05/04/21 where that f	interview on 06/28/22 tely 4:00 PM, Employee #3 ney are working on their ng incidents. to obtain a from all potential witnesses veledge of a sexual abuse esident #112. dmitted to the facility on ses that included: notic Disorder and Anxiety Reported Incident (FRI) documented, "Writer was ge nurse at 14:40p.m (2:40 112] informed the PT taff that she was raped all ng so horrible about this a gun, she can just kill agun, she can just kil	L 204	The Assistant Director of Nur (ADON)/ Designee will comp review/audit of all incidences occurrences to ensure investigation was conducted potential witnesses are interv statement are obtained week monthly times 3 months. The findings of these audits v monthly for 3 months to Qual Performance Improvement (QAPI) commit	lete house wide of unusual and viewed and dy times 4, then, will be presented lity Assurance	09/23/2

	egulation & Licensing A	(X1) Provider/Supplier/Clia	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED		
			5.94/940			С		
		HFD02-0011	B. WING		06/29/2022			
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE				
SERENIT	<b>Y REHABILITATION AND</b>	HEALTH CENTER L	UTHERN AVE SE					
			IGTON, DC 20032					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETE DATE		
L 204	Continued From page	e 50	L 204					
	score of 10, indicating cognition, no indicato or physical behaviors extensive assistance one person physical a transfers, impairment extremities, wheelcha received antipsychoti last 7 days. 07/12/21 at 3:19 PM Practitioner Progress seen for f/u (follow up significant for depress lying on the bed, alert self, generally to plac at this time" 07/19/21 at 1:43 PM "Sexual assault note: report from the ADON Nursing) stating the re was sexually assaulte was in the facility O the ADON and the SV	g moderately impaired rs for psychosis, no verbal directed to others, to total dependence with assist for bed mobility and on both sides for lower air mobility device and cs on a routine basis in the [Psychiatric Nurse Note] "The patient was b). She has a history sion, anxiety. She is seen t and oriented generally to e, receptive to visit Stable [Social Work Progress Note] This worker received a I (Assistance Director of esident informed staff she ed by several men while she nce the resident spoke to V director it was determined						
	that the alleged incident could not have happen due to [Resident #112] stating the men came from outside of the facility. Due to visitation of the facility being very limited do to covid protocols no outside visitors have been allowed to any resident's room. The social work and nursing staff							
	that are made by [Re 07/19/21 at 3:52 PM	nent any of the statement sident #112]." [Nurses Note] "Writer was ge nurse at 14:40p.m that						
	[Resident #112] inform was raped all night, the about this place that it	med the PT staff that she nat she is feeling so horrible if she sees a gun, she can sident #112] said "that						

	egulation & Licensing A FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HFD02-0011	B. WING		06	C / <b>29/2022</b>	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  SERENITY REHABILITATION AND HEALTH CENTER I  1380 SOUTHERN AVE SE							
		1380 SO	UTHERN AVE SE				
ERENII	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032				
ERENITY REHABILITATION AND HEALTH CENTER L     WASHINGTON, DC 20032       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE							
PREFIX TAG			PREFIX TAG			COMPLET DATE	
			_	DEFICIEN	ICY)		
L 204	Continued From page	e 51	L 204				
	someone from the co	mmunity has been following					
		t homes and also followed					
	her to four different h	ospitals that she been to					
	raping her and touchi	ing her inappropriately".					
		resident of her safety while					
		e facility. [Resident #112]					
		es not work in this facility					
		e the mane of any individual.					
	NP (Nurse Practitione						
	· · ·	sentative) son was					
		ed rapeStaff will continue					
	to monitor resident fo	-					
	doctor"	abnormal concerns to the					
	07/19/21 at 7:50 PM	[Nurse Practitioner Progress					
	Note] " Follow up -						
	physical therapist of l	peing rapped last night"					
		nt done by multi-disciplinary					
		llow up of patient comment					
		secured and monitored by					
		aking frequent rounds,					
		enter facility without prior					
		protocols followed on this					
	comment by patient .						
	Review of the facility'	s investigation documents					
	•	ocumented evidence to					
		f obtained statements from					
	-	ve knowledge of the alleged					
	incident.						
	During a face-to-face	interview on 06/23/22 at					
	•	#3 acknowledged the finding					
	and made no further						
		4					
	4. Facility staff failed						
		s from all potential witnesses					
	who might have know						
	ຼາຮອບຮານ-ເບ-ເຮັບຮານຮັກໄ ມ	ncident involving Resident				1	

TATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD02-0011	B. WING		06	C 6/ <b>29/2022</b>
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1380 SO	UTHERN AVE SE			
ERENIIY	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
Image: Construction and Health Center L       1380 SOUTHERN AVE SE WASHINGTON, DC 20032         (x4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE PREFIX TAG         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
				CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE DATE
AME OF PROV ERENITY RE (X4) ID PREFIX TAG L 204 Ca #1 Ca Ca Ca Ca Ca Ca Ca Ca Ca Ca	Continued From page	e 52	L 204			
	#121.					
	02/27/21 with diagnos Schizophrenia, Press	sure Ulcer of Sacral Region Neuromuscular Dysfunction				
	dated 05/27/22 docur (Wednesday) May 25 woke by a strange may wheelchair @ (at) the screamed and called	5, 2022 @ (at) 1:30 AM I was an [Resident #126] in a e bottom side of my bed. I				
	Data Set (MDS) date facility staff coded the for Mental Status (BII no potential indicator	121's Quarterly Minimum d 05/16/22 showed that e following: a Brief Interview MS) summary score of 15, s of psychosis and no verbal symptoms directed towards				
	about 2; 11am a male room 144 A and was Writer asked [Reside touched her, resident touch me, writer aske you have food on the no he was touching the	[Nurses Note] "Late Entry: At e resident wandered into redirected back to his room. nt #121] if the resident t stated that no, he did not ed Ms Freeman again, do table, resident answered, he table and there was no vas trash that was on the				
	documented, " Bas	ance Written Form" dated 05/27/22 ed on these findings, the use case was confirmed				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		HFD02-0011	B. WING		C 06/29/20	
ME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
		1380 SO	UTHERN AVE SE			
	( REHABILITATION AND	WASHIN	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
L 204	Continued From page	e 53	L 204			
	"					
		as abuse on the grievance ed to file an incident report of ent incident.				
	06/22/22 at approxim Employees #6 (Unit 1 Employee #6 stated, speak to the resident interviews. I then put	I Social Worker) and #3, "Once I get a grievance, I and staff involved and get together a packet and it's Social Services Name] and				
	Employee #3 acknow	rementioned interview, /ledged the finding and eport should've been done partment of Health)."				
		s from all potential witnesses vledge of Resident #303's				
	12/13/21 with diagnos	dmitted to the facility on ses that included: Type 2 ck of Coordination and n.				
	8:30am on Dec. 31st by Speech Therapist	end of shift rounds at about 2021, writer was informed that during her session this #303] said one of the				
	Review of Resident # revealed the following					

Health R	egulation & Licensing A	Administration			FORM	1 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	) 29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SE GTON, DC 2003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
L 204	An Admission Minimu 12/21/21 where facilit Interview for Mental S score of 15, indicating potential behaviors of physical behaviors dia refusal of care, extension one-person physical a transfers and persona on one side for lower 12/31/21 at 6:56 AM [ During end of shift rot approached by Speed [Resident #303] just in on the hand by a nurs [Resident #303's] roo happened last night. S hit her on her left wris 12:00AM last night (D injury, and there was discoloration observe question. She denied advised that her comp Review of the facility's on 06/27/22 lacked do potential witnesses w were interviewed or p During a face-to-face 06/27/22 at 9:14 AM, the finding and made 6. Facility staff failed f	Im Data (MDS) dated y staff coded: a brief Status (BIMS) summary g intact cognition, no psychosis, no verbal or rected towards others, no sive assistance with assist for bed mobility, al hygiene and impairment extremity range of motion. (Nurses Note] "Late Entry unds at 8:30AM, writer was ch Therapist; she said nformed her that she was hit se last night. Writer went to m and asked her what She said the female nurse at around 11:30PM and bec. 30th 2021). She denied no swelling, or skin d at the alleged skin area in pain. [Resident #303] was oblaint will be investigated." s investigation documents bocumented evidence that all ith knowledge of the incident rovided a statement. interview conducted on Employee #3 acknowledged no further comment. to implement its policy for ced by failure to interview all knowledge of neglect	L 204			

Resident #304 was admitted to the facility on

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HFD02-0011	B. WING		06	C 5/29/2022
AME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
ERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET
L 204	Continued From page	e 55	L 204			
		e diagnoses that included: ary tract infection (UTI),				
	11/04/21 documented that yesterday night [ did not respond to he requested fro (sp) as (Certified Nurse Aide calls/requests Res morning she was ass	ncident (FRI) received on d, "Resident complained (11/03/21] her assigned staff er call light on time when she sistancethat the CNA ) was ignoring her ident also reported that this sisted to the bathroom but came to assist her back to				
	Review of Resident # revealed the following					
	ADL self-care perform weakness s/p (status	"[Resident #304] has an nance deficit r/t generalized post) lumbar spinal fusion ident to use bell to call for				
	11/08/21 showed that a Brief Interview for M summary score of 14 no potential behavior care, required extens one-person physical transfers, toilet use a limitations in range of extremities, used a w	, indicating intact cognition, s of psychosis, no refusal of sive assistance with assist for be mobility, nd personal hygiene, no f motion for upper and lower valker and wheelchair for ays incontinent of bladder				
	on 06/22/22 showed	s investigation documents no documented evidence rked with Resident #304 on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		SURVEY LETED
		HFD02-0011	B. WING		C 06/29/2022	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		1380 SOI	UTHERN AVE S	E		
ERENITY	REHABILITATION AND	HEALTH CENTER L WASHING	GTON, DC 2003	32		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
L 204	Continued From page	9 56	L 204	L206		09/23/2
	statements.	were interviewed or provided		CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #108 was assessed head Licensed nurse on 5/26/22, for pai apparent injury observed. Resident	n and trauma. no	
	12:55 PM, Employee	interview on 06/22/22 at #7 (Unit 1 Nurse Manager) dings and provided no		to the hospital emergency room on further evaluation for possible sexu abuse. Incident was reported to the Agency late, approximately 22 hou the incident.	5/26/22 for al s State rs after	
L 206	3232.4 Nursing Facili	ties	L 206	Resident #108 returned to the facility from ER/ visit on 05/27/22. Licensed nurse, performed a toe assessment on the resident and no negativ outcome from not reporting the incident to the s	berformed a head to d no negative dent to the State	
	agency within forty-eig occurrence, except the that result in harm to to the licensing agence occurrence. This Statute is not me Based on record revise nine (9) of 67 samples failed to: report allega alleged/witness sexua non-consensual sexua non-consensual sexua survey Agency immes hours of the allegation #145; report a reside involving Resident #1 investigations to the S 5 working days of the #145, #108, #86, #8,	reported to the licensing ght (48) hours of at incidents and accidents a resident shall be reported by within eight (8) hours of et as evidenced by: ews and staff interviews, for d residents, facility staff tions of resident-to-resident al abuse (inappropriate		Agency reporting system within the stipulated by the CMS regulation & requirement. RP/MD notified.	e required time as	
		ailed to report allegations of				
		lleged/witness sexual abuse				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	·	с
		HFD02-0011	B. WING		06/29/2022
ME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	
RENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE S		
			IGTON, DC 200		
X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLE
L 206	Continued From page	e 57	L 206		09/23/2
	State Suvey Agency i two hours of the alleg and #145. 1a. Resident #108 wa 12/10/19 with multiple	al sexual contact) to the mmediately or no later than ation for Residents' #108 as admitted to the facility on e diagnoses including and Major Depression.		Resident #145 was assessed head to toe by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident #145 was transfer to the hospital emergency room on 06/17/22 for further evaluation for possible physica abuse. Resident #145 Responsible Party was notified. The incident was reported to State Agency late approximately 3 hours after the incident. Well check call placed on	I
	Review of the medica following:	I record revealed the		6/20/22.Resident did not return to the facility.	
	Assessment, Result F shift at about 8:30pm the nurse that activity #126]sitting at the F his wheelchair and ha [Resident #108] was f happened due to diag communication deficit assessed from head to of pain/discomfort nor No physical signs of t redness, no bruises a buttocks. [MD's name was given to Transfer room) via 911 for furth physical abuse." It sh to transfer Resident # until 05/26/22 at 4:41 facility after receiving abuse for Resident #	t. [Resident #108] was to toe by the nurse, no sign facial grimace expressed. rauma observed, no round the perineal area and made aware, new order resident to ER (emergency her evaluation for possible ould be noted that the order 108 to ER was not written PM after police came to a call for a call of physical 108			
	resident to ER via 91 <sup>2</sup> possible physical abu				
		ADON Note] - "At about d [two police officers names			

Health Regulation	& Licensing Administration
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		HFD02-0011	B. WING			C 29/2022
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
ERENITY	REHABILITATION AND	HEALTH CENTER L	DUTHERN AVE S			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX TAG	·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLE <sup>-</sup> DATE
L 206	Continued From page	e 58	L 206			09/23/2
	and badge numbers] had a call for alleged room 112-A. Writer re [Resident #126 who r was observed sitting i bedside of [Resident # 3:30pm on 5/25/22. It #126] was observed w front, back, and under also reported that [Re with feces on her thig [Resident #126] was i the scene and [MD's i given to transfer [Res 310-B. Also, [detectiv number] was called to After meeting with the staff members the der [number] [Residen explain what happene cognitive communicat dementia, and Alzhein facility at 17:28pm [5: Review of the facility's st	in the facility who said they abuse for [Resident #108] in accived report from staff that esided in room 147 bed A} in his wheelchair at the #108] room 112-A at about was reported that [Resident with feces on his left-hand rneath his fingernails. It was esident #108] was observed h and her bed spread. immediately removed from name] notified and order ident #126] to Unit 3 - Room e's name and badge the facility by the police. e residents and talking to tective issue report at #108] was unable to ed due to diagnosis of tion deficit, vascular mer's disease left the 28 PM] to [local hospital]"		Resident#145 could not be facility licensed nurse. Resid discharged from the facility Result of the investigation of the State agency via the reporting portal on 7/14/22. Resident #145 suffered no ro outcome from not reporting incident investigation to the Agency within 5 working day Resident #108 was reasses the Unit Manager on 8/17/2 trauma, no apparent injury of Result of the incident inves report was sent to the State reporting portal on 7/14/22. Resident #108 suffered no ro outcome from not reporting incident investigation to the Agency within 5 working day	dent has been on 6/26/2022 report was sent to hegative the result of State ys. sed head to toe by 2for pain and observed. tigation Agency via the hegative the result of State	
	State Agency of the in	ncident of alleged				
	sexual touch [sexual a	happropriate non-consensual abuse] on 05/26/22 at 6:46 2 hours after the incident).				
		interview on 06/28/22				
	(ADON) stated that th	tely 4:00 PM, Employee #3 le State Agency was notified the evening supervisor on				
	05/25/22 failed to not					
	Cross reference 42 C	FR 483.12, F600				
		as admitted on 02/08/22 with				

Health Regulation & Licensing Administration
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Health Re	gulation & Licensing A	dministration				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING:			
			5.14/110			
		HFD02-0011	B. WING		06/2	29/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		1380 SOL	JTHERN AVE S	E		
SERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 2003			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
			-	L206		00/00/0/
L 206	Continued From page	e 59	L 206	Resident #86 was reassessed head to		09/23/22
	multiple diagnoses in	cluding Dementia in other		the Unit Manager on 8/17/22.Result of		
		ewhere without Behavioral		incident investigation report was sent State Agency via the reporting portal		
		ve Communication Deficit,		7/14/22. Resident #86 suffered no neg	ative	
	and Generalized Mus			outcome from not reporting the result of	of incident	
	-			investigation to the State Agency within	n 5	
	Review of the medica	I record revealed the		working days		
	following:			Resident #8 was reassessed head to t	oo hy tho	
	06/17/22 at 5:07AM [I	Physician order] - Transfer		Unit Manager on 8/17/22for		
	resident to ER (emerg	gency) for further		pain and trauma, no apparent injury ot	served.	
	examination due to po	ossible physical abuse.		Result of the incident investigation rep		
				sent to the State Agency via the report		
	06/17/22 at 7:38 AM [	[Nursing Note] - " At 5:00		on 7/14/22. Resident suffered no nega outcome from not reporting the result of		
	AM GNA/CNA was do	oing AM care She		investigation to the State Agency with	n 5	
		nt #126 from] room 310B		working days.		
		Resident #145] in room				
	313B and called write					
		ent was done [for Resident				
		nd writer. No bruises noted,				
		ling noted. Resident denied				
	•	t at this time. Police was				
		cene] An assessment was				
		esponders, and they came				
		nsfer resident to the nearest ) for further evaluation"				
	ER (emergency room					
	During a face-to-face	interview at approximately				
		2 (DON) stated that she				
		eyor (Representative of the				
	State Agency) aware					
		lleged abuse with Resident				
		126. When asked if the				
		d the Department of Health				
	•	onically about the incident?				
	She stated, "No."	,				
		t the facility's staff made the				
		approximately 3 hours after				
	the incident.					
	Cross reference 42 C	ER 483 12 E600				
	ion & Licensing Administrati					

	T OF DEFICIENCIES OF CORRECTION	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		HFD02-0011	B. WING		C 06/29/202	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S		•	
SERENIT	Y REHABILITATION AND	HEALTH CENTER I	UTHERN AVE S GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
L 206	<ol> <li>Facility staff failed investigations to the 3 working days of the in #108, #86, #8, #84 #</li> <li>Resident #145 wa multiple diagnoses in Disease classified els Disturbances, Cognit and Generalized Mus</li> <li>Review of the Facility 06/17/22 at 10:32 AW was informed by the was observed in bed Room 313B[Resid leave the room [Re  no signs of trauma gave orders to transfe ER (emergency room</li> <li>Review of the facility' related to the previou documented evidenc investigation results to Cross reference 42 C</li> <li>Resident #108 wa 12/10/19 with multiple Alzheimer's Disease</li> <li>Review of the FRI da documented, "At 3:30 [Officers names] in th a call for alleged abu Writer received rep observed sitting in his</li> </ol>	to report the results of their State Survey Agency within 5 incident for Residents #145, 112, #303, #304. as admitted on 02/08/22 with including Dementia in other sewhere without Behavioral ive Communication Deficit, scle Weakness. A Reported Incident dated A, documented, " Writer nurse that [Resident #126] with [Resident #145] in ent #126] was redirected to esident #145] was assessed to bserved[MD's name] er [Resident #145] via 911 to h) for further evaluation " s investigative documents usly mentioned FRI lacked e that the facility reported its to the State Survey Agency. CFR 483.12, F600 as admitted to the facility on e diagnoses including and Major Depression. ted 05/26/22 at 11:21 PM,	L 206	Resident #84 was reassessed head the Unit Manager on 8/17/22.Result incident investigation report was sen State Agency via the reporting portal 7/14/22. Resident suffered no negatio outcome from not reporting the resul incident investigation to the State Ag within 5 working days. Resident #112 was reassessed head the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency reporting portal on 7/14/22. Resident #112 suffered no negative outcome from not reporting the resul incident investigation to the State Agency within 5 working days. Resident #303 was reassessed head by the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency reporting portal on 7/14/22. Residen by the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency reporting portal on 7/14/22. Residen no negative outcome from not report result of Agency within 5 working day	of the t to the on ve t of ency d to toe by via the lt of d to toe via the nt suffered ting the	09/23/22

# Health Regulation & Licensing Administration

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLI	
		HFD02-0011	B. WING		C 06/29/202	
	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE. ZIP CODE		
			UTHERN AVE S			
BERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
L 206	Continued From page	9 61	L 206			09/23/2
	was observed with fee [Resident #108] was of thigh and bed spread transferred to Unit 3 . to transfer [Resident a evaluation of possible Review of the facility!s related to the previou documented evidence investigation results to Cross reference 42 C 2c. Resident #86 was 8/28/18 with diagnose	s investigative documents sly mentioned FRI lacked e that the facility reported its o the State Survey Agency.		Resident #304 was reassessed head the Unit Manager on 8/17/22. Result of the incident investigation report was sent to the State Agency reporting portal on 7/14/22. Resident suffered no negative outcome from r reporting the result of incident invest the State Agency within 5 working da Resident #121 was reassessed head the Unit Manager on 8/17/22 for pair trauma, no apparent injury observed Result of the incident investigation report was sent to the State Agency reporting portal on 7/14/22. Resident #121 suffered no negative outcome from not reporting the resul incident investigation to the State Agency within 5 working days.	via the t #304 hot igation to ays. d to toe by h and via the	
	documented, "[Resi #86] in the face"	ted 04/19/22 at 1:14 PM ident #120] hit [Resident		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility ha to be affected.	as potential	
	related to the previou documented evidence	s investigative documents sly mentioned FRI lacked e that the facility reported its o the State Survey Agency.				
	05/26/21 with multiple	der, Delusional Disorder,				
	documented, "At 9:13 arrived at the facility a Room 314 called the hit her neck Assess	ted 10/18/21 at 10:39 AM, B PM, to Metropolitan officers and stated that resident in police and stated that some sment was done, no lumps, a observed on resident's				

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Health Regulation & Licensing Administration
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	egulation & Licensing A FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	ETED
SERENIT		HEALTH CENTER L 1380 SO WASHIN	DDRESS, CITY, STA DUTHERN AVE SE IGTON, DC 2003	E 2		29/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
L 206	neck The alleged a suspended pending in Review of the facility's related to the previou documented evidence investigation results to Cross reference 42 C 2e. Facility staff failed investigation of Resid allegation of neglect t within 5 working days Resident #84 was ad 05/20/21, with multipl Type 2 Diabetes Mell Hemiplegia and Hemi Infarction Affecting Ri Following Cerebral In Organism, Unspecifie Sclerosis, Gastroston Review of a Facility R received on 09/20/21 head to toe assessme left upper back and sa perineal /sacral area water, pat dry and ap each incontinent care leg"	buse [Employee #31] is investigation" is investigative documents sly mentioned FRI lacked e that the facility reported its o the State Survey Agency. FR 483.12, F610 It o report the results of their ent #84's Facility reported o the State Survey Agency of the incident. mitted to the facility on e diagnoses that included: itus Without Complications, paresis following Cerebral ght Dominant Side, Aphasia farction, Sepsis Unspecified d Convulsions, Multiple my Status and Dysphagia. Reported Incident (FRI) , documented, "A complete ent done Multiple scars to acral area. Redness to washed with soap and ply skin barrier cream after , discoloration to left inner	L 206	MEASURES TO PREVENT RECURRENCE: The facility Staff Developer/ Design will provide an education/In-service Director of Nursing (DON), Assistat of Nursing (ADON), Unit Managers and Supervisors on the process of reporting of incident of unusual occ the State Agency within the require stipulated by the CMS regulation & requirement and within 2 hours if se injury occurred. The in-service or education will explain the importance incidences within the required tim stipulated by the CMS regulation & requirement. The compliance date for this intervor The facility Staff Developer/Design education to facility Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers Supervisors on the importance of the importance of ensuring that results the incident investigation report ar the State Agency via the reporting portal /system within 5 working day The compliance date for this intervo 9/23/22. MONITORING CORRECTIVE ACT House wide audit will be conducted Assistant Director of Nursing (ADON)/Designee to ensure report all incidences of unusual occurrence Agency via reporting system timely within 2 hours if seriously bodily in occurred, weekly times 4, then, mor months. The findings of these aud presented monthly for 3 months to Assurance Performance Improvem committee.	to facility th Director a Urrences to ad time as ariously bodily be of reporting the as antion 9/23/22. the will provide and the softhe incider and to sof the incider and to softhe incider and to softhe state and thy times 3 ts will be Quality	ıt.

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Health Regulation & Licensing Administration
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0011	B. WING		00	C 6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER L	OUTHERN AVE SE			
			NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 206	Continued From page	9 63	L 206			09/23/2
	#2 (Director of Nursin findings and stated th investigation results t	at they did not send				
	08/03/20 with diagnos	s admitted to the facility on ses that included: notic Disorder and Anxiety				
	received on 07/19/21 informed by the charg PM) that [Resident # (physical therapist) st night, that she is feeli	Reported Incident (FRI) documented, "Writer was ge nurse at 14:40p.m (2:40 I12] informed the PT saff that she was raped all ng so horrible about this a gun, she can just kill				
	Review of the investig no documented evide reported the results o investigation to the St	f the alleged abuse				
	12/13/21 with diagnos	as admitted to the facility on ses that included: Type 2 ck of Coordination and n.				
	8:30am on Dec. 31st	end of shift rounds at about 2021, writer was informed that during her session this #303] said one of the				
	Review of the investig no documented evide reported the results o investigation to the Si	f the alleged abuse				

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Health Re	egulation & Licensing A	Administration			FORM	1 APPROVED
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0011	B. WING		06/2	) 9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SERENIT	( REHABILITATION AND	HEALTH CENTER L	UTHERN AVE S			
			IGTON, DC 2003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 206	2h. Resident #304 wa 11/02/21 with multiple Low Back Pain, Urina Diabetes Mellitus. Review of a FRI rece documented, "Resid yesterday night [11/0] not respond to her car requested fro (sp) ass (Certified Nurse Aide calls/requests Resimorning she was ass the staff CNA never of the bed" Review of the investig no documented evide reported the results of investigation to the Si During a telephone in 07/14/22 at approxim (Director of Nursing) and stated that they of investigations to the Si 3. Facility staff failed resident-to-resident in #121. Resident #121 was a 02/27/21 with diagnos Stage 4, Paraplegia, of Bladder and Schizer	as admitted to the facility on e diagnoses that included: ary tract infection (UTI), ived on 11/04/21 dent complained that 3/21] her assigned staff did ill light on time when she sistance that the CNA ) was ignoring her ident also reported that this isted to the bathroom but came to assist her back to gation documents showed ence that facility staff of the alleged abuse tate Agency. therview conducted on ately 3:00 PM, Employee #2 acknowledged the findings did not send results of their State Agency. to report a ncident involving Resident dmitted to the facility on ses that included: aure Ulcer of Sacral Region Neuromuscular Dysfunction ophrenia. e made by Resident #121 mented, " Wed 5,2022 @ (at) 1:30 AM I was	L 206	L207 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #108 was assessed head to toe by Licensed nurse on 5/26/22, for pain and trau apparent injury observed. Resident #108 was the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Incident was reported to the State Agency late, approximately 22 hours after the incident. Resident #108 returned to the facility from E visit on 05/27/22. Licensed nurse, performed toe assessment on the resident and no nega outcome from not reporting the incident to the Agency reporting system within the required stipulated by the CMS regulation & requirement. RP/MD notified. Resident #145 was assessed head to toe by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident #145 was transfer to the hospital emergency room on 06/17/22 for further evaluation for possible physical abuse. Resident #145 Responsible Party was notified . The incident was reported to State Agency late approximately 3 hours after the incident. Well check call placed on 6/20/22.Resident did not return to the facility.	ma, no s transfer to R/hospital a head to tive = State	09/23/22

Health Regulation	& Licensing Administration

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HFD02-0011	B. WING		06	C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			UTHERN AVE SE			
SERENII	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 206	Continued From page	9 65	L 206			09/23/2
	screamed and called	an [Resident #] in a bottom side of my bed. I the nurse. He left. The ] came in and said he was				
	Data Set (MDS) date facility staff coded the for Mental Status (BII no potential indicators	121's Quarterly Minimum d 05/16/22 showed that e following: a Brief Interview MS) summary score of 15, s of psychosis and no verbal symptoms directed towards				
	about 2;11am a male room 144 A and was Writer asked [Residen touched her, resident touch me, writer aske you have food on the no he was touching th	[Nurses Note] "Late Entry: At resident wandered into redirected back to his room. nt #121] if the resident stated that no, he did not ed Ms Freeman again, do table, resident answered, ne table and there was no vas trash that was on the				
	Review of the "Grieva Decision/Resolution F documented, " Base grievance/alleged abor confirmed"	Form" dated 05/27/22 ed on these findings, the				
	•	s abuse on the grievance ed to file an incident report of ent incident.				
	06/22/22 at approxim Employees #6 (Unit 1 Employee #6 stated,	Social Worker) and #2, "Once I get a grievance, I and staff involved and get				

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Health Regulation	8 Liconcina	Administration
Health Regulation	a Licensing	Auministration

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			TE SURVEY MPLETED
		HFD02-0011	B. WING		0	C 6/29/2022
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ERENITY	(REHABILITATION AND	HEALTH CENTER L	OUTHERN AVE SE NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 206	given to [Director of S then goes to the Adm At the time of the afo Employee #3 acknow	together a packet and it's Social Services Name] and inistration." rementioned interview, /ledged the findings and eport should've been done	L 206			09/23/2
L 207	3232.5 Nursing Facili	ties	L 207			
	a resident, or inciden resident's funds, shal the appropriate agen Department of Health Department, the Long and Adult Protective 3 This Statute is not m Based on record revis facility staff failed to r resident-to-resident a (inappropriate non-co /willful non-consensu immedailety to the St	a, the Metropolitan Police g Term Care Ombudsman Services. et as evidenced by: ews and staff interviews, eport allegations of illeged/witness sexual abuse onsensual sexual touch				
	The findings included	l: s admitted to the facility on				
	12/10/19 with multiple	e diagnoses including and Major Depression.				
	Review of the medica following:	al record revealed the				
	05/25/22 at 8:59 PM	Situation Background				

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# Health Regulation & Licensing Administration

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · · ·	e survey IPleted
		HFD02-0011	B. WING	B. WING		C 6/29/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
		1380 S	OUTHERN AVE S	E		
SERENIT	Y REHABILITATION AND	HEALTH CENTER I	INGTON, DC 2003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 207	Assessment, Result I shift at about 8:30pm the nurse that activity #126]sitting at the his wheelchair and ha [Resident #108] was happened due to diag communication defici assessed from head of pain/discomfort no No physical signs of t redness, no bruises a buttocks. [MD's name was given to Transfer room) via 911 for furth physical abuse." It sh to transfer Resident # until 05/26/22 at 4:41 facility after receiving abuse for Resident # 05/26/22 at 3:30 PM 3:30pm writer receives and badge numbers] had a call for alleged room 112-A. Writer rec [Resident #126] was observed of front, back, and unde also reported that [Re with feces on her thig [Resident #126] was	Form]- "During the evening writer was made aware by director saw [Resident bedside [of Resident 108] in ad feces on his left hand. unable to explain what gnosis of cognitive t. [Resident #108] was to toe by the nurse, no sign r facial grimace expressed. trauma observed, no around the perineal area and e] made aware, new order r resident to ER (emergency her evaluation for possible ould be noted that the order #108 to ER was not written PM after police came to a call for a call of physical 108 [Physician Order] transfer 1 for further evaluation for	L 207	L207 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the fac potential to be affected.	8	09/23/2

Health Regulation	& Licensing Administration

STATEMEN	egulation & Licensing A T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD02-0011	B. WING		C 06/29/2022
	ROVIDER OR SUPPLIER	1380 SO	NDDRESS, CITY, ST PUTHERN AVE S	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
L 207	310-B. Also, [detectiv number] was called to After meeting with the staff members the de [number] [Residen explain what happene cognitive communicat dementia, and Alzhein facility at 17:28pm [5: Review of the facility's revealed a facility's st State Agency of the ir resident-to-resident ir sexual touch [sexual PM (approximately 22 During a face-to-face starting at approximat (ADON) stated that th on 05/26/22 because 05/25/22 failed to not Cross reference F600 2. Resident #145 was multiple diagnoses im Disease classified els Disturbances, Cogniti and Generalized Mus Review of the medicat following: 06/17/22 at 5:07AM [I resident to ER (emerge examination due to po 06/17/22 at 7:38 AM ] AM GNA/CNA was do	ident #126] to Unit 3 - Room e's name and badge o the facility by the police. e residents and talking to tective issue report at #108] was unable to ed due to diagnosis of tion deficit, vascular mer's disease left the 28 PM] to [local hospital]" is investigative report aff member notified the noident of alleged happropriate non-consensual abuse] on 05/26/22 at 6:46 2 hours after the incident). interview on 06/28/22 tely 4:00 PM, Employee #3 the State Agency was notified the evening supervisor on ify the State Agency. ) a admitted on 02/08/22 with cluding Dementia in other newhere without Behavioral ve Communication Deficit, cle Weakness. If record revealed the Physician order] - Transfer gency) for further possible physical abuse.	L 207	L207 MEASURES TO PREVENT RECURRENCE: The facility Staff Development/ Designee will provide an education /In-service to facility Director of Nursing, ADON, Unit Managers and Supervisors on the process of reporting of incident of unusual occurrences to the State Agency within required time as stipulated by the CMS regulation & requirement. The in-service/education will explain the importance of reporting incidences timely The compliance date for this intervention 9/23/22. The facility Staff Development/Designee will provide education to the facility Unit Managers and Supervisors on the importance of following facility protocol of conducting interviews and obtaining statement from potential witnesses and everyone that wo on that shift during an investigation of all incidences of unusual occurrences, The compliance date for thi intervention 9/23/22.	rk

Health Regulation & Lic	ensing Administration

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/29/2022	
		HFD02-0011				
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST			
	CONDER OR SOLT EIER		JTHERN AVE S			
ERENITY	REHABILITATION AND	HEAI TH CENTER I	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
L 207	Continued From page	69	L 207		09/23/2	
	313B and called write head-to-toe assessme #145] by supervisor a no skin tear, no bleed pain or any discomfor called on the seen [so done by emergency re to a conclusion to tran ER (emergency room During a face-to-face 8:45 AM, Employee # was making the surve State Agency) aware resident-to-resident a #145 and Resident #7 facility's staff informed (State Agency) electro She stated, "No."	ent was done [for Resident nd writer. No bruises noted, ing noted. Resident denied t at this time. Police was sene] An assessment was esponders, and they came hafer resident to the nearest ) for further evaluation" interview at approximately 2 (DON) stated that she eyor (Representative of the of the incident of lleged abuse with Resident 26. When asked if the d the Department of Health bonically about the incident? t the facility's staff made the approximately 3 hours after		MONITORING CORRECTIVE ACTION: The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of incidence of unusual occurrences vial State Agency reporting system within required time as stipulated by the CMS regulation & requirement and within 2 hours if seriously bodily injury occurred. weekly times 4, then, monthly times 3 months. The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of unusual occurrences to ensure investigation was conducted and potential witnesses and everyone that work on that shift are interviewed and statement are obtained weekly times 4, then, monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. L410 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The bathroom vents that were soiled in		
L 410	3256.1 Nursing Facili	ies vide housekeeping and	L 410	resident rooms #115 and #214 were cleaned on 6/24/22 by the facility housekeeping staff. Residents in room #115 and #214 were reassessed on 8/17/22 and suffered no negative outcomes.		
	maintenance services exterior and the interior sanitary, orderly, com- manner. This Statute is not mo- Based on observation failed to provide hous necessary to maintair	a necessary to maintain the or of the facility in a safe, fortable and attractive et as evidenced by: is and interview, facility staff		The Privacy Curtains in residents rooms 110B, 229, 244A, and 313B, were replaced with curtains in good condition on 06/29/22. Resident #110B, #212A, #229, #244A, and #313B were reassessed on 8/17/22, they suffered no negative outcome. Resident room 229 bathroom was cleaned and sanitized on 6/28/22 by the facility housekeeping staff. The oxygen concentrator in resident room 212A was cleaned on 6/29/22		

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Health Re	egulation & Licensing A	Administration			FORM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0011		A. BUILDING: COM		(X3) DATE SURVEY COMPLETED		
				C 06/29/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CEDENITY	REHABILITATION AND	1380 SO	UTHERN AVE S	E		
SERENIT	REHABILITATION AND	WASHIN	GTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	N SHOULD BE COMPLETE E APPROPRIATE DATE	
L 410	Continued From page	e 70	L 410	L410	09/23/22	
	vents in three (2) of 3 privacy curtains in fou a worn out, dirty floor bathroom, and one (1 concentrator in one (1 Concentrator in one (1 The findings include: During an environment facility on June 14, 20 AM, and on June 24, and 1:00 PM the follo 1. Bathroom vents we #115 and #214, two (2 2. Privacy curtains we resident's rooms inclu #244A and #313B 3. The floor in the batt resident's rooms (#22 4. The oxygen concent #212A, one (1) of 34 throughout These observations we Employee #43 and/or face-to-face interview approximately 3:00 P 3258.13 Nursing Facil	4 resident's rooms, soiled ur (4) of 34 resident's rooms, in one (1) of 34 resident's ) of one (1) dusty oxygen 1) of 34 resident's rooms. That walkthrough of the 022, at approximately 11:00 2022, between 10:50 AM wing were observed: ere soiled in resident rooms 2) of 34 resident's rooms. ere soiled in four (4) of 34 uding rooms #110B, #229, throom of one (1) of 34 P(9) was soiled throughout. Intrator in Resident room resident's rooms, was dusty were acknowledged by Employee #44 during a on June 27, 2022, at M. lities	L 442	L410 IDENTIFICATION OF OTHERS WITH THE POTEN BE AFFECTED: All residents residing in the facility has potential to be affected. MEASURES TO PREVENT RECURRENCE: The facility housekeeping Supervisor / Designee will conduct weekly visual audit of all faci vents to ensure they are clean and free from dust. / identified during this audit will be corrected by 09/23 Education will be provided to facility housekeeping staff by the facility Staff Development on importance of maintaining a safe of comfortable environment by 9/23/22. The facility Housekeeping Department head / Desig conduct grand rounds on week days to ensure that maintain a safe, clean, comfortable environment. Any issues identified duri grand round will be corrected by 9/23/22. Education will be provided to facility Licensed Nurse facility Staff Development on importance of maintaining a clean and dust free Ox concentrator for the resident use by 09/23/22 MONITORING CORRECTIVE ACTIONS: The facility housekeeping Supervisor / Designee will conduct visual audit of all facility room ensure they are clean and free from dust. This audit will be done weekly times 4 and then mo 3. The facility housekeeping Supervisor / Designee will visual audit of all facility residents' rooms to ensure curtains are clean and intact. This audit will be done times 4 and then monthly times 3. The facility housekeeping Supervisor / Designee will visual audit of all facility residents' rooms to ensure bathrooms floors are clean. This audit will be done times 4 and then monthly times 3. The Assistant Director of Nursing and Unit Manage conduct house wide audit of Oxygen concentrators rooms to ensure that they are clean and free of dus will be done weekly times 4 then monthly times 3. Findings will be corrected immediately and reporte Assurance Performance Improvement QAPI comm	NTIAL TO	
	The facility shall main mechanical, electrical equipment in safe ope This Statute is not m	l, and patient care erating condition.		Assurance Performance Improvement QAPI comm	ittee.	
lealth Regula	tion & Licensing Administrati	on	1		I	

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Health Regulation & Licensing Admin	istration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/29/2022		
		HFD02-0011					
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		1380 SO	UTHERN AVE SE				
SERENITY	REHABILITATION AND	HEALTH CENTER L WASHIN	IGTON, DC 2003	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 442	Continued From page 71		L 442			09/23/2	
	Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) conveyor dishwasher that failed to automatically move peg racks filled with cups, dishes, silverware and/or food trays through the machine. The findings include: During observations in dietary services on June 21, 2022, at approximately 11:00 AM, one (1) of one (1) conveyor dishwasher failed to automatically move soiled items through the machine. to ensure proper wash, proper rinse, and proper final rinse of peg racks filled with cups, dishes, silverware and/or food trays. Consequently, the necessary parts were ordered, and the dishwasher was repaired on June 22, 2022.			L 442 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT The dishwasher was repaired on June 22, 2022. No negative outcome observed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All facility essential equipment and patient care equipment have potential to be affected. MEASURE TO PREVENT RECURRENCE: The facility Staff Development will provide education/in-services to the facility maintenance staff a Kitchen staff on importance of maintaining essential and patient care equipment in safe condition. MONITORING OF CORRECTIVE ACTION: The Director of Maintenance/Designee will complete house wide audit of all facility essential and patient care equipment to identify potential equipment that is not maintained in a safe condition weekly times 4, then mor times 3 months. The findings of these audits will be presented monthly f months to Quality Assurance Performance Improvement (QAPI) committee.		/	
L 521	Employee #42 during June 21, 2022, at app 3269.1d Nursing Fac (d) To be treated with assured privacy durin receiving personal ca This Statute is not m Based on record revis staff failed to provide evidenced by not prov	ilities respect and dignity and g treatment and when re; et as evidenced by: ew and interview, the facility dignity for a resident as viding personal care a timely manner for one (1)	L 521	L 521 CORRECTIVE ACTION FOR AFFECTED Incontinent care was provided to Resident#256 by the licensed nurse on 6/26/22 after being notified by Resident #256. Resident #256 was reassessed head- toe on 8/17/22 by the Unit Manager/Designee, Resident suffered no negative outcome. The assistant director of nursing/unit mana house wide audit to ensure that assigned n assistant, provide incontinent care in a time residents that require assistance with incor Any negative findings will be corrected by S UDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with requiring assistance with incontinent care have the potential to be affected.	ger will conduct ursing ly manner to all tinent care. J/23/22.		

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Health	Regulation	& Licensin	q Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>		TE SURVEY MPLETED
		HFD02-0011	B. WING		C 06/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		1380 SO	UTHERN AVE SE		
SERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 2003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 521	••••••••••••••••••••••••••••••••••••••		L 521	L 521	09/23/2
	06/10/22 with multiple Diarrhea, Recurrent E	Interocolitis due to C Diff) and Generalized		MEASURES TO PREVENT RECURRENCE: Education will be provided to all facility staff by the Facility Staff Development on resident rights which includes treating each resident with dignity and respect and providing care in timely manner by 09/23/22	
	to the facility at 6:45 F hospital]with discha Colitis abdominal pa summary [Resident's PO (by mouth) Vanco days" 06/13/22 [Concerns a by resident's sister - " residents' needs. The to lay for hours in her answering the call [lig [Resident #256] wash 06/15/22 [Admission 1 the resident had a Bri Status summary scor resident was cognitive #256 was coded for b the physical assistant and always being inco	rge diagnoses of C Diff ain and diarrheadischarge name] is C diff positive on mycin [antibiotic] for 14 nd Comment Form] written They are not staffed to meet y allowed [resident's name] fecese [feces]. They are not ht] when button pushed. ed at 3:00 PM" Winimum Data Set] showed ef Interview for Menatal e of "15", indicating the ely intact. Also, Resident eing totally dependent on ce of one person for toileting		The facility Unit managers and the facility Nursing Supervisors will make frequent rounds on the units on their shifts and ensure incontinent care and ADL care are provided timely to residents. Any issues found will be corrected by 9/23/22. The facility Charge nurses will ensure that all residents are provided ADL care daily and ensure residents are treated with dignity and care on every shift. Any issues found will be corrected by 9/23/22. MONITORING CORRECTIVE ACTIONS: The Assistant Director of Nursing and Unit Managers will conduct house wide audit to ensure that facility assigned Nursing Assistant provide incontinent care in a timely manner to residents that require assistance from the facil staff for incontinent care. Any issue found during this audit will be corrected by 09/23/22.	all
	Focus area - [Resider (activities of daily livin deficit r/t (related to) p weakness.	g) self-care performance			
	Intervention:				

Health Regulation	& Licensing Administration
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STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HFD02-0011	B. WING		06	C 6/ <b>29/2022</b>
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE			
			UTHERN AVE SE	, 211 0002		
SERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 521	Continued From page	e 73	L 521			09/23/22
						00/20/22
	with personal hygiene	<ul> <li> assistance by one staff</li> <li>and oral care.</li> </ul>				
	During a face to face	interview on 06/14/22 at				
		M, Resident #256 stated				
	• •	residents terribly. When				
		t mean? Resident #256				
		in my stool for 5 hours." The				
	resident said that she	e called the desk several				
	times [Employee #31	], came in and threw the				
	supplies to clean her	on the foot of her bed, and				
	•	residents [breakfast] and				
	would come back wh					
		I that staff did not provide				
	1:00 PM and started	ame to the facility around complaining.				
	During a telephone in	terview on 06/14/22 at				
	approximately 1:10 P	M, Resident #256's sister				
		ted that she was on the				
		ent around 8:00 AM or 9:00				
		an employee [Employee #31]				
		e the resident after she				
		r residents. The complaint				
		er sister kept calling her ged, she came to the facility				
		complained to staff, and				
		bassador changed her sister.				
	During a face-to-face	interview on 06/24/22 at				
	-	#28 (Manager-on Duty, LPN)				
		to the floor around 1:00 PM				
	and noticed that the r	esident's light was on, and				
		. The resident informed her				
		e changed, so she provided				
		gave the family member				
	[sister] a Concerns a					
	document her concer	ns.				
	During a face-to-face	interview on 06/27/22 at				
th Regulat	tion & Licensing Administrati					<u> </u>

Health Regulation & Licensi	ing Administration

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
		HFD02-0011	B. WING		C 06/29	9/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	ATE, ZIP CODE		
			JTHERN AVE S			
SERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLET DATE
L 521	Continued From page	e 74	L 521			09/23/2
	that Resident #256 put times when she started the resident didn't tell needed to be changed "I told her [Resident # passing trays. I'll char When asked if she ch was incontinent, Emp know if she was incor pass my trays and I d 10:00 AM." Additional at 10:00 AM security a speaker to report to R resident wanted to be interview revealed that resident. During a face-to-face 2:00 PM, Employee # stated that she spoke family member and ap	at [Resident 28] changed the interview on 06/27/22 at 21 (RN/Unit Manager) with the resident and the pologized for staff not care for multiple hours. aid she talked with -educated her on tts and attending to		L 529 CORRECTIVE ACTION FOR AFFECTED F Resident #108 was assessed head to toe by the facility licensed nurse on 5/26/22 of pain/discomfort nor facial grimace express physical signs of trauma observed, no reduc bruises around the perineal area and buttocks. Resident was tr to the hospital emergency room on 5/26/22 further evaluation. Resident returned to the from ER/ hospital visit on 05/27/22. License performed a head to toe assessment on the and no negative outcomes were found on 5 Resident #145 was assessed head to toe by the facility licensed nurse on 06/17/22 fo and trauma, no apparent injury observed. R transferred to the hospital emergency room 06/17/22 for further evaluation. Responsible	2, no sign sed. No ess, no ansferred for facility d nurse resident /27/22. or pain esident on Party	
L 529	3269.1l Nursing Facili		L 529	was notified of the transfer on 6/17/22. Resi never returned back to the facility. A well ch was done with the RP on 6/20/22. The RP also said that Resident #145 will no be returning to the facility and that she is	eck call	
	(I) To be free from me	ntal or physical abuse;		currently seeking a new placement for resident. Resident #145 never returned bac facility.	k to the	
	facility's staff failed to residents in the samp were free from alleged	et as evidenced by: ew and staff interview, the ensure two (2) of seven (7) le with allegations of abuse, d/witnessed non-consensual I abuse] by Resident #126.				

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### Health Regulation & Licensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD02-0011	B. WING		C 06/29/2022
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
			OUTHERN AVE S		
ERENITY	REHABILITATION AND	HEALTH CENTER L	IGTON, DC 200		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
L 529	Continued From page	e 75	L 529		09/23/2
	(Residents #108 and The findings included	,		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected.	
	Abuse", with a revision sexual abuse as " n contact of any type w	s policy titled, "Prohibition of on date of 05/22, defined ion-consensual sexual ith a resident includes but is narassment coercion or		MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Development /designee to all facility staff on abuse prohibition by 9/23/22 In-service will be provided by Staff	
	05/07/21 with multiple	order and Dementia without		Development /designee to all facility staff about care plan intervention in place for residents with sexual behavior, behavior with the potential to abuse others, and wandering behavior.	
	the following: 03/02/22 [Quarterly M Resident #126 had a Status (BIMs) summa the resident was unal assessment. The resi	t's medical record showed linimum Data Set -(MDS)] - Brief Interview for Mental ary score of "99", indicating ble to complete the ident was not coded for havior symptoms directed		Development /designee to all Licensed Nursing staff on the importance of ensuring that residents identified with sexual behavior have a person-centered care plan that clearly state the type of behavior they are exhibiting and that they are always provided supervision to prevent such behavior. Repeat in-service will be provided as needed.	,
	toward other (ie. abus review of the MDS sh coded for using a whe	navior symptoms directed sing others sexually). Further lowed the resident was eelchair, not walking in room ng frequently incontinent of		Charge nurses will ensure that residents identified with sexual behavior, or behavior with the potential to abuse others, and wandering behavior have adequate supervision and monitored during all shifts, and that there is documentation in place for any behavior observed. Any issues found will be corrected by	
	" Resident last seen room in his bed wash PM writer was inform [Resident #126] wand staff redirection. Activ observed [Resident # at the bedside of [Res	[Nursing Supervisor's Note] - h by writer at 8:15 PM in his ing [watching] TV. At 8:35 ed by assigned nurse the dered in Room 112 despite vity Director reported that he 126] sitting in his wheelchair sident #108] [Resident BM (bowel movement) on		09/23/22.	

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Tiouna	Regulation & Licensing /	Administration			
	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD02-0011	B. WING		C 06/29/2022
NAME O	F PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	-
		1380 SO	UTHERN AVE SI	,	
SEREN	ITY REHABILITATION AND	HEALTH CENTER L	GTON, DC 2003	2	
(X4) II PREFI TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
L 5	his left hand [MD's relocate [Resident #1 wandering behavior, disturbances. [Reside [Room] 310-B. [Reside monitored for safety evaluation" 05/27/22 at 7:00 AM "Patient seen to eval adjust medications fo He was counseled other people's person others inappropriately to respect other peop not to touch anyone if receptiveHis Sertra increased to 50 mg ( depression and comp wandering or touchin 06/02/22 [Quarterly M Resident #126 had a Status (BIMs) summa the resident was sever resident was not cod behavior symptoms of abusing others sexual MDS showed the resident was coded ff feet tall. 06/13/22 at 1:47 PM [12:00 PM] resident of pacing the hallway w other resident's room all times by staff. NP	s name]order given to [26] to another unit for psych consult for behavioral ent #126] was transferred to dent #126] will be closely precautions pending psych [Psychiatric NP Note] - uate mental status and or behavioral disturbances about the risk of invading hal spaces or touching y. He was also encouraged oles' personal spaces and nappropriately; and he was alin [antidepressant]was milligrams) to control his	L 529	Unit Managers and Shift Supervisors will conduct rounds during their shift to ensu that resident with sexual behavior, behavior with the potential to abuse other and wandering behavior are monitored and adequate supervision is provided. Any issues found will be corrected by 9/23/22. MONITORING CORRECTIVE ACTION: House wide audit will be conducted by Assistant Director of Nursing (ADON)and Unit Managers to identify residents demonstrating sexual behavior, with the potential to abuse others, and residents who wander to ensure that appropriate care plans are established consistent with the exhibited behaviors ar provided with adequate supervision to ensure such behavior is prevented. Any issue found during this audit will be addressed by 9/23/22 Unit Mangers and Shift Supervisors will conduct rounds during their shift to ensu that resident with sexual behavior, behav with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Rounds /audit will be conducted weekly ti 4 then monthly times 3.	re rs, I nd re vior

Health Regulation & Licensing Administration

# Health Regulation & Licensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD02-0011	B. WING		C 06/29/2022	2
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1380 SO	UTHERN AVE SE			
ERENII	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		X5) PLET ATE
L 529	Continued From page	277	L 529		09/2	3/2
	consult for behavioral	disturbances"				
	Medication Administra Treatment Administra documented evidence re-evaluated by psych rooms as ordered by 06/17/22 at 8:04 AM [ "At about 5:40 AMv [Resident #126] was [Resident #145]ME #145] to ER for furt name and Detective's interviewed writer, [R nurseand said they investigation" Review of Treatment (TAR) from 05/01/22 to documented hourly th facility. Further review that on 06/17/22 at 5:	tion Records lacked e Resident #126 was n for wandering in residents' NP on 06/13/22. [Nursing Supervisor's Note] - writer was informed by nurse				
	bed at that time.	n with a revision date of				
	manner in which resid inappropriate sexual I resident touches othe inappropriately Sta	nt #126] have problematic dent acts characterized by behavior physical related to: or residents &/ or staff ff reported that [Resident fn top of [Resident #145] in				
	Goal- [Resident #126 of inappropriate sexua tion & Licensing Administrati					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			С
		HFD02-0011	B. WING		06	5/29/2022
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ERENITY	REHABILITATION AND	HEALTH CENTER L	OUTHERN AVE SE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (	OF CORRECTION	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	O THE APPROPRIATE	COMPLETE DATE
L 529	Continued From page	e 78	L 529			
	Interventions:					09/23/2
		nts if unable to protect				
	themselves					
		ing X 24 hours every day for				
	safety precautions. -Remove resident fro	m public area when				
	behavior is disruptive	-				
	NOTE: Please see in	terviews below for the				
	previously mentioned	l incidents involving				
	Residents #108 and	#145.				
		ailed to keep Resident #108				
		126's alleged inappropriate				
	non-consensual sexu	iai louch.				
	Resident #108 was a	dmitted to the facility on				
	12/10/19 with multiple					
	Alzheimer's Disease	and Major Depression.				
	Review of a Facility F	•				
		05/26/22 at 11:21 PM,				
	documented, "At 3:30 [Officers names] in th	e facility who said they had				
		se for [Resident #108]				
		ort that [Resident #126] was				
	0	s wheelchair at the bedside				
		m 112 A at about 8:30 PM eported that [Resident #126]				
		ces on his left hand				
		observed with feces on her				
		[Resident #126] was				
		[MD's name] gave orders #108] to ER for further				
	evaluation of possible	-				
	Review of the resider	nt's medical record showed				
	the following:					

Health Regulation	& Licensing Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0011	B. WING			C 5/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		1380 SC	OUTHERN AVE SE			
SERENIII	REHABILITATION AND	WASHIN	NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 529	Continued From page	e 79	L 529			09/23/2
	Interview for Mental S score of "99" indicatin complete the assesser MDS showed Residen totally dependent on to two staff members for member for personal also coded for always and bowel. 05/25/22 at 5:03 PM [ Report: When prepari [Employee #26 Activit [Resident #126] sittl bedside of [Resident # [Employee #26] obse #126's] left hand front fingernails. Feces was #108's] thigh and her #126] was immediate and relocated to Un be noted that this in a	ident #108 had a Brief Status (BIMs) summary og the resident was unable to ment. Further review of the nt #108 was coded for being the physical assistance of r bed mobility and one staff hygiene. Resident #108 was a being incontinent of urine [Activity Note]- "Incident ing to leave for the evening I ties Director] found ing in his wheelchair at the #108] in room 112-A. Writer rved feces on [Resident t, back, and underneath his s also noticed on [Resident bed spread. [Resident ly removed from the scene iit-3 room 310-B." It should a late entry note that was at 5:16 PM (approximately 2				
		t) with an effective date				
	"During the evening s was made aware by t Director saw [Resider [Resident #108's] roo sitting at the bedside	nt #126] in resident`s m. [Resident #126] was in his wheelchair and had				
	assessed from head t observed. No sign of expressed upon asse was assisted with inco					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
			A. BOILDING.			С
		HFD02-0011	B. WING		0	6/29/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
ERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SE GTON, DC 20032			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
L 529	Continued From page	e 80	L 529			09/23/2
	Pm(pulse) 74, R18, C air), T (temperature) 9 this in a late entry not 05/27/22 at 7:33 AM	BP (blood pressure) 122/67, 02 (oxygen) 99% ra (room 97.8. It should be noted that te that was created on (approximately 2 days after effective date 05/25/22 at				00,20,2
	Assessment, Result I shift at about 8:30pm the nurse that Activity #126]sitting at the his wheelchair and ha [Resident #108] was happened due to diag Communication Defic assessed from head of pain/discomfort no No physical signs of t redness, no bruises a buttocks. [MD's name was given to transfer room) via 911 for furth physical abuse." It sh to transfer Resident # until 05/26/22 at 4:41	cit. [Resident #108] was to toe by the nurse, no sign r facial grimace expressed. trauma observed, no around the perineal area and e] made aware, new order resident to ER (emergency her evaluation for possible bould be noted that the order #108 to ER was not written PM after police came to a call for a call of physical				
		[Physician's Order] "transfer 1 for further evaluation for ıse"				
	3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re	[ADON Note] - "At about ed [two police officers names in the facility who said they abuse for [Resident #108] in eceived report from staff that resided in room 147 Bed A				

Health Regulation	& Licensing Administration

STATEMENT	egulation & Licensing A FOF DEFICIENCIES DF CORRECTION	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0011	B. WING		06	C 5/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE			
			OUTHERN AVE SE			
SERENITY	Y REHABILITATION AND	HEALTH CENTER L	NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 529	Continued From page	e 81	L 529			09/23/22
	was observed sitting bedside of [Resident 8:30pm on 5/25/22. It #126] was observed of front, back, and unde also reported that [Re with feces on her thig [Resident #126] was the scene and [MD's given to transfer [Res 310-B. Also, [Detection number] was called to After meeting with the staff members the de arrest was made. How gave order to transfer (emergency room) via for possible physical	in his wheelchair at the #108] Room 112-A at about was reported that [Resident with feces on his left-hand rneath his fingernails. It was esident #108] was observed h and her bed spread. immediately removed from name] notified and order sident #126] to Unit 3 - Room				
	#108] returned from [ 5:10am The media from the hospital state assault was observed doctor and she is free treatment active prior During multiple obser 06/22/22 from approx PM, Resident #108 w	[Nursing Note] - "[Resident local hospital] at about c who accompanied her ed no evidence of physical d after examination by the e to resume all activities and to transfer to the ER" vations from 06/19/22 to trimately 11:00 AM to 4:00 vas observed in bed sleeping responding to verbal stimuli. on- interviewable.				
aalth Paquia	3:00 PM, Employee # that he was made aw					

Health Regulation	& Licensing Administration
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			TE SURVEY MPLETED
		HFD02-0011	B. WING			C 06/29/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE		
			OUTHERN AVE SE	, 2 0002		
ERENITY	REHABILITATION AND	HEALTH CENTER L	NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
L 529	Continued From page	82	L 529			09/23/2
	Resident #121). The	omployee stated on				09/23/2
		ately 8:00 PM, he went to				
		6's and could not find him in				
		e hallway where he usually				
		n other residents. Employee				
		ted the nursing staff, and				
		g for the resident. The				
		nd Resident #126 in Room				
		elchair at the bedside of				
		vas in bed A. The employee				
	then called nursing st	aff to Room 112 and moved				
	Resident #126 into th	e hallway.				
		ealed Employee #26 asked				
	-	vas in Resident 108's room,				
		d not provide an answer.				
		bserved the resident with				
		. The employee asked the				
		owel movement, and the owever, when he went back				
		he nursing staff, he noticed				
		pread had stool on it. When				
		108 say anything, He stated,				
		" Additionally, the employee				
		#126 was moved to the third				
	floor 310B after the in	icident.				
		interview on 06/23/22 at				
		<sup>t</sup> 3 (ADON) stated that the				
		t #126 and Resident #108				
		morning stand-up meeting				
		r, he was unaware the				
		al assault until he saw the				
		n 05/26/22 responding to a				
	•	e" against Resident #108.				
		ed the police, Employee #3				
		now. Additionally, the				
		de the physcian aware and transfer Resident #108 to				
	was olved an order in		1			1

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## Health Regulation & Licensing Administration

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0011	B. WING		00	C 6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		1380 SC	UTHERN AVE SE			
SERENIT	(REHABILITATION AND	HEALTH CENTER I	IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
L 529	Employee #25 (CNA) Resident #126 when Room 112. Resident is hallway with stool [fec also observed Reside she had stool [feces] stomach and thighs." provided incontinent of When asked did Resi employee said, "No", had tears rolling down Additionally, the empl assisted Resident #11 resident kept trying to leg. When she asked the resident said, "Dir was not dirt; it was sto stated, "I changed hir was not incontinent o his hand." The emplo the next day [05/26/2 anonymous call." Review of records an that the facility's staff #108 was safe from F	interview on 06/24/22, stated she was looking for Employee #26 called her to #126 was sitting in the ces] on his left hand. She ent #108 "diaper was off, and smeared all over her The employee said she care for Resident #108. dent #108 say anything, the she doesn't talk. She just	L 529	DEFICIENCY		09/23/2
	safe from Resident # non-consensual sexu					
	multiple diagnoses in Disease classified els	dmitted on 02/08/22 with cluding Dementia in other ewhere without Behavioral ve Communication Deficit,				

Health Re	egulation & Licensing A	Administration				
STATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			-			
			D WINC		C	
		HFD02-0011	B. WING		06/2	9/2022
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA			
SERENITY	Y REHABILITATION AND	HEALTH CENTER L	UTHERN AVE SE			
		WASHIN	GTON, DC 2003	2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
L 529	Continued From page	<b>8</b> 4	L 529			
		5 0 -				
	and Generalized Mus	cle Weakness.				
	Review of the Facility	Reported Incident				
		06/17/22 at 10:32 AM,				
		er was informed by the				
		#126] was observed in bed				
	-	in Room 313B[Resident				
	#126] was redirected					
	-					
		assessed no signs of				
		D's name] gave orders to				
	transfer [Resident #1					
	(emergency room) for	r further evaluation "				
	Review of the medica	al record revealed the				
	following:					
	05/06/22 [Quarterly N	1inimum Data Set -MDS] -				
	revealed the following	g: Resident #145 had a Brief				
		Status summary score of				
	"99" indicating the res	•				
	-	ment. Further review of the				
		nt #145 was coded for				
		ssistance of one staff person				
	for bed mobility, trans	•				
		sident was coded for being				
	93 pounds and 5 feet	lan.				
		Physician order] - Transfer				
	resident to ER (emerg					
	examination due to p	ossible physical abuse.				
		[Nursing Note] - "At 5:00				
	AM CNA [Employee					
		he Resident in [from] room				
	310B [Resident #126]	] was on top of the [Resident				
	#145] in room 313B .	Writer called the supervisor				
		other staff on the floor.				
	-	I the resident [Resident				
		tiated a 1:1 (one-to-one)				
	-	vitaring until further potice				

around the clock monitoring until further notice. A

Health Regulation & Licensing Administration

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
ID PLAN O	FORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			PLETED
		HFD02-0011	B. WING		06	C 5/29/2022
ME OF PF	OVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		1380 SOL	JTHERN AVE SE			
	REHABILITATION AND	WASHING	GTON, DC 20032			
(X4) ID			ID			(X5) COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	) THE APPROPRIATE	DATE
L 529	Continued From page	2.95	L 529	DEHOL		
L 020			2 323			
		ent was done [for Resident and writer. No bruisesskin				
		I. Resident denied pain or				
		s time. Police was called on				
		ergency responders were				
		cene] too. An assessment				
		ncy responders, and they				
	, ,	to transfer resident to the				
		er evaluation per physician's				
		party was notified. V/S (vital				
		P 142/67 R 18 O2SAT 98%				
	Room Air."					
		[Nursing Supervisor Note]-				
		iter received a call from				
	[Resident #126's nam					
		eport to the third floor ASAP				
	,	). When writer arrived on the				
		[Resident #126's name]				
	-	He had his gown on and he				
		r. Writer was informed by the				
	-	#126] was observed in the				
	bed with [Resident #1					
	•	se, [Resident #126] was				
		ed to leave the [his] room assessed by writer and the				
	• •	he floor. Her skin warm and				
	dry to touch, she den					
	•	s of trauma observed as				
	-	and cooperativebrief was				
	intact and appropriate	-				
		the other nurses could not				
		an open brief on full head to				
		D (medical doctor) gave				
		a 911 to ER for further				
		[Resident #145] left facility				
	06/17/22 at 8:32 AM	[Situational Background				
		Louranonal Daokground,				

ATEMENT	egulation & Licensing A OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
ND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
		HFD02-0011	B. WING		06	C 5/29/2022
AME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1380 SO	UTHERN AVE SE	,		
ERENITY	REHABILITATION AND	HEALTH CENTER L WASHIN	GTON, DC 20032			
(X4) ID			ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLET DATE
L 529	Continued From page	e 86	L 529			
	documented, " At a	about 5:40 AM writer was				
	informed by the nurse	e that [Resident #126] was				
		with [Resident #145] in				
		ent #145] was assessed no				
	signs of pain express					
		moisture/urine observed nt #145] left facilityto ER				
	-	er's name and Detective's				
		y and interviewed writer				
		Employee #14], and				
	[Resident #126]"	[p.of co // · ·], ee				
	06/17/22 at 10·26 AM	1 [Unit Manager Note]-				
		pllow-up) call to the RP				
		to notified about the resident				
		sferto ER for further				
	examination due to p	ossible physical abuse."				
		[Attending Physician Note] -				
	•	orted that during monitoring				
		sident [Resident 126] was				
		ident [Resident #145] early				
		? [06/17/22] Resident been evaluated by assault				
		the acute care hospital				
	emergency departme	•				
		She has requested another				
	facility for resident'					
	Review of witness sta	atements showed the				
	following:					
		#15 - CNA] documented, "I				
		esident #126] hourly. He				
		n the hall by room 313 b all				
		arted rounds, when I came				
		noticed 313 [Resident #145]				
	B [Resident #126] na	d, I opened the and saw 310 ked on top of 313 B				
	[Resident #145]."					
	tion & Licensing Administrati					

Health Regulation & Lice	ensing Administration		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
	HFD02-0011	B. WING	C 06/29/2022
NAME OF PROVIDER OR SUPP	JER STR	ET ADDRESS, CITY, STATE, ZIP CODE	
SERENITY REHABILITATIO	138 N AND HEALTH CENTER L	SOUTHERN AVE SE	
	WA	HINGTON, DC 20032	
PREFIX (EACH DI	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE / TAG CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
L 529 Continued Fro	m page 87	L 529	
<ul> <li>"Around 5:40, room 313 B 310 B on top to 313 B other resident [Resi [Resident #14]</li> <li>06/17/22 [Emg "Around 5:40 helpwent to #126] was on #145] NAKED</li> <li>06/17/22 [Emg "Around 5:40 and #16] I was [313] where I son [Resident #16] I was [313] where I son [Resident #16] from [Employe third floor ASA arrived on the walking to his he was wearing informed by [Ewas observed room 313 B"</li> <li>During a face-approximately (assigned num #15] was very When she arrived on the arrived on the mathematical structure in the structure i</li></ul>	ployee #16, RN] documented, [AM] [Employee #14] was calling fo Room 313 Bsaw [Resident top of Resident 313 B [Resident " ployee #19, LPN] documented, [AM] the 2 nurses [Employee #14 s working with called me to room saw [Resident #126] naked sitting		
lealth Regulation & Licensing Ad		, I	I

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(X5) COMPLETE

DATE

(X3) DATE SURVEY COMPLETED С 06/29/2022

	egulation & Licensing A				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) [
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		C
		HFD02-0011	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
0-0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		1380 S	OUTHERN AVE SE		
SERENII	REHABILITATION AND		NGTON, DC 20032		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIC	
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	RIATE
TAG L 529			TAG L 529		RIATE
-	Continued From page				RIATE

During a face to face-to-face interview on 06/17/22 at approximately 9:15 AM. Resident #126 stated that he went to Resident #145's room naked, sat on her bed, rubbed her legs, then pull her gown up and open her incontinent pad and laid on top of her. When asked, if she [Resident #145] invited him in her room? Resident #126 stated, "No". When asked, what did [Resident #145] do when he laid on top of her? Resident #126, stated, "She didn't do nothing and didn't say anything". When asked, why did he lay on top of [Resident #145] if she didn't invite him in her room? Resident #126 stopped answering questions.

dress and escorted him to his room.

During a face-to-face interview on 06/17/22 at 3:00 PM, Employee #45 (Unit Manager) stated that Resident #126 was recently [05/26/22] moved to her floor from the first floor after staff suspected that he inappropriately touched a female resident. The employee then said that the staff consistently monitored Resident #126 for inappropriate sexual behavior. When asked if she provided staff education about Resident #126's alleged inappropriate behavior after he moved to the floor? The employee stated that she did but did not have documented evidence of what she taught to staff.

During a face-to-face interview on 06/17/22 at approximately 3:30 PM, Employee #22 (Temporary Nursing Aide), stated that she worked on the floor since April 2022. The employee said that she was not provided any education about Resident #126 when he was moved to the floor.

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FZSW11

Health Regulation & Licensing Administration

STATE FORM

Health Regulation	& Licensing	Administration
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Health Regulation & Licensing Administration           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMFLETED	
		HFD02-0011	B. WING		C 06/29/2022	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ERENITY	REHABILITATION AND	HEALTH CENTER L	UTHERN AVE S GTON, DC 2003			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
L 529	Continued From page	e 89	L 529		09/23/2	
	approximately 7:30 A stated that she worke years. The employee provided any education when he was moved					
	approximately 7:45 A stated that she has w years. The employee any education about moved to the floor. It Employee #25 worke	interview on 06/22/22 at M, Employee #25 (CNA) vorked on the floor for 5 said she was not provided Resident #126 when he should be noted that d the morning of 06/17/22 was observed naked on top				
	approximately 4:00 P stated that she provid needed, and when th facility. When asked o staff after Resident # floor for allegedly inal female resident? She provide education to Review of records an that the facility's staff	d staff interviews revealed failed to ensure Resident Resident #126's witness		L534 CORRECTIVE ACTIONS ON RESIDEN AFFECTED: Resident #84 was assessed from head toe on 08/17/22 by Unit Manager. Resident suffered no negative outcome Resident/Responsible party will be updated on the bed hold policy by 09/23 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:	to s.	
L 534	nursing facility shall b the Nursing Home an Facility Residents' Pr	ge of a resident from a be done in accordance with nd Community Residence	L 534	All residents residing in the facility have potential to be affected.	the	

Health Regulation & Licensing Administration STATE FORM

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FZSW11

If continuation sheet 90 of 92

Health Regulation	& Licensing Administration	
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	egulation & Licensing A					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING.			
			B. WING			
		HFD02-0011	B. WING		06/2	9/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		1380 SO	UTHERN AVE S	E		
SERENITY	REHABILITATION AND	HEALTH CENTER L	GTON, DC 2003			
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(7.1)12		PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
			_			
L 534	Continued From page	90	L 534	L 534		
				IDENTIFICATION OF OTHERS		09/23/22
		003.01, et seq. (2005 Repl.		WITH THE POTENTIAL TO BE AFFECTED:		00/20/22
	& 2011 Supp.)).			All residents residing in the facility have		
	This Statute is not m	at an avidanced by		the potential to be affected.		
	This Statute is not m	ed to provide a written notice		MEASURES TO PREVENT		
	-	old policy to Resident #84		RECURRENCE:		
		epresentative on multiple		Staff Development/Designee will provide education/in-service to the facility		
		dent #84 was transferred to		Admission Director/ Designee on the		
	the Hospital from the			importance of providing the bed hold policy to the resident and/or responsible party/		
		lacinty.		designee within stipulated time by CMS		
	Resident #84 was ad	mitted to the facility on		requirement and regulation.		
		e diagnoses that included:		MONITORING CORRECTIVE		
	-	itus Without Complications,		ACTION:		
		iparesis following Cerebral		Director of Admission/Designee will conduct house wide audit to ensure		
		ght Dominant Side, Aphasia		that responsible parties		
	-	farction, Sepsis Unspecified		are notified or provided with a copy		
		d Convulsions, Multiple		of the bed hold policy when a resident is out of the facility and update them		
		ny Status and Dysphagia.		in writing of the bed hold		
				days and ensure documentation of bed hold policy and bed hold days in the		
	Review of the Quarte	rly Minimum Data Set		resident medical record, weekly times		
	(MDS) dated 02/18/22	2, revealed that the facility		4, then, monthly times 3 months. Any issue	s found will	
	staff coded the follow	ing:		be corrected by 9/23/22. The findings of these audits will be		
		Patterns): "Should a Brief		presented monthly for 3 months to		
	Interview for Mental S	Status be Conducted? "NO"		Quality Assurance Performance Improvement (QAPI) committee .		
		an orders showed the				
		Resident returned from				
	hospital"					
	Deview of the man					
		progress notes revealed				
	the following:					
	01/02/22 at 2.27	'Resident was observed with				
		rated brief during incontinent				
	•	essment revealed profuse				
	bleeding from her vac					
		fied and oder (sp) given to				
		R (Emergency room)"				
	02/20/22 at 4.29 PM '	"resident was observed				
alth Barul-4	ion & Licensing Administrati					

Health Regulation & Licensing Administration STATE FORM

Health Regulation	& Licensing Administration

CODDECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
	HFD02-0011	B. WING		00	C 5/29/2022
VIDER OR SUPPLIER	STREET	ADDRESS CITY STATE		•	
			, 0002		
REHABILITATION AND	HEALTH CENTER L				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	e 91	L 534			09/23/2
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Resident with (Hospice name) made aware and give order to send resident to nearest ER for G-tube replacement911 call at 7:55pm and EMT arrived at 8:05 pm bed side assessment done, and resident was transfer"         There is no documented evidence in the medical record of a notice of the bed hold policy being given to resident or resident representative.         A face-to-face interview was conducted on 06/24/22 at 11:57 AM with Employee #29 [Licensed Social worker] the surveyor asked for documented evidence that the resident or resident representative was notified of the facilities bed hold policy for each of resident's nospitalizations. Employee # 29 was unable to provide any documented evidence and stated "I cannot find the 6-108 for the January 3 and February 22nd hospitalizations for Ms. (Resident	WIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE         TREHABILITATION AND HEALTH CENTER L       1380 SOUTHERN AVE SE         WASHINGTON, DC 20032       SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 91       L 534         again vomiting large amount of coffee ground emesis and continuously bleeding fresh red blood from both nostrils911 was called, paramedics arrived at resident bedside at SPM assessed resident and left the unit with resident to (Hospital hame)"       L 534         03/31/22 at 7:33 PM "nurse observed resident with dislodged G-(Gastrostomy)Tube during medication administrationwriter attempt to replace G-tube unable on two attempts with resistance. 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