| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HFD02-0011 | A. BUILDING: _____ B. WING _____ | C 06/29/2022 |

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| SERENITY REHABILITATION AND HEALTH CENTER LLC | 1380 SOUTHERN AVE SE WASHINGTON, DC 20032 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| L 000 | Initial Comments<br><br>An unannounced Annual Survey was conducted at this facility on June 14 - 29, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 162 and the survey sample included 67 residents.<br><br>The following complaints were investigated during this survey: DC00010161, DC00010279, DC00010280, and DC00010578.<br><br>The following Facility Reported Incidents were investigated during this survey: DC00010151, DC00010195, DC00010264, DC00010280, DC00010316, DC00010379, DC00010402, DC00010403, DC00010416, DC00010439, DC00010486, DC00010609, DC00010680, DC00010684, DC00010685, DC00010735, DC00010774, DC00010802, DC00010821, and DC00010825.<br><br>Federal and/or Local deficiencies were cited related to the investigation(s) of: DC00010151, DC00010161, DC00010264, DC00010316, DC00010379, DC00010402, DC00010403, DC00010486, DC00010578, DC00010680, DC00010685, DC00010735, DC00010774, DC00010802, DC00010821, and DC00010825.<br><br>After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 for Nursing Facilities.<br><br>This survey identified actual harm at F600 for Residents #108 and #145.<br><br>The following is a directory of abbreviations | L 000 | Serenity Rehabilitation and Health Center Disclaimer:<br><br>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 the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or any admission of any wrongdoing. | 09/23/22 |

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| L 000 | Continued From page 1 | L 000 | | |

and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set

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| L 000 | Continued From page 2<br>Mg - milligrams (metric system unit of mass)<br>M- minute<br>mL - milliliters (metric system measure of volume)<br>mg/dl - milligrams per deciliter<br>mm/Hg - millimeters of mercury<br>MN midnight<br>N/C- nasal canula<br>Neuro - Neurological<br>NFPA - National Fire Protection Association<br>NP - Nurse Practitioner<br>O2- Oxygen<br>PASRR - Preadmission screen and Resident Review<br>Peg tube - Percutaneous Endoscopic Gastrostomy<br>PO- by mouth<br>POA - Power of Attorney<br>POS - physician ' s order sheet<br>Prn - As needed<br>Pt - Patient<br>Q- Every<br>RD- Registered Dietitian<br>RN- Registered Nurse<br>ROM Range of Motion<br>RP R/P - Responsible party<br>SBAR - Situation, Background, Assessment, Recommendation<br>SCC Special Care Center<br>Sol- Solution<br>TAR - Treatment Administration Record<br>Ug - Microgram | L 000 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical | L 051 | | |

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| L 051 | Continued From page 3<br>and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents.<br>This Statute is not met as evidenced by:<br>Based on record review and staff interviews, for two (2) of 67 sampled residents, facility staff failed to revise Resident #124's comprehensive care plan reflect the resident's preference to not be discharged and implement the care plan intervention for changing Resident #354's central line dressing.<br><br>The findings included:<br><br>Review of the facility policy "Interdisciplinary Team Meeting (IDT) Care Plan Meeting" revised 02/22 documented, "It is the policy of [Facility Name] to develop and implement a person-centered care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care..." | L 051 | CARE PLAN F656 and F657<br><br>L051<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>The facility cannot retroactively correct this deficiency<br>Resident #124 was discharged from the facility 07/1/2022.<br>Resident suffered no negative outcome<br><br>Resident #354 PICC line dressing was changed immediately on 6/14/22. Resident was reassessed from head to toe on 08/17/22 by licensed burse and suffered no negative outcomes.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have potential to be affected. | 09/23/22 |

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| L 051 | Continued From page 4 | L 051 | | 09/23/22 |

1. Facility staff failed to revise Resident #124's comprehensive care plan reflect the resident's preference to not be discharged.

Resident #124 was admitted to the facility on 04/21/21 with diagnoses that included: Difficulty Walking, Hypothyroidism, Hypertension, Anemia and Dysphagia.

Review of Resident #124's medical record revealed the following:

Care Plan focus area "[Resident #124's] goal and expectation for discharge is to return back to the community" initiated on 04/22/21, documented, "... 05/2/22 IDT meeting held today. Care plan reviewed and updated. Continue with POC (plan of care)..."

02/01/22 at 3:27 PM [Social Work Progress Note] "Care Plan Note: IDT (interdisciplinary team) Meeting was held on behalf of resident...There are no plans for discharge at this time, resident will continue to be a long term care resident in the facility..."

05/03/22 at 11:27 AM [Social Work Progress Note] "The clinical/IDT team met to review resident's care plan. Social worker, Activity, Nursing, Dietitian, Rehab services were in attendance. Resident chose not to attend the meeting...There were no changes since the last update, this worker will continue to work with the resident to assist with any needs or issues. There are no plans for discharge at this time, resident will continue to be a long term care resident in the facility."

05/14/22 Quarterly Minimum Data Set (MDS)

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| L 051 | Continued From page 5<br>showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential for psychosis, no verbal or physical behavioral symptoms directed towards others, independent for locomotion on and off the unit and no active discharge planning for the resident to return to the community.<br><br>The evidence showed that facility staff faield to revise Resident #124's care plan to reflect that she was to remain in the longterm care facility.<br><br>During a face-to-face interview on 06/16/22 at 10:31 AM, Employee #6 (Unit 1 Social Worker) stated, "Discharge was discussed but the resident never verbalized a desire to leave the facility. That was the original goal (discharge) when she first was admitted here, it (care plan) should have been changed to say that she wanted to be long term care."<br><br>2. Facility staff failed to implement the care plan interventions of changing Resident #354's central line dressing every seven (7) days.<br><br>According to the Centers for Disease Control (CDC), "... Replace dressings used on short-term CVC (central venous catheter) sites at least every 7 days..."<br><br>https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html#rec6<br><br>During an observation on 06/14/22 at 10:40 AM, Resident #354 was observed receiving intravenous (IV) antibiotics via a peripherally inserted central catheter (PICC). The resident stated, "I told the staff they needed to change the dressing. It has not been changed since it was | L 051 | MEASURE TO PREVENT RECURRENCE:<br><br>The facility Staff Development will provide education/in-services to the facility social worker on the importance of ensuring resident comprehensive care plan is revised to reflect resident preferences not to be discharged and to remain in Long Term Care. This will be completed by 9/23/22<br><br>The facility Staff Development will provide education/in-services to the facility licensed nurses on the importance of Implementing the care plan intervention for changing Resident intravenous line insertion site dressing by 9/23/22. | 09/23/22 |

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| L 051 | Continued From page 6<br>put in in the hospital." Upon closer observation, the dressing was noted to have the date "6/6/22" in bold, black ink.<br><br>Review of Resident #354's medical record revealed the following:<br><br>Resident #354 was admitted to the facility on 06/10/22 with diagnoses that included: Infection and Inflammatory Reaction Due to Other Internal Joint Prosthesis.<br><br>Care Plan focus area"[Resident #354] has an right upper line picc line" initiated on 06/10/22 documented "... Interventions: Change transparent dressing on insertion site every 7 days ... Monitor right upper line picc line q (every) shift ..."<br><br>06/11/22 at 10:43 AM [Nurses Progress Note] "Late Entry...Admitted with right upper picc line and left shoulder surgical wound..."<br><br>06/11/22 [Physician's Order] "Observe right upper arm and call MD (medical doctor)/NP (Nurse Practitioner) for bleeding, swelling s/s (signs and symptoms) of infection or any IV related complications every shift"<br><br>The evidence showed that facility staff failed to change the transparent dressing to Resident #354's insertion site every 7 days as specified in the care plan.<br><br>During a face-to-face interview conducted on 06/14/22 at 11:10 AM, Employee #5 (Registered Nurse) acknowledged the finding and stated, "I didn't notice that the dressing was due to be changed. I will change it today." | L 051 | MONITORING CORRECTIVE ACTION:<br>The Director of Social Service/ Designee will complete house wide review/audit of all residents to identify any residents with the preference not to be discharged, and ensure that the comprehensive care plan reflects the resident's preference to remain in long term care. Any issue found during this audit will be corrected by 9/23/22. The audit will be conducted weekly times 4, then, monthly times 3 months.<br>The findings of these audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement (QAPI) committee.<br><br>The Unit Manager/ Designee will complete house wide review/audit of all residents to identify residents with Intravenous line to ensure that care plans and interventions are properly implemented including care of the intravenous line insertion site dressing. This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected. | 09/23/22 |

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| L 052 | Continued From page 7 | L 052 | | 09/23/22 |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;<br><br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities;<br><br>(f)Encouragement and assistance to:<br><br>(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist | L 052 | L052<br><br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>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 8/10/2022. Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions.<br><br>This intervention for Resident #126 will remain until cleared by the Attending Physician/Designee and the Psychiatrist/ Designee. Resident #126 was assessed by Psychiatrist, Psych NP, and FNP, medication review and behavioral management on 06/17/22. Medical treatment was updated on 6/17/22. Resident will remain on 1 on 1 supervision x 24 hours.<br><br>Resident #133 was reassessed from head to toe on 08/17/22 by the licensed nurse, Resident medications is administered as ordered by the physician.<br>Resident did not suffer any negative outcome.<br><br>Resident #133 was immediately given pain medication per physician orders. This in ongoing. Licensed nurse was educated on proper administration of medication and accurate documentation. Resident was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome. | |

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| L 052 | Continued From page 8<br>him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, including oral acre; and<br><br>j)Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br>Based on record reviews and staff interviews, for nine (9) of 67 sampled residents, the facility failed to allow sufficeint nursing time to: follow the nurse practitioner's recommendations for Resident #126's psychiatric consult [treatment] for behavioral disturbances [wandering in residents' rooms]; administer Resident #133's narcotic pain medication as ordered by the physician; ensure Resident #257 received care consistent with professional standards of practice to minimize pressure ulcer (Stage 3) development; protect Resident #35 who uses a wheelchair for mobility, from an avoidable accident (fall); follow physcian orders for oxygen therapy for Resident #54; administered opioid pain medication as prescribed for Resident #104; provide baths for Residents' #84 and #4 for several days in May 2022 and June 2022; and follow a physician order to document care provided on a sign-in sheet for Resident #102. Residents' #126, #133, #257, #35, #54, #104, #84, #4 and #102.<br><br>The findings included:<br><br>1. Facility's staff failed to follow the nurse practitioner's recommendations for a psychiatric consult [treatment] for behavioral disturbances [wandering in residents' rooms].<br><br>Resident #126 was admitted to the facility on | L 052 | Resident #257 skin sweep observation sheet was implemented immediately. The licensed nurse completed head to toe reassessment including skin assessment on 08/17/22 no new skin issue observed. The licensed nurse completes and sign Resident weekly skin assessment by licensed nurses is being completed and skin sweep observation sheet ongoing. Resident suffered no negative outcome.<br><br>Resident #35 was assessed from head to toe on 05/20/22 by the licensed nurse post fall . No complaint of pain or apparent injury sustained. The resident is now provided with adequate supervision when returned from dialysis. Resident #35 was reassessed from head to toe on 08/17/22 by the licensed nurse Resident did not suffered any negative outcome. Education was immediately provided to the assigned staff with regards to providing proper assistance during care transfer.<br><br>The affected Resident #54 oxygen therapy was administered in accordance with physician order and parameters on 6/23/22 Resident was reassessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #54 did not suffer any negative outcome.<br><br>Resident #104 pain medication was administered immediately according to the physician orders and assigned licensed nurse was immediately educated on medication administration process and medication reconciliation process. Resident was reassessed head to toe on 8/17/22. Resident did not suffer any negative outcome. | 09/23/22 |

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| L 052 | Continued From page 9<br>05/07/21 with multiple diagnoses including Major Depressive Disorder and Dementia without Behavioral Disturbances.<br><br>Review of the medical record<br><br>06/13/22 at 1:47 PM [Nursing Note] - " ...at 1200 [12:00 PM] resident was observed wandering and pacing the hallway with his wheelchair, entering other resident's room, resident was redirected at all times by staff. NP ... notified, recommends to monitor and redirect as required and psych consult for behavioral disturbances ... "It should be noted that on 06/17/22 (4 days later) Resident #126 wandered in Resident #145 room and laid on top of her naked [non-consenual sexual contact].<br><br>Review of progress notes, consults, medication administration record, and treatment administration records from 06/13/22 to 06/17/22 lacked documented evidence Resident #126 was evaluated by a psych for behavioral disturbance of wandering in other resident's room [uninvited].<br><br>During a face-to-face interview on 06/21/22 starting at approximately 1:30 PM, Employee #21 (RN/Unit Manager) stated that the psychiatric evaluation was not done.<br><br>Cross Reference 42 CFR 483.12, F600<br><br>2. Facility staff failed to administer Resident #133's narcotic pain medication as ordered by the physician.<br><br>Resident #133 was admitted to the facility on 07/08/21 with diagnoses that included: Pain in Right Leg and Acute Kidney Failure. | L 052 | Resident#84 reassessed from head to toe including skin assessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing.<br><br>The affected Resident #4 was reassessed from head to toe including skin assessment on 08/17/22 by licensed nurse, no new skin issue observed. Resident suffered no negative outcome. Resident weekly skin assessment by licensed nurses is being completed and ongoing.<br><br>Resident #102 was reassessed from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome.<br>The resident care sign-in sheet was immediately implemented after being notified. Staff are signing when care is rendered. | 09/23/22 |

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| L 052 | Continued From page 10<br><br>During a medication administration observation on 06/15/22 at 8:46 AM, Resident #133 stated that his pain level was "6" on a scale of 1 to 10. Employee #11 (Registered Nurse) then proceeded to administer Oxycodone (narcotic pain reliever) - APAP (Acetaminophen) 5-325 MG (milligram) 1 tablet by mouth to Resident #133.<br><br>Review of Resident #133's medical record revealed the following:<br><br>05/27/22 [Physician's Order] "Fentanyl (narcotic pan reliever) Patch 72 Hour 25 MCG (micrograms)/HR (hour) Apply 1 patch transdermally one time a day every 3 day(s) for pain management and remove per schedule"<br><br>05/28/22 [Physician's Order] "Acetaminophen (pain reliever) Tablet 500 MG Give 2 tablet by mouth one time a day for Pain 30 minutes prior to wound care"<br><br>05/30/22 [Physician's Order] "Oxycodone-Acetaminophen Tablet 5-325 MG (Percocet) (Give 1 tablet by mouth two times a day for Pain [level of ] 7-10..."<br><br>A Significant Change Minimum Data Set (MDS) dated 06/06/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resdeint had an intact cognitive response, received scheduled and PRN (as needed) pain medication and experienced pain occasionally.<br><br>Care plan revised on 06/14/22 "[Resident #133] is on pain medication therapy (Percocet) r/t right leg pain ... Administer analgesic medications as ordered by physician. Review for pain medication efficacy ..." | L 052 | | 09/23/22 |

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| L 052 | Continued From page 11<br><br>Review of the June 2022 Medication Administration Record (MAR) showed that facility staff administered Oxycodone-Acetaminophen Tablet 5-325 MG 1 tablet as followed:<br><br>06/01/22 at 9:00 AM and 6:00 PM - Pain level =5<br>06/02/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/04/22 at 9:00 AM Pain level =6 and 06/04/22 at 6:00 PM Pain level= 4<br>06/05/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/06/22 at 9:00 AM Pain level =2 and 06/06/22 at 6:00 PM Pain level= 0<br>06/07/22 at 9:00 AM and 6:00 PM Pain level =3<br>06/08/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/09/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/10/22 at 9:00 AM Pain level =2 and 06/10/22 at 6:00 PM Pain level= 0<br>06/11/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/12/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/13/22 at 9:00 AM and 6:00 PM Pain level =0<br>06/14/22 at 9:00 AM Pain level =2 and 06/14/22 at 6:00 PM Pain level= 0<br>06/15/22 at 9:00 AM Pain level =6 and 06/15/22 at 6:00 PM Pain level =0<br>06/16/22 at 9:00 AM Pain level =4<br><br>During a face-to-face interview conducted on 06/16/22 at 9:45 AM, Employee #10 acknowledged the finding and stated, "Sometimes when I ask, he (Resident #133) says "6" or something lower but I know it's not possible with what he has going on medically. He has a lot of wounds. I know the pain level he's saying is not possible."<br><br>The evidence showed that facility staff failed to follow the physician's order for administering Resident #133's narcotic pain medication evidenced by licensed staff administering | L 052 | | 09/23/22 |

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| L 052 | Continued From page 12<br>Percocet when the resident's pain level was less than 7 on the pain scale.<br><br>3. Facility staff failed to ensure Resident #257 received care consistent with professional standards of practice to minimize pressure ulcer (Stage 3) development.<br><br>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.<br><br>Review of Resident #257's medical record revealed the following:<br><br>04/06/22 at 10:09?AM [Skin/Wound Note] "Resident is a 86 years old male re-admitted on 04/06/22 with left foot diabetic ulcer, absence of left toe, right lateral foot necrotic tissue measured 2.95cm (centimeter) X 1.71cm, left second toe open area 1.80ccm X 1.29cm, right great toe necrotic tissue 0.83cm x 1.62cm ..."<br><br>Physician's orders:<br><br>04/06/22 "Weekly skin assessment by licensed nurse. Document and notify MD (medical doctor)/NP (Nurse Practitioner) for abnormal findings every day shift every Wed (Wednesday)"<br><br>04/06/22 "Apply moisturizing lotion daily for skin lubrication every day shift"<br><br>Care Plan updated on 04/13/22 [Resident #257] has potential for pressure ulcer development r/t (related to) decreased mobility, fragile skin and incontinence ... Monitor/document/report PRN any changes in skin status ... Skin assessment | L 052 | IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have potential to be affected. | 09/23/22 |

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| L 052 | Continued From page 13<br>weekly and as needed by licensed nurse ..."<br><br>Care Plan updated on 04/13/22 [Resident #257] has an ADL (activities of daily living) self-care performance deficit r/t generalized weakness ... totally dependent on staff to provide bath/shower twice weekly and as necessary ... Provide sponge bath when a full bath or shower cannot be tolerated ... totally dependent on staff for repositioning and turning in bed and as necessary ... Reposition q 2 hours and as necessary to avoid injury ... requires skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes ..."<br><br>06/01/22 [Weekly Skin Assessment] " ...Describe skin impairment: none ..."<br><br>A Quarterly MDS dated 06/03/22 where facility staff coded: moderately impaired cognition, no potential indicators of psychosis, no rejection of care, extensive assistance one person physical assist for bed mobility and personal hygiene, impairment on both sides for lower extremities, always incontinent for bowel and bladder, 2 unstageable pressure ulcers that were present upon admission/entry or reentry and diabetic foot ulcers.<br><br>06/06/22 at 2:51 PM [Situation Background Assessment Request] "Situation: Observe wound on coccyx... During incontinent care at 2:45 pm, writer was notified by CNA (Certified Nurse Aide) staff assigned to resident of an opening area ... on coccyx which measure L=0.87cm X W= 0.55cm. Moderate drainage noted from sites ..."<br><br>06/06/22 at 2:51 PM [Skin Observation Tool] " ...Coccyx wound 0.87cm 0.55cm ..." | L 052 | | 09/23/22 |

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| L 052 | Continued From page 14<br><br>06/07/22 at 10:40 AM [Skin/Wound Note] " ... Comprehensive skin and wound evaluation ... sacrum stage 3 pressure ulcer ..."<br><br>06/10/22 at 1:02 PM [Wound/Pressure Ulcer Note] " ... Pressure ulcer/Stage 3 sacrum length 0.87 cm width 0.55 cm depth 0.1 cm ... in house acquired ..."<br><br>Review of the form "Unit 3 Resident Bath/Shower List" (not dated) provided to the surveyor on 06/23/22 showed that Resident #257 was on the schedule for a bath/shower every Monday and Thursday.<br><br>During a face-to-face interview on 06/23/22 at 11:05 AM, Employee #12 (Registered Nurse) stated, "Skin sweep assessments are done on scheduled shower days. A skin sweep form is completed by the CNA and nurse. If there's no sheet, then it (skin sweep assessment) wasn't done."<br><br>Review of Resident #257's medical record lacked documented evidence that a "Skin Sweep Observation Sheet" was completed on 06/02/22 (Thursday), which is Resident #257's scheduled bath/shower day.<br><br>Review of the CNA documentation showed that Resident #257 received a bed bath (BB) every day from 06/02/22 to 06/05/22.<br><br>Review of the Treatment Administration Record (TAR) showed that facility staff initialed in the area that directed, "Apply moisturizing lotion daily for skin lubrication every day shift" from 06/02/22 to 06/05/22 (4 days) indicating that the task was completed. | L 052 | | 09/23/22 |

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| L 052 | Continued From page 15 | L 052 | | 09/23/22 |

The evidence showed that for a period of 4 days (06/02/22 to 06/05/22), the facility's nursing staff failed to document and report any changes in Resident #257's skin. Subsequently, Resident #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22.

During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages. The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bath, shower or the skin sweep, it should be documented on the form and in a [nurse's] note."

4. The facility failed to provide sufficient nursing time to protect Resident #35 who uses a wheelchair for mobility, from a avoidable accident while being escorted by facility staff back into the facility..'

Resident #35 was re-admitted to the facility on 03/15/22 with diagnoses including Pneumonia, Type 2 Diabetes Mellitus, Dependence on Renal Dialysis, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarct without Residual Deficits, and Dysphagia.

A Quarterly Minimum Data Set (MDS) dated 04/11/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview For Mental Status Summary Score (BIMS) of "15," indicating intact cognition. Section G (Functional Status), facility staff documented that Resident #54: used a wheelchair for mobility, required extensive assistance with one person physical assistance

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| L 052 | Continued From page 16<br>for transfers, and required supervision for setup for locomotion on and off the unit.<br><br>A review of Resident #35's medical record revealed:<br><br>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: standard ...recline. Wheel lock: push -to-lock ...Tilt/recline access manually: ...Notes: Resident had major stroke 3 years ago. Pt(patient) has R (right) hemiplegia ...Patient cannot stand by herself and transfer on the wheelchair she need [max (maximum aid)] to be transfer[red] ...Patient uses an ostomy bag ...Pt 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 wheelchair ..."<br><br>05/20/22 [Care Plan]: ...Focus: [Resident #35] slid out of the wheelchair in a sitting position on the floor ...Goal: Reduce falls..[Resident #35] will minimize[the] risk for falls ...Interventions: Provide assistance to transfer ..."<br><br>05/20/22 at 5:00 PM [Nurses Notes]: "Resident returned ...at 1600 (4:00 PM) via wheelchair from dialysis. CNA (Certified Nurse's Assistant) informed writer, that she went to escort [the] resident from the transportation van back into the facility. CNA stated , that after [the] resident was taken from the van and she turned the wheelchair around to take [the] resident into the building, [the] resident slid out of her w/c (wheelchair) to the ground in a sitting position. CNA stated that | L 052 | MEASURE TO PREVENT RECURRENCE:<br>In-service will be provided by Staff Development /designee to all facility staff on abuse prohibition by 9/23/22<br><br>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.<br><br>In-service will be provided by Staff 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.<br>Repeat in-service will be provided as needed.<br><br>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.<br>Any issues found will be corrected by 09/23/22. | 09/23/22 |

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| L 052 | Continued From page 17<br>resident did not hit her head. Resident was assisted back into her w/c with 2-person assist and brought to the unit, Resident was assisted to bed and assessed no apparent injury noted. Resident denied having any pain or discomfort. MD [Medical Doctor] was notified no new orders given. Resident RP ... was also notified."<br><br>05/20/22 at 5:25 PM [Incident Report] documented: " ... Incident Location: Reception/Lobby ...Person Preparing Report: Employee #3 (Assistant Director of Nursing) Incident Description: Writer was informed by CNA that when she went to the van to pick up resident assisted her in the building when she returned to the facility at 1600p.m from her dialysis session. CNA stated, when she turned the wheelchair around to enter the building, the resident slid out of the wheelchair in a sitting position on the floor with her wheelchair on her back ..."<br><br>05/20/22 Witness Statement from Employee # 35 read: "Resident went for dialysis treatment on 05/20/2022. Upon arrival, escort notified Charge Nurse and writer[Employee #] that resident slipped out of the wheelchair into a sitting position while transferring her into the facility. Resident was assessed in her room, she denied discomfort and no apparent injury observed... Resident was monitored throughout the shift."<br><br>05/20/22 Witness Statement from Employee # 36 read: "[Resident #35] was back from dialysis when another staff went to assist her on the wheelchair to the build. [Resident #35] slide off the wheelchair. I assisted to reposition [Resident #35] back in her wheelchair. Nurse was informed."<br><br>During a face-to-face interview on 06/28/22 at | L 052 | Unit Mangers and Shift Supervisors will conduct rounds during their shift to ensure that resident with sexual behavior, behavior with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Any issues found will be corrected by 9/23/22 .<br><br>The facility Staff Development and PharmScript Pharmacy Consultants will provide education to the facility licensed nurses to ensure that medication administration meet professional standard of practice, by ensuring that licensed nurses administer medications and treatments following physician orders by 9/23/22.<br><br>The facility Staff Development and will provide education to the facility licensed nurses and nursing assistants to ensure that residents received treatment and care per the comprehensive care plan or in accordance with professional standards of practice. | 09/23/22 |

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| L 052 | Continued From page 18<br><br>10:42 AM, Resident #35 reported, "I was coming back from dialysis before I fell. The van driver got me off the van. Three escorts were waiting at the curb when I got off. One of the escorts was pushing me back to building, talking to another escort when I slid out of the chair onto the ground. The escort was not paying attention. I wasn't hurt. Two escorts helped me get back into my chair, and one brought me back upstairs."<br><br>During a face-to-face interview on 06/28/22 at 11:17 AM Employee #3 Assistant Director of Nursing, stated. "The transportation driver is responsible for getting resident from the lobby and putting resident on the van. The driver is also responsible for getting the resident off van to the lobby. In some cases, when the van comes, security pages the unit and the staff from the resident's unit will escort the resident back into the building." When asked if wheelchair safety training was provided to facility staff, the employee responded only when needed and if so, physical therapy usually does the training.<br><br>During a face-to-face interview on 06/29/22 at 10:37 AM Employee #34 (Unit Clerk/ Escort for Resident #35 on 05/20/22), stated [Resident #35] was coming back from dialysis on the van. There were two other residents on the van. There were two CNAs and me to escort the residents back into the building. There is an incline where the van parks to come back into the building. When [Resident #35] got off the van, I was helping the resident come back in the building at the incline. When I turned the resident in her chair to face the building, she slid out the chair. Employee # 6 (Social Worker for Unit 1) helped us put the resident back in the chair. I told Employee #37 to notify the nurse that [Resident #35] had fallen." | L 052 | | 09/23/22 |

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| L 052 | Continued From page 19<br><br>During a face-to-face interview on 06/28/22 at 11:30 AM Employee #10, Rehabilitation Manager stated that, "We (Rehabilitation Therapy Department) do provide wheelchair safety training to staff and residents on an as-needed basis. We didn't train the staff or the resident this time because [Resident #35] is independent. [Resident # 35] also has a custom chair with a special cushion like a donut to ensure the resident is seated to the back of the chair to prevent falls."<br><br>5. Facility staff failed to provide sufficient nursing time to ensure that oxygen therapy was administered as prescribed by the physician to Resident #54.<br><br>Resident #54 was re-admitted to the facility on 01/08/21 with diagnoses including, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Type 2 Diabetes Mellitus, Dependence on Supplemental Oxygen, and Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance.<br><br>A Quarterly Minimum Data Set (MDS) dated 04/25/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview for Mental Status Summary Score (BIMS) of "00," indicating that the resident had severely impaired cognition. In Section G (Functional Status), facility staff documented that Resident #54 required extensive assistance with one person physical assistance for bed mobility and was totally dependent and required assistance from one staff person for transfers.<br><br>Review of Resident #54's medical record revealed: | L 052 | The facility Staff Development will provide education/in-services to the facility licensed nurses and nursing assistants on the importance of assisting and providing Activity of Daily Living (ADL) to residents who are unable to independently carryout activities of daily living (ADLs) and importance of documentation of care provided for the residents by 09/23/22<br><br>Charge nurses will ensure the nursing assistants are providing ADL's which include but not limited to shower, bath, shaving , grooming and personal hygiene to the residents as indicated during their shift by making frequent rounds on their units . Any issues found will be addressed by 09/23/22. | 09/23/22 |

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| L 052 | Continued From page 20<br><br>05/20/22 [Physician's Order] directed, "O2 (oxygen) at 2 L(liters)/min(minute) for SOB (shortness of breath) or respiratory distress."<br><br>05/22/22 [Care Plan] Focus: [Resident # 54] has diagnosis of COPD exacerbation, acute bronchopneumonia; Interventions: ...Give nebulizer treatments and oxygen therapy as ordered."<br><br>A review of Resident 54's Vital Signs Report documented the following oxygen saturation levels from 06/23/22: at 2:06 AM, 98% room air; 5:24 AM, 98% room air; 10:42 AM, 97% oxygen via nasal cannula.<br><br>During an observation on 06/23/22 at 12:12 PM, Resident #54 was awake, resting comfortably, with non-labored breathing. The resident was receiving supplemental humidified oxygen via nasal cannula at a rate of 5 liters per minute.<br><br>During a face-to-face interview on 06/23/22 at approximately 12:15 PM, Employee #33 (Unit Manager) acknowledged that Resident #54 was receiving 5 liters of oxygen per minute. The employee then stated, "Oh, the oxygen level is too high," and the employee turned down the resident's oxygen rate to 2 liters oxygen. When asked who was responsible for ensuring the resident's oxygen rate was correct, the employee commented that it is the assigned nurse's responsibility to ensure that the resident is administered oxygen at the rate stated in the physician's order.<br><br>6. Facility staff failed to provide sufficient nursing time to ensure that an opioid pain medication was administered as prescribed by the physician to | L 052 | MONITORING CORRECTIVE ACTION:<br><br>House wide audit will be conducted by Assistant Director of Nursing (ADON)/ Designee to ensure that residents have been assessed for sexual behavior, with the potential to abuse others, and wandering behavior, that care plans for residents with behavioral issues clearly indicate the kind of behavior the resident is exhibiting.<br>Also that residents with sexual behavior, and behavior with the potential to abuse others, and wandering behavior have adequate supervision, and that<br>staff members are fully trained on<br>how to care for residents with with<br>sexual behavior problems,<br>behavior with potential to abuse others and wandering behavior weekly times<br>four, then monthly times 3 months.<br><br>Residents with wandering behavior<br>will be redirected, supervised, and monitored every shift by charge nurses and CNA'S. | 09/23/22 |

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| L 052 | Continued From page 21<br>Resident #104.<br><br>Resident #104 was re-admitted to the facility on 05/05/22 with multiple diagnoses, including, Malignant Neoplasm of Prostate, Moderate Protein -Calorie Malnutrition, Acidosis, Vitamin D Deficiency, Pressure Ulcer of Sacral Region , Unstageable, and Pressure Ulcer of Left Buttock, Unstageable.<br><br>Quarterly Minimum Data Set (MDS) dated 05/12/22 showed in Section C (Cognitive Patterns) that facility staff 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 one person physical assistance for bed mobility and eating, was totally dependent requiring one person physical assistance for transfers, dressing, toilet use and personal hygiene. In Section N (Medications) facility documented that resident received opioids for 3 days during the last 7 days or since admission/entry or reentry.<br><br>A review of Resident #104's medical record revealed:<br><br>05/05/2022 at 11:00 PM [Physician's Orders] directed: "Pain assessment every shift."<br><br>05/17/22 at 6:00 PM [Physician's Orders] directed: "Percocet (narcotic pain medication) Tablet 5-325 mg (Oxycodone-Acetaminophen ). Give 2 tablet(s) by mouth four times a day for chronic pain." D/C (Discontinue) date: 06/04/22."<br><br>On 06/20/22 at 6:00 PM the physician changed | L 052 | Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents that facility licensed nurses failed to provide pain management in accordance with physician orders weekly times four, then monthly times 3 months.<br><br>The facility Assistant Director of Nursing/Designee will conduct house wide visual audit of all residents to identify potential resident that the facility staff failed to ensure received adequate monitoring and supervision to prevent avoidable accidents weekly times four, then monthly times 3 months.<br><br>The facility Staff Developer/designee will provide education/ in-services to the facility licensed nurses to ensure residents receive care consistent with professional standards of practice and importance of completing skin assessments and implementing ongoing skin assessment as ordered by physician. This will be completed by 9/23/22. | 09/23/22 |

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| L 052 | Continued From page 22<br><br>the order to specify that facility staff should administer Percocet to Resident #104 for a pain level of 7-10; [Physician's Orders] directed: "Percocet Tablet 5-325 mg (Oxycodone-Acetaminophen ). Give 2 tablet(s) by mouth four times a day for pain 7-10." (this is confusing)<br><br>June 2022 Pain Rating Report (Numeric Scale) documented:<br>06/20/22 - 5:44 AM- 4/10; 8:08 AM-0/10; 1:16 PM-0/10; 5:45 PM- 0/10<br>06/21/22 - 12:55 AM-4/10, 1:55-0/10 AM, 6:11 AM-4/10, 2:15 PM-1/10, and 6:25 PM- 0/10<br>06/22/22 - 9:36 AM-0/10, 5:36 PM-0/10, and 11:51 PM- 0/10<br>06/23/22 - 1:58 AM-0/10; 6:07 AM-0/10, 10:59 AM-0/10; 12:14 PM-0/10, 5:23 PM-0/10<br>06/24/22 - 12:00 AM-6/10 and 6:00 AM 6/10<br><br>Medication Administration Record (MAR) for June 2022 revealed that the facility's licensed nursing staff marked that they administered Percocet Tablet 5-325 mg (Oxycodone-Acetaminophen), to Resident #104 from 06/21/22 to 06/24/22.<br><br>A review of Resident's #104's medical record revealed that from 06/21/22 to 06/24/22, facility staff failed to administered Percocet in accordance with the physician's order, which specified to administer the medication to the resident for a pain rating of 7-10.<br><br>During a face-to-face interview on 06/20/22, Employee #3, Assistant Director of Nursing (ADON), after reviewing Resident #104 June MAR, acknowledged that the facility's licensed nursing staff administered Percocet to Resident#104 when the resident's pain rating was less than 7-10 and the employee offered no | L 052 | Assistant Director of Nursing (ADON)/Designee will conduct house wide audit of resident skin sweep and documentation to identify potential residents that facility staff failed to provide care consistent with professional standards of practice to prevent the development of wound weekly times four, then monthly times 3 months.<br><br>The Unit Manager/ Designee will complete house wide review/audit of all residents to identify potential residents facility staff failed to ensure that residents received treatment and care per the comprehensive care plan or in accordance with professional standard of practice weekly times 4 then, monthly times 3 months. | 09/23/22 |

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| L 052 | Continued From page 23<br>further comment.<br><br>7. Facility staff failed to provide documented evidence of bathing Residents' #84 and Resident #4 on multiple days during the months of May 2022 and June 2022.<br><br>7a. Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that the facility staff coded the following:<br>Section C (Cognitive Patterns): "Should a Brief Interview for Mental Status be Conducted? "NO"<br>Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "One-person physical assist" Transfer, "Extensive assistance" requiring "Two-person physical assist"<br>Toilet use, "Extensive assistance" requiring "One-person physical assist"<br>Personal hygiene, "Extensive assistance" requiring "One-person physical assist"<br>Bathing "Total dependence"<br>Upper extremity "Impairment on one side"<br>Lower extremity "Impairment on one side"<br><br>Review of the physicians' orders showed the following: 04/06/22 "Adjust to nursing home placement; Promote good nutritional status and skin care; &/or Improve physical function; Meet ADL (Activities of daily living) needs daily ..." | L 052 | The Unit Manager/Designee will conduct house wide review/audit to identify potential residents who were<br>unable to independently carry out activities of daily living (ADLs) that facility staff failed provide services necessary to maintain personal hygiene weekly times 4 then, monthly times 3 months.<br><br>The Unit Manager/ Designee will complete a review/audit of ADL care signing sheet in resident room to ensure ADL is provided on every shift according to physician order and the signing sheet is visible in the resident room and signed by nursing assistant and licensed nurses.This audit will be conducted weekly times 4, then monthly times 3 months.<br><br>The Unit Manager/Designee will conduct house wide review/audit to identify potential residents that<br>Activity of Daily Living (ADL)<br>care provided are not documented in the resident in the resident medical<br>records weekly times 4<br>then, monthly times 3 months.<br><br>The Unit Manager/ Designee will complete house wide review/audit of all incontinent residents to ensure that residents are provided with one incontinent brief as standard of care.This audit will be conducted weekly times 4, then monthly times 3 months.<br>Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents on oxygen therapy to ensure oxygen is administered to residents in accordance with the Physician's order and parameters. This audit will be conducted weekly times 4, then monthly times 3 months. All findings will be corrected.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |

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| L 052 | Continued From page 24<br><br>Review of the care plan with a focus area of "[Resident #84] has an ADL self-care performance deficit r/t (related to) Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, adult failure to thrive" initiated on 05/21/21, included the following interventions: "(Resident #84) requires 2 staff participation with transfers ...the resident is totally dependent on staff to provide a bath as necessary ...[Resident #84] requires total assistance with personal hygiene care ... The resident is totally dependent on staff for dressing ..."<br><br>Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated from, 05/01/22 to 05/31/22, shows that there was no documented evidence of Resident #84 being bathed on the following dates:<br><br>05/11/22<br>05/14/22<br>05/15/22<br>05/16/22<br>05/17/22<br>05/29/22<br><br>During a face-to face interview conducted on 06/23/22 at 11:01 AM, Employee #33 (Unit Manager 2nd Floor) stated "Its not documented" Employee #33 acknowledged the findings and made no further comment.<br><br>7b. Resident #4 was admitted to the facility on 05/23/22 with multiple diagnoses that included: Pressure Ulcer Sacral Region Stage 4, Type 2 Diabetes Mellitus with Unspecified Complications, | L 052 | | |

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| L 052 | Continued From page 25<br>Legal Blindness as Defined in USA, Unspecified Glaucoma, and Muscle Weakness.<br><br>Review of the Admission Minimum Data Set (MDS) dated 05/27/22, revealed that the facility staff coded the following:<br>Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "02" Indicating severely impaired cognition.<br>Section G (Functional Status): Bed Mobility, "Extensive assistance" requiring "Two-person physical assist"<br>Transfer, "Activity did not occur"<br>Dressing, "Total dependence" requiring "One-person physical assist"<br>Toilet Use, "Total dependence" requiring "Two-person physical assist"<br>Personal hygiene, "Total dependence" requiring "One-person physical assist"<br>Bathing, "Total dependence"<br>Upper extremity "Impairment both sides"<br>Lower extremity "Impairment on both sides"<br>Section H (Bladder and Bowel): Indwelling Catheter<br>Urinary Continence "Not rated"<br>Bowel Continence "Always Incontinent"<br>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 pressure ulcer present on admission and moisture associated skin damage.<br>Review of the physicians' orders revealed the following: 05/21/22, " ...Meet ADL (Activities of Daily Living) needs daily ..."<br><br>Review of the care plan with a focus area of: "[Resident #4] ADL self-care deficit related to physical limitations, visual impairment, change in mental status ..." initiated on 05/23/22, included the following interventions: "Assist to | L 052 | | |

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| L 052 | Continued From page 26<br>Bathe/Shower as needed ...Assist with daily hygiene, grooming, dressing, oral care and eating as needed ..."<br><br>Review of the document titled "Documentation Survey Report v2" which is part of the electronic health record where the CNA's (Certified Nurse Aides) document ADL and other care that they provide dated 05/21/22 to 6/28/2022, shows that there was no documented evidence of Resident #4 being bathed on the following dates:<br><br>05/22/22<br>05/24/22<br>05/29/22<br>06/07/22<br>06/25/22<br>06/26/22<br>06/28/22<br><br>On the above dates staff documented NA (Not Applicable) or RN (Resident Not Available).<br><br>An observation and face-to-face interview were conducted on 06/27/22 at 1:15 PM, Resident #4 stated "They are short, and they do not always come to give me a bath."<br><br>During a face-to-face interview conducted on 06/28/22 at 10:37 AM, Employee #3 (Assistant Director of Nursing) stated "She (Resident #4) was available the staff failed to document appropriately."<br><br>Employee #3 acknowledged that there was no documented evidence that staff bathed resident on multiple days in May and June 2022.<br><br>8. Facility staff failed to follow a physician's order | L 052 | | |

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| L 052 | Continued From page 27<br>to complete a sign in sheet in residents' room every time care is rendered for Resident #102.<br><br>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.<br><br>Review of a Complaint received by DOH (Department of Health) on 09/20/2021, concerning Resident #102, documented " ...says he has only had 13 showers and been out of bed 12 times since he has been there. Some of this issues were addressed during a careplan meeting ..."<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following:<br><br>Section C (Cognitive Patterns): Brief Interview for Mental Status Summary Score "15" indicating intact cognition.<br>Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited<br>Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"<br>Transfer "extensive assistance" requiring "Two-person physical assist"<br>Dressing "Extensive assistance" requiring "Two-person physical assist"<br>Toilet use "Extensive assistance" requiring "One -person physical assist"<br>Personal Hygiene "Extensive assistance" requiring "One-person physical assist" | L 052 | | |

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| L 052 | Continued From page 28<br>Bathing "Total dependence"<br>Balance during transitions and walking Surface to surface transfer "Not steady only able to stabilize with staff assistance"<br>Upper extremity "no impairment"<br>Lower extremity "Impairment on both sides"<br>Section K (Swallowing/Nutritional status):<br>Swallowing Disorder "None of the above"<br>Review of the physicians' orders revealed:<br>08/21/21 "Please sign signing sheet in residents' room each time care is rendered ..."<br><br>Observation of resident's room was conducted on 06/24/22 at approximately 12:30 PM, the surveyor did not observe a sign in sheet for ADL care.<br><br>During a face-to-face interview conducted on 06/24/22 at approximately 1:00 PM, Employee #3 (Assistant Director of Nursing) when asked by the surveyor where was the sign in sheet for staff to fill in after care is rendered? Employee #3 stated "I cannot find it at the bedside" | L 052 | The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #95 is clinically stable. Resident #95 currently on Occupation Therapy started 08/11/22.<br>Resident #95 did not suffer any negative outcome<br><br>L065<br>THE CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>Resident#28 was reassessed by the Unit Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's right resting hand splint was applied immediately and psychiatric consult was completed after being notified on 7/19/22.The Unit manager will ensure that Resident #28 receives right resting hand splint as ordered by the physician. | 09/23/22 |
| L 065 | 3213.2 Nursing Facilities<br><br>Each nursing employee shall provide restorative nursing in his or her daily care of residents, which shall include the following:<br><br>(a)Maintaining good body alignment and proper positioning of bedridden residents;<br><br>(b)Encouraging and assisting bedridden residents or those residents that are confined to a chair to change position at least every two (2) hours or more often as the resident's condition warrants, day and night, to stimulate circulation; prevent bed sores, pressure ulcers and deformities; and to promote the healing of pressure ulcers; | L 065 | | |

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| L 065 | Continued From page 29<br><br>(c)Encouraging residents to be active and out of bed for reasonable periods of time, except when contraindicated by physician's orders;<br><br>(d)Encouraging residents to be independent in activities of daily living by teaching and explaining the importance of self-care, ensuring and assisting with transfer and ambulating activities, by allowing sufficient time for task completion by the residents, and by encouraging and honoring resident's<br>choices;<br><br>(e)Assisting residents to adjust to their condition and to their use of prosthetic devices;<br><br>(f)Achieving good body alignment and balance for residents who use mechanical supports, which are properly designed and applied under the supervision of a licensed nurse;<br><br>(g)Identifying residents who would benefit from a bowel and bladder training program and initiating such a program to decrease incontinence and unnecessary use of catheters; and<br><br>(h)Assessing the nature, causes and extent of behavioral disorientation difficulty and implementing appropriate strategies and practices to improve the same.<br><br>This Statute is not met as evidenced by:<br>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 | L 065 | The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident #95 is clinically stable. Resident #95 currently on Occupation Therapy started 08/11/22. 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.<br><br>Resident #9 received Right resting hand splint as ordered by the physician and as outline in the comprehensive care plan by 09/23/22 | 09/23/22 |

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| L 065 | Continued From page 30<br>splint); and provide Resident #102 with their prescribed orthotics and multi-podus boots as ordered by the physician. Residents' #28, #95 and #102.<br><br>The findings included:<br><br>1. Facility staff failed to assist Resident #28 with his left hand splint as outlined in his comprehensive care plan.<br><br>Resident #28 was admitted to the facility on 10/28/20 with multiple diagnoses, including Contracture of Left Hand, Hemiplegia, and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Lack of Coordination, and Weakness.<br><br>Review of the medical record revealed the following:<br><br>MDS 04/05/22 - Quarterly restorative services not listed because the order came the day after.<br><br>04/06/22 [physician's order] - "Discontinue skilled OT (occupation therapy) as a patient has achieved the highest practical level. Patient will start on RNP (restorative nursing program) 3-5 x (times) a week for 15 minutes.<br><br>Review of the comprehensive care plan showed the following.<br><br>Focus area - Resident on restorative nursing for resting/hand splinting/palmar guard to the left upper extremity to prevent further left-hand contracture ...<br><br>Intervention - Discontinue and refer back to OT (occupational therapy) if redness, swelling, or | L 065 | Resident #102 was applied prescribed orthotics, multi-podus boots immediately after being notified and is ongoing per physician orders. Resident was reassessed from head to toe on 08/17/22 by licensed nurse Resident did not suffer any negative outcome. | 09/23/22 |

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

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| L 065 | Continued From page 31<br>bruising noted ...restorative staff will assist with daily exercise as per order.<br><br>Observation on 06/17/22 starting at approximately 10:00 AM to 5:00 PM on 06/23/22, showed Resident #28 was not wearing a left-hand splint or receiving restorative nursing services. Contined observation showed the resdient's left hand splint was in the top drawer of his night stand.<br><br>During a face-to-face interview on 06/23/22 at approximately 4:30 PM, Employee #3 (ADON) stated that the resident was not receiving restorative nursing services because his name was accidentally omitted from the facility's list of residents on the restorative nursing program. The employee was asked if restorative nursing applied splints? He said "Yes". The employee was then asked if licensed nursing staff can apply splint? He said. "Yes", however, he failed to provide an answer why licensing nursing staff failed to apply Resident #28's left hand splint from 06/17/22 starting at approximately 10:00 AM to 5:00 PM on 06/23/22.<br><br>2. Facility staff failed to assist Resident #95 with her prescribed prosthetic devices (right hand splint) as specified in the resident's comprehensive care plan.<br><br>During an observation on 06/14/22 at 10:31 AM, Resident #95 was observed in bed with a sign at the head of her bed that directed "...Apply right hand splint for 6-8 hours daily ..." At the time of this observation, a right hand splint was noted above the bed in a clear, plastic bag. | L 065 | IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have potential to be affected. | 09/23/22 |

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| L 065 | Continued From page 32<br><br>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."<br><br>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.<br><br>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.<br><br>Review of Resident #95's medical record revealed the following:<br><br>06/02/21 [Physician's Order] "Right resting hand splint"<br><br>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 ..."<br><br>A Quarterly MDS dated 05/31/2022 showed facility staff coded the Resident #95 as severe cognitive impaired, totally dependent on staff with two persons physical assist for bed mobility, toilet use and personal hygiene; range of motion impairment on both sides for upper and lower extremities and received OT services from 04/19/22 to 05/31/22.<br><br>06/01/22 [Occupational Therapy Discharge | L 065 | MEASURES TO PREVENT RECURRENCE:<br><br>The facility Staff Developer/ Designee will provide education to the facility nursing staff (licensed nurses and Nursing Assistants) on the importance of ensuring that residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion and educate staff on the importance of providing restorative nursing services as ordered by the physician. Training will be completed by 09/23/22.<br><br>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.<br><br>MONITORING CORRECTIVE ACTION:<br>Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential residents with sexual behavior to ensure that the proper comprehensive care plan and interventions are in place in accordance with professional standards of practice. Audit will be done weekly times 4, then monthly times 3 months.<br><br>The facility ADON/Designee will complete house wide review/audit of all facility residents to identify potential residents with limited range of motion to ensure residents receive appropriate treatment and services to prevent further decrease in range of motion. This audit will be conducted weekly times 4, then monthly times 3. All findings will be corrected.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |

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| L 065 | Continued From page 33<br>Summary] "... Discharge recommendations: RNP... to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been completed with the IDT: bed mobility and R (right) H (hand) splint or brace care..."<br><br>Review of the "Restorative Nursing Program" document provided to the surveyor on 06/21/22 at 9:20 AM, did not list Resident #95 as receiving RNP for the right hand resting hand splint.<br><br>Review of Resident #95's medical record showed no documented evidence to show that facility staff was applying the right hand splint as specified by the physician's order and care plan.<br><br>During a face-to-face interview conducted on 06/24/22 at approximately 4:00 PM, Employee #2 acknowledged the findings and made no further comments.<br><br>3. Facility staff failed to provide Resident #102 with their prescribed orthotics and multi-podus boots as ordered by the physician.<br><br>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.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following:<br><br>Section C (Cognitive Patterns): Brief Interview for | L 065 | L091<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>Resident #38 was assessed was from head to toe on 08/17/22 by Unit Manager/Designee<br>Resident suffered no negative outcome<br>Resident #66 was assessed and monitored closely x 3 day for signs and symptoms of Covid-19 by licensed nurses post exposure to an employee who was not vaccinated with Covid-19 vaccine and was not wearing recommended Face shield and N95 06/29/22. Resident #66 remained clinically without any symptoms of Covid-19.<br>Resident suffered no negative outcome.<br>Employee #6 was verbally educated on importance of the of wearing PPE and marinating a minimum of 6 feet while working with resident or in the care area.<br>Employee #6 was written up and suspended pending termination.<br>Employee resigned during suspension. | 09/23/22 |

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| L 065 | Continued From page 34<br>Mental Status Summary Score "15" indicating intact cognition.<br><br>Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited<br><br>Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"; Upper extremity "no impairment"; Lower extremity "Impairment on both sides"<br><br>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<br><br>Review of the physicians' orders revealed the following:<br><br>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."<br><br>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."<br><br>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 | L 065 | IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have potential to be affected. | 09/23/22 |

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| L 065 | Continued From page 35<br><br>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 ..."<br><br>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:<br><br>06/01/22<br>06/02/22<br>06/03/22<br>06/06/22<br>06/07/22<br>06/16/22<br>06/17/22<br>06/20/22<br>06/23/22<br><br>For all the above-mentioned section, facility staff either left the space blank or documented "NA" which means "Not Applicable" according to the documentation.<br><br>A face-to-face interview was conducted on 06/24/22, at 2:40 PM with Employee #3 (Assistant Director of Nursing) he acknowledged the findings and stated, "The restorative aide does the restorative nursing program and applies the | L 065 | MEASURE TO PREVENT RECURRENCE:<br>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 feet while interacting with others. Importance of minimizing or prevent the potential spread infection<br>(COVID-19) and other infectious diseases by 09/23/22. | 09/23/22 |

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| L 065 | Continued From page 36<br>orthotics, I know we have some challenges sometimes they assist the unit." | L 065 | L 065<br>MONITORING CORRECTIVE ACTION:<br>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 the potential spread infection (COVID-19) by not properly wearing Personal Protective Equipment (PPE) when interacting with Resident less than six (6) feet away 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. | 09/23/22 |
| L 091 | 3217.6 Nursing Facilities<br><br>The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter.<br>This Statute is not met as evidenced by:<br>Based on observation, record review, and staff interviews, the Infection Control Committee failed to ensure an unvaccinated employee followed the "COVID-19 Healthcare Staff Vaccination" policy to minimize or prevent the potential spread COVID-19.<br><br>The findings included:<br><br>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.<br><br>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.<br><br>Review of the facility's COVID-19 Staff Vaccination Status for Provider form showed | L 091 | L091<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:<br>Resident #66 was assessed and monitored closely x 3 days for signs and symptoms of Covid-19.<br>by licensed nurses post exposure to an employee 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-19. Resident suffered no negative outcome.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.<br>All the residents in the facility have the potential to be affected . | |

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| L 091 | Continued From page 37<br>Employee #6 (Social Worker) was not vaccinated for COVID-19.<br><br>Review of Resident #66 medical record revealed the resident was admitted to the facility 08/08/15 with multiple diagnoses including Brady Cardia, Pacemaker, Hypertension, and Obesity. Continued review of the record showed the resident received Moderna (COVID-19) vaccinations on the following dates: 1st dose - 02/09/21, 2nd dose -03/08/21, and 1st Booster - 02/08/22.<br><br>During a face-to-face interview on 06/29/22 at approximately 2:10 PM, Employee #6 was not receptive to speaking with the surveyor.<br><br>During a face-to-face interview with Employee #6 and Employee #2 (DON) on 06/29/22 at approximately 2:15 PM, Employee #6 stated that he did not have on a face shield or N95 because he only spoke with Resident #66 for a few minutes. When asked what was the facility's policy for wearing PPEs? The employee stated that he was to wear a face shield and N95 mask at all times. | L 091 | L 091<br>MEASURE TO PREVENT RECURRENCE:<br>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 feet while interacting with others. Importance of minimizing or prevent the potential spread infection (COVID-19) and other infectious diseases and the importance of proper cleaning and sanitizing resident rooms and shared equipment.<br><br>MONITORING OF CORRECTIVE ACTION:<br>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 the potential spread infection (COVID-19) by not properly wearing Personal Protective Equipment (PPE) when interacting with Resident less than six (6) feet away weekly times 4, then, monthly times 3 months.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |
| L 099 | 3219.1 Nursing Facilities<br><br>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:<br>Based on observations and staff interview, facility staff failed to prepare and serve foods under sanitary conditions as evidenced by a cracked and loose ceiling light in the main kitchen, a | L 099 | | |

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| L 099 | Continued From page 38<br>damaged wall behind the grease fryer, and staff failure to follow food service standards of practice.<br><br>The findings include:<br><br>During a walkthrough of dietary services on June 14, 2022, at approximately 10:00 AM, the following were observed:<br><br>1. A ceiling light located in a common area of the kitchen was cracked and loose.<br><br>2. The wall behind the grease fryer was damaged with holes.<br><br>3. Staff failed to connect one (1) of one (1) plate warmer to help maintain hot food temperatures on the tray line on<br>June 21, 2022, at approximately 12:45 PM. Subsequently, three (3) of four (4) hot food items tested below<br>required temperatures during a test tray assessment on June 21, 2022, at approximately 2:00 PM.<br><br>These observations were acknowledged by Employee #38 and/or Employee #42 during a face-to-face interview on June 27, 2022, at approximately 3:00 PM. | L 099 | L 099<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:<br>No resident was affected by this deficient practice.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.<br>All the residents in the facility have the potential to be affected .<br><br>MEASURES TO PREVENT REOCCURENCE:<br>The facility Staff Development will provide education/in-services to the maintenance staff on importance of :<br>1.maintaining and ensuring no ceiling light are cracked and loose around the facility.<br>2.maintaining and ensuring that the facility walls are not damaged with holes. by 9/23/22.<br><br>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 standards of practice and ensuring that the food plate warmer are connected to electricity to help maintain hot food temperatures on the tray line by 9/23/22.<br><br>MONITORING OF CORRECTIVE ACTION:<br>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.<br>Director of Maintenance /Designee will conduct house wide round/audit of common areas within the facility and the residents rooms to ensure no ceiling light are cracked and loose, and walls do not have hole damage, weekly times 4, then monthly times 3 months. | 09/23/22 |
| L 108 | 3220.2 Nursing Facilities<br><br>The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. | L 108 | | |

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| L 108 | Continued From page 39<br><br>This Statute is not met as evidenced by:<br>Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 140 degrees Fahrenheit on three (3) of four (4) observations.<br><br>The findings include:<br><br>During a food test tray assessment on June 21, 2022, at approximately 2:00 PM, hot foods such as ham (117 degrees Fahrenheit), cabbage (105.7 degrees Fahrenheit), and mechanical ham (111.7 degrees Fahrenheit), tested below the minimum required temperature of 140 degrees Fahrenheit (F).<br><br>These observations were acknowledged by Employee #38 and/or Employee #42 during a face-to-face interview on June 21, 2022, at approximately 2:15 PM. | L 108 | L108<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:<br>No resident was affected by this deficient practice.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.<br>All the residents in the facility have the potential to be affected .<br><br>MEASURES TO PREVENT REOCCURENCE:<br>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 standards of practice, food served is warm at the required temperature and ensuring that the food plate warmer are connected to electricity to help maintain hot food temperatures on the tray line by 9/23/22.<br><br>MONITORING OF CORRECTIVE ACTION:<br>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. | 09/23/22 |
| L 109 | 3220.3 Nursing Facilities<br><br>If a resident refuses food, appropriate substitutions of comparable nutritive value shall be offered at the same mealtime.<br>This Statute is not met as evidenced by:<br>Based on observation, record review, staff and resident interview for two (2) of 67 sampled residents, facility staff failed to provide appropriate food substitutions of comparable nutritive value and offered at the same mealtime to residents as evidenced by the facility's failure to provide menu options so that residents could make meal choices. Residents' #102 and #82.<br><br>The findings included: | L 109 | | |

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| SERENITY REHABILITATION AND HEALTH CENTER L | 1380 SOUTHERN AVE SE WASHINGTON, DC 20032 |

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| L 109 | Continued From page 40<br><br>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.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 06/02/22, revealed facility staff coded the following:<br><br>Section C (Cognitive Patterns): Brief Interview for Mental Status Summary Score "15" indicating intact cognition.<br><br>Section E (Behavior): Rejection of Care -Presence & Frequency "0" Behavior not exhibited<br><br>Section G (Functional Status): Bed mobility "Extensive Assistance" requiring "Two-person physical assist"<br>Transfer "extensive assistance" requiring "Two-person physical assist"<br>Dressing "Extensive assistance" requiring "Two-person physical assist"<br>Eating "Supervision" requiring "Set-up help only"<br>Toilet use "Extensive assistance" requiring "One -person physical assist"<br>Personal Hygiene "Extensive assistance" requiring "One-person physical assist"<br><br>Section K (Swallowing/Nutritional status): Swallowing Disorder "None of the above"<br><br>Review of the Physicians orders revealed the following: | L 109 | L109<br><br>L109<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:<br>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 negative outcomes noted.<br><br>The affected Resident #82 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 negative outcomes noted.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.<br>All the residents in the facility have the potential to be affected .<br><br>MEASURE TO PREVENT RECURRENCE:<br>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.<br><br>The Director of Food and Nutrition Services/Designee will conduct house wide audit to 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.<br><br>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 times 4, then monthly times 3 months.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |

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| L 109 | Continued From page 41<br>08/07/20 "Regular diet Regular texture, Thin Liquids consistency (Double portion) per preference"<br><br>Review of the care plan with a focus area of "(Resident #102) is at nutritional risk r/t (related to) Clinical DX (Diagnosis) Adult Failure to Thrive, Protein Calories Malnutrition, Type 1 Diabetes, Sickle Cell Trait, Calculus of Kidney, GERD, HTN (Hypertension) Requiring liberalized diet and oral nutritional supplements ..." initiated on 07/31/20, had multiple interventions including the following: "Continue providing education on importance of adherence to facility diet order/limiting food from outside facility. ... Food service staff to regularly check on resident's food preference changes. ..."<br><br>During an observation and face-to-face interview conducted on 06/24/22 at approximately 1:00PM, Resident #102 stated "The food is terrible and there is not enough ...One time they gave me mac and cheese for a meat ...I can't get cold ice water." The surveyor asked the resident about the menu and if he raised these issues with staff? Resident 102 stated "I do not get a menu"<br><br>During a face-to-face interview conducted on 06/24/22 at approximately 2:23 PM, Employee #30 (Registered Dietician) stated "He (Resident #102) complains he has been seen by the director of food services and she follows up.<br><br>The surveyor asked the dietician where the menus are and how resident could get a meal replacement. The dietician then showed the surveyor a menu that was posted for the month of May 2022 (The current month at the time of survey was June 2022), on a bulletin board on a wall by the nursing station. The menu was noted to be in a small type of font and in area not | L 109 | | 09/23/22 |

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| L 109 | Continued From page 42 | L 109 | | |

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.

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.

An observation and face-to-face interview were conducted on 06/22/22 at 10:18 AM with Resident #82, the surveyor observed resident in his room and noticed his breakfast tray appeared untouched and covered. The surveyor asked the resident if he had eaten and how was the food to which Resident # 82 stated "It was disgusting I can't eat those powered eggs" The surveyor asked the resident if he told staff to which Resident # 82 responded "That ain't going to do no good they don't send a menu ..."

Review of the Annual Minimum Data Set (MDS) dated 06/02/22, revealed that facility staff coded the following:

Section B (Hearing, Speech, and Vision) Vision "Impaired"
Corrective Lenses "Yes"

Section C (Cognitive Patterns) Brief Interview for Mental Status Summary Score "14" indicating intact cognition.

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| L 109 | Continued From page 43<br><br>Section G (Functional status) Eating "Independent" requiring "No set up or physical help from staff"<br><br>Section K (Swallowing/Nutritional Status) Swallowing Disorder "None of the above"<br><br>Review of the Physicians orders revealed the following: 06/01/22 "Regular diet Regular texture, Thin liquids consistency, Double Portion per residents request"<br><br>Review of the care plan with a focus area of "(Resident #82) is at nutritional risk related to Dementia, Heart Failure, Major Depressive Disorder-requiring Regular diet and oral nutritional supplements ..." date revised 06/02/22, had interventions which included the following "Regular Diet, Regular texture, Thin Liquid Consistency, Feeding Ability Independent with tray set up ..."<br><br>During a face-to-face interview conducted on 06/22/22 at 10:55 AM with Employee #33 (2nd Floor Unit Manager) "If they don't like the meal, they have to say something then we can give them something else" The surveyor asked if there is a menu where residents can make choices and how would a resident get a meal or item on the tray replaced. Employee #33 stated she would get the dietician to speak with the surveyor.<br><br>During a face-to-face interview conducted on 06/22/22 at 12:07 PM with Employee #30 (Registered Dietitian) The surveyor asked how residents choose alternatives or replacements if they do not like a food item that is being served. Employee #30 stated she was not sure and that she would get the kitchen director. | L 109 | | 09/23/22 |

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| L 109 | Continued From page 44<br><br>During a face-to-face interview conducted 06/22/22 at approximately 12:15 PM with Employee #38 (Kitchen Director) "This (alternative menu) is always available it is on the wall right here."<br><br>The form that Employee #38 said is an alternative menu is labeled "Next Level Hospitality services" The form was not accessible to all the residents and not visble due to being behind other papers on a bulletin board. | L 109 | | 09/23/22 |
| L 204 | 3232.2 Nursing Facilities<br><br>A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:<br><br>(a)The date, time, and description of the incident;<br><br>(b)The name of the witnesses;<br><br>(c)The statement of the victim;<br><br>(d)A statement indicating whether there is a pattern of occurrence; and<br><br>(e)A description of the corrective action taken.<br><br>This Statute is not met as evidenced by:<br>Based on record review and staff interviews, for six (6) of 67 sampled residents, the facility's staff failed to follow their "Investigation Process" policy by not interviewing or obtaining statements from all potential witnesses for the following allegations: resident-to-resident inappropriate | L 204 | | |

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| L 204 | Continued From page 45<br>non-consensual sexual touch [sexual abuse] for Resident #108; resident-to-resident altercation for Resident #86, sexual abuse of Resident #112, resident-to-resident incident involving Resident #121, staff physical abuse of Resident #303's and staff neglect of Resident #304. Residents' #108, #86, #112, #121, #303 and #304.<br><br>The findings included:<br><br>Review of the facility's policy titled, "Investigation Process', with a revision date of 06/22, documented, interview and/or obtain statements from potential witnesses as determined by the scope of the investigation ..."<br><br>1. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] for Resident #108.<br><br>Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.<br><br>05/25/22 at 8:59 PM [Situation, Background, Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order | L 204 | L204<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT :<br>The facility cannot retroactively correct this deficiency.<br>Resident #108 was assessed head to toe on 5/26/22, for pain and trauma. No apparent injury observed. Resident was transferred to the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Resident returned to the facility from ER/ hospital visit on 05/27/22. Licensed nurse performed a head to toe assessment on the resident and no negative outcomes were found on 5/27/22. Resident #108 was reassessed head to toe on 8/17/22 by the facility licensed nurse no evidence of physical abuse was observed. | 09/23/22 |

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| L 204 | Continued From page 46<br>was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108<br><br>05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse.<br><br>05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report ... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse. Resident was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ...911 emergency arrive the facility at 17:0pm [5:00 PM] | L 204 | L204<br>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 the CMS regulation & requirement to State Agency or for not conducting interviews and obtaining statements from potential witness of allegation of abuse.<br><br>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.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility has potential to be affected. | |

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| L 204 | Continued From page 47<br>and left the facility at 17:28pm [5:28 PM] to [local hospital] ..."<br><br>Review of the staff assignment revealed Unit 1 had two licensed staff and four (4) CNAs working on evening shift (3:00 PM to 11:00 PM) on 05/25/22. However, review of the facility's investigative report lacked documented evidence of the four (4) CNAs [potential witnesses] interviews or statements.<br><br>During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents.<br><br>Cross Reference 42 CFR 483.12, F600<br><br>2. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the resident-to-resident altercation for Resident #86.<br><br>Resident #86 was admitted to the facility on 08/28/18 with multiple diagnoses including: Dementia without Behavioral Disturbances and Generalized Muscle Weakness.<br><br>Review of a Facility Reported Incident [DC00010685] dated 04/14/22 at 9:09 PM documented, "Around 11:00 AM writer was informed by the smoking monitor that ... [Resident #86] was hit in the face by [Resident #120] ...[Resident #86] stated it all started when [Resident #120] didn't want to ride with me in the elevator to go to the smoke patio ...[Resident #120] approached him and smacked him [in] his face and promised to do so each time he [sees] him ...writer called 911 for intervention. [Officer's name] ... reassured [Resident #86] that he was | L 204 | MEASURES TO PREVENT RECURRENCE:<br>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 on timely. The in-service/education will explain the importance of reporting incidences timely. The compliance date for this intervention 9/23/22.<br>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 during an investigation of all incidences of unusual occurrences. The compliance date for this intervention 9/23/22. | 09/23/22 |

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| L 204 | Continued From page 48<br>taking [Resident #120] to the ER for evaluation ..."<br><br>Review of the medical record showed the following:<br><br>04/19/22 at 11:25 PM [MD Note] - "Resident complained another resident [Resident # 120] who was unprovoked struck him on the right side of the neck two days ago ...Plan continue admission to skilled NH (nursing home) ..."<br><br>04/20/22 at 1:47 PM [Social Work Note] - "The writer and recreation director was informed of a physical altercation between [Resident #86] and [Resident #120] on 04/14/22 ...[Resident #86] expressed that he does not feel safe if [Resident #120] returns to the facility ...I want to press charges ...This writer and activities director accompanied [Resident #86] to the 7th District Police Prescient to report incident and press charges ... "<br><br>Review of facility's investigative report showed the following:<br><br>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 #120] stated nobody can't stop me from getting to you ...I better not catch in the elevator ... because I got something for your [expletive] ..."<br><br>Further review of the lacked documented evidence of an interview of statement from the other resident that was present on the smoking patio at the time of the incident. | L 204 | MONITORING CORRECTIVE ACTION:<br>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 timely and within 2 hours if seriously bodily injury occurred. weekly times 4, then, monthly times 3 months. | 09/23/22 |

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| L 204 | Continued From page 49<br><br>During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that they are working on their process of investigating incidents.<br><br>3. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of a sexual abuse allegation made by Resident #112.<br><br>Resident #112 was admitted to the facility on 08/03/20 with diagnoses that included: Schizophrenia, Psychotic Disorder and Anxiety Disorder.<br><br>Review of a Facility Reported Incident (FRI) received on 07/19/21 documented, "Writer was informed by the charge nurse at 14:40p.m (2:40 PM) that [Resident #112] informed the PT (physical therapist) staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ..."<br><br>Review of Resident #112's medical record revealed the following:<br><br>02/09/21 [Physician's Order] "Sertraline (antidepressant) HCl (hydrochloride) Tablet 50 MG (milligram) give 1 tablet by mouth in the morning for Depression/Anxiety"<br><br>03/20/21 [Physician's Orders] "Quetiapine Fumarate (antipsychotic) Tablet 50 MG give 1 tablet by mouth at bedtime for Schizophrenia"<br><br>A Quarterly Minimum Date Set (MDS) dated 05/04/21 where that facility staff coded: ta brief Interview for Mental Status (BIMS) summary | L 204 | 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 are interviewed and statement are obtained weekly times 4, then, monthly times 3 months.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |

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| L 204 | Continued From page 50<br>score of 10, indicating moderately impaired cognition, no indicators for psychosis, no verbal or physical behaviors directed to others, extensive assistance to total dependence with one person physical assist for bed mobility and transfers, impairment on both sides for lower extremities, wheelchair mobility device and received antipsychotics on a routine basis in the last 7 days.<br><br>07/12/21 at 3:19 PM [Psychiatric Nurse Practitioner Progress Note] "...The patient was seen for f/u (follow up). She has a history significant for depression, anxiety. She is seen lying on the bed, alert and oriented generally to self, generally to place, receptive to visit ... Stable at this time ..."<br><br>07/19/21 at 1:43 PM [Social Work Progress Note] "Sexual assault note: This worker received a report from the ADON (Assistance Director of Nursing) stating the resident informed staff she was sexually assaulted by several men while she was in the facility... Once the resident spoke to the ADON and the SW 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 will continue to document any of the statement that are made by [Resident #112]."<br><br>07/19/21 at 3:52 PM [Nurses Note] "Writer was informed by the charge nurse at 14:40p.m that [Resident #112] informed the PT staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself ... [Resident #112] said "that | L 204 | | |

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| L 204 | Continued From page 51<br>someone from the community has been following her from all her street homes and also followed her to four different hospitals that she been to raping her and touching her inappropriately". Writer reassured the resident of her safety while being a resident in the facility. [Resident #112] said the individual does not work in this facility ... was unable to provide the mane of any individual. NP (Nurse Practitioner) ...was notified ... Resident's RP (representative) ... son was informed of the alleged rape ...Staff will continue to monitor resident for safety and document/report any abnormal concerns to the doctor ..."<br><br>07/19/21 at 7:50 PM [Nurse Practitioner Progress Note] "... Follow up - "patient verbalized to physical therapist of being rapped last night" ... Thorough assessment done by multi-disciplinary team members on follow up of patient comment of rape. Facility well secured and monitored by security staff, staff making frequent rounds, visitors/guests do not enter facility without prior authorization. Facility protocols followed on this comment by patient ..."<br><br>Review of the facility's investigation documents on 06/23/22 lacked documented evidence to show that facility staff obtained statements from all staff that might have knowledge of the alleged incident.<br><br>During a face-to-face interview on 06/23/22 at 2:15 PM, Employee #3 acknowledged the finding and made no further comment.<br><br>4. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of the alleged resident-to-resident incident involving Resident | L 204 | | |

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| L 204 | Continued From page 52<br>#121.<br><br>Resident #121 was admitted to the facility on 02/27/21 with diagnoses that included: Schizophrenia, Pressure Ulcer of Sacral Region Stage 4, Paraplegia, Neuromuscular Dysfunction of Bladder and Schizophrenia.<br><br>Review of a grievance made by Resident #121 dated 05/27/22 documented, "...Wed (Wednesday) May 25, 2022 @ (at) 1:30 AM I was woke by a strange man [Resident #126] in a wheelchair @ (at) the bottom side of my bed. I screamed and called the nurse. He left ... [Nurse's Name] came in and said he was looking for snacks..."<br><br>Review of Resident #121's Quarterly Minimum Data Set (MDS) dated 05/16/22 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of 15, no potential indicators of psychosis and no verbal or physical behavior symptoms directed towards others.<br><br>05/25/22 at 2:11 AM [Nurses Note] "Late Entry: At about 2; 11am a male resident wandered into room 144 A and was redirected back to his room. Writer asked [Resident #121] if the resident touched her, resident stated that no, he did not touch me, writer asked Ms Freeman again, do you have food on the table, resident answered, no he was touching the table and there was no food on the table, it was trash that was on the table."<br><br>Review of the "Grievance Written Decision/Resolution Form" dated 05/27/22 documented, "... Based on these findings, the grievance/alleged abuse case was ... confirmed | L 204 | | |

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| L 204 | Continued From page 53<br>..."<br><br>Although confirmed as abuse on the grievance form, facility staff failed to file an incident report of the resident-to-resident incident.<br><br>During a face-to-face interview conducted on 06/22/22 at approximately 1:00 PM with Employees #6 (Unit 1 Social Worker) and #3, Employee #6 stated, "Once I get a grievance, I speak to the resident and staff involved and get interviews. I then put together a packet and it's given to [Director of Social Services Name] and then goes to the Administration."<br><br>At the time of the aforementioned interview, Employee #3 acknowledged the finding and stated, "An incident report should've been done and sent to DOH (Department of Health)."<br><br>5. Facility staff failed to obtain statements/interviews from all potential witnesses who might have knowledge of Resident #303's physical abuse allegation.<br><br>Resident #303 was admitted to the facility on 12/13/21 with diagnoses that included: Type 2 Diabetes Mellitus, Lack of Coordination and Urinary Tract Infection.<br><br>A FRI was received on 01/02/22 that documented, "During end of shift rounds at about 8:30am on Dec. 31st 2021, writer was informed by Speech Therapist that during her session this morning ... [Resident #303] said one of the nurses hit her on her hand ..."<br><br>Review of Resident #303's medical record revealed the following: | L 204 | | |

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| L 204 | Continued From page 54 | L 204 | | |

An Admission Minimum Data (MDS) dated 12/21/21 where facility staff coded: a brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition, no potential behaviors of psychosis, no verbal or physical behaviors directed towards others, no refusal of care, extensive assistance with one-person physical assist for bed mobility, transfers and personal hygiene and impairment on one side for lower extremity range of motion.

12/31/21 at 6:56 AM [Nurses Note] "Late Entry... During end of shift rounds at 8:30AM, writer was approached by Speech Therapist; she said [Resident #303] just informed her that she was hit on the hand by a nurse last night. Writer went to [Resident #303's] room and asked her what happened last night. She said the female nurse hit her on her left wrist around 11:30PM and 12:00AM last night (Dec. 30th 2021). She denied injury, and there was no swelling, or skin discoloration observed at the alleged skin area in question. She denied pain. [Resident #303] was advised that her complaint will be investigated."

Review of the facility's investigation documents on 06/27/22 lacked documented evidence that all potential witnesses with knowledge of the incident were interviewed or provided a statement.

During a face-to-face interview conducted on 06/27/22 at 9:14 AM, Employee #3 acknowledged the finding and made no further comment.

6. Facility staff failed to implement its policy for investigations evidenced by failure to interview all staff who might have knowledge of neglect allegation of Resident #304.

Resident #304 was admitted to the facility on

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| L 204 | Continued From page 55<br><br>11/02/21 with multiple diagnoses that included: Low Back Pain, Urinary tract infection (UTI), Diabetes Mellitus.<br><br>A Facility Reported Incident (FRI) received on 11/04/21 documented, "...Resident complained that yesterday night [11/03/21] her assigned staff did not respond to her call light on time when she requested fro (sp) assistance ...that the CNA (Certified Nurse Aide) was ignoring her calls/requests ... Resident also reported that this morning she was assisted to the bathroom but the staff CNA never came to assist her back to the bed..."<br><br>Review of Resident #304's medical record revealed the following:<br><br>11/02/21 [Care Plan] "[Resident #304] has an ADL self-care performance deficit r/t generalized weakness s/p (status post) lumbar spinal fusion ... Encourage the resident to use bell to call for assistance."<br><br>An Admission Minimum Data Set (MDS) dated 11/08/21 showed that facility coded the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition, no potential behaviors of psychosis, no refusal of care, required extensive assistance with one-person physical assist for be mobility, transfers, toilet use and personal hygiene, no limitations in range of motion for upper and lower extremities, used a walker and wheelchair for mobility devices, always incontinent of bladder and frequently incontinent for bowel.<br><br>Review of the facility's investigation documents on 06/22/22 showed no documented evidence that the staff who worked with Resident #304 on | L 204 | | |

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| L 204 | Continued From page 56<br>the night of 11/03/21 were interviewed or provided statements.<br><br>During a face-to-face interview on 06/22/22 at 12:55 PM, Employee #7 (Unit 1 Nurse Manager) acknowledged the findings and provided no further comments. | L 204 | L206<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>Resident #108 was assessed head to toe by the facility Licensed nurse on 5/26/22, for pain and trauma, no apparent injury observed. Resident #108 was transfer to 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.<br>Resident #108 returned to the facility from ER/hospital visit on 05/27/22. Licensed nurse, performed a head to toe assessment on the resident and no negative outcome from not reporting the incident to the State Agency reporting system within the required time as stipulated by the CMS regulation & requirement. RP/MD notified. | 09/23/22 |
| L 206 | 3232.4 Nursing Facilities<br><br>Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence.<br>This Statute is not met as evidenced by:<br>Based on record reviews and staff interviews, for nine (9) of 67 sampled residents, facility staff failed to: report allegations of resident-to-resident alleged/witness sexual abuse (inappropriate non-consensual sexual touch /willful non-consensual sexual contact) to the State Survey Agency immediately or no later than two hours of the allegation for Residents #108 and #145; report a resident-to-resident incident involving Resident #121; and report the results of investigations to the State Survey Agency, within 5 working days of the incident for Residents' #145, #108, #86, #8, #84, #112, #303 and #304. Residents' #108, #145, #86, #8, #84, #112, #303, #304 and #121.<br><br>The findings included:<br><br>1. The facility's staff failed to report allegations of resident-to-resident alleged/witness sexual abuse (inappropriate non-consensual sexual touch | L 206 | | |

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| L 206 | Continued From page 57<br>/willful non-consensual sexual contact) to the State Suvey Agency immediately or no later than two hours of the allegation for Residents' #108 and #145.<br><br>1a. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.<br><br>Review of the medical record revealed the following:<br><br>05/25/22 at 8:59 PM [Situation, Background, Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108<br><br>05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse.<br><br>05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names | L 206 | 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. | 09/23/22 |

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| L 206 | Continued From page 58<br>and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A} was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report [number] .... [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ... left the facility at 17:28pm [5:28 PM] to [local hospital] ..."<br><br>Review of the facility's investigative report revealed a facility's staff member notified the State Agency of the incident of alleged resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] on 05/26/22 at 6:46 PM (approximately 22 hours after the incident).<br><br>During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Agency.<br><br>Cross reference 42 CFR 483.12, F600<br><br>1b. Resident #145 was admitted on 02/08/22 with | L 206 | Resident#145 could not be reassessed by facility licensed nurse. Resident has been discharged from the facility on 6/26/2022<br>Result of the investigation report was sent to the State agency via the reporting portal on 7/14/22.<br>Resident #145 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days.<br><br>Resident #108 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma, no apparent injury observed.<br>Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22.<br>Resident #108 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days. | 09/23/22 |

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| L 206 | Continued From page 59<br>multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.<br><br>Review of the medical record revealed the following:<br>06/17/22 at 5:07AM [Physician order] - Transfer resident to ER (emergency) for further examination due to possible physical abuse.<br><br>06/17/22 at 7:38 AM [Nursing Note] - " ... At 5:00 AM GNA/CNA was doing AM care ... She observed ... [Resident #126 from] room 310B ... [laying] on top of the [Resident #145] in room 313B and called writer to the room ... A head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises noted, no skin tear, no bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene] ... An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER (emergency room) for further evaluation ..."<br><br>During a face-to-face interview at approximately 8:45 AM, Employee #2 (DON) stated that she was making the surveyor (Representative of the State Agency) aware of the incident of resident-to-resident alleged abuse with Resident #145 and Resident #126. When asked if the facility's staff informed the Department of Health (State Agency) electronically about the incident? She stated, "No."<br><br>It should be noted that the facility's staff made the State Agency aware approximately 3 hours after the incident.<br><br>Cross reference 42 CFR 483.12, F600 | L 206 | L206<br>Resident #86 was reassessed head to toe by the Unit Manager on 8/17/22.Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident #86 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days<br><br>Resident #8 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma, no apparent injury observed. Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days. | 09/23/22 |

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| (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 |
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| L 206 | Continued From page 60<br><br>2. Facility staff failed to report the results of their investigations to the State Survey Agency within 5 working days of the incident for Residents #145, #108, #86, #8, #84 #112, #303, #304.<br><br>2a. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.<br><br>Review of the Facility Reported Incident dated 06/17/22 at 10:32 AM, documented, " ...Writer was informed by the nurse that [Resident #126] was observed in bed with [Resident #145] in Room 313B ...[Resident #126] was redirected to leave the room ... [Resident #145] was assessed ... no signs of trauma observed...[MD's name] gave orders to transfer [Resident #145] via 911 to ER (emergency room) for further evaluation... "<br><br>Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency.<br><br>Cross reference 42 CFR 483.12, F600<br><br>2b. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.<br><br>Review of the FRI dated 05/26/22 at 11:21 PM, documented, "At 3:30 PM writer received [Officers names] in the facility who said they had a call for alleged abuse for [Resident #108] ...Writer received report that [Resident #126] was observed sitting in his wheelchair at the bedside of [Resident 108] room 112 A at about 8:30 PM | L 206 | Resident #84 was reassessed head to toe by the Unit Manager on 8/17/22.Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days.<br><br>Resident #112 was reassessed head to toe by the Unit Manager on 8/17/22.<br>Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22.<br>Resident #112 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days.<br><br>Resident #303 was reassessed head to toe by the Unit Manager on 8/17/22.<br>Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident suffered no negative outcome from not reporting the result of Agency within 5 working days. | 09/23/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| L 206 | Continued From page 61<br>on 05/25/22. It was reported that [Resident #126] was observed with feces on his left hand ... [Resident #108] was observed with feces on her thigh and bed spread...[Resident #126] was transferred to Unit 3 ...[MD's name] gave orders to transfer [Resident #108] to ER for further evaluation of possible physical abuse ..."<br><br>Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency.<br><br>Cross reference 42 CFR 483.12, F600.<br><br>2c. Resident #86 was admitted to the facility on 8/28/18 with diagnoses that included Dementia without Behavioral Disturbance and Generalized Muscle Weakness.<br><br>Review of the FRI dated 04/19/22 at 1:14 PM documented, "...[Resident #120] ... hit [Resident #86] in the face.."<br><br>Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency.<br><br>2d. Resident #8 was admitted to the facility on 05/26/21 with multiple diagnoses including Schizoaffective Disorder, Delusional Disorder, and Bipolar Disorder ...<br><br>Review of the FRI dated 10/18/21 at 10:39 AM, documented, "At 9:13 PM, to Metropolitan officers arrived at the facility and stated that resident in Room 314 called the police and stated that some hit her neck ... Assessment was done, no lumps, no bruises, no trauma observed on resident's | L 206 | Resident #304 was reassessed head to toe by the Unit Manager on 8/17/22.<br>Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22. Resident #304 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days.<br><br>Resident #121 was reassessed head to toe by the Unit Manager on 8/17/22 for pain and trauma, no apparent injury observed.<br>Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22.<br>Resident #121 suffered no negative outcome from not reporting the result of incident investigation to the State Agency within 5 working days.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility has potential to be affected. | 09/23/22 |

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| L 206 | Continued From page 62<br>neck ... The alleged abuse [Employee #31] is suspended pending investigation ..."<br><br>Review of the facility's investigative documents related to the previously mentioned FRI lacked documented evidence that the facility reported its investigation results to the State Survey Agency.<br><br>Cross reference 42 CFR 483.12, F610<br><br>2e. Facility staff failed to report the results of their investigation of Resident #84's Facility reported allegation of neglect to the State Survey Agency within 5 working days of the incident.<br><br>Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia.<br><br>Review of a Facility Reported Incident (FRI) received on 09/20/21, documented, "A complete head to toe assessment done Multiple scars to left upper back and sacral area. Redness to perineal /sacral area washed with soap and water, pat dry and apply skin barrier cream after each incontinent care, discoloration to left inner leg ..."<br><br>Review of the facility's investigation documents showed no documented evidence that the facility staff reported the results of the alleged neglect investigation to the State Agency.<br><br>During a telephone interview conducted on 07/14/22 at approximately, 3:00 PM, Employee | L 206 | MEASURES TO PREVENT RECURRENCE:<br>The facility Staff Developer/ Designee will provide an education/In-service to facility Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Supervisors on the process of reporting of incident of unusual occurrences to the State Agency within the required time as stipulated by the CMS regulation & requirement and within 2 hours if seriously bodily injury occurred. The in-service or education will explain the importance of reporting incidences within the required time as stipulated by the CMS regulation & requirement.<br>The compliance date for this intervention 9/23/22.<br><br>The facility Staff Developer/Designee will provide education to facility Director of Nursing (DON),Assistant Director of Nursing (ADON), Unit Managers and Supervisors on the importance of the importance of ensuring that results of the incident investigation report are sent to the State Agency via the reporting portal /system within 5 working days of the incident.<br>The compliance date for this intervention 9/23/22.<br><br>MONITORING CORRECTIVE ACTION:<br><br>House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure reporting of all incidences of unusual occurrences to the State Agency via reporting system timely and within 2 hours if seriously bodily injury occurred, 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. | 09/23/22 |

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| L 206 | Continued From page 63<br>#2 (Director of Nursing) acknowledged the findings and stated that they did not send investigation results to the State Agency.<br><br>2f. Resident #112 was admitted to the facility on 08/03/20 with diagnoses that included: Schizophrenia, Psychotic Disorder and Anxiety Disorder.<br><br>Review of a Facility Reported Incident (FRI) received on 07/19/21 documented, "Writer was informed by the charge nurse at 14:40p.m (2:40 PM) that [Resident #112] informed the PT (physical therapist) staff that she was raped all night, that she is feeling so horrible about this place that if she sees a gun, she can just kill herself..."<br><br>Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency.<br><br>2g. Resident #303 was admitted to the facility on 12/13/21 with diagnoses that included: Type 2 Diabetes Mellitus, Lack of Coordination and Urinary Tract Infection.<br><br>Review of a FRI was received on 01/02/22 documented, "During end of shift rounds at about 8:30am on Dec. 31st 2021, writer was informed by Speech Therapist that during her session this morning ... [Resident #303] said one of the nurses hit her on her hand..."<br><br>Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency. | L 206 | | 09/23/22 |

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| L 206 | Continued From page 64<br><br>2h. Resident #304 was admitted to the facility on 11/02/21 with multiple diagnoses that included: Low Back Pain, Urinary tract infection (UTI), Diabetes Mellitus.<br><br>Review of a FRI received on 11/04/21 documented, "...Resident complained that yesterday night [11/03/21] her assigned staff did not respond to her call light on time when she requested fro (sp) assistance ...that the CNA (Certified Nurse Aide) was ignoring her calls/requests ... Resident also reported that this morning she was assisted to the bathroom but the staff CNA never came to assist her back to the bed ..."<br><br>Review of the investigation documents showed no documented evidence that facility staff reported the results of the alleged abuse investigation to the State Agency.<br><br>During a telephone interview conducted on 07/14/22 at approximately 3:00 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated that they did not send results of their investigations to the State Agency.<br><br>3. Facility staff failed to report a resident-to-resident incident involving Resident #121.<br><br>Resident #121 was admitted to the facility on 02/27/21 with diagnoses that included: Schizophrenia, Pressure Ulcer of Sacral Region Stage 4, Paraplegia, Neuromuscular Dysfunction of Bladder and Schizophrenia.<br><br>Review of a grievance made by Resident #121 dated 05/27/22 documented, "... Wed (Wednesday) May 25,2022 @ (at) 1:30 AM I was | L 206 | L207<br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br><br>Resident #108 was assessed head to toe by the facility Licensed nurse on 5/26/22, for pain and trauma, no apparent injury observed. Resident #108 was transfer to 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.<br>Resident #108 returned to the facility from ER/hospital visit on 05/27/22. Licensed nurse, performed a head to toe assessment on the resident and no negative outcome from not reporting the incident to the State Agency reporting system within the required time as stipulated by the CMS regulation & requirement. RP/MD notified.<br><br>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. | 09/23/22 |

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| L 206 | Continued From page 65 | L 206 | | 09/23/22 |

woke by a strange man [Resident #] in a wheelchair @ (at) the bottom side of my bed. I screamed and called the nurse. He left. The nurse [Nurse's Name] came in and said he was looking for snacks..."

Review of Resident #121's Quarterly Minimum Data Set (MDS) dated 05/16/22 showed that facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of 15, no potential indicators of psychosis and no verbal or physical behavior symptoms directed towards others.

05/25/22 at 2:11 AM [Nurses Note] "Late Entry: At about 2;11am a male resident wandered into room 144 A and was redirected back to his room. Writer asked [Resident #121] if the resident touched her, resident stated that no, he did not touch me, writer asked Ms Freeman again, do you have food on the table, resident answered, no he was touching the table and there was no food on the table, it was trash that was on the table."

Review of the "Grievance Written Decision/Resolution Form" dated 05/27/22 documented, "... Based on these findings, the grievance/alleged abuse case was ... confirmed..."

Although confirmed as abuse on the grievance form, facility staff failed to file an incident report of the resident-to-resident incident.

During a face-to-face interview conducted on 06/22/22 at approximately 1:00 PM with Employees #6 (Unit 1 Social Worker) and #2, Employee #6 stated, "Once I get a grievance, I speak to the resident and staff involved and get

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| L 206 | Continued From page 66<br>interviews. I then put together a packet and it's given to [Director of Social Services Name] and then goes to the Administration."<br><br>At the time of the aforementioned interview, Employee #3 acknowledged the findings and stated, "An incident report should've been done and sent to DOH (Department of Health)." | L 206 | | 09/23/22 |
| L 207 | 3232.5 Nursing Facilities<br><br>Incidents of abuse or neglect resulting in injury to a resident, or incidents of misappropriation of a resident's funds, shall be reported immediately to the appropriate agencies, including the Department of Health, the Metropolitan Police Department, the Long Term Care Ombudsman and Adult Protective Services.<br>This Statute is not met as evidenced by:<br>Based on record reviews and staff interviews, facility staff failed to report allegations of resident-to-resident alleged/witness sexual abuse (inappropriate non-consensual sexual touch /willful non-consensual sexual contact) immedailety to the State Suvey Agency for for two (2) of 67 sampld residents. Residents #108 and #145.<br><br>The findings included:<br><br>1. Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.<br><br>Review of the medical record revealed the following:<br><br>05/25/22 at 8:59 PM [Situation, Background, | L 207 | | |

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| L 207 | Continued From page 67<br><br>Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that activity director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to Transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108<br><br>05/26/22 at 4:41 PM [Physician Order] transfer resident to ER via 911 for further evaluation for possible physical abuse.<br><br>05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126 who resided in room 147 bed A} was observed sitting in his wheelchair at the bedside of [Resident #108] room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order | L 207 | L207<br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have the potential to be affected. | 09/23/22 |

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| L 207 | Continued From page 68<br>given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report [number] .... [Resident #108] was unable to explain what happened due to diagnosis of cognitive communication deficit, vascular dementia, and Alzheimer's disease ... left the facility at 17:28pm [5:28 PM] to [local hospital] ..."<br><br>Review of the facility's investigative report revealed a facility's staff member notified the State Agency of the incident of alleged resident-to-resident inappropriate non-consensual sexual touch [sexual abuse] on 05/26/22 at 6:46 PM (approximately 22 hours after the incident).<br><br>During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Agency.<br>Cross reference F600<br><br>2. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.<br><br>Review of the medical record revealed the following:<br>06/17/22 at 5:07AM [Physician order] - Transfer resident to ER (emergency) for further examination due to possible physical abuse.<br><br>06/17/22 at 7:38 AM [Nursing Note] - " ... At 5:00 AM GNA/CNA was doing AM care ... She observed ... [Resident #126 from] room 310B ... | L 207 | L207<br><br>MEASURES TO PREVENT RECURRENCE:<br>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.<br>The in-service/education will explain the importance of reporting incidences timely.<br>The compliance date for this intervention 9/23/22.<br><br>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 work on that shift during an investigation of all incidences of unusual occurrences,The compliance date for this intervention 9/23/22. | 09/23/22 |

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| L 207 | Continued From page 69<br><br>[laying] on top of the [Resident #145] in room 313B and called writer to the room ... A head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises noted, no skin tear, no bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene] ... An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER (emergency room) for further evaluation ..."<br><br>During a face-to-face interview at approximately 8:45 AM, Employee #2 (DON) stated that she was making the surveyor (Representative of the State Agency) aware of the incident of resident-to-resident alleged abuse with Resident #145 and Resident #126. When asked if the facility's staff informed the Department of Health (State Agency) electronically about the incident? She stated, "No."<br><br>It should be noted that the facility's staff made the State Agency aware approximately 3 hours after the incident.<br><br>Cross Reference 42 CFR 483.12, F600 | L 207 | MONITORING CORRECTIVE ACTION:<br>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.<br><br>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.<br><br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |
| L 410 | 3256.1 Nursing Facilities<br><br>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.<br>This Statute is not met as evidenced by:<br>Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled bathroom | L 410 | L410<br><br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:<br>The bathroom vents that were soiled in 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.<br><br>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.<br>Resident room 229 bathroom was cleaned and sanitized on 6/28/22 by the facility housekeeping staff.<br>The oxygen concentrator in resident room 212A was cleaned on 6/29/22 | |

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| L 410 | Continued From page 70<br>vents in three (2) of 34 resident's rooms, soiled privacy curtains in four (4) of 34 resident's rooms, a worn out, dirty floor in one (1) of 34 resident's bathroom, and one (1) of one (1) dusty oxygen concentrator in one (1) of 34 resident's rooms.<br><br>The findings include:<br><br>During an environmental walkthrough of the facility on June 14, 2022, at approximately 11:00 AM, and on June 24, 2022, between 10:50 AM and 1:00 PM the following were observed:<br><br>1. Bathroom vents were soiled in resident rooms #115 and #214, two (2) of 34 resident's rooms.<br><br>2. Privacy curtains were soiled in four (4) of 34 resident's rooms including rooms #110B, #229, #244A and #313B<br><br>3. The floor in the bathroom of one (1) of 34 resident's rooms (#229) was soiled throughout.<br><br>4. The oxygen concentrator in Resident room #212A, one (1) of 34 resident's rooms, was dusty throughout<br><br>These observations were acknowledged by Employee #43 and/or Employee #44 during a face-to-face interview on June 27, 2022, at approximately 3:00 PM. | L 410 | L410<br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility has potential to be affected.<br><br>MEASURES TO PREVENT RECURRENCE:<br>The facility housekeeping Supervisor / Designee will conduct weekly visual audit of all facility rooms vents to ensure they are clean and free from dust. Any issue identified during this audit will be corrected by 09/23/22.<br><br>Education will be provided to facility housekeeping staff by the facility Staff Development on importance of maintaining a safe clean, comfortable environment by 9/23/22.<br><br>The facility Housekeeping Department head / Designee will conduct grand rounds on week days to ensure that the facility maintain a safe, clean, comfortable environment. Any issues identified during the grand round will be corrected by 9/23/22.<br><br>Education will be provided to facility Licensed Nurse by the facility Staff Development on importance of maintaining a clean and dust free Oxygen concentrator for the resident use by 09/23/22<br><br>MONITORING CORRECTIVE ACTIONS:<br>The facility housekeeping Supervisor / Designee will conduct visual audit of all facility rooms vents to ensure they are clean and free from dust.<br>This audit will be done weekly times 4 and then monthly times 3.<br><br>The facility housekeeping supervisor / designee will conduct visual audit of all facility residents' rooms to ensure all privacy curtains are clean and intact. This audit will be done weekly times 4 and then monthly times 3.<br><br>The facility housekeeping Supervisor / Designee will conduct visual audit of all facility residents' rooms to ensure the bathrooms floors are clean. This audit will be done weekly times 4 and then monthly times 3.<br><br>The Assistant Director of Nursing and Unit Managers will conduct house wide audit of Oxygen concentrators in residents rooms to ensure that they are clean and free of dust. This audit will be done weekly times 4 then monthly times 3.<br><br>Findings will be corrected immediately and reported to Quality Assurance Performance Improvement QAPI committee. | 09/23/22 |
| L 442 | 3258.13 Nursing Facilities<br><br>The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br>This Statute is not met as evidenced by: | L 442 | | |

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| L 442 | Continued From page 71<br>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.<br><br>The findings include:<br><br>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.<br><br>These observations were acknowledged by Employee #42 during a face-to-face interview on June 21, 2022, at approximately 2:15 PM. | L 442 | L 442<br><br>CORRECTIVE ACTION FOR THE AFFECTED RESIDENT<br>The dishwasher was repaired on June 22, 2022. No negative outcome observed.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All facility essential equipment and patient care equipment have potential to be affected.<br><br>MEASURE TO PREVENT RECURRENCE:<br>The facility Staff Development will provide education/in-services to the facility maintenance staff and Kitchen staff on importance of maintaining essential and patient care equipment in safe condition.<br><br>MONITORING OF CORRECTIVE ACTION:<br>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 monthly times 3 months.<br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. | 09/23/22 |
| L 521 | 3269.1d Nursing Facilities<br><br>(d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care;<br><br>This Statute is not met as evidenced by:<br>Based on record review and interview, the facility staff failed to provide dignity for a resident as evidenced by not providing personal care (incontinent care) in a timely manner for one (1) of 67 sampled residents (Resident #256).<br><br>The findings include: | L 521 | L 521<br>CORRECTIVE ACTION FOR AFFECTED RESIDENT:<br>Incontinent care was provided to Resident#256 by the licensed nurse on 6/26/22 after being notified by Resident #256.<br>Resident #256 was reassessed head- toe on 8/17/22 by the Unit Manager/Designee, Resident suffered no negative outcome.<br><br>The assistant director of nursing/unit manager will conduct house wide audit to ensure that assigned nursing assistant, provide incontinent care in a timely manner to all residents that require assistance with incontinent care.<br>Any negative findings will be corrected by 9/23/22.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents with requiring assistance with incontinent care have the potential to be affected. | |

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| L 521 | Continued From page 72<br><br>Resident #256 was admitted to the facility on 06/10/22 with multiple diagnoses including Diarrhea, Recurrent Enterocolitis due to Clostridium Difficile (C Diff) and Generalized Muscle Weakness,.<br><br>Record review revealed the following:<br><br>06/10/22 [Admission Nursing Note] - "... admitted to the facility at 6:45 PM form [local hospital]...with discharge diagnoses of C Diff Colitis... abdominal pain and diarrhea ...discharge summary [Resident's name] is C diff positive on PO (by mouth) Vancomycin [antibiotic] for 14 days..."<br><br>06/13/22 [Concerns and Comment Form] written by resident's sister - "They are not staffed to meet residents' needs. They allowed [resident's name] to lay for hours in her fecese [feces]. They are not answering the call [light] when button pushed. [Resident #256] washed at 3:00 PM..."<br><br>06/15/22 [Admission Minimum Data Set] showed the resident had a Brief Interview for Menatal Status summary score of "15", indicating the resident was cognitively intact. Also, Resident #256 was coded for being totally dependent on the physical assistance of one person for toileting and always being incontinent of bowel.<br><br>Review of Care Plan dated 06/12/22 revealed the following:<br><br>Focus area - [Resident's name] has a ADL (activities of daily living) self-care performance deficit r/t (related to) pain and generalized weakness.<br><br>Intervention: | L 521 | L 521<br><br>MEASURES TO PREVENT RECURRENCE:<br>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<br><br>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.<br><br>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.<br><br>MONITORING CORRECTIVE ACTIONS:<br>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 all residents that require assistance from the facility staff for incontinent care.<br>Any issue found during this audit will be corrected by 09/23/22.<br><br>This audit will be done weekly x4 and then monthly x3. The report will be presented to Quality Assurance Performance Improvement QAPI Committee. | 09/23/22 |

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| L 521 | Continued From page 73<br>The resident requires ... assistance by one staff with personal hygiene and oral care.<br><br>During a face-to-face interview on 06/14/22 at approximately 1:00 PM, Resident #256 stated that the staff treated residents terribly. When asked what does that mean? Resident #256 stated, "They left me in my stool for 5 hours." The resident said that she called the desk several times [Employee #31], came in and threw the supplies to clean her on the foot of her bed, and said she was feeding residents [breakfast] and would come back when she was finished. Resident #256 stated that staff did not provide care until her sister came to the facility around 1:00 PM and started complaining.<br><br>During a telephone interview on 06/14/22 at approximately 1:10 PM, Resident #256's sister [the complainant] stated that she was on the phone with the resident around 8:00 AM or 9:00 AM when she heard an employee [Employee #31] say she would change the resident after she finishes feeding other residents. The complaint then said because her sister kept calling her about not being changed, she came to the facility around 1:00 PM and complained to staff, and then a resident's ambassador changed her sister.<br><br>During a face-to-face interview on 06/24/22 at 9:50 AM, Employee #28 (Manager-on Duty, LPN) stated that she came to the floor around 1:00 PM and noticed that the resident's light was on, and she went to the room. The resident informed her that she needed to be changed, so she provided incontinent care and gave the family member [sister] a Concerns and Comment form to document her concerns.<br><br>During a face-to-face interview on 06/27/22 at | L 521 | | 09/23/22 |

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| L 521 | Continued From page 74<br><br>1:00 PM, Employee #31 (Assigned CNA) stated that Resident #256 put the light on about four times when she started her shift at 7:00 AM, but the resident didn't tell her until "9:45 AM she needed to be changed". The employee then said, "I told her [Resident #256] I'm in the middle of passing trays. I'll change you as soon as I can." When asked if she checked to see if the resident was incontinent, Employee #31 stated, "I don't know if she was incontinent because I had to pass my trays and I don't start AM care until 10:00 AM." Additionally, the employee stated that at 10:00 AM security announced over the loud speaker to report to Room 330 because the resident wanted to be changed. Continued interview revealed that [Resident 28] changed the resident.<br><br>During a face-to-face interview on 06/27/22 at 2:00 PM, Employee #21 (RN/Unit Manager) stated that she spoke with the resident and the family member and apologized for staff not providing incontinent care for multiple hours. Employee #21 also said she talked with Employee #31 and re-educated her on responding to call lights and attending to residents' needs in a timely manner. | L 521 | | 09/23/22 |
| L 529 | 3269.1l Nursing Facilities<br><br>(l) To be free from mental or physical abuse;<br><br>This Statute is not met as evidenced by:<br>Based on record review and staff interview, the facility's staff failed to ensure two (2) of seven (7) residents in the sample with allegations of abuse, were free from alleged/witnessed non-consensual sexual contact [sexual abuse] by Resident #126. | L 529 | L 529<br>CORRECTIVE ACTION FOR AFFECTED RESIDENT<br><br>Resident #108 was assessed head to toe by the facility licensed nurse on 5/26/22, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. Resident was transferred to the hospital emergency room on 5/26/22 for further evaluation. Resident returned to the facility from ER/ hospital visit on 05/27/22. Licensed nurse performed a head to toe assessment on the resident and no negative outcomes were found on 5/27/22.<br><br>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 transferred to the hospital emergency room on 06/17/22 for further evaluation. Responsible Party was notified of the transfer on 6/17/22. Resident never returned back to the facility. A well check call was done with the RP on 6/20/22.<br>The RP also said that Resident #145 will not be returning to the facility and that she is currently seeking a new placement for resident. Resident #145 never returned back to the facility. | |

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| L 529 | Continued From page 75<br>(Residents #108 and #145).<br><br>The findings included:<br><br>Review of the facility's policy titled, "Prohibition of Abuse", with a revision date of 05/22, defined sexual abuse as "... non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault..."<br><br>Resident #126 was admitted to the facility on 05/07/21 with multiple diagnoses including Major Depressive Disorder and Dementia without Behavioral Disturbances.<br><br>Review of the resident's medical record showed the following:<br><br>03/02/22 [Quarterly Minimum Data Set -(MDS)] - Resident #126 had a Brief Interview for Mental Status (BIMs) summary score of "99", indicating the resident was unable to complete the assessment. The resident was not coded for exhibiting physical behavior symptoms directed toward other (ie. abusing others sexually). Further review of the MDS showed the resident was coded for using a wheelchair, not walking in room or in corridor, and being frequently incontinent of stool.<br><br>05/25/22 at 9:27 PM [Nursing Supervisor's Note] - "... Resident last seen by writer at 8:15 PM in his room in his bed washing [watching] TV. At 8:35 PM writer was informed by assigned nurse the [Resident #126] wandered in Room 112 despite staff redirection. Activity Director reported that he observed [Resident #126] sitting in his wheelchair at the bedside of [Resident #108] ... [Resident #126] was seen with BM (bowel movement) on | L 529 | IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have the potential to be affected.<br><br>MEASURES TO PREVENT RECURRENCE:<br>In-service will be provided by Staff Development /designee to all facility staff on abuse prohibition by 9/23/22<br><br>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.<br><br>In-service will be provided by Staff 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.<br>Repeat in-service will be provided as needed.<br><br>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.<br>Any issues found will be corrected by 09/23/22. | 09/23/22 |

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| L 529 | Continued From page 76<br>his left hand ... [MD's name] ...order given to relocate [Resident #126] to another unit for wandering behavior, psych consult for behavioral disturbances. [Resident #126] was transferred to [Room] 310-B. [Resident #126] will be closely monitored for safety precautions pending psych evaluation..."<br><br>05/27/22 at 7:00 AM [Psychiatric NP Note] - "Patient seen to evaluate mental status and adjust medications for behavioral disturbances ...He was counseled about the risk of invading other people's personal spaces or touching others inappropriately. He was also encouraged to respect other peoples' personal spaces and not to touch anyone inappropriately; and he was receptive ...His Sertralin [antidepressant]...was increased to 50 mg (milligrams) ... to control his depression and compulsive behavior of wandering or touching others inappropriately..."<br><br>06/02/22 [Quarterly Minimum Data Set -MDS] - Resident #126 had a Brief Interview for Mental Status (BIMs) summary score of "06", indicating the resident was severly impaired cognitively.The resident was not coded for exhibiting physical behavior symptoms directed toward other (ie. abusing others sexually). Further review of the MDS showed the resident was coded for using a wheelchair, not walking in room or in corridor, and being frequently incontinent of stool. Also, the resdient was coded for being 257 pounds and 6 feet tall.<br><br>06/13/22 at 1:47 PM [Nursing Note] - "...at 1200 [12:00 PM] resident was observed wandering and pacing the hallway with his wheelchair, entering other resident's room, resident was redirected at all times by staff. NP... notified, recommends to monitor and redirect as required and psych | L 529 | Unit Managers and Shift Supervisors will conduct rounds during their shift to ensure that resident with sexual behavior, behavior with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Any issues found will be corrected by 9/23/22 .<br><br>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 and provided with adequate supervision to ensure such behavior is prevented. Any issue found during this audit will be addressed by 9/23/22<br><br>Unit Mangers and Shift Supervisors will conduct rounds during their shift to ensure that resident with sexual behavior, behavior with the potential to abuse others, and wandering behavior are monitored and adequate supervision is provided. Rounds /audit will be conducted weekly times 4 then monthly times 3. | 09/23/22 |

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| L 529 | Continued From page 77<br>consult for behavioral disturbances..."<br><br>06/13/22 to 06/17/22 - review of progress notes, Medication Administration Records and Treatment Administration Records lacked documented evidence Resident #126 was re-evaluated by psych for wandering in residents' rooms as ordered by NP on 06/13/22.<br><br>06/17/22 at 8:04 AM [Nursing Supervisor's Note] - "At about 5:40 AM ...writer was informed by nurse [Resident #126] was observed in bed with [Resident #145] ...MD order to transfer [Resident #145] ... to ER for further evaluation ...[Officer's name and Detective's name] ... the detective interviewed writer, [Resident #126], assigned nurse ...and said they will continue with their investigation ..."<br><br>Review of Treatment Administrator Records (TAR) from 05/01/22 to 06/17/22 showed nurses documented hourly the resdients location in the facility. Further review of the June TAR showed that on 06/17/22 at 5:00 AM the doucumented "IB" indicating that she observed Resient #126 in bed at that time.<br><br>Review of a Care Plan with a revision date of 06/17/22 revealed the following:<br><br>Focus Area - [Resident #126] have problematic manner in which resident acts characterized by inappropriate sexual behavior physical related to: resident touches other residents &/ or staff inappropriately ... Staff reported that [Resident #126] was observed on top of [Resident #145] in Room 313 B."<br><br>Goal- [Resident #126] will have reduced incidents of inappropriate sexual behavior. | L 529 | | 09/23/22 |

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| L 529 | Continued From page 78<br><br>Interventions:<br>-Protect other residents if unable to protect themselves<br>-One-on-one monitoring X 24 hours every day for safety precautions.<br>-Remove resident from public area when behavior is disruptive/unacceptable ...<br><br>NOTE: Please see interviews below for the previously mentioned incidents involving Residents #108 and #145.<br><br>1.The facility's staff failed to keep Resident #108 safe from Resident #126's alleged inappropriate non-consensual sexual touch.<br><br>Resident #108 was admitted to the facility on 12/10/19 with multiple diagnoses including Alzheimer's Disease and Major Depression.<br><br>Review of a Facility Reported Incident [DC00010774] dated 05/26/22 at 11:21 PM, documented, "At 3:30 PM writer received [Officers names] in the facility who said they had a call for alleged abuse for [Resident #108] ...Writer received report that [Resident #126] was observed sitting in his wheelchair at the bedside of [Resident 108] room 112 A at about 8:30 PM on 05/25/22. It was reported that [Resident #126] was observed with feces on his left hand ... [Resident #108] was observed with feces on her thigh and bed spread...[Resident #126] was transferred to Unit 3 ...[MD's name] gave orders to transfer [Resident #108] to ER for further evaluation of possible physical abuse ..."<br><br>Review of the resident's medical record showed the following: | L 529 | | 09/23/22 |

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| L 529 | Continued From page 79<br><br>04/11/22 [MDS] - Resident #108 had a Brief Interview for Mental Status (BIMs) summary score of "99" indicating the resident was unable to complete the assessment. Further review of the MDS showed Resident #108 was coded for being totally dependent on the physical assistance of two staff members for bed mobility and one staff member for personal hygiene. Resident #108 was also coded for always being incontinent of urine and bowel.<br><br>05/25/22 at 5:03 PM [Activity Note]- "Incident Report: When preparing to leave for the evening I [Employee #26 Activities Director] found [Resident #126]... sitting in his wheelchair at the bedside of [Resident #108] in room 112-A. Writer [Employee #26] observed feces on [Resident #126's] left hand front, back, and underneath his fingernails. Feces was also noticed on [Resident #108's] thigh and her bed spread. [Resident #126] was immediately removed from the scene and... relocated to Unit-3 room 310-B." It should be noted that this in a late entry note that was created on 05/27/22 at 5:16 PM (approximately 2 days after the incident) with an effective date 05/25/22 at 5:03 PM.<br><br>05/25/22 at 8:30 PM [Nursing Supervisor Note]- "During the evening shift at about 8:30pm writer was made aware by the nurse that Activity Director saw [Resident #126] in resident`s [Resident #108's] room. [Resident #126] was sitting at the bedside in his wheelchair and had feces on his left hand. [Resident #108] was assessed from head to toe. No injury was observed. No sign of pain nor discomfort expressed upon assessment. [Resident #108] was assisted with incontinent care and resident`s [responsible party's name] made aware. resident was monitored through the shift with no other | L 529 | | 09/23/22 |

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| L 529 | Continued From page 80<br><br>concerns reported ... BP (blood pressure) 122/67, Pm(pulse) 74, R18, O2 (oxygen) 99% ra (room air), T (temperature) 97.8. It should be noted that this in a late entry note that was created on 05/27/22 at 7:33 AM (approximately 2 days after the incident) with an effective date 05/25/22 at 8:30 PM.<br><br>05/25/22 at 8:59 PM [Situation, Background, Assessment, Result Form]- "During the evening shift at about 8:30pm writer was made aware by the nurse that Activity Director saw [Resident #126] ...sitting at the bedside [of Resident 108] in his wheelchair and had feces on his left hand. [Resident #108] was unable to explain what happened due to diagnosis of Cognitive Communication Deficit. [Resident #108] was assessed from head to toe by the nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks. [MD's name] made aware, new order was given to transfer resident to ER (emergency room) via 911 for further evaluation for possible physical abuse." It should be noted that the order to transfer Resident #108 to ER was not written until 05/26/22 at 4:41 PM after police came to facility after receiving a call for a call of physical abuse for Resident #108..."<br><br>05/26/22 at 4:41 PM [Physician's Order] "transfer resident to ER via 911 for further evaluation for possible physical abuse"<br><br>05/26/22 at 3:30 PM [ADON Note] - "At about 3:30pm writer received [two police officers names and badge numbers] in the facility who said they had a call for alleged abuse for [Resident #108] in room 112-A. Writer received report from staff that [Resident #126] who resided in room 147 Bed A | L 529 | | 09/23/22 |

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| L 529 | Continued From page 81 | L 529 | | 09/23/22 |

was observed sitting in his wheelchair at the bedside of [Resident #108] Room 112-A at about 8:30pm on 5/25/22. It was reported that [Resident #126] was observed with feces on his left-hand front, back, and underneath his fingernails. It was also reported that [Resident #108] was observed with feces on her thigh and her bed spread. [Resident #126] was immediately removed from the scene and [MD's name] notified and order given to transfer [Resident #126] to Unit 3 - Room 310-B. Also, [Detective's name and badge number] was called to the facility by the police. After meeting with the residents and talking to staff members the detective issue report ... No arrest was made. However, [MD's name] also gave order to transfer [Resident #108] to ER (emergency room) via 911 for further evaluation for possible physical abuse... Resident ... left the facility at 17:28pm [5:28 PM] to [local hospital] ..."

05/27/22 at 6:53 AM [Nursing Note] - "[Resident #108] returned from [local hospital] at about 5:10am ... The medic ... who accompanied her from the hospital stated no evidence of physical assault was observed after examination by the doctor and she is free to resume all activities and treatment active prior to transfer to the ER..."

During multiple observations from 06/19/22 to 06/22/22 from approximately 11:00 AM to 4:00 PM, Resident #108 was observed in bed sleeping or eyes open and not responding to verbal stimuli. Resident #108 was non- interviewable.

During a face-to-face interview on 06/22/22 at 3:00 PM, Employee #26 (Activity Director) stated that he was made aware that Resident #126 was in another resident's room uninvited but could not remember the date (Cross reference F607

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Resident #121). The employee stated on 05/25/22 at approximately 8:00 PM, he went to look for Resident #126's and could not find him in his Room 147 or in the hallway where he usually sits playing cards with other residents. Employee #26 said he then alerted the nursing staff, and they all started looking for the resident. The employee said he found Resident #126 in Room 112 sitting in his wheelchair at the bedside of Resident #108, who was in bed A. The employee then called nursing staff to Room 112 and moved Resident #126 into the hallway.

Further interview revealed Employee #26 asked the resident why he was in Resident 108's room, but Resident #126 did not provide an answer. The employee also observed the resident with feces on his left hand. The employee asked the resident if he had a bowel movement, and the resident said, "No." However, when he went back into Room 112 with the nursing staff, he noticed Resident #108's bedspread had stool on it. When asked did Resident #108 say anything, He stated, No, she's non-verbal." Additionally, the employee stated that Resident #126 was moved to the third floor 310B after the incident.

During a face-to-face interview on 06/23/22 at 9:37 AM, Employee #3 (ADON) stated that the incident with Resident #126 and Resident #108 was discussed in the morning stand-up meeting on 05/26/22. However, he was unaware the incident was a physical assault until he saw the police in the facility on 05/26/22 responding to a call for "alleged abuse" against Resident #108. When asked who called the police, Employee #3 said that he did not know. Additionally, the employee said he made the physcian aware and was given an order to transfer Resident #108 to the emergency room to be evaluated for possible

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physical assault.

During a face-to-face interview on 06/24/22, Employee #25 (CNA) stated she was looking for Resident #126 when Employee #26 called her to Room 112. Resident #126 was sitting in the hallway with stool [feces] on his left hand. She also observed Resident #108 "diaper was off, and she had stool [feces] smeared all over her stomach and thighs." The employee said she provided incontinent care for Resident #108. When asked did Resident #108 say anything, the employee said, "No", she doesn't talk. She just had tears rolling down her face."

Additionally, the employee stated that when she assisted Resident #126 to his room, and the resident kept trying to hide his left hand under his leg. When she asked him what was on his hand, the resident said, "Dirt." The employee said that it was not dirt; it was stool [feces]. The employee stated, "I changed him [Resident #126], and he was not incontinent of stool. I only found stool on his hand." The employee said, "The police came the next day [05/26/22] when they received an anonymous call."

Review of records and staff interviews revealed that the facility's staff failed to ensure Resident #108 was safe from Resident #126's alleged inappropriate non-consensual sexual touch.

2. The facility's staff failed to keep Resident #145 safe from Resident #126's witnessed willful non-consensual sexual contact.

Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit,

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| L 529 | Continued From page 84<br>and Generalized Muscle Weakness.<br><br>Review of the Facility Reported Incident [DC00010821] dated 06/17/22 at 10:32 AM, documented, " ...Writer was informed by the nurse that [Resident #126] was observed in bed with [Resident #145] in Room 313B ...[Resident #126] was redirected to leave the room ... [Resident #145] was assessed ... no signs of trauma observed...[MD's name] gave orders to transfer [Resident #145] via 911 to ER (emergency room) for further evaluation... "<br><br>Review of the medical record revealed the following:<br><br>05/06/22 [Quarterly Minimum Data Set -MDS] - revealed the following: Resident #145 had a Brief Interview for Mental Status summary score of "99" indicating the resident was unable to complete the assessment. Further review of the MDS showed Resident #145 was coded for requiring extensive assistance of one staff person for bed mobility, transferring, and personal hygiene. Also, the resident was coded for being 93 pounds and 5 feet tall.<br><br>06/17/22 at 5:07AM [Physician order] - Transfer resident to ER (emergency) for further examination due to possible physical abuse.<br><br>06/17/22 at 7:38 AM [Nursing Note] - " ...At 5:00 AM... CNA [Employee #15] was doing AM care...she observed the Resident in [from] room 310B [Resident #126] was on top of the [Resident #145] in room 313B ...Writer called the supervisor immediately and the other staff on the floor. Supervisor redirected the resident [Resident #126] to his room. Initiated a 1:1 (one-to-one) around the clock monitoring until further notice. A | L 529 | | |

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| L 529 | Continued From page 85<br><br>head-to-toe assessment was done [for Resident #145] by supervisor and writer. No bruises ...skin tear... bleeding noted. Resident denied pain or any discomfort at this time. Police was called on the seen [scene]. Emergency responders were called on the seen [scene] too. An assessment was done by emergency responders, and they came to a conclusion to transfer resident to the nearest ER for further evaluation per physician's orders. Responsible party was notified. V/S (vital signs) T 97.6 P 87 BP 142/67 R 18 O2SAT 98% Room Air."<br><br>06/17/22 at 8:23 AM [Nursing Supervisor Note]- "At about 5:40am, writer received a call from [Resident #126's name] assigned nurse requesting writer to report to the third floor ASAP (as soon as possible). When writer arrived on the floor, writer observed [Resident #126's name] walking to his room. He had his gown on and he was wearing a diaper. Writer was informed by the nurse that [Resident #126] was observed in the bed with [Resident #145] in Room 313B. According to the nurse, [Resident #126] was immediately redirected to leave the [his] room ... [Resident #145] was assessed by writer and the two other nurses on the floor. Her skin warm and dry to touch, she denied pain upon further assessment. No signs of trauma observed as resident remain calm and cooperative ...brief was intact and appropriate, no moisture/urine observed. Writer and the other nurses could not observe any signs of an open brief on full head to toe assessment ...MD (medical doctor) gave order to transfer ...via 911 to ER for further evaluation/treatment ... [Resident #145] left facility ..."<br><br>06/17/22 at 8:32 AM [Situational Background, Assessment, Request (SBAR) Tool], | L 529 | | |

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| L 529 | Continued From page 86<br><br>documented, "... At about 5:40 AM writer was informed by the nurse that [Resident #126] was observed in the bed with [Resident #145] in Room 313B...[Resident #145] was assessed no signs of pain expressed. Her brief was intact/appropriate, no moisture/urine observed ...911 called [Resident #145] left facility ...to ER ...police called [Officer's name and Detective's name] came to facility ... and interviewed writer [Employee 20], nurse [Employee #14], and [Resident #126]..."<br><br>06/17/22 at 10:26 AM [Unit Manager Note]- "Writer made a f/u (follow-up) call to the RP (responsible party) ...to notified about the resident [Resident #145] transfer ...to ER for further examination due to possible physical abuse."<br><br>06/17/22 at 6:37 PM [Attending Physician Note] - " ... Nursing staff reported that during monitoring round that a male resident [Resident 126] was found in bed with resident [Resident #145] early morning of 7/17/2022 [06/17/22] ... Resident [Resident #145] has been evaluated by assault forensic specialist at the acute care hospital emergency department ... I have updated resident's daughter... She has requested another facility for resident ..."<br><br>Review of witness statements showed the following:<br><br>06/17/22 [Employee #15 - CNA] documented, "I checked on 310 B [Resident #126] hourly. He was in his bed. I sat in the hall by room 313 b all night. At 5:45 AM I started rounds, when I came around the corner, I noticed 313 [Resident #145] room door was closed, I opened the and saw 310 B [Resident #126] naked on top of 313 B [Resident #145]." | L 529 | | |

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| L 529 | Continued From page 87<br><br>06/17/22 [Employee #14, LPN] documented, "Around 5:40 AM ... called by [Employee #15] in room 313 B ...observed a resident in [from] room 310 B on top the resident [Resident #145] in room 313 B ... other staff members to help get the resident [Resident #126] off the other resident [Resident #145] ..."<br><br>06/17/22 [Employee #16, RN] documented, "Around 5:40 [AM] [Employee #14] was calling for help ...went to ...Room 313 B ...saw [Resident #126] was on top of Resident 313 B [Resident #145] NAKED..."<br><br>06/17/22 [Employee #19, LPN] documented, "Around 5:40 [AM] ... the 2 nurses [Employee #14 and #16] I was working with ... called me to room [313] where I saw [Resident #126] naked sitting on [Resident #145's] bed."<br><br>06/17/22 [Employee #20, RN Nursing Supervisor] documented, "At about 5:40 AM ...received a call from [Employee #14] requesting ... to report to the third floor ASAP (as soon as possible). When ... arrived on the floor ...observed [Resident #126] walking to his room [310]. He had on a gown, and he was wearing a diaper [incontinent pad] ... informed by [Employee #14] that [Resident #126] was observed in the bed with [Resident #145] in room 313 B ... [Resident #145's] brief was intact ..."<br><br>During a face-to-face interview on 06/17/22 at approximately at 8:30 AM, Employee #14, LPN (assigned nurse) stated that the CNA [Employee #15] was very upset and called her to room 313. When she arrived at the room, she observed Resident #126 naked laying on top of Resident #145, who was also naked. The employee then | L 529 | | |

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said that the staff helped her get Resident #126 off Resident #145. Then the staff helped him get dress and escorted him to his room.

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.

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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| L 529 | Continued From page 89<br><br>During a face-to-face interview on 06/22/22 at approximately 7:30 AM, Employee #24 (CNA), stated that she worked on the floor for three years. The employee said that she was not provided any education about Resident #126 when he was moved to the third floor.<br><br>During a face-to-face interview on 06/22/22 at approximately 7:45 AM, Employee #25 (CNA) stated that she has worked on the floor for 5 years. The employee said she was not provided any education about Resident #126 when he moved to the floor. It should be noted that Employee #25 worked the morning of 06/17/22 when Resident #126 was observed naked on top of Resident #145.<br><br>During a face-to-face interview on 06/24/22 at approximately 4:00 PM, Employee #13 (Educator) stated that she provides education annually, as needed, and when there is a concern in the facility. When asked did she provide education to staff after Resident #126 was moved to the third floor for allegedly inappropriately touching a female resident? She stated that she did not provide education to staff.<br><br>Review of records and staff interviews revealed that the facility's staff failed to ensure Resident #145 was safe from Resident #126's witness willful non-consensual sexual touch. | L 529 | | 09/23/22 |
| L 534 | 3270.1 Nursing Facilities<br><br>A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. | L 534 | L534<br>CORRECTIVE ACTIONS ON RESIDENTS AFFECTED:<br>Resident #84 was assessed from head to toe on 08/17/22 by Unit Manager.<br>Resident suffered no negative outcomes.<br>Resident/Responsible party will be updated on the bed hold policy by 09/23/22.<br><br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have the potential to be affected. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0011 | A. BUILDING: _____ B. WING _____ | C 06/29/2022 |

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

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| L 534 | Continued From page 90<br>Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)).<br><br>This Statute is not met as evidenced by:<br>The facility's staff failed to provide a written notice of the facilities bed-hold policy to Resident #84 and the Resident's Representative on multiple occasions when Resident #84 was transferred to the Hospital from the facility.<br><br>Resident #84 was admitted to the facility on 05/20/21, with multiple diagnoses that included: Type 2 Diabetes Mellitus Without Complications, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Aphasia Following Cerebral Infarction, Sepsis Unspecified Organism, Unspecified Convulsions, Multiple Sclerosis, Gastrostomy Status and Dysphagia.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, revealed that the facility staff coded the following:<br>Section C (cognitive Patterns): "Should a Brief Interview for Mental Status be Conducted? "NO"<br><br>Review of the physician orders showed the following: 04/07/22, "Resident returned from hospital ..."<br><br>Review of the nurse's progress notes revealed the following:<br><br>01/03/22 at 3:37 PM "Resident was observed with bright red blood saturated brief during incontinent care at 1:30 PM. Assessment revealed profuse bleeding from her vagina ...NP (nurse practitioner) was notified and oder (sp) given to transfer resident to ER (Emergency room) ..."<br><br>02/20/22 at 4:29 PM " ...resident was observed | L 534 | L 534<br>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:<br>All residents residing in the facility have the potential to be affected.<br><br>MEASURES TO PREVENT RECURRENCE:<br>Staff Development/Designee will provide education/in-service to the facility Admission Director/ Designee on the importance of providing the bed hold policy to the resident and/or responsible party/ designee within stipulated time by CMS requirement and regulation.<br><br>MONITORING CORRECTIVE ACTION:<br>Director of Admission/Designee will conduct house wide audit to ensure that responsible parties are notified or provided with a copy of the bed hold policy when a resident is out of the facility and update them in writing of the bed hold days and ensure documentation of bed hold policy and bed hold days in the resident medical record, weekly times 4, then, monthly times 3 months. Any issues found will be corrected by 9/23/22.<br>The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee . | 09/23/22 |

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| L 534 | Continued From page 91<br>again vomiting large amount of coffee ground emesis and continuously bleeding fresh red blood from both nostrils ...911 was called, paramedics arrived at resident bedside at 5PM assessed resident and left the unit with resident to (Hospital name) ..."<br><br>03/31/22 at 7:33 PM " ...nurse observed resident with dislodged G-(Gastrostomy)Tube during medication administration ...writer attempt to replace G-tube unable on two attempts with resistance. Resident with (Hospice name) made aware and give order to send resident to nearest ER for G-tube replacement ...911 call at 7:55pm and EMT arrived at 8:05 pm bed side assessment done, and resident was transfer ..."<br><br>There is no documented evidence in the medical record of a notice of the bed hold policy being given to resident or resident representative.<br><br>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 hospitalizations. 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 #84)" | L 534 | | 09/23/22 |