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 000	Initial Comments An unannounced Recertification Survey was conducted at this facility on January 4, 2023 to January 9, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census for the survey was 12 and the survey sample included 16 residents. The following complaints were investigated during this survey: DC00010517 and DC00010872. The following Facility Reported Incidents were investigated during this survey: DC00010459, DC00010586, DC00010740, DC00010869, and DC00011255. Federal and/or Local deficiencies were cited related to the investigation(s) of: DC00010459, DC 00010586, DC00010740, DC00010869 and DC00010872. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municpal Regulations (DCMR) Chapter 32 for Nursing Homes. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid	L 000	Sibley Memorial Hospital Renaissance is filing the following plan of correction for the purposes of regulatory compliance. The facility is submitting this plan of corrections to comply with the applicable law and not as an admission or statement of agreement with respect to the alleged deficiencies.	

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L 000	Continued From page 1	L 000		

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
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner

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L 000	Continued From page 2 O2- Oxygen 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 TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;	L 051	**L051(A) – Develop/ Implement Comprehensive Care Plan** **1.** The importance of resident-centered care plans is acknowledged. The Care plan for resident #3 was assessed and updated on 2/24/23 to demonstrate recent COVID-19 infection/hospitalization. There was no negative outcome from this deficient practice on the resident. Resident #128 was discharged from the facility on 1/25/23, there is no further action for compliance. 2. All residents have the potential to be affected/ corrective action taken: a. Resident care plans assessed	

			and updated. There were no negative outcomes from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. MDS coordinator to provide education to nursing staff on the importance of resident-centered care plans i. Including the change in status related to COVID-19 and polypharmacy/ >9 medications 4. Plan for Monitoring performance/sustainability: a. The Quality Compliance Nurse or designee will perform a monthly audit for the appropriateness of the care plan created on admission. b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

L051(B) – Care Plan revisions

1. The importance of resident-centered care plans and revisions when there is a change is acknowledged. Both residents (#277 and #278) have been discharged from our facility, there is no further action for compliance. Resident 277 was discharged on 1/17/23 and Resident 278 was discharged on 1/11/23.

2. All residents have the potential to be affected/ corrective action taken:

    a. Resident care plans assessed and updated. There were no negative outcomes from this deficient practice.

3. Systemic changes that will be made to ensure deficient practice does not reoccur:
    a. MDS coordinator to provide education to nursing staff on the importance of resident-centered care plans and revisions when there is a change
        i. Including family bringing food from outside the facility and after a resident fall
    b. Revision of resident care plan after a fall will be included on the fall reporting algorithm for charge nurse

4. Plan for monitoring performance/sustainability:
    a. The Quality Compliance Nurse or designee will perform a monthly audit for the appropriateness of the care plan created on admission and revisions when there is a change.
    b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months.

			c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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L 051	Continued From page 3 (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interviews, for two (2) of 16 sampled residents, facility staff failed to develop and implement comprehensive person-centered care plans with goals and approaches to address one (1) resident who is prescribed nine (9) prescribed medications; and one (1) resident who contracted COVID-19. Residents' #128 and #3. The findings included: 1. Facility staff failed to develop a comprehensive-person-centered care plan with goals and approaches to address Resident #128 being on nine (9) prescribed medications. Resident #128 was admitted to the facility on 12/21/22 with multiple diagnoses that included: Hypertension, Hyperlipidemia, Benign Prostatic Hyperplasia (BPH), and Hypothyroidism. Review of resident #128's medical record revealed the following physician's orders: 12/21/22 "Benzonatate (cough suppressants) ... capsule 100mg (Milligram)..." 12/21/22 "Enoxaparin (anticoagulant) ... syringe 40 mg Subcutaneous, every evening"	L 051		

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L 051	Continued From page 4 12/21/22 "Simvastatin (cholesterol lowering medication) tablet 5 mg oral nightly" 12/21/22 "Guaifenesin (expectorant) 12 hr (hour) tablet 600 mg oral 2 times daily" 12/21/22 "Tamsulosin (treats BPH) 24 hr (hour) capsule 0.4 mg oral daily" 12/21/22 "Polyethylene Glycol (laxative) packet 17 g oral daily" 12/21/22 "Levothyroxine (thyroid hormone supplement) tablet 88 mcg (microgram) oral every morning" 12/21/22 "Finasteride (treats BPH) tablet 5 mg oral every morning" 12/24/22 "Rivastigmine (treats dementia) 4.6 mg/24-hour patch: 1 patch transdermal daily..." A review of Resident #128's medical record lacked documented evidence of a polypharmacy care plan to address the resident receiving nine (9) prescribed medications. During a face-to-face interview conducted on 01/09/23 at 4:20 PM, Employee #5 (Charge Nurse) acknowledged the findings and stated, "I don't see it [polypharmacy care plan]." 2. Facility staff failed to develop a comprehensive patient-centered care plan that included Resident #3's recent COVID-19 infection on 12/10/22. Resident #3 was re-admitted to the facility on 12/20/22 with diagnoses including a Personal	L 051		

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L 051	Continued From page 5 History of COVID-19, Pneumonia due to COVID-19, and Unspecified Intellectual Disabilities. Review of Resident #3's medical record revealed: A 5 Day Scheduled Assessment dated 12/27/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15," indicating intact cognition. 12/09/22 [Department of Health (DOH) Notice of Discharge Transfer or Relocation] form "... (1) The proposed action is transfer (2) The specific reason(s) to this section is...transfer to acute for positive COVID..." 12/20/22 [History and Physical/Physician's Note]: "...had no new acute problems until 12-10-22 when he developed onset congested cough and rhinorrhea. He had repeat covid testing performed and was positive with [COVID-19] and again transferred to the main hospital Covid Unit... He returns today c/o (complaining of) a stiff neck, resolved cough, generalized weakness, and increased dependence for care ..." 12/20/22 [Care Plan]: " ...Problem: Ineffective Breathing Pattern. Start Date: 12/20/23 ...Goal: Resident's breathing pattern will be maintained. Interventions: Assess Resident for changes in orientation, increase restlessness, anxiety, and hunger...Monitor vital signs, lung sounds, and presence of secretion every shift. Notify physician for abnormal changes... Position resident with proper body alignment for optimal breathing pattern ... ...Maintain a clear airway ...Call Rapid Response for acute respiratory distress for immediate intervention ..."	L 051		

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L 051	Continued From page 6 Of note, there was no documented evidence that facility staff included Resident #3's recent COVID-19 infection and hospitalization in the resident's comprehensive care plan. During a face-to-face interview on 01/06/23 at 10:38 AM, Employee #5 (Unit Manager) stated that facility staff did not include the Resident's recent COVID-19 infection and hospitalization in the Resident's comprehensive care plan." B.Based on record review and staff interviews, for two (2) of 16 sampled residents, facility staff failed to revise/update the comprehensive care plan with new goals and approaches that addressed: one (1) resident's family bringing in foods from outside the facility; and one (1) resident's fall. Residents' #277 and #278. The findings included: 1. Facility staff failed to revise/update Resident #277's nutritional care plan to include foods brought in from outside the facility. Policy "NUSE-GEN061" dated 11/04/20 documented, " ...Food and Nutrition Services will not serve food prepared outside the food and nutrition services ...The department of Food and Nutrition Services does not accept responsibility for patient illness resulting from foods provided by a family member or outside sources ..." Resident #277 was admitted to the facility on 12/26/22, with multiple diagnoses that included Asthma, Congestive Heart Failure, Chronic Lymphocytic Leukemia, Hypertension, and Hyponatremia.	L 051		

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L 051	Continued From page 7 During an interview on 01/04/23 at 11:00 AM, Resident #277 stated, "I only eat breakfast here. My family brings in my lunch and dinner." At this time, the private aide in the resident's room and resident's daughter both confirmed this statement made by Resident #277. Review of Resident #277's medical record revealed: Admission MDS dated 12/26/22 showed that facility staff coded a Brief Interview for Mental Status summary score of "15", indicating intact cognition; independent for eating; active diagnosis of Gastroesophageal Reflux Disease (GERD), or Ulcer (e.g. Esophageal, Gastric, and Peptic Ulcers); and was on a therapeutic diet (e.g., low salt, diabetic, low cholesterol). 12/15/22 [physician's order] "Nutrition - Oral diet: Heart Healthy (low fat, sodium select)..." 12/20/22 at 4:26 PM [Nutrition Recommendation (dietitian) Note] "Continue Heart Healthy, 2 g (gram) Na+ (sodium) Diet with easy chew/IDD7 [International Dysphagia Diet Level 7 (Regular/easy to chew)] [and] diet texture; monitor PO (by mouth) intake and document on flow sheet the percentage of meals and volume of supplements consumed..." 12/20/22 [Nutritional Assessment] "RD (Registered Dietician) provided sitter with Heart Healthy 2gNA+ menu for ease of ordering, noting that some items may not be available due to the Easy to Chew/IDD7 diet texture ... Pt (patient) caregiver at bedside stated that ...family is bringing in pt lunch and dinner foods that are not in compliance w/heart healthy diet. Caregiver	L 051		

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L 051	Continued From page 8	L 051		

requesting to have pt diet transitioned to regular. Secure chat message sent to attending MD (medical doctor) w/this information."

12/27/22 at 9:56 AM [Nutrition Recommendation Note] "Continue Heart Healthy, 2g Na+ Diet with Easy to Chew/IDD7 diet texture. Please consider liberalization to regular diet as pt does not like menu options and is having family bring in lunch and dinner daily. Secure chat sent to MD [with] request."

Review of the Nutritional status care plan with a start date of 12/19/22, showed no documented evidence that the facility staff revised this care plan to indicate that Resident #277's family was bringing in foods from outside.

During a face-to-face interview on 01/09/23 at 10:00 AM, Employee #4 (Director of Nutrition Food) acknowledged the findings and made no further comments.

2. Facility staff failed to update Resident #278's fall care plan after a fall.

Resident #278 was admitted to the facility on 12/19/22 with multiple diagnoses that included: Sundowning, Spondylosis with Myelopathy, Hypertension and Hyperlipidemia.

A Facility Reported Incident (FRI), DC00011445, received by the State Agency on 01/04/23 documented, "... Around 12:23 [AM] [on] January 3, 2023, received call from 6B that patient could not reach his call button. Nurse went to patient room, found him lying on his back, beside his bed talking to someone on using the hospital phone. When asked what happened patient said, "I tried

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L 051	Continued From page 9 to [sit] at the edge of the bed to use the urinal and I slid off the bed ... Patient said I did not hit my head and I don't feel any hurt. Resident was examined and did not sustain any injuries." Review of Resident #278's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/26/22, where facility staff coded: cognitively intact; extensive assistance with one-person physical assist for bed mobility and transfers; extensive assistance with two-person physical assist for walking in room; extensive assistance with two-person physical assist, for surface-to-surface transfer; functional limitation/impairment in range of motion in both upper and lower extremities; uses a walker for mobility; and no falls since admission/entry of reentry to the facility. 01/03/23 at 8:22 AM [Nurse progress note] "Patient is alert x 3, around 0025 (12:25 AM) nurse received telephone call from 6B that patient could not reach his call button Nurse went to patient room and found patient lying on his back on the floor beside his bed. Patient said "I wanted to seat at the edge of the bed to urinate but I slide off the bed. Patient is on Aspirin (blood thinner), house supervisor and Rapid Respond called to the unit. Patient denied [hitting] his head and stated he just slide off the bed to the floor ...Patient remains stable, safety measures maintained ..." 01/03/23 at 1:54 AM [Physician progress note] "... I saw the patient after rapid response was called for a fall. The patient states that he was sitting at the side of the bed to urinate and was bending over. He states that he did not have his	L 051		

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L 051	Continued From page 10 prescription socks on and began to slip forward. He states that he slipped forward but was able to lower himself to the floor with his arms. He states he was down for about 10 minutes before being helped back into the bed by nursing ...We will continue to monitor". 01/03/23 at 7:21 PM [Nurse's Note] "...safety... and fall precautions in placed (sp)" Review of the "Fall" care plan with a start date of 12/19/22, showed no documented evidence that facility staff revised it to include the actual fall on 01/03/22, or any new goals and approaches/interventions. During a face-to-face interview on 01/06/23 at 11:54 AM, Employee #5 (Charge Nurse) stated that the care plans are being reviewed.	L 051		
L 076	3215.4 Nursing Facilities As appropriate, ventilator care personnel shall be competent in the following: (a) The fundamentals of cardiopulmonary physiology and of fluids and electrolytes; (b) The recognition, interpretation and recording of signs and symptoms of respiratory dysfunction and medication side effects, particularly those that require notification of a physician; (c) The initiation and maintenance of cardiopulmonary resuscitation and other related life-support procedures; (d) The mechanics of ventilation and ventilator function;	L 076	**L076 – Respiratory/ Tracheostomy Care and Suctioning** 1. All expired nasal cannulas were removed from the cart by the respiratory care manager on January 5, 2023. a. There were no negative resident outcomes from this deficient practice. 2. All residents have the potential to be affected. a. All expired supplies removed on 1/5/23. There were no negative resident outcomes. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: b. Nasal cannulas were removed from the free-standing respiratory cart and are located and tracked in clean supply. c. DON provided education to the nursing team on updated respiratory care supply location.	

			d. The free-standing respiratory supply cart has been removed from the unit on Jan 17, 2023. 4. Plan for Monitoring performance/sustainability: a. Respiratory care manager or designee will audit nasal cannula expiration dates in the clean supply room once a week until there are 4 consistent weeks of 100% compliance with unexpired nasal cannulas i. Audit report will be sent to the Administrator each week ii. Audit report will be shared in the monthly QAPI meeting until compliance is achieved for 4 consecutive weeks iii. Non- compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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L 076	Continued From page 11 (e) The principles of airway maintenance, including endotracheal and tracheotomy care; (f) The effective and safe use of equipment for administrative oxygen and other therapeutic gases and providing humidification, nebulization, and medication; (g) Pulmonary function testing and blood gas analysis when these procedures are performed within the ventilator care unit; (h) Methods that assist in the removal of secretions from the bronchial tree, such as hydration, breathing and coughing exercises, postural drainage,therapeutic percussion and vibration, and mechanical clearing of the airway through proper suctioning technique; (i) Procedures and observations to be followed during and after extubation; and (j) Recognition of and attention to the psychosocial needs of residents and their families. This Statute is not met as evidenced by: Based on observation of nine (9) nasal cannulas (delivers oxygen via the nose), facility staff failed to maintain respiratory/oxygen care equipment in accordance with the professional standards of practice. The findings included: During an observation of the "Respiratory Equipment Cart" on 01/04/23 at 12:14 PM, nine	L 076		

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L 076	Continued From page 12 (9) of nine (9) Vyaire (manufacturer) nasal cannula tubing with expiration dates of "2022-10-08" (October 8, 2022) were stored for resident use, approximately three (3) months after the expiration date. During a face-to-face interview conducted on 01/04/23 at 12:59 PM, Employee #12 (Respiratory Therapy Manager) stated, "There's no daily or weekly inventory check of the respiratory equipment cart. If supplies are needed, they [the nurses] call us and we bring the supplies." The employee was shown the expired nasal cannula tubing's and stated, "Oh wow! I will get rid of these and get new ones." Employee #12 further stated that the nasal cannulas come from central supply. During a face-to-face interview on 01/04/23 at 2:13 PM, Employee #13 (Supply Chain Manager) stated, "We are responsible for checking the expiration dates before putting them [nasal cannula tubing] for use on the units. We would be the root cause of something expired being on the units."	L 076		
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 observation, record review, and staff interview, for one (1) of 16 sampled residents, the facility's staff failed to maintain infection control policies and procedures as evidenced by:	L 091	L 091 **Infection Prevention and Control** 1. Employee #9 and #14 were made aware of the deficient IP practices and the behavior was corrected. a. There was no negative impact on residents from the deficient practice. 2. All residents have the potential to be affected/ corrective action taken: a. There are signs posted throughout the facility to address required PPE use, and safe infection prevention practices. b. There was no negative impact on residents from the deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. RCA regarding infection control deficiencies was completed on	

			2/21/2023 b. Nutrition Services Manger to provide education to the nutrition services team regarding proper PPE use (face mask) and hand hygiene practices when entering resident rooms c. Director of Nursing Excellence and Education provide education to the wound care nursing team regarding carrying of soiled linen when providing wound care d. Signage posted on all resident doors to remind staff/visitors to practice hand hygiene before entering the room. 4. Plan for Monitoring performance/sustainability: a. 10 monthly hand hygiene audits will be completed by the QA Coordinator or designee b. 10 monthly PPE use will be completed by the QA Coordinator or designee c. 5 monthly audits of proper linen carrying will be completed by Director Excellence in Nursing Practice or designee d. Results of the audits will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. e. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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L 091	Continued From page 13 inappropriately transporting soiled linen; staff not performing hand hygiene and wearing a facemask inappropriately during meal tray distribution. Resident #1. The findings included: Review of the facility's policy titled "Wound Care Policy" with an effective date of 06/23/20 instructed staff to "...maintain standard precautions and isolation precautions as indicated. After completion of the procedure, clean, store and/ or dispose of equipment and supplies in the appropriate manner as identified per facility infection control policy..." Review of the policy titled "Hand Hygiene Policy" with an effective date of 06/15/20 instructs staff to do the following " ...Hand hygiene with either alcohol-based hand sanitizer and or soap and water is required ...Before handling food ...when carrying supplies, dietary trays or transporting a patient into or out of a room, hand hygiene is required as soon as hands are free..." Review of the CDC (Center for Disease Control) guidelines for "best practices for linen and laundry handling instructed, " ...Never carry soiled linen against the body. Always place it in the designated container." https://www.cdc.gov/hai/prevent/resource 1. Employee #9 failed to appropriately transport soiled linens after providing wound care for Resident #1 who is on contact precautions/isolation. Resident #1 was admitted to the facility on	L 091		

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L 091	Continued From page 14 11/04/22 with diagnoses including: Pressure Ulcer Sacral Region Stage 4, Non-Healing Right Heal Wound, Multiple Wounds, and Heart Failure. During an observation on 01/06/23 starting at 10:48 AM, Employee #9 (Registered Nurse) was observed performing wound care dressing change to Resident #1's Stage 4, sacral, pressure ulcer. After changing the resident's wound dressings, Employee #9 picked up a soiled blanket, placed it under her arm, which moved the protective gown, causing direct contact of the soiled blanket with the employee's uniform. It should be noted that Resident #1 had a sign on his door stating that he was on "Contact Isolation Precautions" requiring staff to wear personal protective equipment (gown, gloves, and mask) when entering the room to provide care. A review of the medical record revealed the following: 11/04/22 at 12:34 PM [Physician's Order] "...Contact isolation ..." 01/06/23 at 10:09 AM [Physician's Order] "...change dressing...dressing type: cleanse the wound with Vashe (Wound cleanser) with VAC (vacuum-assisted closure) dressing change Site: Sacrum ...2 times weekly ..." During a face-to-face interview conducted at the time of the observation, Employee #9 (Registered Nurse) stated, "I wasn't thinking but I know better." 2. Facility staff failed to perform hand hygiene and	L 091		

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L 091	Continued From page 15 was observed not wearing their facemask appropriately. During an observation on 01/04/23 at approximately 12:00 PM, Employee #14 (Dietary Aide) was observed on the unit pushing a meal cart down the hallway and stopping at each resident's room. The employee was noted to be wearing a face mask below the nose, and only partially covering their mouth. Employee #14 was also seen not performing hand hygiene in between coming out of one resident's room, and then touching and delivering another resident's meal tray. At the time of the observation, Employee #14 was asked why his facemask was not covering his nose and mouth. The employee refused to answer. This observation was brought to the attention of Employee #2 (Director of Nursing) on 01/04/23 at 12:03 PM. Employee #2 acknowledged the findings and made no comment.	L 091		
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 foods such as grilled chicken and beans that tested below 135 degrees Fahrenheit (F), inconsistent dish machine final rinse temperatures that were below	L 099	**L 099 (1) – Food Tray Temp** 1.Immediate: • Defective bases were removed from service on Jan 6, 2023. • Nutrition Services Manger Contacted Base manufacturer to test our bases used for maintaining temperature in our patient trays on Jan 6, 2023. 2. All residents have the potential to be affected. • Defective bases were removed from service on Jan 6, 2023.	

- Nutrition Services Manger Contacted Base manufacturer on Jan 6, 2023 to test our bases used for maintaining temperature in resident trays
- There were no negative outcomes for residents from this deficient practice.

3. Systemic changes that will be made to ensure deficient practice does not reoccur:

- Nurtrition services manager will provide education to the nurtriion services team on correcting this deficent practice.
- Nutrition services manager will implement daily test trays audits to ensure proper temperatures are maintained.
- Nutrition services manager will implement monitoring of bases to ensure defective bases are not being used in service rotation.
- Nutrition services manager or designee will lead a weekly huddle to review test tray audit findings with nutrition services staff.

4. Plan for Monitoring performance/sustainability:

- Daily Test Tray Audit will be completed by nutrition services staff
- Test tray audit compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months.
- Non- compliance will be tracked and addressed immediately.

5. Date corrective action will be complete: March 10, 2023

L099 (2) – Dish machine temps

1.Immediate: Dish machine unit was cleaned on Jan 5, 2023.

2.All residents had the potential to be impacted by this deficient practice.

- There were no negative resident outcomes.

3.Systemic changes that will be made to ensure deficient practice does not reoccur:

- Nurtrition services manager will provide education to the nurtriion services team on correcting this deficent practice.
- Nutrition Services Manager or designee will implement daily Monitoring tool for Dish machine Temperatures tracking
- Nutrition Services Manager will implement additional days of scheduled preventive maintenance for Dish-machine.

4. Plan for Monitoring performance/sustainability:

- Nutrition Services Manager will receive a weekly report from Ecolab to ensure dish machine is functioning properly
- Daily audit of Temperature will be completed by nutrition services staff
- Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months.
- Non- compliance will be tracked and addressed immediately.

5. Date corrective action will be complete: March 10, 2023

L 099 (3)– Pest

1.Immediate: Nutrition Services team member removed insect and discarded all food within suspected area on Jan 5, 2023.

2.All residents had the potential to be impacted by this deficient practice.

- Removed insect and discarded all food within suspected area Jan 5, 2023.
- There were no negative resident outcomes from this deficient practice.

3.Systemic changes that will be made to ensure deficient practice does not reoccur:

- Nutrition services manager will provide education to the nnutritionservices team on correcting this deficiency.

- Nutrition Services manager will Develop/implement tool for daily auditing of the area affected
- Regional pest control will be on-site every Friday to assess, monitor, and control the area.

4. Plan for Monitoring performance/sustainability:

- Manager of Nutrition Services will receive a weekly report from Regional Pest Control on the targeted area.
- Nutrition services manager or designee will complete a Daily audit of targeted areas
- Compliance will be reported monthly at each QAPI meeting until >90% compliance is sustained for 3 months.
- Non- compliance will be tracked and addressed immediately.

5. Date corrective action will be complete: March 10, 2023

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L 099	Continued From page 16 180 degrees Fahrenheit (F), and a crawling pest that was observed on the kitchen floor. The findings include: 1. Lunch food temperatures were inadequate and failed to test above 135 degrees Fahrenheit (F) or more during a food tray test on January 4, 2023, at approximately 1:00 PM, on two (2) of three (3) observations. Grilled chicken breast tested at 126°F, and black beans tested at 127°F . 2. Final rinse dish machine temperatures failed to reach 180°F during observations on January 4, 2023. Dishes and utensils were disinfected with the disinfectant solution from the 3-compartment sink. Final rinse temperatures were normal on January 5, 2023, at approximately 2:30 PM 3. A crawling insect was observed on the kitchen floor near the grill during observations on January 5, 2023, at approximately 2:30 PM. Employee # 4 acknowledged the findings on January 6, 2023, at approximately 10:00 AM.	L 099		
L 108	3220.2 Nursing Facilities 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	**L 108 – Food Tray Temp** 1.Immediate: • Defective bases were removed from service on Jan 6, 2023. • Nutrition Services Manger Contacted Base manufacturer to test our bases used for maintaining temperature in our patient trays on Jan 6, 2023. 2. All residents have the potential to be affected. • Defective bases were removed from service on Jan 6, 2023.	

			• Nutrition Services Manger Contacted Base manufacturer on Jan 6, 2023 to test our bases used for maintaining temperature in resident trays • There were no negative outcomes for residents from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Nutrition services manager will implement daily test trays audits to ensure proper temperatures are maintained. • Nutrition services manager will implement monitoring of bases to ensure defective bases are not being used in service rotation. • Nutrition services manager or designee will lead a weekly huddle to review test tray audit findings with nutrition services staff. • Nurtrition services manager will provide education to the nurtriion services team on correcting this deficent practice. 4. Plan for Monitoring performance/sustainability: • Daily Test Tray Audit will be completed by nutrition services staff • Test tray audit compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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L 108	Continued From page 17 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 foods such as grilled chicken and beans that tested below 140 degrees Fahrenheit (F) The findings include: Lunch food temperatures were inadequate and failed to test above 140 degrees Fahrenheit (F) or more during a food tray test on January 4, 2023, at approximately 1:00 PM, on two (2) of three (3) observations. Grilled chicken breast tested at 126 degrees Fahrenheit, and black beans tested at 127 degrees Fahrenheit. Employee # 4 acknowledged the findings on January 6, 2023, at approximately 10:00 AM.	L 108		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a) The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b) Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c) Medicaid, Medicare and health insurance numbers;	L 201	**L 201 Advanced Directives** 1. The advance directive for resident #79 was signed and dated January 9, 2023, when the deficiency was identified. This resident was discharged on 1/11/23. 2. All residents have the potential to be affected. Corrective action taken: a. Charts were reviewed and there were no other residents impacted by this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. Director of Case Management will provide education to the Case Management team regarding advanced directives i. Including the	

			importance of having a signature and date on advanced directives 4. Plan for monitoring performance/sustainability: a. The Director of Case Management or a designee will perform a monthly audit on advanced directive compliance b. Results of the audit will be reported in the monthly QAPI meeting until there is 100% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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L 201	Continued From page 18 (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge, and condition on discharge; (g) Hospital discharge summaries or a transfer form from the attending physician; (h) Medical history and allergies; (i) Descriptions of physical examination, diagnosis and prognosis; (j) Rehabilitation potential; (k) Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l) Current status of resident's condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n) The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged;	L 201		

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L 201	Continued From page 19 (o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 16 sampled residents, facility staff failed to offer a resident or their representative the right to formulate or refuse an Advanced Directive (AD). Resident #79. The findings included: Resident #79 was admitted to the facility on 12/20/22 with diagnoses that included Osteoarthritis, Osteoporosis, Chronic Pain Syndrome, Right Hip Pain, and Obesity. Review of Resident #79's medical record revealed the following: Review of the Resident's Face Sheet revealed that the resident had a legal guardian.	L 201		

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L 201	Continued From page 20 An Admission Minimum Data Set (MDS), dated 12/27/22, showed facility staff coded the resident as having a Brief Interview for Mental Status score of "15," indicating intact cognition. Resident #79's electronic medical record documented, "Advance Directives - Living Will - Patient has [an] advance directive. Copy in [physical] Chart." Review of Resident #79's physical chart showed that there were no documents filed under the "Advance Directive" tab. During a face-to-face interview on 01/06/23 at 9:12 AM, Employee #5 (Unit Manager) acknowledged that there was no documented evidence that facility staff offered Resident #79 or their legal guardian the opportunity to formulate or refuse Advanced Directives.	L 201		
L 204	3232.2 Nursing Facilities 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	L 204	**L 204- Investigate / Prevent/Correct Alleged Violation** 1. There are no further corrective actions for this deficient practice as the residents have been discharged home. Resident 80 was discharged on 6/16/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: e. Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse,	

			neglect, exploitation, or mistreatment at the facility. f. There were no open incidences at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: g. Administrator will educate DON on the Resident Abuse and Neglect Policy REN 001 i. Including investigation requirements h. Tracking logs for incident reporting will be created by Administrator to include a checklist of required steps for reporting and thoroughly investigating allegations of abuse, neglect, and falls. i. Administrator will educate nursing staff on reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: j. Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and thorough investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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L 204	Continued From page 21 (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on review of facility records, reported incidents, policies, and staff interviews for two (2) of 16 sampled residents, the facility's staff failed to show evidence of conducting thorough investigations for one (1) resident that had a fall with injury and one (1) resident with an injury of unknown origin. Residents' #81 and #80. The findings included: Review of the facility's policy titled " Abuse and Neglect Policy" with an effective date of 12/23/21 instructs " ...The Director of Nursing, and or Administrator or designee of the [Facility Name], will investigate all allegations as soon as they have knowledge of the event ...The facility shall report the results of all investigations to the administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident and if the alleged violation is verified, appropriate corrective action must be taken ... " 1. Facility staff failed to thoroughly investigate Resident #81's witnessed fall with staff that resulted in an injury. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH). Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident	L 204		

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L 204	Continued From page 22 requested to be transferred from chair to bed. The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor. According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission. 12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..." 12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported. 12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has	L 204		

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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
L 204	Continued From page 23 skin abrasion on left upper shoulder ..." 12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..." The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff. The medical record lacked documented evidence that the facility staff conducted a thorough investigation into Resident #81's witnessed fall with staff as evidenced by: no statement from the PCT present at the time of the fall; and no resident interview. During a face-to-face interview conducted on 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation)." 2. Facility staff failed to thoroughly investigate Resident #80's injury of unknown origin later diagnosed as a dislocation of the right hip. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around	L 204		

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	HFD02-0026	A. BUILDING: _____ B. WING _____	C 01/09/2023

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L 204	Continued From page 24 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..." A review of Resident #80's medical record revealed the following: An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker. 05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..." 05/13/22 at 10:52 AM [Physician's Assistant Note]	L 204		

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L 204	Continued From page 25 "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom. As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency Department) and it was reduced by the orthopedic resident under conscious sedation..." A review of the facility's incidents binder and investigation documents lacked documented evidence that the facility investigated Resident #80's injury of unknown origin. During a face-to-face interview conducted on 01/09/23 at 3:19 PM, Employee #2 (Director of Nursing) stated "I am not aware of a reason why we did not complete an investigation."	L 204		
L 206	3232.4 Nursing Facilities 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. This Statute is not met as evidenced by: Based on record review and staff interviews, for three (3) of 16 sampled residents, facility staff failed to implement its policies and procedures for reporting and investigating incidents involving abuse, neglect, and injuries of unknown origin. Residents' #81, #80 and #85.	L 206	**L206 –Abuse/Neglect Policies** 1. Immediate: There are no further corrective actions for this deficient practice as the residents involved have been discharged. Resident 80 was discharged on 6/16/22, Resident 85 was discharged on 7/6/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: a. Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility – including an injury of unknown origin. b. There were no active incidences	

			at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. Resident Abuse and Neglect Policy will be reviewed by the Administrator to ensure compliance with state and federal requirements. b. Administration to provide education to DON on the Resident Abuse and Neglect Policy REN 001- including required reporting time frames and investigating process. c. Tracking log for incident reporting updated by Administrator to include a checklist of required steps for reporting and investigating allegations of abuse, neglect, and falls. d. Administrator will educate nursing staff on reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: a. Incidents from the month prior will each be reported and reviewed in the monthly QAPI meeting b. Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until 100% compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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L 206	Continued From page 26 The findings included: Review of the "Abuse and Neglect Policy" with an effective date of 12/23/21, documented, "...The Director of Nursing (DON) shall be notified in order to assist in appropriately implementing the notification requirements ... incidents of abuse ...shall be reported to the DC (District of Columbia) Metropolitan Police, the Long-Term Care Ombudsman, and Adult Protective Services: within 2 hours after the allegation has been made if the event(s) that caused the allegation involve(s) abuse ...Investigation ... All reports of alleged abuse, misappropriation of property, and injuries of unknown origin are investigated promptly in a systematic and thorough manner ... The facility shall report the results of all investigations to the Administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken..." 1. Facility staff failed to follow their policy to investigate a potential allegation of neglect involving Resident #81's witnessed fall with injury and failed to report it to State Agency in the required timeframe. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH). Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident requested to be transferred from chair to bed.	L 206		

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L 206	Continued From page 27 The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor. According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission. 12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..." 12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported. 12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has	L 206		

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L 206	Continued From page 28 skin abrasion on left upper shoulder ..." 12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..." The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff. The medical record lacked documented evidence that the facility staff conducted a thorough investigation into Resident #81's witnessed fall with staff as evidenced by: no statement from the PCT present at the time of the fall; and no resident interview. During a face-to-face interview conducted on 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation)." 2. Facility staff failed to follow their policy to investigate injuries of unknown origin as evidenced by failing to investigate Resident #80's injury of unknown origin which occurred on 05/12/22. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the	L 206		

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L 206	Continued From page 29 State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..." A review of Resident #80's medical record revealed the following: An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker. 05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..."	L 206		

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L 206	Continued From page 30 05/13/22 at 10:52 AM [Physician's Assistant Note] "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom. As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency Department) and it was reduced by the orthopedic resident under conscious sedation..." A review of the facility's incidents binder and investigation documents lacked documented evidence that the facility investigated Resident #80's injury of unknown origin. During a face-to-face interview conducted on 01/09/23 at 3:19 PM, Employee #2 (Director of Nursing) stated "I am not aware of a reason why we did not complete an investigation." 3. Facility staff failed to report an alleged incident of staff-to-resident verbal abuse between Resident #85 and Employee #11 to the State Agency within the required timeframe per the facility's Abuse policy. Resident #85 was re-admitted to the facility on 07/06/22 with diagnoses including Acute and Chronic Pain, Type 2 Diabetes, Diabetic Neuropathy and Anxiety Disorder. Review of Resident #85's medical record revealed: A face sheet that showed Resident #85 resided in	L 206		

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L 206	Continued From page 31 room 306. A 5-Day Assessment dated 07/13/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15", indicating intact cognition; no rejection of care and was almost always in pain. 07/07/22 [Physician's Order]: "Hydromorphone (Dilaudid) (narcotic pain medication) Take 1 tablet 8 mg (milligrams) total by mouth every 6 hours as needed for pain (severe pain)." 07/07/22 [Physician's Order]: "Zolpidem (Ambien) (narcotic sleeping medication) 12.5 mg CR (controlled release) tablet. Take 12.5 mg by mouth nightly as needed for sleep." 07/08/22 at 7:32 AM [Nurses Progress Note written by Employee #11]: "Late entry for care provided on the 7th July 2022 - Assumed care of [Resident #85] at 7 PM 7/7/2022. Patient was met sitting in bed watching TV (television), was assisted throughout the night, and medicated for pain and Ambien for sleep; she requested another dose of 8 mg (milligrams) of Dilaudid and was reminded that it was too early for another dose of Dilaudid ...She was not happy...but reluctantly accepted the message and went back to sleep at bedtime ..." 07/12/22 at 1:41 PM, a Facility Reported Incident (FRI), DC00010859, received by the State Agency documented, "... [Resident #85] alleges that on Friday, July 8th during the night shift (7p-7a), she was confronted by an RN (Registered Nurse) in her room who said, "Do you have a problem with me." The patient was uncomfortable with this interaction and was concerned she wouldn't receive proper care. The	L 206		

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L 206	Continued From page 32 RN in question was not assigned to this Resident at the time of the alleged verbal confrontation..." 07/12/22 at 3:07 PM [Nurses Progress Note/Late Entry]: "This writer met with [Resident #85] at her request on 07.09.2022. [Resident #85] expressed to me an unpleasant interaction she had with an RN. Her perception was that RN was not caring and responsive to her pain med needs ...At the Resident's request, the RN involved will not be assigned to her while she is in the facility ..." The evidence showed that the alleged incident between Resident #85 and Employee #11 occurred on the night shift on 07/07/22. Facility staff reported this incident to the State Agency on 07/12/22, six (6) days later. During a face-to-face interview on 01/09/23 at 2:43 PM, Employee #1 (Administrator) stated that she was not working at the facility when the incident occurred. She acknowledged that facility staff should have reported the incident between Resident # 85 and Employee #11 to the State agency immediately.	L 206		
L 207	3232.5 Nursing Facilities 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. This Statute is not met as evidenced by: Based on review of facility records, reported incidents, policies, and staff interview for four (4) of 16 sampled residents, facility staff failed to	L 207	. **F609 – Timely Reporting of Alleged Violations** 1. There are no further corrective actions for this deficient practice as the residents involved have been discharged home. Resident 80 was discharged on 6/16/22, Resident 85 was discharged on 7/6/22 and Resident 81 was discharged on 12/2/21. 2. All residents have the potential to be affected/ corrective action taken: a. Residents impacted by this deficient practice are identified when there is a reportable	

			incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility. b. There were no active incidences at the time of the survey or at the time this POC is being written. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: c. Administrator will educate DON on the Resident Abuse and Neglect Policy REN 001- i. including required reporting time frames d. Tracking log for incident reporting will be created by Administrator to include a checklist of required steps for reporting and thoroughly investigating allegations of abuse, neglect, and falls. e. Administrator will educate the nursing team on timely reporting and investigation requirements for allegations of abuse, neglect, and falls. 4. Plan for Monitoring performance/sustainability: f. Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and investigation of incidents. i. Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. ii. Any identified instances of non-compliance will be addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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L 207	Continued From page 33 report the following incidents to the state agency in the required timeframes for one (1) resident who had a witnessed fall with staff that resulted in injury, one (1) residents with injuries of unknown origin, and one (1) resident with an allegation of abuse. (Residents' #81, #80, and #85) The findings included: A facility policy titled "Abuse and Neglect Policy" (Formerly 01-28-01), effective 12/23/2021, documented: " ...Procedure ...E. The Director of Nursing shall be notified to assist in appropriately implementing the notification requirements ... incidents of abuse...shall be reported to the DC Metropolitan Police, the Long-Term Care Ombudsman, and Adult Protective Services: within 2 hours after the allegation has been made if the event(s) that caused the allegation involve abuse ...Investigation:.. a. All reports of alleged abuse, misappropriation of property, and injuries of unknown origin are investigated promptly in a systematic and through manner ...e. The facility shall report the results of all investigations to the Administrator or his/her designated representative and to other officials in accordance with DC law, including the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken ..." 1. Facility staff failed to report Resident #81's witnessed fall with staff that occurred on 12/10/21, to the state agency within 24 hours but instead reported the fall on 12/16/2021. Resident #81 was admitted to the facility on 12/02/21 with multiple diagnoses that included: Unspecified Fall, Hypertension, and Benign Prostatic Hyperplasia (BPH).	L 207		

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L 207	Continued From page 34 Review of a Facility Reported Incident (FRI), DC00010459, submitted to the State Agency on 12/16/21, showed, "...Date 12/10/21 Time 1730 (5:30 PM) At 1730H (5:30 PM) Resident requested to be transferred from chair to bed. The patient care tech (technician) (PCT) assisted the resident gait belt in place and help the resident stand and move the chair to give space for resident to turn, after standing started to sit so the PCT assisted the resident to the floor. According to the resident, he thought that the chair is still at the back ...RN (registered nurse) assessed resident vital sign (Sp) was stable and treated the small abrasion on the left upper shoulder ..." A review of Resident #81's medical record revealed the following: An Admission Minimum Data Set (MDS) dated 12/09/21, showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", which indicates intact cognition; required two-person physical assistance for transfers; used a walker for mobility; and had fall in the last one (1) to six (6) months prior to admission. 12/10/21 [Physician's Order] "CT (computed tomography) Head/Brain WO (without) Contrast Order ...stat ..." 12/10/21 at 5:30 PM, the "Post Fall Safety Huddle" showed facility staff placed a checkmark in the section that stated, " ...All falls must be reported to the DOH (Department of Health) ..." to indicate that the incident was reported.	L 207		

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SIBLEY MEM HOSP RENAISSANCE	5255 LOUGHBORO ROAD NW WASHINGTON, DC 20016

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L 207	Continued From page 35 12/10/21 at 8:20 PM [Nurse's Note] "...At 1730 (5:30 PM) pt (Patient) had incident, assisted fall when transferred him from chair to bed. After notified to his provider ...Pt sent to CT (computed tomography) scan (no Hemorrhage, Mass lesion, Acute infarction). Patient denied pain and has skin abrasion on left upper shoulder ..." 12/13/21 at 5:57 PM [Physician's Note] "...CT of the head WO (without) contrast showed no acute intracranial pathology ..." The evidence showed that the facility's staff did not report the fall incident that occurred on 12/10/21 to the State Agency until 12/16/21, seven (7) days later and there was no documented evidence that an investigation into the fall incident had been conducted by the facility's staff. During a face-to-face interview conducted on 01/09/23 at 3:14 PM, Employee #2 (Director of Nursing) stated, "I have no record of it (Facility incident investigation). 2. Facility staff failed to report an injury of unknown origin that resulted in Resident #80's right hip dislocation within 2 hours to the state agency. Resident #80 was admitted to the facility on 04/21/22 with multiple diagnoses that included: Hypertension, Dislocation of Internal Right Hip Prosthesis, Presence of Left Artificial Hip Joint, and Infection and Inflammatory Reaction. Review of a facility-reported incident (FRI), DC00010740, submitted by the facility to the State Agency on 05/13/22 documented, "...5/12/22 Time: 0515 (5:15 AM) ...At around	L 207		

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L 207	Continued From page 36 0515 (5:15) CNA (Certified Nurse Aide) called the attention of the assigned nurse to resident, she stated that the resident was having pain. Interpreter was called. Resident related to interpreter that when she got up with the help of the CNA to go to the bathroom she felt as if her hip was out of place. Resident was assessed. Hip abductor brace was in placed (sp) but noted that the legs are uneven ...The Charge nurse was informed and ...called the on-call doctor ...order was written and carried out, X-ray (X radiation) of rt (right) hip and pelvis was done, result was hip arthroplasty dislocation ..." A review of Resident #80's medical record revealed the following: An Admission MDS dated 04/28/22, showed that the facility staff coded: preferred language as Spanish to communicate; a Brief Interview for Mental Status summary score of "15", indicating intact cognition; needed limited assistance requiring one-person physical assistance from staff for bed mobility, transfer, walk-in room, toilet use, and personal hygiene; and the resident was coded as using a walker. 05/12/22 at 9:43 AM [Physician's Note] " ...Contacted by RN (Registered Nurse) at 7:45 AM that patient is concerned that her right hip has dislocated again RN also confirms that her leg length is uneven. I contacted the Ortho resident who requested Xrays of hip and pelvis. Xrays ordered stat (immediately). At 9:10am - I have been contacted by the Radiologist, patient does in fact have a dislocation ...asked for patient to be transferred to the ER (emergency room) promptly..." 05/13/22 at 10:52 AM [Physician's Assistant Note]	L 207		

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L 207	Continued From page 37 "...Use of language line interpreter ...to interview patient. Patient states she woke up yesterday morning and asked for assistance to restroom. As she was ambulating noted that her Right leg felt much shorter than her left it may be dislocated. She denies any difficulty ambulating earlier in the day and denies any occurrence of a sharp pain or a "pop" in that hip. ..She was subsequently sent to the ED (Emergency Department) and it was reduced by the orthopedic resident under conscious sedation..." There was no documented evidence that the facility staff reported Resident #80's injury of unknown origin, resulting in a dislocation of the right hip to the State agency within the 2-hour required time. During a face-to-face interview conducted on 01/09/23 at approximately 5:00 PM Employee #2 (Director of Nursing) acknowledged the findings and stated, "There were instructions where we should call a number to DOH (Department of Health) and leave a message and that's probably what staff did." 3. Facility staff failed to immediately report an alleged incident of staff-to-resident verbal abuse involving Resident #85 on 07/08/22 to the State Agency. Resident #85 was re-admitted to the facility on 07/06/22 with diagnoses including Acute and Chronic Pain, Type 2 Diabetes, Diabetic Neuropathy and Anxiety Disorder. Review of Resident #85's medical record revealed:	L 207		

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L 207	Continued From page 38 A face sheet that showed Resident #85 resided in room 306. A 5-Day Assessment dated 07/13/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15", indicating intact cognition; no rejection of care and was almost always in pain. 07/07/22 [Physician's Order]: "Hydromorphone (Dilaudid) (narcotic pain medication) Take 1 tablet 8 mg (milligrams) total by mouth every 6 hours as needed for pain (severe pain)." 07/07/22 [Physician's Order]: "Zolpidem (Ambien) (narcotic sleeping medication) 12.5 mg CR (controlled release) tablet. Take 12.5 mg by mouth nightly as needed for sleep." 07/08/22 at 7:32 AM [Nurses Progress Note written by Employee #11]: "Late entry for care provided on the 7th July 2022 - Assumed care of [Resident #85] at 7 PM 7/7/2022. Patient was met sitting in bed watching TV (television), was assisted throughout the night, and medicated for pain and Ambien for sleep; she requested another dose of 8 mg (milligrams) of Dilaudid and was reminded that it was too early for another dose of Dilaudid ...She was not happy...but reluctantly accepted the message and went back to sleep at bedtime ..." 07/12/22 at 1:41 PM, a Facility Reported Incident (FRI), DC00010859, received by the State Agency documented, "... [Resident #85] alleges that on Friday, July 8th during the night shift (7p-7a), she was confronted by an RN (Registered Nurse) in her room who said, "Do you have a problem with me." The patient was uncomfortable with this interaction and was	L 207		

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L 207	Continued From page 39 concerned she wouldn't receive proper care. The RN in question was not assigned to this Resident at the time of the alleged verbal confrontation..." 07/12/22 at 3:07 PM [Nurses Progress Note/Late Entry]: "This writer met with [Resident #85] at her request on 07.09.2022. [Resident #85] expressed to me an unpleasant interaction she had with an RN. Her perception was that RN was not caring and responsive to her pain med needs ...At the Resident's request, the RN involved will not be assigned to her while she is in the facility ..." The evidence showed that the alleged incident between Resident #85 and Employee #11 occurred on the night shift on 07/07/22. Facility staff reported this incident to the State Agency on 07/12/22, six (6) days later. During a face-to-face interview on 01/09/23 at 2:43 PM, Employee #1 (Administrator) stated that she was not working at the facility when the incident occurred. She acknowledged that facility staff should have reported the incident between Resident # 85 and Employee #11 to the State agency immediately.	L 207		
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, clean, comfortable environment as evidenced by soiled bathroom	L 410	**L 410 – Safe / Clean / Comfortable/ Homelike Environment** 1. Immediate action: a. Bathroom vents in rooms 322, 327, 328, and 330 were cleaned on January 5, 2023. b. Plastic was mounted over areas of chipped paint in rooms 322, 327, and 330. 2. All residents have the potential to be affected. Corrective action taken:	

			a. All bathroom vents were cleaned on January 5, 2023. b. There was no negative outcome on residents from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: a. Director of Plant Operations will provide Education to the plant operations team regarding LTC regulations i. Including bathroom vents being dust free ii. Rooms being free of peeling paint 4. Plan for monitoring performance/sustainability: a. Room audits will be completed monthly by Plant Operations Director or designee i. Paint integrity and vent cleanliness will be tracked b. Results of the audit will be reported in the monthly QAPI meeting until there is >90% compliance for a consecutive 3 months. c. Non-compliance will be tracked and addressed immediately 5. Date corrective action will be complete: March 10, 2023	

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L 410	Continued From page 40 vents in four (4) of eight (8) resident's rooms, and walls marred with peeling paint in three (3) of eight (8) resident's rooms. The findings include: During an environmental walkthrough of the facility on January 4, 2023, at approximately 3:15 PM, the following were observed: Bathroom vents were soiled on the inside and side in four (4) of eight (8) resident's rooms luding rooms #322, #327, #328, and #330. Paint was peeling from the walls in three (3) of ht (8) resident's rooms (#322, #327, #330). These findings were acknowledged by Employee #8 on January 4, 2023, at approximately 4:00 PM.	L 410		
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to maintain an effective pest control program as evidenced by a crawling pest observed on the floor, around the flat grill, in dietary services. The findings include: A crawling pest was seen on the kitchen floor, by the flat grill, on January 5, 2023, at approximately	L 426	**L 426– Pest** 1.Immediate: Nutrition Services team member removed insect and discarded all food within suspected area on Jan 5, 2023. • All residents had the potential to be impacted by this deficient practice. o Removed insect and discarded all food within suspected area Jan 5, 2023. o There were no negative resident outcomes from this deficient practice. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Nutrition Services manager will Develop/implement tool for daily auditing of the area affected • Regional pest control will be on-site every Friday to assess, monitor, and control the area. • Nurtrition services manager will provide education to the nurtriion services team on correcting this deficent practice. 4. Plan for Monitoring performance/sustainability:	

			• Manager of Nutrition Services will receive a weekly report from Regional Pest Control on the targeted area. • Nutrition services manager or designee will complete a Daily audit of targeted areas • Compliance will be reported monthly at each QAPI meeting until >90% compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	

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L 426	Continued From page 41 2:30 PM. The vermin were removed and discarded by staff. Employee # 4 acknowledged the findings on January 6, 2023, at approximately 10:00 AM.	L 426		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by dish machine final rinse temperatures that were below 180 degrees Fahrenheit (F) on January 4, 2023, at approximately 2:30 PM. The findings include: During observation in dietary services on January 4, 2023, at approximately 2:30 PM, final rinse temperatures from the dish machine were about 154°F and did not reach a minimum of 180°F as required. Dishes and utensils were disinfected from the three-compartment sink disinfectant solution. Final rinse temperatures were at or above 180°F on January 5, 2023, at approximately 2:30 PM Employee #6 acknowledged the findings on January 4, 2023, at approximately 3:00 PM.	L 442	**L 442– Dish machine temps** 1.Immediate: Dish machine unit was cleaned on Jan 5, 2023. 2.All residents had the potential to be impacted by this deficient practice. o Dish machine unit was cleaned on Jan 5, 2023 o There were no negative resident outcomes. 3. Systemic changes that will be made to ensure deficient practice does not reoccur: • Nutrition Services Manager or designee will implement daily Monitoring tool for Dish machine Temperatures tracking • Nutrition Services Manager will implement additional days of scheduled preventive maintenance for Dish-machine. • Nurtrition services manager will provide education to the nurtriion services team on correcting this deficent practice. 4. Plan for Monitoring performance/sustainability: • Nutrition Services Manager will receive a weekly report from Ecolab to ensure dish machine is functioning properly • Daily audit of Temperature will be completed by nutrition services staff • Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months. • Non- compliance will be tracked and addressed immediately. 5. Date corrective action will be complete: March 10, 2023	
L 529	3269.1l Nursing Facilities (l) To be free from mental or physical abuse;	L 529	L 529 – **Abuse/ Neglect Policy and investigation process**	

- There are no further corrective actions for this deficient practice as the resident (#85) has been discharged home on 7/6/22.

- All residents have the potential to be affected/ corrective action taken:
    - Residents impacted by this deficient practice are identified when there is a reportable incident related to an allegation of abuse, neglect, exploitation, or mistreatment at the facility.
    - There were no active incidences at the time of the survey or at the time this POC is being written.

- Systemic changes that will be made to ensure deficient practice does not reoccur:
    - Administrator will educate DON on the Resident Abuse and Neglect Policy REN 001-
        - including required employee leave during investigation
    - Tracking log for incident reporting will be created by Administrator to include a checklist of required steps for reporting and thoroughly investigating allegations of abuse, neglect, and falls.
    - Administrator will educate the nursing team on timely reporting and investigation requirements for allegations of abuse, neglect, and falls.

- Plan for Monitoring performance/sustainability:
    - Administrator will conduct monthly audits for 3 months to ensure compliance with the abuse and neglect policy for timely reporting and investigation of incidents.
        - Compliance will be reported monthly at each QAPI meeting until compliance is sustained for 3 months.
        - Any identified instances of non-compliance will be addressed immediately.

- Date corrective action will be complete: March 10, 2023

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L 529	Continued From page 42 This Statute is not met as evidenced by: Based on observation, record review, and staff interview, for one (1) of 16 sampled residents, facility staff failed to ensure that a resident was free from mental or physical abuse by keeping a staff person who was involved in an alleged incident of staff-to-resident verbal abuse on the schedule. Resident #85. The findings included: A facility policy entitled, "Abuse and Neglect Policy (Formerly 01-28-01)", effective 12/23/2021, documented: " ... Procedure ... F. If a staff member is cited as contributing to the alleged abuse, that staff member will be removed immediately and placed on administrative leave, until completion of the investigation of the incident ..." On 07/12/22 at 1:41 PM, a State Agency Intake Information Sheet (Intake Number: DC00010859), documented the following facility-reported incident: " ...[Name of Resident #85] alleges that on Friday, July 8th during the night shift (7p-7a), she was confronted by an RN (Registered Nurse)in her room who said, "Do you have a problem with me." The patient was uncomfortable with this interaction and was concerned she wouldn't receive proper care. The RN in question was not assigned to this Resident at the time of the alleged verbal confrontation..." In a letter dated 07/15/22 to the State Agency, the facility documented: "This is a summary report response report of the alleged verbal "abusive" staff behavior that we filed with your office. The director of Nursing and Administrator...were aware of a report made by	L 529		

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L 529	Continued From page 43 the Resident [Name of Resident #85] about verbal communications between her and a staff nurse ...Background Information: ...when formally interviewed. [Resident #85] shared the following: Interview of [Name Resident #85]: 'Nurse A entered her room [Resident #85] asked, "May I help you? The Nurse reportedly responded, "I want to know if you have a problem with me ... [Resident# 85] further explained that she said to the Nurse: I understand why you're mad. I complained about you ...I asked that you not be my Nurse ...' Interview of Nurse A ...: Nurse A recalled that she provided care to [Name of Resident #85] on the night of July 7 (Thursday 7 PM-7 AM) ...Nurse A states that on the following evening (July 8), she went to [Resident #85] 's room, knocked and opened the door ...Upon entering the room, the Resident screamed.. [obscenities] ..Nurse A left the room ...Interview of Nurse B: Nurse B recalled that on July 8, at the beginning of the shift, Nurse A had come to her to ask if she could go into [Resident #85's room to speak with her ...That night, it was confirmed shortly thereafter that Nurse A and Nurse B had started the shift with each other's assignments ...Once they realized this they swapped the assignments ..." Resident #85 was re-admitted to the facility on 07/06/22 with diagnoses including Acute and Chronic Pain, Fibromyalgia, Type 2 Diabetes, Diabetic Neuropathy, Anxiety Disorder, and Obesity. A review of Resident #85's medical record revealed: A 5-Day Assessment dated 07/13/22 showed that facility staff documented the following for Resident #84: Brief Interview for Mental Status	L 529		

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L 529	Continued From page 44 Summary Score: "15" indicating intact cognition, required extensive assistance for bed mobility, transfers, walking in the room and toilet use, balance during transitions and walking not steady, no rejection of care and almost always in pain was noted. 07/07/22 [Physician's Order]: "Hydromorphone (Dilaudid)n[narcotic used for pain relief]. Take 1 tablet 8 mg (milligrams) total by mouth every 6 hours as needed for pain (Severe pain)." 07/07/22 [Physician's Order]: "Zolpidem (Ambien) [sleeping agent] 12.5 mg CR (controlled release) tablet. Take 12.5 mg by mouth nightly as needed for sleep." 07/0822 at [Nurses Progress Note/Nurse A]: "Late entry for care provided on the 7th July 2022 - Assumed care of the [Resident] at 7 PM 7/7/2022. Patient was met sitting in bed watching TV, was assisted throughout the night, and medicated for pain and Ambien for sleep; she requested another dose of 8 mg (milligrams) of Dilaudid and was reminded that it was too early for another dose of Dilaudid ...She was not happy...but reluctantly accepted the message and went back to sleep at bedtime ..." 07/12/222 at 3:07 PM [Nurses Progress Note/ Late Entry]: "This writer met with [Resident #85] at her request on 07.09.2022.[Resident #85] expressed to me an unpleasant interaction she had with an RN. Her perception was that RN was not caring and responsive to her pain med needs ...At the Resident's request, the RN involved will not be assigned to her while she is in the facility. July 11, 2022 I was informed ...that [Resident #85] was calling 911 for assistance ...I went to inquire about the call to 911 ...Resident	L 529		

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L 529	Continued From page 45	L 529		

expressed another unpleasant interaction that she had with the same RN ...The Administrator, [Former Adminstrator's Name] was notified, and we began the investigation process on Monday, July 11, 2022."

A review of the facility's nursing assignments for 07/07/22 and 07/08/22 showed that Employee # 11, (Registered Nurse assigned to Resident #85), worked the 7:00 PM-7:00 AM shift on 07/07/22 (the night of the incident), and worked the following day 07/08/22 from 7:00 PM-7:00 AM. In addition, Employee #11's time card showed that the Employee clocked in at 7:07 PM on 07/0722 and clocked out at 7:57 AM on 07/08/22. On 07/08/22, the Employee clocked in at 7:00 PM and clocked out on 07/09/22 at 9:08 AM.

A review of Resident #85's medical record and a review of the facility's administrative records revealed that facility staff failed to protect Resident #85, who reported an incident of staff-to-resident verbal abuse, by not removing Employee #11 from the schedule immediately. The Employee completed her shift (7:00 PM-7:00 AM shift on 07/08/22, and remained on schedule to complete her shift on 07/09/22.

Employee #11 was not available for an interview during the survey.

During a telephone interview on 01/06/23 at 11:16 AM, Employee #10 (Registered Nurse who assumed care for Resident #85 on 07/08/22) stated, "One of the nurses came to me at the beginning of the shift on 07/08/22 and asked me to switch an assignment because the Resident said, she did not want her as their Nurse, so we switched ...When I went to the Resident's room, the Resident also told me she did not want

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L 529	Continued From page 46 Employee #11 to be her Nurse. I switched assignments with Employee # 11, and I became the Resident's Nurse. I never had a problem with the Resident. I never asked Employee # what happened between her and the Resident." During a face-to-face interview on 01/09/23 at 2:43 PM, Employee #1 (Current Administrator) stated that she was not working at the facility when the incident occurred. She acknowledged that Employee #11 should have been removed from the schedule immediately.	L 529		