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L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility from October 10, 2023, to October 20, 2023. Survey activities consisted of observations, record reviews, and resident, family and staff interviews. The facility's census on the day of the survey was 168 residents. The following Facility Reported Incidents (FRIs) were investigated: DC~11122, DC~11228 DC~12257, DC~12231, DC~12228, DC~12210, DC~12195, DC~12174, DC~12083, DC~12078, DC~12118, DC~12106, DC~12103, DC~11960, DC~11886, DC~11885, DC~11876, DC~11793, DC~11652, DC~11630, DC~11584, DC~11408, DC~11344, DC~11260, DC~11247, DC~11233, DC~11322, DC~11190, DC~11158, and DC~11677. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. Citations are being cited for: DC~12257, DC~12228, DC~12083, DC~12106, DC~11886, DC~11885, DC~11584, and DC~11190. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations	L 000	**Serenity Rehabilitation and Health Center Disclaimer:** Serenity Rehab and Health LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	11.10.2023

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L 000	Continued From page 1 CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury	L 000		

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L 000	Continued From page 2 MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		11.10.2023
L 015	3203.5 Nursing Facilities Each facility shall maintain the following administrative records: (a) Payroll records; (b) Reports of fire inspections; (c) Compliance reports required to be maintained	L 015	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The facility cannot retroactively correct this deficient practice. The dialysis residents did not receive any adverse reaction from this deficient practice. The facility has implemented a new process to ensure all new admissions receiving dialysis services have written contract / agreement with the facility prior to being admitted.	

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L 015	Continued From page 3 pursuant to the 1996 BOCA National Building Code, construction and permit regulations; (d) Reports of inspections of the fire alarm system and fire drills; (e) Reports of elevator inspections; (f)Disaster plan and procedures; (g) Certification of flame spread ratings of carpets, curtains and wall coverings; (h) Each contract for professional and facility services; (i) Radiation survey reports of x-ray equipment, if applicable; (j) Summaries and analyses of each incident involving residents, staff and visitors; and (k) Policies and procedures governing the operation of the facility. This Statute is not met as evidenced by: Based on record review and staff interviews, facility staff failed to maintain contract/agreement for dialysis services. The findings included: Review of the facility matrix document provided to this surveyor on 10/10/23, it documented that the facility had three (3) residents on dialysis. During a review of the facility's contracts on 10/10/23 at approximately 4:00 PM, it was noted that the facility failed to have dialysis contracts	L 015	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** The facility has determined that all residents receiving dialysis services have the potential to be affected. **3. MEASURE TO PREVENT REOCURRENCE** The Administrator was In-serviced on October 18, 2023 by the Governing Body on the importance of ensuring the facility has current contracts with Dialysis providers for each dialysis residents. The facility has implemented a new process to ensure it has a written contract for all new dialysis residents. The Admissions Director will ensure the contract is in place prior to Admissions. **4. MONITORING CORRECTIVE ACTION** A member of the Governing Body will monitor all new Dialysis admissions to ensure current contracts are in place for the residents. Any negative findings will be addressed upon discovery. Monitoring will be completed weekly x 4 and monthly x 2.	11.10.203

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L 015	Continued From page 4 with any dialysis service providers. During a face-to-face interview conducted on 10/10/23 at 4:35 PM, Employee #2 (Director of Nursing/DON) stated, "We do not have any contracts or agreements with the dialysis facilities. We have 3 dialysis residents who go to two (2) different dialysis centers. I will double check." During a face-to-face interview conducted on 10/11/23 at 11:30 AM, Employee #1 (Administrator) stated, "I checked with the dialysis centers, and we do not have any contracts with them. The residents that use their services came to us already with them as their dialysis service provider. We are working on getting contracts now."	L 015	The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;	L 051	1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS Resident#159 currently resides in the facility. The Licensed Nurse completed a head-to-toe assessment on October 11, 2023, there were no adverse findings identified. The physician was informed of the untimely administration of the medications. There were no new orders given.	

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L 051	Continued From page 5 (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 57 sampled residents, facility staff failed to review medication orders for completeness and accuracy in the transcription of physician's orders. Resident #159. The findings included: According to the National Institute of Health (NIH): -One of the five traditional rights of medication administration is the right time -Certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. https://www.ncbi.nlm.nih.gov/books/NBK560654/ According to the Mayo Clinic: -Food in your stomach may change the amount of Methimazole (antithyroid) that is able to enter the bloodstream. To make sure that you always get the same effects, try to take Methimazole at the same time in relation to meals every day. That is, always take it with meals or always take it on an empty stomach. https://www.mayoclinic.org/drugs-supplements/antithyroid-agent-oral-route-rectal-route/proper-use/drg-20069661#:~:text=Food%20in%20your%20stomach%20may,it%20on%20an%20empty%20stomach.	L 051	2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED All Residents currently residing in the facility who have orders for medications have the potential to be affected. An audit was completed by the DON/Designee to identify any resident who have had medications administered untimely. No adverse findings were identified. This audit was completed on October 18, 2023. 3. MEASURE TO PREVENT REOCURRENCE The Director of Nursing has re-educated all licensed nurses on the Medication Administration Guideline with emphasis on ensuring medications are administered timely and signed in the Medication Administration Record. This was completed on November 10, 2023. 4. MONITORING CORRECTIVE ACTION The DON/ Designee will randomly audit 5 residents using the Medication Administration Record for timely completion weekly x 4 weeks and monthly x 2 to ensure timely	11.10.2023

administration of meds per physician orders.

Findings of these audits will be reported to the monthly QAPI for further recommendations.

All negative findings will be corrected upon discovery.

Date of Compliance: 11-10-2023

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L 051	Continued From page 6 Resident #159 was admitted to the facility on 09/11/23 with diagnoses that included: Type 2 Diabetes Mellitus and Thyrotoxicosis. Review of Resident #159's medical record revealed the following: A hospital discharge summary dated 09/19/23 documented discharge medication instructions of: -Insulin Glargine 15 units subcutaneously nightly -Methimazole 10 mg (milligrams) by mouth daily A physician's order dated 09/19/23 directed, "Methimazole oral tablet 10 MG, give 1 tablet by mouth every night shift for Hyperthyroidism". A physician's order dated 09/20/23 directed, "Insulin Glargine subcutaneous solution 100 Units/ML (milliliters), inject 15 units subcutaneously every night shift, hold if FBS (fasting blood sugar) < (less than) 100". An Admission Minimum Data Set (MDS) assessment dated 09/25/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 14, indicating intact cognitive response and that the resident received Insulin injections every day during the last 7 days. Resident #149's Medication Administration Record (MAR) from 09/19/23 to 10/12/23, a total of 23 days, showed the administration time for Insulin Glargine and Methimazole as "11:00 PM - 7:00 AM" with no specific administration time. It should be noted that Resident #159's other ordered medications documented specific administration times.	L 051		11.10.2023

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L 051	Continued From page 7 During a face-to-face interview on 10/12/23 at 4:47 PM, Employee #2 (Director of Nursing/DON) reviewed Resident #159's physician's orders and MAR, acknowledged the findings and stated that one of the rights of medication administration is the right time and that there should be specific administration times for all ordered medications.	L 051		11.10.2023
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;	L 052		

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L 052	Continued From page 8 (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility staff failed to ensure that sufficient nursing time was given to three (4) of 57 sampled residents, as evidenced by the staff failing to do the following: ensure an intervention (treatment) is included in Resident #54's fall care plan, perform a weekly skin assessment for Resident #418, use a 2-person assist when transferring Resident #102 from a wheelchair to the bed using a Hoyer lift and ensure Resident #145 received assistance in arranging an ophthalmology consult as prescribed by the physician. Residents #54, 418 #102, and #145 1) Facility staff failed to perform weekly skin assessments in December 2022 for Resident #418. Resident #418 was admitted to the facility on 12/09/2022 with multiple diagnoses that included	L 052	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** a) This deficiency cannot be retroactively corrected. Resident#418 no longer resides in the facility. b) Resident #102 was assessed for required transfer assistance of two-person transfer assist when using mechanical lifts. A head-to-toe assessment was conducted by the DON/ Designee on October 16, 2023 and no adverse findings were resulted. Employee #15 was educated to ensure required transfer assistance is met for transferring resident while using a lift. c) Resident #145 remains stable in the facility and an appointment for eye surgical evaluation was scheduled for 12/16/2023. A head-to toe assessment was conducted for resident#145 and no adverse findings were discovered. d) The Director of Rehabilitation and the Director of Nursing reviewed and revised Resident #54 comprehensive care plan on November 10, 2023 to ensure therapy services are provided by the facility to meet professional standards of quality. The resident had no negative outcome from this deficient practice	11.10.2023

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the following: Diabetes Mellitus Type 2, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Benign Neoplasm of Parathyroid Gland.

A Facility Reported Incident (FRI) DC00011344, was received by the State Agency on 12/13/2022 and documented the following, " ...readmitted with an open area 1 X 4 X 0.1cm on her sacrum. She also has rash excoriation on her groins and buttocks. The open area on her buttocks was cleansed with normal saline, pat dry ..."

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

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

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

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

[Nurse Progress Note] 12/10/22 " ...Her skin warm to touch, discoloration observed on bilateral

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I DENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED

a) All residents residing in the facility requiring a skin assessment has the potential to be affected by this deficient practice. A house wide audit was done for all skin assessment. This was completed on November 03, 2023.

b) All residents residing in the facility who require 2-person assistance for transfers when using a lift have the potential to be affected by this deficient practice. The DON or designee completed 100% record review of residents requiring a 2 person assist on transfers when using a lift to ensure that staff are compliant with the transfer assistance. There were no negative findings. This audit was completed on November 3, 2023

c) All residents with vision impairment are at risk for this alleged deficient practice. An audit was conducted on October 18, 2023, for all in-house residents with vision impairment to ensure that all follow-up appointments are made timely. There were no negative findings

d) All residents with a therapy referral have the potential to be affected by this deficient practice. The Director of Rehab completed a 100% record

review on therapy services orders and referrals for therapy from October 18, 2023, to present. All residents with an order and referral to therapy were addressed timely and appropriately.

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L 052	Continued From page 10 heels. She was admitted with an open area 1 X (times) 4 X (times) 0.1cm (centimeters) on her sacrum and rash/excoriation on her groins and buttocks ..." [Tissue and Analytics] Wound evaluation 12/13/22 at 12:58 PM, documents "Location Perineum (Scattered) Length 16.80 cm Width 15.45 cm, L (Length) x (times) W (Width) 259.56 Depth - Total 185.48 ..." [Tissue and Analytics] Wound Evaluation 12/13/22 at 1:00 PM documents "Location Sacrum ...Length 1.94 cm Width 0.62 cm, L(length) x (times) W (width) 1.20 cm Depth-Total 0.50 ...Pressure Ulcer-Stage 3 ..." [Admission Minimum Data Set Assessment] 12/13/22 The facility staff coded that the resident has one or more unhealed pressure ulcer/injuries including one that is a stage 3 pressure ulcer. The facility staff also coded that the resident is at risk of developing pressure ulcers. [Weekly Skin Assessment] 12/19/22 documents "Date of Assessment 12/18/2022 Current Wound Orders No Wound Order ...Describe the Skin Impairment No Wound ..." It is noted that there were no weekly skin assessments documented in the medical record from December 11, 2022, through December 18, 2022, and none from December 20, 2022, until January 3, 2023. During a face-to-face interview conducted on 10/17/23 at 10:41 AM, Employee #5 (Wound Care Nurse) stated that the resident went to the hospital and came back with a wound on her sacrum and that the staff got orders for wound	L 052	**3. MEASURE TO PREVENT REOCURRENCE** a) The Director of Nursing or Designee will monitor on a weekly basis that all residents weekly skin assessment is completed Negative findings, if any, will be addressed upon discovery. b) Staff Developer/designee provided training and competency on for proper transfer technique and always following the care plan on the required number of staff when transferring residents to ensure safety of resident and staff. This in-service will be completed by November 10, 2023 c) Staff Developer/Designee provided training to all Clinical Managers on October 18, 2023, on the importance of following up on referrals on vision care to ensure they are coordinated and scheduled timely. Nursing Managers will be re-educated to review optometry consultations and make follow-up appointments as necessary. d) Staff Developer provided education to the Therapy Department, facility, and Licensed Nursing Staff, that services provided or arranged by the facility as outlined by the comprehensive care plan, must-meet professional standards of quality. Education included implementation of a process to review physician orders and referrals for therapy services and to communicate therapy services orders to appropriate facility disciplines during the clinical morning meeting. The Director of Nursing or Designee will monitor newly admitted residents and	11.10.2023

residents with new therapy referrals to ensure orders are obtained, therapy services provided as indicated and comprehensive care plans reviewed and revised accordingly.

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L 052	Continued From page 11 care. During a face-to-face interview conducted on 10/17/23 at approximately 10:50 AM, Employee #9 (Unit Manager 3rd floor) stated that the weekly assessments should have been done weekly and they were not documented. The nurse that documented that the resident did not have any wounds in December 2022 no longer works at the facility. Employee #9 acknowledged the findings. 2) Facility staff failed to provide a 2 person assist when transferring Resident #102 from the Wheelchair to the bed with a Hoyer lift. Resident #102 was admitted to the facility on 02/27/21 with multiple diagnoses that included the following: Paraplegia, Complete, Pressure Ulcer of Sacral Region Stage 4, and Major Depressive Disorder Recurrent. A review of Resident #102's medical record revealed the following: [Quarterly Minimum Data Set Assessment] 09/28/23 revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of 15 indicating intact cognition. Facility staff coded the resident as requiring extensive assistance and a two-person physical assist for bed mobility, transfer and toilet use. Facility staff coded that the resident has an indwelling catheter. A care plan focus area " ... (Resident #102) has a ADL (activities of daily living) self-care performance deficit r/t (related to) paraplegia, muscle weakness and impaired visual function" was initiated on 02/28/2, had interventions that	L 052	**4. MONITORING CORRECTIVE ACTION** a) The Unit Manager or Designee will monitor all residents weekly skin assessment to ensure compliance. All negative findings will be addressed upon discovery. The review will be done weekly times 4 and monthly times 2. b) An observation tool was developed to check at least three randomly selected residents, requiring a 2-person assist for transfers when using lifts weekly x 4 and monthly x 2 to ensure that staff are using required and proper assistance during transfers, based on plan of care. This will be conducted by Unit Manager or designee. All Negative findings will be addressed upon discovery. c) Unit Managers/ designee will complete audits of in-house residents with optometry recommendations to ensure optometry follow-up appointments are made as necessary. This audit will be conducted weekly times 4 and monthly x 2. All negative findings will be corrected upon discovery.	11.10.2023

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L 052	Continued From page 12 included the following: (Resident #102) requires mechanical aid sling for transfers, (Resident #102) requires total assistance with transfers ...2 person assist for ADL (activities of daily living). During an observation in Resident #102's room conducted on 10/12/23 at approximately 4:15PM, the Surveyor observed Employee #15 (Certified Nurse Aide) place Resident #102 into a Hoyer sling lift and transfer the resident from her motorized wheelchair onto her bed. After Employee #15 placed the resident in the bed she then opened the privacy curtain and opened the door that leads to the public hallway. The resident's urine collection bag was visible on the bed between the resident's legs and the resident's clothing was disheveled with resident's bare shoulders and legs exposed. A face-to-face interview was conducted at the time of observation with Employee #15, and she stated, "I did not know I needed to pull the privacy curtain". During a face-to-face interview conducted on 10/12/23 at approximately 4:30 PM, Resident #102 stated that she is supposed to have 2 people assisting with care. During a face-to-face interview conducted on 10/19/23 at approximately 3:00 PM, Employee #4 (Unit Manager 1st floor) stated that it should be two (2) staff assisting when Resident #418 was transferred from the wheelchair to the bed using the Hoyer lift. Employee #4 stated that she will re-educate the staff. 3) Facility staff failed to ensure that the resident received assistance for an ophthalmology consult as prescribed by the physician.	L 052	d) Monitoring of therapy orders and referrals will be completed weekly x 4 and monthly x 2 to ensure therapy services are provided timely and appropriately. This audit will be done by the Director of Rehab or Designee and will present results of audits to the QAPI Committee monthly and make changes to the plan as necessary to maintain compliance with services to meet professional standards of quality. All Negative findings will be addressed upon discovery. Date of Compliance: 11.10.2023	11.10.2023

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Resident #145 was admitted to the facility on 03/17/23 with multiple diagnoses that included the following: Hypertension, History of Falling and Heart Failure.

A review of Resident #145's medical record revealed the following:

[Physician Order] 03/17/23 "Ophthalmology consult as needed ..."

[Admission Minimum Data Assessment (MDS)] 03/23/23 revealed that the facility staff coded the resident as having adequate vision and not requiring corrective lenses. The facility staff coded the resident as having severe cognitive impairment.

[Quarterly Minimum Data Set assessment] 09/22/23 revealed that the facility staff coded the resident as having moderate cognitive impairment.

[Consult Form] Visit Date 07/24/23 " ...Recommendations ...Please refer patient to (Hospital Name) for a cataract surgery consult. Please have the patient see the next available Ophthalmologist who is available to perform cataract surgery. Please call.

It is noted that the bottom of the consult form has handwritten initials and dated on "08/08/23."

[Nurse Practitioner Progress Note] 08/10/23 "...Continue current Tx (Treatment) ..."

The medical record lacks any documented evidence that the resident was seen by an ophthalmologist or that the resident's attending

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physician was informed that the resident was not seen by the ophthalmologist.

A face-to-face interview was conducted with Resident #145 on 10/11/23 at approximately 10:00 AM in which the resident stated that she cannot see well due to cataracts, and she is supposed to have cataract surgery, but the facility can't take her to her appointment.

During a face-to-face interview conducted on 10/20/23 at 10:22 AM with Employee #10 (Unit Manager 2nd floor) stated that resident #145 was seen in the facility by an eye doctor who recommended that the resident be seen by an ophthalmologist to be evaluated for cataract surgery. The Nurse Practitioner signed off on the consult form.

Employee #10 acknowledged that Resident #145's physician was never notified that the resident was not seen by an ophthalmologist.

During a face-to-face interview conducted with Employee #11 (Medical Records Coordinator) stated that the appointment was not made because the resident did not have insurance to cover the transportation for the visit to the Ophthalmologist's office.

It is noted that the facilities (POC) Plan of Correction with compliance date of 8/3/2023, documented the following " an audit was done by the Unit Managers on 07/25/2023 to ensure that all residents with orders for Ophthalmology consult have an appointment scheduled. The audit resulted in zero negative findings..."

4. The facility's staff failed to follow an

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intervention included in Resdient#54's fall care plan.

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

A review of the policy titled, "Fall and Fall Management" with a review date of 05/23 instructed, "When a fall occurs, referral to rehabilitation or other disciplines depending on the reason for the fall. The staff, with the input of the interdisciplinary team will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the attending physician and interdisciplinary team, the staff will identify and implement relevant interventions to try to minimize serious consequences of falling."

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

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

A physician order dated 07/11/23 at 11:27 AM instructed, "Transfer resident to ER (emergency

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room) for unwitnessed fall and open area on the occipital area one time only."

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

A Referral to Therapy form dated 07/11/23 at 12:15 PM documented, "PT (Physical Therapy) evaluation and treatment, post-fall evaluation."

A review of a State Survey Agency Facility Reported Incident Intake form
DC ~ 12106 submitted on 07/11/23 at 3:37 PM documented the following but not limited to: "At about 11:21a.m during wellness/safety rounds on the unit [Resident #54] was observed by writer lying in a supine position on the floor in her room; her head towards the foot of the bed while her feet stretch forward towards the door entrance.

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L 052	Continued From page 17 On assessment resident was observed with an open area on the occipital area of her head with bleeding. [NP's name] gave order to transfer resident to the ER via 911 due to unwitnessed fall with open area to the occipital area of the head. " A nursing progress note dated 07/11/23 at 8:40 PM documented the following but not limited to: "[Resident #54] returned from [hospital's name] at 7:30 PM on a stretcher via [transportation company's name]. During assessment alert and oriented x 1, normal baseline status. No distress noted from resident, denies any pain. Resident has 5 stiches on the occipital part of the head. No bleeding or drainage noted. Discharge Report stated that CT (computerized tomography) scan done at the hospital of the head and cervical spine did not show any acute fracture. There was no bleeding or hematoma in the brain according to the result." A review of a care plan dated 07/11/23 documented the following but not limited to: Focus - [Resident #54] has a fall on 07/11/23 with injury open area on occipital. Interventions: Hospital transfer for further evaluation and Physical Therapy consult for strength and mobility. An observation on 10/13/23 at 11:00 AM of Resident #54 in her room showed the resident ambulating around the room safely and independently. The resident was alert, oriented to name, and could not recall falling or having a head injury. During a face-to-face interview on 10/16/23 at 11:00 AM, Employee #7 (Rehab. Area Manager/PT) stated that the Physical Therapy	L 052		11.10.2023

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L 052	Continued From page 18 (PT) evaluation was an error, and an Occupational Therapy (OT) evaluation should have been done. In addition, the employee said she could not find documented evidence that an occupational therapy evaluation was conducted. Cross reference 483.12 Freedom from Abuse, Neglect, and Exploitation (F609).	L 052		11.10.2023
L 091	3217.6 Nursing Facilities 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. This Statute is not met as evidenced by: Based on an observation, record review and staff interview, the Infection Controll Commitee staff failed to ensure Infection Control and Prevention Practices proctols were followed during wound care for one (1) of 57 sampled residents. (Resident #5). The findings included: Resident #5 was admitted to the facility on 07/02/21 with multiple diagnoses including Lower Back Stage 4 Pressure Ulcer and Paraplegia. A physician's order dated 06/08/23 at 5:37 PM instructed, "Cleanse lower back with normal saline pat dry apply collagen with silver and cover with bordered foam dressing daily every day shift for wound care." A care plan with a review date of 07/19/23	L 091	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficient practice cannot be retroactively corrected. Resident# 5 did not receive any negative outcome from this deficient practice. Employee #5 was re-educated by the staff educator on the importance of maintaining proper infection control prevention procedures when providing wound care. This In-service was done on October 16, 2023.	

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L 091	Continued From page 19 documented the following but not limited to: Focus- [Resident #5] has a pressure ulcer to lower back. Interventions-administer treatments as ordered and monitor effectiveness. A Quarterly Minimum Data Set assessment dated 09/25/23 documented the following but not limited to the resident had a Brief Interview for Mental Status summary score of "14", indicating the resident's cognitive status was intact, the resident required extensive assistance from staff with toileting and bed mobility, the resident was frequently incontinent of stool and occasionally incontinent of urine, and the resident had one Stage 4 Pressure Ulcer. A weekly wound/pressure ulcer progress note dated 10/13/23 at 2:25 PM documented the following but not limited to: " Type of Break in Skin Integrity: Pressure Ulcer /Stage 4 Location: Lower back, Length: 2.5cm (centimeters), Width: 1cm, Depth: 0.1cm, Drainage: Moderate Serosanguinous, Color: 100% granulation, Odor: No odor, Type of Dressing: Collagen Ag.(silver), Community acquired. Improving." During an observation on 10/16/23 starting at approximately 10:00 AM, Employee #5 (Wound Care Nurse/LPN) was noted performing the following actions: - Gathered supplies at the bedside to provide lower back wound care. - Performed hygiene. - Put on Gloves. - Assisted Employee #6 (CNA) with repositioning the resident on his left side. - When the resident was repositioned, his incontinent pad appeared soiled with stool and the sheet directly beneath him had brown stains. However, Employee #5 failed to maintain	L 091	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who experience wound care are identified as having the potential to be affected by this deficient practice. The Director of Nursing / Designee will participate in wound care rounds x 1 week with the wound nurse to ensure the proper protocols are being adhered to. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education will be conducted for all licensed clinical staff who participate in wound care services on the importance of adhering to the standards of practices of infection control prevention. This Education will be conducted by the Staff Educator. This education will be completed by 11.10.2023.	11.10.2023

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L 091	Continued From page 20 Infection Control Prevention and Practices. As evidenced by, not ensuring the resident's incontinent brief was changed and not putting a clean field underneath the resident before she provided wound care. During a face-to-face interview on 10/16/23 at approximately 10:15 AM, Employee #5 stated that to maintain Infection Control Practices. Incontinent care should have been provided by the staff. In addition, a clean field should have been placed underneath the resident before wound care was provided. The employee said, "I'll have staff change him now."	L 091	**4.MONITORING CORRECTIVE ACTION** An audit will be done by the Quality Assurance / Infection Preventionist to ensure proper infection control protocols are being carried out during wound care services. This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations.	11.10.2023
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by one (1) of one (1) ice machine that was soiled on the inside, eight (8) of eight (8) four-inch pans and ten (10) of ten (10) six-inch pans that were stacked wet, torn air curtains in one (1) of one (1) walk-in freezer, one (1) of one (1) flour bin and one (1) of one (1) sugar bin without scoops, and one (1) of one (1) milk box that lacked a thermometer. The findings include: 1. One (1) of one (1) ice machine was soiled on the inside. The ice machine was emptied and	L 099	Date of Compliance: 11.10.2023 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** 1.The ice machine in the kitchen was cleaned on October 13, 2023. This deficiency cannot be retroactively corrected but the Dietary Manager purchased a drying Rack on October 18, 2023. This rack will be used to ensure pots and pans are properly air dried after washing and stored in a clean dry location. The torn air curtain was replaced on October 10, 2023. The Dietary Manager immediately placed a scoop in the flour bin and the rice bin on October 10, 2023. On October 13, 2023, the Dietary Manager immediately placed a thermometer in the milk box/ refrigerator.	

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L 099	Continued From page 21 cleaned on the day of observation. 2. Eight (8) of eight (8) four-inch pans and ten (10) of ten (10) six-inch pans were stored wet, one on top of the other, on a clean and ready-for-use shelf. 3. Air curtains located at the entrance of one (1) of one (1) walk-in freezer were torn throughout. 4. One (1) of one (1) flour bin and one (1) of one (1) rice bin were not equipped with a scoop. 5. One (1) of one (1) refrigerator box, used for milk storage, did not have a thermometer. Employee #13 acknowledged the findings during a face-to-face interview on October 10, 2023, at approximately 11:00 AM.	L 099	In-Service was provided on October 18, 2023 to all Dietary staff by the Dietary manager on the importance of ensuring accurate freezer temperatures and ensuring that thermometers are in all freezers and refrigerators. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** 1.All residents have the potential to be affected by this deficient practice. A house wide audit was done by the Dietary Manager to ensure all Ice Machines are lean and maintained in a safe sanitary condition. This audit was conducted on October 13,2023. All negative findings were addressed. To ensure the changes are effective the Dietary Manager re-educated all dietary staff on the importance of properly storing and air drying all pots and pans to prevent cross contamination. This education was done on October 13, 2023.	11.10.2023
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 57 sampled residents, facility staff failed to ensure each entry into medical records were current, accurate and complete. Residents' #23 and #415. The findings included: Review of the facility policy "Clinical Documentation/Record" documented: - It is the policy of this facility to ensure accurate documentation of important elements contributing	L 200	The Dietary Manager received in-service from the Staff Educator on the importance of maintaining a clean and sanitary environment to include the importance of maintaining safe temperatures in the freezers. This In-service was done on October 12, 2023. Scoops were immediately placed in the flour and rice bins. The Dietary Manager was re-educated by the Staff Educator on Oct 18, 2023 on the importance of ensuring scoops are placed in each bins to prevent cross contamination.	

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L 200	Continued From page 22 to high quality care of our residents - Clinical documentation is required to record pertinent facts, findings, and observations about resident's health history - Documentation entries into organization documents or the health record must be accurate and valid. a) Resident #23 was admitted to the facility on 03/26/15 with diagnoses that included: Peripheral Vascular Disease, Anemia and Hypertension. Review of Resident #23's medical record revealed the following: A physician's order dated 09/05/23 that directed, "Gentamicin (antibiotic) Sulfate External Cream, apply to BLE (bilateral lower extremities) topically one time a day every Monday, Wednesday and Friday for antimicrobial protection"; Collagenase (ointment to help the healing of burns and skin ulcers) external ointment, apply to bilateral heels topically one time a day for wound healing." It should be noted that both orders were discontinued 09/15/23. A physician's order dated 09/08/23 that directed, "Weekly skin assessment by licensed nurse every night shift every Friday" A Weekly Skin Assessment form dated 09/16/23 at 12:16 AM showed facility staff documented: - Current wound orders - Bilateral heels - Collagenase external ointment to both heels daily - Bilateral lower leg - Gentamicin A Weekly Skin Assessment form dated 09/22/23 at 11:48 PM showed facility staff documented: - Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily	L 200	A house wide audit of all refrigerators and freezers in the kitchen, were done to ensure each unit has thermometer. This audit was conducted on October 23, 2023.No negative findings were discovered. **4. MONITORING CORRECTIVE ACTION** a. The Dietary manager will monitor the ice machine daily for four weeks to ensure the machine is always kept clean. b. The Dietary Manager will conduct weekly audits by observing and monitoring the proper storage of pans and pots. c. The Dietary Manager will conduct weekly audits by observing and monitoring the air curtains to ensure they're properly maintained and not damaged. This is to ensure freezer temperatures are accurately maintained. d. The Dietary department will monitor all flour and rice bins to ensure scoops are present at all times. e. The Dietary Manager will audit the freezers/refrigerators daily for two weeks., weekly for 4 weeks and monthly for 2 months. All of these mentioned audits (a.b.c.d.e) will be done weekly for four (4) weeks and monthly for two (2) months Any negative findings will be addressed immediately upon discovery. Findings to be reported to the monthly QAPI for further recommendations.	11.10.2023

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L 200	Continued From page 23 - Bilateral lower leg - Gentamicin A Weekly Skin Assessment form dated 09/29/23 at 2:53 PM showed facility staff documented: - Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily - Bilateral lower leg - Gentamicin A physician's order dated 09/29/23 that directed, "Please wash wound every day with soap and water, then soak open wounds with Vashe (wound cleanser) soaked gauze for 10 minutes, prior to applying ACTi coat to the wounds, be sure to pack wounds so ACTi coat is touching all of the wound beds; reapply ACTi coat, Drawtex (hydroconductive wound dressing) and Allevyn (adhesive foam dressing) pad (5-layer silicone bordered foam dressing with Tubigrip [tubular bandage]); dressing can be changed more frequently if needed every day shift for wound care; Bilateral lower extremities, please wash wound every day with soap and water, then soak open wounds with Vashe soaked gauze for 10 minutes prior to applying Xeroform (occlusive dressing impregnated with petrolatum), SPD (subatmospheric pressure dressing), Kerlix (bandage roll), and Coban (self-adherent wrap used to secure dressings) every day shift for wound care" A Weekly Skin Assessment form dated 10/06/23 at 1:04 PM showed facility staff documented: - Current wound orders; Bilateral heels - Collagenase external ointment to both heels daily - Bilateral lower leg - Gentamicin The evidence showed that facility staff failed to document Resident #23's current wound care orders on the Weekly Skin Assessment form for four (4) consecutive weeks.	L 200	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** a) This deficient practice cannot be retroactively corrected. The DON audited both residents Medical Records for inaccuracy and no negative findings resulted. Resident# 23 and 418 did not receive any negative outcome from this deficient practice. The nursing staff will be educated on the professional expectations of accurately and timely documenting Physician order and assessments in Residents Medical Records. b) Resident 415 # was noted to have a fall on 08.17.2023. This was corrected on the quarterly MDS upon discovery. Resident was assessed head to toe post fall by the charge nurse on 08.17.2023 and no adverse findings resulted. MDS nurse was educated by MDS consultant upon discovery to ensure fall incidences are coded properly in the MDS. This in-service was conducted October 18, 2023.	11.10.2023

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L 200	Continued From page 24 During a face-to-face interview on 10/13/23 at 11:20 AM, Employee #2 (Director of Nursing/DON) reviewed the documents, acknowledged the findings and made no further comments. 2. Facility staff failed to accurately code the Resident #415 Quarterly Minimum Data Set (MDS) assessment to accurately reflect the resident's fall that occurred on 08/17/23. Resident #415 was admitted to the facility 08/18/16, with multiple diagnoses that included the following: Diabetes Mellitus Type 2, Dementia in other Diseases Unspecified Severity With Behavioral Disturbance, and Insomnia. A Facility Reported Incident (FRI) DC00012210, was received by the State Agency on 08/17/23, and documented the following: " ...Writer notified by CNA (Certified Nurse Aide) that the resident was on the floor in his room. Writer immediately went to the resident room and observed the resident on the floor in a supine position beside his bed. Assigned CNA stated that the resident slid off his bed and got out of her grip while she tried to assist the resident with morning care ..." Review of Resident #415's medical record revealed the following: [Physician Order] 09/28/16 "Fall precautions Q (every) Shift ..." [Nurse Progress Note] 08/17/23 at 4:55 PM, " ...Writer notified by CNA (Certified Nurse Aide) that the resident was on the floor in his room. The writer immediately went to the resident room and observed the resident on the floor in a supine	L 200	**2 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** a) All residents have the potential to be affected by this deficient practice. The Director of Nursing will conduct weekly review of all physician orders and weekly skin assessment sheets to ensure then re correctly entered in the residents medical records. b) An audit of residents with falls was completed to ensure the MDS is accurate to reflect the fall incident by the MDS Director from 10.17.2023 to 10.21.2023. No other discrepancies on fall documentation and MDS coding were found on the audit. This is to ensure that residents with falls were coded correctly. This audit was completed on October 26, 2023, and no negative findings were discovered.	11.10.2023

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L 200	Continued From page 25 position beside his bed. Assigned CNA stated that the resident slid off his bed and got out of her grip while she tried to assist the resident with morning care. Resident was unable to explained (sp) what happened due to diagnosis of dementia. Upon assessment, resident is A (alert) & O (Oriented) x (times) 1(to person) associated to his baseline status. Resident was observed with swelling on his right forehead with small amount of blood. Pressure applied. Bleeding stopped immediately. Order given to transfer resident to hospital for further evaluation and treatment ..." A [Care Plan] initiated on 08/17/23 with a focus area of " ...(Resident #415) has a fall resident was observed on the floor in supine position" has interventions that included the following: "encouraged resident to change positions slowly, Bed in low position ..." [(Hospital facility name) Patient Visit Information] 08/17/23 " ...You were seen today for: Head injury Laceration of head ..." [Quarterly Minimum Data Set] 09/08/23, In Section J (Health Conditions) the facility staff coded that the resident did not have any falls since admission, entry or prior assessment. The facility left the section blank that documents number of falls since admission entry or prior assessment. The evidence showed that the facility staff failed to code the Quarterly Minimum Data Set assessment accurately to reflect Resident #415's fall with injury that occurred on 08/17/23. During a face-to-face interview conducted on 10/18/23 at approximately 1:00 PM, with	L 200	**3. MEASURE TO PREVENT REOCURRENCE** Staff Education will conduct a house wide in-service for all license nurses regarding the importance of documenting accurate information in residents medical record. This in-service will be completed by November 10, 2023. Education was done on October 18, 2023, for the MDS coordinator by the Regional MDS Director to ensure that the MDS coding reflects the resident's Fall status correctly. Additionally, MDS will be informed through risk management meeting for all incidences of fall to ensure proper coding. **4. MONITORING CORRECTIVE ACTION** The clinical Managers will conduct weekly audits of all wound care orders and skin assessments to ensure they are accurately recorded in the residents' medical records. This audit will be conducted weekly times 4 and monthly times 2. All negative findings will be addressed upon discovery. An audit will be done by the MDS Director to ensure that Fall status is coded appropriately for the MDS section.	11.10.2023

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L 200	Continued From page 26 Employee #16 (MDS Coordinator), stated that the facility staff usually has a clinical meeting and a risk meeting where the team informs us of falls, and this was an oversight. 3) Facility staff failed to accurately document Resident #418's weekly skin assessment in the medical record. Resident #418 was admitted to the facility on 12/09/2022 with multiple diagnoses that included the following: Diabetes Mellitus Type 2, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Benign Neoplasm of Parathyroid Gland. A Facility Reported Incident (FRI) DC00011344, was received by the State Agency on 12/13/2022, and documented the following, " ...readmitted with an open area 1 X (Times) 4 X 0.1cm (centimeters) on her sacrum. She also has rash excoriation on her groins and buttocks. The open area on her buttocks was cleansed with normal saline, pat dry ..." A review of Resident #418's medical record revealed the following: [Physicians Order] 12/09/22 "Weekly skin assessment by licensed nurse ..." A [Care Plan] dated 12/09/22 with Focus area " ... (Resident 418) has a pressure ulcer on the sacrum upon admission 12/09/22 ...had interventions that included the following : Monitor/document/report PRN (as needed) any changes in skin status ...Administer treatments as ordered and monitor for effectiveness ..."	L 200	This audit will be done weekly for four (4) weeks and monthly for two (2) months. All negative findings will be corrected upon discovery. Findings of these audits will be reported to the monthly Quality Assurance Performance Improvement (QAPI) committee for further recommendations. Date of Compliance: 11.10.2023	11.10.2023

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L 200	Continued From page 27 [Nurse Progress Note] 12/10/22 " ...Her skin warm to touch, discoloration observed on bilateral heels. She was admitted with an open area 1X(times) 4 X (times) 0.1cm on her sacrum and rash/excoriation on her groins and buttocks ..." [Physician Order] 12/13/22 "Calmoseptine (Miscellaneous topical agents) Ointment 0.44-20.6% (Menthol-Zinc Oxide) (medicated cream, ointment or paste) Apply to perineum scattered topically every shift for wound care ..." [Physician Order] 12/13/22 "Calmoseptine (Miscellaneous topical agents) Ointment 0.44-20.6% (Menthol-Zinc Oxide) Apply to Sacrum topically every shift for wound care." [Tissue and Analytics] Wound evaluation 12/13/22 at 12:58 PM, documents "Location Perineum (Scattered) Length 16.80 cm Width 15.45 cm, L (Length) x (times) W (Width) 259.56 Depth - Total 185.48 ..." [Tissue and Analytics] Wound Evaluation 12/13/22 at 1:00 PM documents "Location Sacrum ...Length 1.94 cm Width 0.62 cm, L(Length) x (Times) W (Width) 1.20 cm Depth-Total 0.50 ...Pressure Ulcer-Stage 3 ..." [Admission Minimum Data Set Assessment] 12/13/22 The facility staff coded that the resident has one or more unhealed pressure ulcer/injuries including one that is a stage 3 pressure ulcer. The facility staff also coded that the resident is at risk of developing pressure ulcers. [Weekly Skin Assessment] 12/19/22 documents "Date of Assessment 12/18/2022 Current Wound Orders No Wound Order ...Describe the Skin Impairment No Wound ..."	L 200		11.10.2023

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L 200	Continued From page 28	L 200		11.10.2023

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

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

L 204 — 3232.2 Nursing Facilities — L 204

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:

(a) The date, time, and description of the incident;

(b) The name of the witnesses;

(c) The statement of the victim;

(d) A statement indicating whether there is a pattern of occurrence; and

(e) A description of the corrective action taken.

This Statute is not met as evidenced by:
Based on record reviews and staff interviews, for four (4) out of 57 sampled residents, facility staff failed to have documented evidence that a thorough summary and analysis of each incident

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L 204	Continued From page 29 was completed for allegations of abuse. Residents' #103, #46, #366, and #91. The findings included: The facility policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" documented: -All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. 1A. Resident #103 was admitted to the facility on 03/22/21 with diagnoses that included: Aphasia, Major Depressive Disorder and Muscle Weakness. Review of Resident #103's medical record revealed the following: A census tracking that documented Resident #103 resided in room 128, bed A. A Quarterly Minimum Data Set (MDS) assessment dated 08/13/23 showed facility staff coded: sometimes able to make self understood; a BIMS Summary Score of 9, indicating moderately impaired cognitive function; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; functional limitation in range of motion on one side for upper extremities; and used a walker and wheelchair for mobility. A Nurse Practitioner (NP) Progress Note dated 08/29/23 at 2:00 PM documented: -Reported resident had an altercation with another resident; [Resident #103] stated she was	L 204	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The resident-to-resident incident involving Resident #s 103, 46, 366, & 391 final investigation reports sent to the State Agency were not thoroughly completed. This deficiency cannot be retroactively corrected. The residents did not receive any adverse reaction from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** No other residents were identified to have any current allegations that needed to be investigated or reported to the proper authorities. On October 13, 2023, a member of the Governing body completed an audit of reported abuse incidents from October 10, 2023, to present, to ensure all reported allegations of abuse investigations were accurately and thoroughly done. An audit of all documents relevant to the investigation was also conducted. No additional negative findings were discovered.	11.10.2023

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L 204	Continued From page 30 hit by [Resident #46]. 1B. Resident #46 was admitted to the facility on 01/06/14 with multiple diagnoses that included: Anxiety Disorder, Hyperlipidemia and Hypertension. Review of Resident #46's medical record revealed the following: A census tracking that documented Resident #46 resided in room 126, bed A. A MDS assessment dated 06/07/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 13, indicating intact cognitive response; no verbal or physical behavioral symptoms directed towards others; no wandering behaviors; required supervision for locomotion on unit the unit; had functional limitation in range of motion on one side for upper extremities; and used a wheelchair for mobility. A Situation Background Assessment and Request (SBAR) Tool dated 08/29/23 at 3:04 PM documented: - Situation: Resident-to-resident altercation - Resident #103 of room 128A reported that she was hit on the face by Resident #46, room 126A, in the hall. A Facility Reported Incident (FRI), DC~12257, received by the State Agency on 08/30/23 at 1:35 PM documented: - Resident #103 reported to the NP that she was hit on the face by Resident #46. Review of the facility's investigation documents on 10/13/23 revealed that facility staff failed to have documented evidence that the Certified	L 204	**3. MEASURE TO PREVENT REOCURRENCE** The Staff Educator will conduct an In-service on expectation of thoroughly investigating an allegation of abuse. This in-service will be completed by all Nurses, Nursing Supervisor, Clinical Manager. This in-service will be completed by November 10, 2023. On October 13, 2023, the current Administrator was educated by the Governing Body on the expectation and protocols for conducting a thorough investigation. The Administrator is the designated Abuse Coordinator and will be responsible for ensuring compliance with all allegations of abuse. An audit was conducted for all incidents reported to the state agency on October 26, 2023, and no negative findings were discovered.	11.10.2023

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L 204	Continued From page 31 Nurse Aide (CNA) assigned to Resident #103 on 08/29/23, day shift, was interviewed and or provided a statement. The evidence showed that facility staff failed to conduct a thorough investigation as evidenced by no having an interview and or statement from all staff present at the time of the incident or who might have knowledge of the incident. During a face-to-face interview on 10/13/23 at 2:15 PM, Employee #3 (Assistant Director of Nursing/ADON) acknowledged the finding and stated that their investigation should have included a statement from all the staff present on the date and shift that the alleged incident occurred. 2A. Resident #366 was admitted to the facility on 08/16/22 with diagnoses that included: Anxiety Disorder, Cognitive Community Deficit, and Muscle Weakness. Review of Resident #366's medical record showed the following: A census tracking that documented Resident #366 resided in room 139, bed B. A Quarterly MDS assessment dated 04/14/23 showed facility staff coded: BIMS Summary Score of 12, indicating moderate cognitive impairment; no physical, verbal or any other behavioral symptoms directed towards others. A Nurses Note dated 04/15/23 at 2:24 PM documented: -At about 12:15 PM, Resident #366's brother reported to the writer about a situation with his sister and roommate, Resident #91	L 204	**4. MONITORING CORRECTIVE ACTION** A member of the Governing Body will monitor all paperwork / findings of Abuse reportable to ensure a thorough investigation was completed. On October 26, 2023, the Governing Body implemented a new audit compliance tool that will be used for all Facility Reported Incidents. This audit tool will be used to ensure compliance with reporting, data collection and thorough investigation with all incidents. Monitoring will be completed weekly x 4 and monthly x 3. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023

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L 204	Continued From page 32 -He stated, "Verbal threating language [by Resident #91]; throwing things that hit [Resident #366]". A FRI, DC~11885, submitted to the State Agency on 04/16/23 at 4:56 PM documented: -Alleged [Resident #91] verbally and physically abused Resident #366 by throwing things at her -When asked, Resident #366 stated, "My roommate verbally threaten me and throws things like lotion bottle at me." 2B. Resident #91 was admitted to the facility on 06/12/2020 with diagnoses that included Dementia and Muscle Weakness. Review of Resident #91's medical record showed the following: A census tracking that documented Resident #46 resided in room 139, bed A. A Quarterly MDS assessment dated 02/20/23 showed facility staff coded: a BIMS Summary Score of 7, indicating severe cognitive impairment; did not exhibit any physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); did not exhibit any verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); exhibited other behavioral symptoms that were not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) that occurred 1 to 3 days; and had wandering behavior that occurred 1 to 3 days.	L 204		11.10.2023

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L 204	Continued From page 33 A FRI, DC~11886, submitted to the State Agency on 04/16/23 at 5:27 PM documented: -Resident #366 and her son alleged that Resident #91 verbally and physically abused Resident #366 by throwing things at her. Review of the facility's investigation documents on 10/17/23 revealed that facility staff failed to have documented evidence that the Certified Nurse Aide (CNA) assigned to Residents' #366 and #91 on 04/15/23, day shift, was interviewed and or provided a statement. The evidence showed that facility staff failed to conduct a thorough investigation as evidenced by no having an interview and or statement from all staff present at the time of the incident or who might have knowledge of the incident. During a face-to-face interview on 10/17/23 at 3:35 PM, Employee #3 (Assistant Director of Nursing/ADON) reviewed the investigation documents and stated, "We did not get a statement from her (assigned CNA on 04/15/23, day shift)."	L 204	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The chain on the window blind in room #128 was replaced on October 10, 2023 during the annual Survey. **2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**	11.10.2023
L 410	3256.1 Nursing Facilities 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. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, comfortable environment as evidenced by a window blind in	L 410	The facility has determined that all residents have the potential to be affected by this deficient practice. The Maintenance Director / Designee conducted a house wide inspection of all blinds/chain in each room to ensure they were operable. This inspection was conducted on October 26, 2023. All negative findings were resolved upon discovery.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0011	A. BUILDING: ___ B. WING ___	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L 410	Continued From page 34 one (1) of 34 resident's rooms with a broken chain. The findings include: During a walkthrough of the facility on October 10, 2023, at approximately 1:15 PM, the window blind in one (1) of 34 residents' room (#128) would not open due to a broken pull chain. Employee #14 acknowledged the finding on October 11, 2023, at approximately 11:00 AM, and replaced the broken chain.	L 410	**3. MEASURE TO PREVENT REOCURRENCE** Education will be done by the Staff Educator for the Maintenance personnel to check for broken blinds/chain and replace them when found. This education was completed on October 26, 2023. All rooms will be monitored weekly, during grand rounds by the Director of Maintenance or Designee to ensure a safe and comfortable environment. Any negative findings will be addressed upon discovery. **4. MONITORING CORRECTIVE ACTION** The Director of Maintenance / designee will conduct weekly inspections of all rooms to ensure safe and comfortable environment. This inspection will be done weekly x 4 and monthly x 2. All negative findings will be addressed upon discovery. Findings of these audits will be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 11-10-2023	11.10.2023
L 519	3269.1b Nursing Facilities (b) To be fully informed by the nursing facility of all resident rights and all facility rules governing resident conduct and responsibilities upon admission and annually thereafter; This Statute is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, for one (1) of 57 sampled residents, the facility staff failed to treat Resident #102 with respect and dignity and care for the resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, as evidenced by staff not closing the privacy curtain before opening the resident's door that opens to a public hallway. Resident #102. The findings included: Resident #102 was admitted to the facility on 02/27/21, with multiple diagnoses that included the following: Paraplegia, Complete, Pressure Ulcer of Sacral Region Stage 4, and Major	L 519	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident # 102 was immediately protected by pulling their privacy curtain. The certified nursing assistant assigned was educated on October 12, 2023 by the Staff Educator.	

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	HFD02-0011	A. BUILDING: ______ B. WING ______	C 10/20/2023

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L 519	Continued From page 35 Depressive Disorder Recurrent. A review of Resident #102's medical record revealed the following: [Quarterly Minimum Data Set Assessment] 09/28/23 revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) Score of 15 indicating intact cognition. Facility staff coded that the resident has an indwelling catheter. [Physicians Order] 09/23/33 "...Change Foley bag and tubing every 2 weeks and as needed ..." During an observation in Resident #102's room conducted on 10/12/23 at approximately 4:15PM, the Surveyor observed Employee #15 (Certified Nurse Aide) place Resident #102 into a Hoyer sling lift and transfer the resident from her motorized wheelchair onto her bed. After Employee #15 placed the resident in the bed she then opened the privacy curtain and opened the door that leads to the public hallway. The resident's urine collection bag was visible and uncovered on the bed and located between the resident's legs and the resident's clothing was disheveled with resident's bare shoulders and bare legs exposed. A face-to-face interview was conducted at the time of observation with Employee #15, and she stated, "I did not know I needed to pull the privacy curtain". During a face-to-face interview conducted on 10/19/23 at approximately 3:00 PM, Employee #4 (Unit Manager 1st floor) stated that the privacy curtain should have been pulled and re-education will be provided.	L 519	**2.IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** The facility has determined that all residents have the potential to be affected. A house wide interview was conducted by the Administrative Assistant for all residents on 10.25.23 and 10.26.23 to ensure their privacy is maintained. All negative findings were addressed. The facility Staff Educator provided house wide education for all staff on Residents Rights. This education will be completed by 11.10.2023. **3. MEASURE TO PREVENT REOCURRENCE** Immediately on October 12, 2023, the Director of Nursing called a mandatory in-service for all CNA's. Staff were educated by the Director of Nursing on the facility policy regarding resident privacy and dignity. The DON/ designee checked each room on Oct 12th, 2023 to ensure a privacy curtain was in place. The Director of Nursing/ designee performed random audits to ensure privacy curtains were pulled while providing care. All staff will be in-serviced by November 10, 2023 **. MONITORING CORRECTIVE ACTION** The Unit Manager/designee will conduct random observations to ensure curtain is pulled while providing care. This audit will be done for five residents per day weekly x 4 and monthly x 2.	11.10.2023

Any staff found non-compliant will receive education as evidenced by remedial documentation in the individual's employee file. Any further non-compliance by the employee will result in progressive disciplinary action.

Findings of these audits will be reported to the monthly QAPI for further recommendations.

All negative findings will be corrected upon discovery.

Date of Compliance: 11-10-2023