DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

GENTER	STON WEDICARE &	WEDICAID SERVICES				0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		E SURVEY
		095015	B. WING			C 5/29/2022
		ile to contra a				5/29/2022
NAME OF PE	ROVIDER OR SUPPLIER		92.5	TREET ADDRESS, CITY, STATE	, ZIP CODE	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC	1	380 SOUTHERN AVE SE		
Serverin	RENADICITATION AND		- V	VASHINGTON, DC 20032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLA	N OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX		E ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		D TO THE APPROPRIATE	DATE
				DEFI	CIENCY)	
E 000	Initial Comments		E 000	Serenity Rehabilitation	and Health	09/23/202
	initial Comments		2000	Genter Disciainer.		
				The facility submits this	s plan of correction	
	An Emergency Prepa	aredness Survey was		under procedures esta		
	conducted June 22, 2	2022, by the Department of		department of Health i		
	Health, Health Regula			with the departments d conditions which the de		
		cordance with 42 CFR		deficient under state re	epartment alleges are	
		ound that the facility was in			hould not be construed	
		rgency Preparedness		as either a waiver of th		
	requirements for Med				the accuracy or severity	,
		rs and Suppliers, 42 CFR			or any admission of any	
				wrongdoing.	······································	
	494.62. The census v					
F 000	INITIAL COMMENTS		F 000			
	An unannounced Re	certification Survey was				
		ility on June 14 - 29, 2022.				
		sisted of observations,				
		esident and staff interviews.				
		during the survey was 162				
	and the survey samp	le included 67 residents.				
		ints were investigated during				
	this survey: DC00010					
	DC00010280, and D	C00010578.				
		Reported Incidents were				
	investigated during th	nis survey: DC00010151,				
	DC00010195, DC000	010264, DC00010316,				
	DC00010379, DC000	010402, DC00010403,				
	DC00010416, DC000	010439, DC00010486,				
		010680, DC00010684,				
		010735, DC00010774,				
		010821, and DC00010825.				
	Federal and/or Local	deficiencies were cited				
		gation(s) of: DC00010151,				
		010264, DC00010316,				
		010402, DC00010403,				
		010578, DC00010680,				
	DC00010685, DC000	010735, DC00010774,				
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ē	TITLE		(X6) DATE
1		1Sholete			NHA 9	11/22
	milayo Tr	www.				A122
		sterisk (*) denotes a deficiency which the tion to the patients . (See instructions.)				
		t a plan of correction is provided. For nur			이는 그 방법에서 그는 그 것은 방법에서 집을 받았는 것이 없다. 것이 것 같은 것이 있는 것이 없는 것이 없는 것이 없다.	
		are made available to the facility. If defici				

program participation.

		ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MUI	TIPI	E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			LETED
							C
		095015	B. WING			06/	29/2022
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CEDENITY	SERENITY REHABILITATION AND HEALTH CENTER LLC			·	1380 SOUTHERN AVE SE		
SERENT	REPADILITATION AND	HEALTH CENTER LLC		1	WASHINGTON, DC 20032		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG					DEFICIENCY)		
			1				
F 000	Continued From page	e 1	F	000			
		010821, and DC00010825.					
	,,,						
		indings, it was determined					
		ot in compliance with the					
		FR Part 483, Subpart B, and					
	Requirements for Lor	ng Term Care Facilities.					
	This survey identified	actual harm at F600 for					
	Residents #108 and #						
	The following is a dire	ectory of abbreviations					
	and/or acronyms that	may be utilized in the					
	report:						
	AMS - Altered Mer ARD - Assessmen	ntal Status It Reference Date					
	AV- Arteriovenous						
	BID - Twice- a-da						
	B/P - Blood Pres						
	cm - Centimet	ers					
		Federal Regulations					
		r Medicare and Medicaid					
	Services	Nume e Aide					
		Nurse Aide					
		y Residential Facility Registered Nurse Practitioner					
	D.C District of	-					
		Columbia Municipal					
	Regulations						
	D/C- Discontii	nue					
	DI- Deciliter						
		t of Mental Health					
	DOH- Department						
	EKG - 12 lead Elec EMS - Emergency	trocardiogram Medical Services (911)					
	F - Fahrenheit						
	F- Famelinen						
	G-tube- Gastrostor	ny tube					
	HR- Hour	-					

Event ID: FZSW11

Facility ID: HCI

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		ID HUMAN SERVICES				FORI	D: 08/12/2022
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		095015	B. WING				C 1 <b>29/2022</b>
NAME OF PROVIDER O	R SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				1	380 SOUTHERN AVE SE		
SERENITY REHABI	LITATION AND	HEALTH CENTER LLC		v	VASHINGTON, DC 20032		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
HSC - HVAC ID - IDT - IPCP- Prograr LPN- L - Lbs - MAR - MD- MDS - Mg - M- mL - volume mg/dl - mm/Hg MN N/C- Neuro NFPA - NP - O2- PASRR Review Peg tub Gastros	<ul> <li>Heating ve Intellectua Interdiscipl Infection P</li> <li>Licensed F</li> <li>Liter Pounds (u Medication Medical Do Minimum E milligrams minute milligrams</li> <li>Medical Do Minimum E milligrams</li> <li>Medical Do Minimum E</li> <li>Medical Do</li> <li>Medical D</li></ul>	rvice Center ntilation/Air conditioning I disability inary team revention and Control Practical Nurse nit of mass) Administration Record octor Data Set (metric system unit of mass) metric system measure of is per deciliter is of mercury anula cal re Protection Association ctitioner ion screen and Resident cous Endoscopic	F	000			

Facility ID: HCI

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	). 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	LETED
						С
		095015	B. WING		06/	29/2022
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE		
OEINEINII				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 000	Recommendation SCC Special C Sol- Solution	are Center Administration Record		F550 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT : Incontinent care was provided to Resident#256 by the licensed nurse on 6/26/22 after being notified by Resi #256. Resident #256 was reassessed head- on 8/17/22 by the Unit Manager/Desig	toe nee,	09/23/22
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)( §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, int this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The facil severity of condition, must establish and m practices regarding tr provision of services residents regardless of §483.10(b) Exercise of The resident has the	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in ty must treat each resident ity and care for each and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and the resident. clilty must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States.	F 550	Resident suffered no negative outcom The assistant director of nursing/unit r conduct house wide audit to ensure th nursing assistant, provide incontinent manner to all residents that require as incontinent care. Any negative finding corrected by 9/23/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with requiring assistance incontinent care have the potential to affected.	ne. nanager will at assigned care in a timely sistance with s will be with	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				13	380 SOUTHERN AVE SE		
SERENIT	RENITY REHABILITATION AND HEALTH CENTER LLC			N	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
							09/23/22
F 550	Continued From page	e 4	F	550			
	interference, coercion from the facility.	n, discrimination, or reprisal			MEASURES TO PREVENT RECURRENCE:		
	free of interference, c reprisal from the facili rights and to be suppo- exercise of his or her subpart. This REQUIREMENT by: Based on record revi staff failed to provide evidenced by not prov timely manner for one residents (Resident # The findings include: Resident #256 was an 06/10/22 with multiple Diarrhea, Recurrent E	256). dmitted to the facility on a diagnoses including			Education will be provided to all facility staff by the Facility Staff Developer on resident rights which includes treating eac resident with dignity and respect and providing care in a timely manner by 09/23/22.	ch	
	Record review reveal	ed the following:					
	to the facility at 6:45 F hospital]with discha Colitis abdominal pa summary [Resident's	Nursing Note] - " admitted PM form [local rge diagnoses of C Diff ain and diarrheadischarge name] is C diff positive on mycin [antibiotic] for 14					
	by resident's sister - " residents' needs. The	nd Comment Form] written They are not staffed to meet y allowed [resident's name] fecese [feces]. They are not					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	00	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	[Resident #256] wash 06/15/22 [Admission I the resident had a Bri Status summary score resident was cognitive #256 was coded for b the physical assistance and always being inco Review of Care Plan of following: Focus area - [Resider (activities of daily livin deficit r/t (related to) p weakness. Intervention: The resident requires with personal hygiene During a face-to-face approximately 1:00 Pl that the staff treated re asked what does that stated, "They left me i resident said that she times [Employee #31] supplies to clean her of said she was feeding	ht] when button pushed. led at 3:00 PM" Minimum Data Set] showed ef Interview for Menatal e of "15", indicating the ely intact. Also, Resident eing totally dependent on ce of one person for toileting pontinent of bowel. dated 06/12/22 revealed the ht's name] has a ADL g) self-care performance bain and generalized assistance by one staff e and oral care. interview on 06/14/22 at M, Resident #256 stated esidents terribly. When mean? Resident #256 in my stool for 5 hours." The called the desk several , came in and threw the on the foot of her bed, and residents [breakfast] and	F 550	MONITORING CORRECTIVE ACTIONS: The Assistant Director of Nursing Managers will conduct house wid ensure that facility assigned Nurs provide incontinent care in a timel all residents that require assistand facility staff for incontinent care. Any issue found during this audit corrected by 09/23/22. This audit will be done weekly x4 and then monthly x3. The report v presented to Quality Assurance P Improvement QAPI Committee.	e audit to ing Assistant ly manner to ce from the will be	09/23/22
	care until her sister ca 1:00 PM and started o During a telephone in	that staff did not provide ame to the facility around				

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	MENT OF HEALTH AN S FOR MEDICARE & I				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING		06/	C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	
OF DENITY	(REHABILITATION AND		1	380 SOUTHERN AVE SE		
SERENII	RENABILITATION AND		v	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	15		F 550	F584		9/23/22
	[the complainant] stat phone with the reside AM when she heard a say she would change finishes feeding other then said because he about not being chang around 1:00 PM and of then a resident's amb During a face-to-face 9:50 AM, Employee # stated that she came and noticed that the re she went to the room. that she needed to be incontinent care and of [sister] a Concerns an document her concern During a face-to-face 1:00 PM, Employee # that Resident #256 put times when she started the resident didn't tell needed to be changed "I told her [Resident # passing trays. I'll char When asked if she ch was incontinent, Emp know if she was incom pass my trays and I d 10:00 AM." Additional at 10:00 AM security a speaker to report to R resident wanted to be	ed that she was on the nt around 8:00 AM or 9:00 an employee [Employee #31] e the resident after she residents. The complaint r sister kept calling her ged, she came to the facility complained to staff, and assador changed her sister. interview on 06/24/22 at 28 (Manager-on Duty, LPN) to the floor around 1:00 PM esident's light was on, and The resident informed her e changed, so she provided gave the family member ad Comment form to ns. interview on 06/27/22 at 31 (Assigned CNA) stated at the light on about four ed her shift at 7:00 AM, but her until "9:45 AM she d". The employee then said, 256] I'm in the middle of nge you as soon as I can." ecked to see if the resident loyee #31 stated, "I don't tinent because I had to on't start AM care until ly, the employee stated that announced over the loud toom 330 because the		CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The bathroom vents that were soiled in resident rooms #115 and #214 were cle on 6/24/22 by the facility housekeeping staff. Residents in room #115 and #214 reassessed on 8/17/22 and suffered no outcomes. The Privacy Curtains in residents rooms 110B, 229, 244A, and 313B, were repla with curtains in good condition on 06/28 Resident #110B, #212A, #229, #244A, a #313B were reassessed on 8/17/22, the suffered no negative outcome. Resident room 229 bathroom was clean and sanitized on 6/28/22 by the facility housekeeping staff. The oxygen concentrator in resident roo 212A was cleaned on 6/29/22	were negative icced 0/22. and ey ed	

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	с		
		095015	B. WING			/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OFDENIT				1380 SOUTHERN AVE SE		
SERENIT	( REHABILITATION AND	HEALTH CENTER LLC		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
				F584		09/23/22
F 550			F 550	)		
	During a face-to-face interview on 06/27/22 at 2:00 PM, Employee #21 (RN/Unit Manager)					
		#21 (RN/Unit Manager)		IDENTIFICATION OF OTHERS WIT		
		pologized for staff not		THE POTENTIAL TO BE AFFECTED All residents residing in the facility ha		
		care for multiple hours.		potential to be affected.	5	
	Employee #21 also s	•				
	Employee #31 and re					
	responding to call lig					
	residents' needs in a	-				
F 584 SS=D	Safe/Clean/Comforta CFR(s): 483.10(i)(1)-	ble/Homelike Environment (7)	F 584	L .		
	§483.10(i) Safe Envir	ronment.				
	The resident has a right					
	comfortable and hom	elike environment, including				
	but not limited to rece	•				
	supports for daily livir	ng safely.				
	The facility must prov	vide-				
		clean, comfortable, and				
		nt, allowing the resident to				
		al belongings to the extent				
	possible.	uring that the regident can				
		iring that the resident can vices safely and that the				
		facility maximizes resident				
		pes not pose a safety risk.				
		exercise reasonable care for				
	the protection of the I	resident's property from loss				
	or theft.					
	8483.10(i)(2) Housek	eeping and maintenance				
		o maintain a sanitary, orderly,				
	and comfortable inter					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		095015	B. WING		00	C 5/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 584	Continued From page	o 8	F 58	F584	ŀ	09/23/22
1 004	§483.10(i)(4) Private		F JC	MEASURES TO PREVE RECURRENCE:	NT	
	levels in all areas;	ate and comfortable lighting		The facility housekeeping Designee will conduct we facility rooms vents to en free from dust. Any issue audit will be corrected by	eekly visual audit of all sure they are clean and identified during this	
	§483.10(i)(6) Comfortable and safe temperatulevels. Facilities initially certified after October 1990 must maintain a temperature range of 7 81°F; and	Ily certified after October 1,		Education will be provide housekeeping staff by the Development on importa clean, comfortable enviro	e facility Staff nce of maintaining a safe	
	sound levels. This REQUIREMEN by:	maintenance of comfortable Γ is not met as evidenced ons and interview, facility staff	s not met as evidenced besignee win conduct grand to to ensure that the facility mainta comfortable environment. Any i during the grand round will be c 9/23/22	and rounds on week days maintain a safe, clean, t. Any issues identified		
f r e V F a t	environment as evide vents in three (2) of 3 privacy curtains in for a worn out, dirty floor bathroom, and one (2	sekeeping services in a safe, clean, comfortable enced by soiled bathroom 34 resident's rooms, soiled ur (4) of 34 resident's rooms, in one (1) of 34 resident's 1) of one (1) dusty oxygen 1) of 34 resident's rooms.		Education will be provide Nurse by the facility Staff importance of maintainin Oxygen concentrator for 09/23/22	f Development on g a clean and dust free	
	The findings include:					
	facility on June 14, 20 AM, and on June 24,	ntal walkthrough of the 022, at approximately 11:00 2022, between 10:50 AM owing were observed:				
		ere soiled in resident rooms 2) of 34 resident's rooms.				
		ere soiled in four (4) of 34 uding rooms #110B, #229,				

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	MENT OF HEALTH AN S FOR MEDICARE & I				FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING			C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE		
			<b>\</b>	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 584 F 600 SS=G	resident's rooms (#22 4. The oxygen concer #212A, one (1) of 34 in throughou.t These observations w Employee #43 and/or face-to-face interview approximately 3:00 PI Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the in neglect, misappropria and exploitation as definded includes but is not lim corporal punishment, any physical or chemit treat the resident's me §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corpor involuntary seclusion; This REQUIREMENT by:	hroom of one (1) of 34 9) was soiled throughout. htrator in Resident room resident's rooms, was dusty rere acknowledged by Employee #44 during a on June 27, 2022, at M. Neglect In Abuse, Neglect, and right to be free from abuse, tion of resident property, fined in this subpart. This ited to freedom from involuntary seclusion and cal restraint not required to edical symptoms. y must- e verbal, mental, sexual, or ral punishment, or	F 584	F584 MONITORING CORRECTIVE ACTION The facility housekeeping Supervisor / Designee will conduct visual audit of all rooms vents to ensure they are clean a from dust. This audit will be done weekly times 4 then monthly times 3. The facility housekeeping supervisor / designee will conduct visual audit of all residents' rooms to ensure all privacy c are clean and intact. This audit will be weekly times 4 and then monthly times The facility housekeeping Supervisor / Designee will conduct visual audit of all facility residents' rooms to ensure the bathrooms floors are clean. This audit v done weekly times 4 and then monthly 3. The Assistant Director of Nursing and 1 Managers will conduct house wide aud Oxygen concentrators in residents room ensure that they are clean and free of c This audit will be done weekly times 4 t monthly times 3. Findings will be corrected immediately a reported to Quality Assurance Performat Improvement QAPI committee.	facility nd free and facility urtains lone 3. I vill be times Jnit t of ns to ust. hen and	09/23/22
	facility's staff failed to residents in the samp were free from alleged	ew and stall interview, the ensure two (2) of seven (7) le with allegations of abuse, d/witnessed non-consensual sident #126. (Residents				

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING			C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	<ul> <li>#108 and #145.</li> <li>The findings include:</li> <li>Review of the facility's Abuse", with a revision sexual abuse as " n contact of any type with not limited to sexual h sexual assault"</li> <li>Resident #126 was and 05/07/21 with multiple Depressive Disorder and Behavioral Disturbance</li> <li>Review of the resident the following:</li> <li>A Quarterly Minimum assessment dated 03 Interview for Mental S score of "99", indicating to complete the assess not coded for exhibiting symptoms directed to of the MDS showed the using a wheelchair, m- corridor, and being free Review of a Care Plan 05/27/22 revealed the [Resident #126] has p resident acts character sexual behavior physic</li> </ul>	a actual harm to Residents s policy titled, "Prohibition of in date of 05/22, defined ion-consensual sexual ith a resident includes but is narassment coercion or dmitted to the facility on e diagnoses including Major and Dementia without ces. at's medical record showed Data Set-(MDS) /02/22 documenting a Brief Status (BIMs) summary ing the resident was unable assment. The resident was	F 60	F600 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #108 was assessed head to toe by the facility licensed nurse on 5/2 sign of pain/discomfort nor facial grimac expressed. No physical signs of trauma observed, no redness, no bruises aroun perineal area and buttocks. Resident was transferred to the hospital emergency ro 5/26/22 for further evaluation. Resident to the facility from ER/ hospital visit on O Licensed nurse performed a head to toe assessment on the resident and no neg outcomes were found on 5/27/22.	e d the as joom on returned 5/27/22.	09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 1 APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION (		SURVEY LETED
		095015	B. WING				_ 29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		13	REET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 600	of inappropriate sexu Interventions: Protect protect themselves; F public area when beh disruptive/unacceptal of each episode. A 06/02/22 quarterly #126 had a Brief Inte (BIMs) summary scor resident was severely resident was not code behavior symptoms of Further review of the was coded for using a the room or corridor, incontinent of stool. A as weighing 257 pour Review of Treatment (TAR) from 05/01/22 documented hourly th facility. -06/13/22 at 1:47 PM [12:00 PM] resident w pacing the hallway wi other resident's room all times by staff. NP monitor and redirect a consult for behavioral Review of progress n Administration Recor- failed to reveal docum	] will have reduced incidents al behavior. to ther residents if unable to Remove resident from the havior is oble; Document a summary MDS documented - Resident rview for Mental Status re of "06", indicating the y impaired cognitively. The ed for exhibiting physical lirected toward others. MDS showed the resident a wheelchair, not walking in and being frequently Nso, the resident was coded nds and being 6 feet tall. Administrator Records to 06/17/22 showed nurses he resident's location in the [Nursing Note] - "at 1200 vas observed wandering and ith his wheelchair, entering , resident was redirected at notified, recommends to as required and psych I disturbances" otes, Medication ds, and Treatment ds for 06/13/22 to 06/17/22 nented evidence Resident ad by psych for wandering in	F 6	00	Resident #145 was assessed head t by the facility licensed nurse on 06/7 for pain and trauma, no apparent inju observed. Resident transferred to the hospital emergency room on 06/17/2 further evaluation. Responsible Party notified of the transfer on 6/17/22. Resident never returned back to the facility. A well check call was done w RP on 6/20/22.	17/22 ury e 22 for y was	09/23/22

Facility ID: HCI

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/202: 1 APPROVEI ). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		095015	B. WING _				C 29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC	·	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	Note] documented th AMwriter was infor #126] was observed MD order to transfe for further evaluation Detective's name] writer, [Resident #12 said they will continue Further review of the 06/17/22 at 5:00 AM indicating that she ob bed at that time. Continued review of the facility's staff revie 06/17/22 with the folle -Focus Area - "Staff r was observed on top 313 B." -Intervention- One-or every day for safety p 1A. Resident #108 w 12/10/19 with multiple Alzheimer's Disease An MDS assessment Resident #108 had a Status (BIMs) summa the resident was una assessment. Further Resident #108 was c dependent on the phy members for bed mo	M [Nursing Supervisor's e following- "At about 5:40 med by nurse [Resident in bed with [Resident #145] er [Resident #145] to ER [Officer's name and the detective interviewed 6], assigned nurseand e with their investigation" June TAR showed that on the nurse documented "IB" oserved Resident #126 in the Care Plan showed that sed the care plan on owing information: reported that [Resident #126] of [Resident #145] in Room n-one monitoring X 24 hours precautions. as admitted to the facility on e diagnoses including and Major Depression. at dated 04/11/22 documented Brief Interview for Mental ary score of "99" indicating ble to complete the review of the MDS showed	F6	600	F600 The RP also said that Resident #14 be returning to the facility and that currently seeking a new placement resident. Resident #145 never returned back facility. Resident#126 was assessed head on 6/17/22 by the facility licensed r for any signs of pain or trauma,no a injury or pain observed. Resident #126 was placed on 1 on monitoring X24hrs everyday for saf precaution. This intervention for Re #126 will remain until cleared by th Attending Physician/Designee and Psychiatrist/ Designee. Resident #126 was assessed by Psychiatrist, Psych NP, and FNP, medication review and behav management on 06/17/22. Medical treatment was updated on The resident is not exhibiting sexual behavior towards other residents ar	she is for to the to toes nurses apparent 1 ety esident ne the ioral 6/17/22.	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	С	OMPLETED
		095015	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	00/25/2022
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
						09/23/22
F 600	coded for always bein bowel. Review of a Facility F (DC00010774) dated 11:21 PM, documenter received report that [I observed sitting in his of [Resident 108] room on 05/25/22 [Wedness [Resident #126] was left hand[Resident feces on her thigh an #126] was transferred gave orders to transfer	Ag incontinent of urine and Reported Incident 05/26/22 [Thursday] at ed, "At 3:30 PMWriter Resident #126] was is wheelchair at the bedside im 112-A at about 8:30 PM aday]. It was reported that observed with feces on his #108] was observed with d bed spread[Resident d to Unit 3[MD's name] er [Resident #108] to ER r further evaluation of use"	F 60	IDENTIFICATION OF OTHER WITH THE POTENTIAL TO E AFFECTED: All residents residing in the fa the potential to be affected.	BE	09/23/22
	3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re [Resident #126] who was observed sitting bedside of [Resident 8:30pm on 5/25/22. It #126] was observed front, back, and unde also reported that [Re with feces on her thig [Resident #126] was the scene and [MD's given to transfer [Res 310-B. Also, [Detective	[ADON Note] - "At about ed [two police officers names in the facility who said they abuse for [Resident #108] in eceived report from staff that resided in room 147 Bed A in his wheelchair at the #108] Room 112-A at about a was reported that [Resident with feces on his left-hand rneath his fingernails. It was esident #108] was observed h and her bed spread. immediately removed from name] notified and order sident #126] to Unit 3 - Room ve's name and badge to the facility by the police.				

Facility ID: HCI

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /	LE CONSTRUCTION	(X3) DATE	
AND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		PLETED
		095015	B. WING			C /29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	20,2022
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	After meeting with the staff members the de arrest was made. How gave order to transfer (emergency room) via for possible physical afacility at 17:28pm [5: -05/26/22 at 4:41 PM resident to ER via 91' possible physical abut Late entry dated 05/2 "05/25/22 at 5:03 PM Report: When prepar [Employee #26 Activi [Resident #126] sitt bedside of [Resident [Employee #26] obse #126's] left hand from fingernails. Feces wa #108's] thigh and her #126] was immediate and relocated to Ur It should be noted that that was created on 0 (approximately 2 days effective date of 05/2? Late entry created on showed, "05/25/22 at Supervisor Note]- "Du about 8:30pm writer won urse that Activity Dir resident's [Resident #126] was sitting at the stress of th	e residents and talking to tective issue report No wever, [MD's name] also r [Resident #108] to ER a 911 for further evaluation abuse Resident left the 28 PM] to [local hospital]" [Physician's Order] "transfer 1 for further evaluation for ise" 7/22 at 5:16 PM showed, [Activity Note]- "Incident ing to leave for the evening I ties Director] found ing in his wheelchair at the #108] in room 112-A. Writer rved feces on [Resident t, back, and underneath his s also noticed on [Resident bed spread. [Resident dy removed from the scene nit-3 room 310-B." at this was a late entry note 05/27/22 at 5:16 PM s after the incident) with an 5/22 at 5:03 PM.	F 60	<ul> <li>F600 MEASURES TO PREVENT RECURRENCE: In-service will be provided by Staff Development /designee to all facility on abuse prohibition by 9/23/22</li> <li>In-service will be provided by Staff Development /designee to all facility about care plan intervention in place residents with sexual behavior, beha with the potential to abuse others, ar wandering behavior.</li> <li>In-service will be provided by Staff Development /designee to all License Nursing staff on the importance of e that residents identified with sexual behavior have a person-centered can that clearly state the type of behavior they are exhibiting and th are always provided supervision to p such behavior.</li> <li>Repeat in-service will be provided as needed.</li> <li>Charge nurses will ensure that reside identified with sexual behavior, or be with the potential to abuse others, ai wandering behavior have adequate supervision and monitored during all and that there is documentation in pl any behavior observed. Any issues found will be corrected b 09/23/22.</li> </ul>	staff for vior id ed nsuring re plan nat they revent s havior nd shifts, ace for	09/29/22

Facility ID: HCI

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						D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	. ,	SURVEY PLETED
						С
		095015				/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
						09/23/2
F 600	observed. No sign of pain nor discomfort expressed upon assessment. [Resident #108] was assisted with incontinent care and resident's [responsible party's name] made aware. resident was monitored through the shift with no other concerns reported BP (blood pressure) 122/67, P(pulse) 74, R18, O2 (oxygen) 99% ra (room air), T temperature) 97.8." It should be noted that this was a late entry note		F 600	Unit Mangers and Sh conduct rounds durin that resident with sext behavior with the pote and wandering behav and adequate supervi Any issues found will 9/23/22.	ig their shift to ensure ual behavior, ential to abuse others ior are monitored ision is provided.	
	that was created on ( (approximately 2 day effective date of 05/2 A 05/27/22 at 6:53 Al documented- "[Resid [local hospital] at abo who accompanied he evidence of physical examination by the d	05/27/22 at 7:33 AM s after the incident) with an 5/22 at 8:30 PM.		MONITORING CORRECT House wide audit will be co Assistant Director of Nursir Unit Managers to identify ro demonstrating sexual beha with the potential to abuse residents who wander to en appropriate care plans are consistent with the exhibite provided with adequate su ensure such behavior is po Any issue found during this addressed by 9/23/22	onducted by ng (ADON)and esidents avior, e others, and nsure that e established ed behaviors and pervision to revented.	
	Form signed and data Supervisor (Employe evening shift at about aware by the nurse the [Resident #126]sitt Resident 108] in his w his left hand. [Reside explain what happen Cognitive Communic was assessed from he sign of pain/discomfor expressed. No physic	cal signs of trauma s, no bruises around the		Unit Mangers and Shift Sup conduct rounds during the that resident with sexual b with the potential to abuse wandering behavior are m adequate supervision is pu Rounds /audit will be condu 4 then monthly times 3.	ir shift to ensure ehavior, behavior others, and onitored and rovided.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       095015       B. WING       06/29/2022         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       06/29/2022         SERENITY REHABILITATION AND HEALTH CENTER LLC       STREET ADDRESS, CITY, STATE, ZIP CODE       1380 SOUTHERN AVE SE         (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 COMPLETIC DEFICIENCY)       (x5) COMPLETIC DATE		RTMENT OF HEALTH AN ERS FOR MEDICARE &					FORM	: 08/12/2022 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SERENITY REHABILITATION AND HEALTH CENTER LLC     STREET ADDRESS, CITY, STATE, ZIP CODE       (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) COMPLETIC DATE       F 600     Continued From page 16     F 600	STATEMENT C	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SERENITY REHABILITATION AND HEALTH CENTER LLC       1380 SOUTHERN AVE SE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (x5) COMPLETIC DATE         F 600       Continued From page 16       F 600			095015	B. WING		-		
SERENITY REHABILITATION AND HEALTH CENTER LLC         WASHINGTON, DC 20032         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) COMPLETIO DATE         F 600       Continued From page 16       F 600       F 600       O9/23/	NAME OF PF	F PROVIDER OR SUPPLIER	I	s	TREET ADDRESS, CITY, STA	TE, ZIP CODE	1 00	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         F 600       Continued From page 16       F 600       F 600 <td< td=""><td>SERENITY</td><td>ITY REHABILITATION AND</td><td>HEALTH CENTER LLC</td><td></td><td></td><td>2</td><td></td><td></td></td<>	SERENITY	ITY REHABILITATION AND	HEALTH CENTER LLC			2		
F 600   Continued From page 16   F 600	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD B		COMPLETION
evaluation for possible physical abuse."         During multiple observations from 06/19/22 to 06/22/22 from approximately 11:00 AM to 4:00 PM, Resident #108 was observed in bed sleeping or eyes open and not responding to verbal stimuli. Resident #108 was not interviewable.         During a face-to-face interview on 06/22/22 at 3:00 PM. Employee #26 (Activity Director) stated that he was made aware that Resident #126 was in another resident's room uninvited but could not remember the date. The employee stated on 05/25/22 at approximately 3:00 PM, he went to look for Resident #126's and could not find him in his room (#147) or in the hallway where he usually sits playing cards with other residents. Employee #26 said he then alerted the nursing staff, and they all stated looking for the resident. The employee said he found Resident #126 in Room 112 sitting in his wheelchair at the bedside of Resident #108, who was in bed A. The employee then called nursing staff to Room 112 and moved Resident #126 into the hallway.         Further interview revealed Employee #26 asked the resident #126 id not provide an answer. The employee also observed the resident with feces on his left hand. The employee asked the resident #126 id not provide an answer. The employee also observed the resident with feces on his left hand. The employee asked the resident #108's bedspread had stool on it. When asked did Resident #108's apy anything, he stated, No, she's non-verbal." Additionally, the employee stated that Resident #126 was moved to the third	F 600	to ER (emergency roc evaluation for possibl During multiple obser 06/22/22 from approx PM, Resident #108 was not Resident #108 was not During a face-to-face 3:00 PM, Employee # that he was made aw in another resident's not remember the date. T 05/25/22 at approxim look for Resident #12 his room (#147) or in usually sits playing ca Employee #26 said he staff, and they all star The employee said he Room 112 sitting in hi of Resident #108, wh employee then called and moved Resident Further interview revert the resident why he w but Resident #126 did The employee also of feces on his left hand resident said, "No." H into Room 112 with th Resident #108's beds asked did Resident # No, she's non-verbal.	om) via 911 for further e physical abuse." vations from 06/19/22 to timately 11:00 AM to 4:00 vas observed in bed sleeping responding to verbal stimuli. ot interviewable. interview on 06/22/22 at t26 (Activity Director) stated are that Resident #126 was room uninvited but could not The employee stated on ately 8:00 PM, he went to 6's and could not find him in the hallway where he ards with other residents. e then alerted the nursing ted looking for the resident. e found Resident #126 in is wheelchair at the bedside o was in bed A. The nursing staff to Room 112 #126 into the hallway. ealed Employee #26 asked vas in Resident 108's room, d not provide an answer. bserved the resident with . The employee asked the owel movement, and the lowever, when he went back he nursing staff, he noticed spread had stool on it. When 108 say anything, he stated, " Additionally, the employee	F 600				09/23/22

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION			LETED
		095015	B. WING					C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	•	
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 2003	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	17	F	600				
	<ul> <li>9:37 AM, Employee # incident with Resident was discussed in the on 05/26/22. Howeve incident was a physic police in the facility or call for "alleged abuse When asked who call said that he did not kr employee said he ma was given an order to the emergency room physical assault.</li> <li>During a face-to-face Employee #25 (CNA) Resident #126 when Room 112. Resident # hallway with stool [feces] stomach and thighs." provided incontinent of When asked did Reside she had stool [feces] stomach and thighs." provided incontinent of When asked did Resident #12 kept trying to hide his When she asked him resident said, "Dirt." T was not dirt; it was sto stated, "I changed him was not incontinent of his hand." The employ</li> </ul>	de the physician aware and transfer Resident #108 to to be evaluated for possible interview on 06/24/22, stated she was looking for Employee #26 called her to #126 was sitting in the tes] on his left hand. She ent #108 "diaper was off, and smeared all over her The employee said she care for Resident #108. dent #108 say anything, the she doesn't talk. She just						

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING		_	06/2	) 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page anonymous call."	9 18	F 600				
	that the facility's staff #108 was safe from R	nd staff interviews revealed failed to ensure Resident Resident #126's alleged nsensual sexual touch.					
	(Cross reference 42 0 #121)	CFR 483.12, F607 Resident					
	with multiple diagnose other Disease classifi Behavioral Disturband						
	Set (MDS) revealed th had a Brief Interview to score of "99" indicatin complete the assessm MDS showed Resider requiring extensive as						
	documented, "Write nurse that [Resident # with [Resident #145] i #126] was redirected [Resident #145] was a	06/17/22 at 10:32 AM, er was informed by the #126] was observed in bed in Room 313B[Resident to leave the room assessed no signs of D's name] gave orders to 45] via 911 to ER					

Facility ID: HCI

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						0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	· · · ·	E SURVEY PLETED
						С
		095015	B. WING			6/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE
F 600	Continued From page	e 19	F 6	00		
	Review of the medica following:					
		[Physician order] - Transfer ther examination due to lse.				
/ 3 3 4 1 1 1 5 5 4 2 4 2 4 5 4 1 4 5 5 1 1 1 1 5 5 1 1 1 1 5 1 1 1 1	AM CNA [Employed careshe observed t 310B [Resident #126] #145] in room 313B immediately and the of Supervisor redirected	he Resident in [from] room ] was on top of the [Resident Writer called the supervisor other staff on the floor. I the resident [Resident				
	around the clock mor head-to-toe assessm #145] by supervisor a tear bleeding noted	tiated a 1:1 (one-to-one) nitoring until further notice. A ent was done [for Resident and writer. No bruisesskin . Resident denied pain or time. Police was called on				
	called on the seen [so was done by emerger came to a conclusion nearest ER for further orders. Responsible p	ergency responders were cene] too. An assessment ncy responders, and they to transfer resident to the r evaluation per physician's party was notified. V/S (vital				
	signs) T 97.6 P 87 BF Room Air."	P 142/67 R 18 O2 SAT 98%				
	"At about 5:40am, wr [Resident #126's nam requesting writer to re (as soon as possible)	eport to the third floor ASAP . When writer arrived on the				
	walking to his room. H was wearing a diaper	[Resident #126's name] He had his gown on and he Writer was informed by the #126] was observed in the				

Facility ID: HCI

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
							С
		095015	B. WING			0	6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			SOUTHERN AVE SE HINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 20	F6	500			
	, and the second s	se, [Resident #126] was					
		ed to leave the [his] room					
		assessed by writer and the he floor. Her skin warm and					
	dry to touch, she den						
	•	s of trauma observed as					
		and cooperativebrief was					
	intact and appropriate						
ol to ol		the other nurses could not					
		an open brief on full head to					
		D (medical doctor) gave					
		a 911 to ER for further [Resident #145] left					
	facility"						
	During a face-to-face	interview on 06/17/22 at					
		) AM, Employee #14, LPN					
	(assigned nurse) stat	ed that the CNA [Employee					
		and called her to room 313.					
		the room, she observed					
		I laying on top of Resident					
		naked. The employee then ped her get Resident #126					
		nen the staff helped him get					
	dressed and escorted						
		ound, Assessment, Request					
		22 at 8:32 AM documented,					
		I writer was informed by the #126] was observed in the					
	bed with [Resident #1	-					
		assessed no signs of pain					
		was intact/appropriate, no					
	moisture/urine observ	ved911 called [Resident					
		ERpolice called [Officer's					
		s name] came to facility					
	and interviewed write [Employee #14], and	r [Employee 20], nurse					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	approximately 9:15 A that he went to Residu on her bed, rubbed he up and open her inco- of her. When asked, if invited him into her ro "No". When asked, wi when he laid on top o "She didn't do nothing When asked, why did #145] if she didn't invi Resident #126 stoppe A nursing note docum on 6//17/22 at 10:26 A a f/u (follow-up) call to to notified about the transferto ER for fu possible physical abu A note from the Atten 06/17/22 at 6:37 PM o staff reported that dur male resident [Resider 7/17/2022 [06/17/22] has been evaluated b at the acute care hos I have updated resi requested another fac Review of witness stat the time of the incider Employee #14-LPN, E Employee #19-LPN, a Nursing Supervisor co	interview on 06/17/22 at M, Resident #126 stated ent #145's room naked, sat er legs, then pull her gown intinent pad and laid on top f she [Resident #145] om, Resident #126 stated, hat did [Resident #145] do f her, Resident #126, stated, g and didn't say anything". he lay on top of [Resident ite him into her room, ed answering questions. Nented by the Unit Manager AM indicated, "Writer made the RP (responsible party) e resident [Resident #145] rther examination due to se." ding Physician dated documented " Nursing ing monitoring round that a ent 126] was found in bed int #145] early morning of Resident [Resident #145] y assault forensic specialist pital emergency department ident's daughter She has cility for resident"	F	600			

Facility ID: HCI

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	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: 08/12 FORM APPRO OMB NO. 0938-	OVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	00001
		095015	B. WING			C 06/29/2022	,
NAME OF PF	ROVIDER OR SUPPLIER		S	REET ADDRESS, CITY, STATE	E, ZIP CODE		·
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		80 SOUTHERN AVE SE ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		TION
F 600	Continued From page who was also naked.	22	F 600			09/23/	'22
	3:00 PM, Employee # that Resident #126 was moved to her floor fro suspected that he ina female resident. The staff consistently mon inappropriate sexual & provided staff educati alleged inappropriate the floor, the employer not have documented taught to staff. During a face-to-face approximately 3:30 PM	m the first floor after staff ppropriately touched a employee then said that the itored Resident #126 for behavior. When asked if she on about Resident #126's behavior after he moved to be stated that she did but did evidence of what she interview on 06/17/22 at M, Employee #22					
	on the floor since Apri that she was not prov Resident #126 when I During a face-to-face approximately 7:30 A stated that she worke years. The employee	ide), stated that she worked il 2022. The employee said ided any education about he was moved to the floor. interview on 06/22/22 at M, Employee #24 (CNA), d on the floor for three said that she was not on about Resident #126					
	when he was moved to During a face-to-face approximately 7:45 Al stated that she has w years. The employee any education about F moved to the floor. It Employee #25 worked	to the third floor. interview on 06/22/22 at M, Employee #25 (CNA) orked on the floor for 5 said she was not provided Resident #126 when he					

Facility ID: HCI

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STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				D. 0938-0391	
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		095015	B. WING			C /29/2022	
				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE			
SERENITYR	REHABILITATION AND	HEALTH CENTER LLC		WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600 C	Continued From page	23	F 60	00		09/23/22	
A A A A A A A A A F 607 SS=E C SS=E S S S S S S S S S S S S S S S S S	approximately 4:00 PP stated that she provid- needed, and when the acility. When asked d staff after Resident #1 loor for allegedly inap- emale resident, she s provide education to s An attempt was made Administrator and the egarding the failure to Resident #126, however esponse. It should be noted that 06/17/22 the facility in of one-to-one services emained on that inter survey. Develop/Implement Al DFR(s): 483.12(b)(1)- 6483.12(b) The facility mplement written poli 6483.12(b)(1) Prohibit reglect, and exploitati nisappropriation of re	to interview the Director of Nursing b keep residents safe from yer they did not provide a t after the incident on hplemented an intervention s for Resident #126, and he vention throughout the buse/Neglect Policies (3) y must develop and cies and procedures that: t and prevent abuse, on of residents and sident property, sh policies and procedures	F 60	77			
ş	483.12(b)(3) Include baragraph §483.95,	n allegations, and training as required at is not met as evidenced					

Facility ID: HCI

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		MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED
		095015	B. WING			C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
SERENITY	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
						09/23/22
F 607		e 24 iew and staff interviews, for led residents, facility staff	F 601	7 F607 CORRECTIVE ACTION FOF THE AFFECTED RESIDENT Resident #108 was assessed	-:	
	failed to implement: the policy by not reporting to the State Survey A for Residents #108 and "Investigation Process or obtaining statement witnesses with knowle Residents' #108, #14 and #304.	heir "Prohibition of Abuse" g allegations of sexual abuse gency within two (2) hours nd #145; and their s" policy by not interviewing nts from all potential edge of an incident for 5, #86, #112, #121, #303		Resident #108 was assessed head to toe on 5/26/22, for pain and trauma. N apparent injury observed. Resident was transferred to the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Resident returned to the facility from ER/ hospital visit on 05/27/22. Licensed nurse performed a head to toe assessment on the resident and no negative outcomes were found on 5/27/22. Resident #108 was reassessed head to toe on 8/17/22 by the facility licensed nurse no evidence of physical abuse was observed.		
	Abuse", with a revision sexual abuse as non- of any type with a res limited to sexual hara assaultAll alleged v Director of Nursing, o Department of Health Event Reporting Syst	s policy titled, "Prohibition of on date of 05/22, defined consensual sexual contact ident includes but is not issment coercion or sexual violations, the Administrator, or designee shall notify the [State Agency] via the em electronicallywithin usly bodily injury occurred				
	allegations of residen inappropriate non-cor [sexual abuse] for Re non-consensual sexu	" policy by not reporting t-to-resident alleged nsensual sexual touch				
	of resident-to-residen	failed to report an allegation t inappropriate al touch [sexual abuse] for				

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		095015	B. WING		C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/29/2022
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTI
F 607	Continued From page	25	F 60	7	09/23/22
	Resident #108 was at 12/10/19 with multiple Alzheimer's Disease a Situation, Background signed and dated on Supervisor (Employed evening shift at about aware by the nurse th [Resident #126]sitt Resident #126]sitt Resident #126]sitt Resident 108] in his v his left hand. [Reside explain what happene cognitive communicat was assessed from h sign of pain/discomfo expressed. No physic observed, no redness perineal area and but aware, new order was to ER (emergency roo evaluation for possibl be noted that the order to ER was not written after police came to fa for a call of physical abu 05/26/22 at 4:41 PM [ resident to ER via 91] possible physical abu 05/26/22 at 3:30 PM [ 3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re	dmitted to the facility on e diagnoses including and Major Depression. d, Assessment, Result Form 5/31/22 by Nursing e #11) showed "During the as 300m writer was made hat activity director saw ing at the bedside [of wheelchair and had feces on nt #108] was unable to ed due to diagnosis of tion deficit. [Resident #108] ead to toe by the nurse, no rt nor facial grimace cal signs of trauma s, no bruises around the tocks. [MD's name] made s given to Transfer resident om) via 911 for further e physical abuse." It should er to transfer Resident #108 until 05/26/22 at 4:41 PM acility after receiving a call abuse for Resident #108. [Physician Order] transfer 1 for further evaluation for ise. [ADON Note] - "At about ed [two police officers names in the facility who said they abuse for [Resident #108] in eceived report from staff that esided in room 147 bed A		Resident #145 was assessed head by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resident #145 was transfer to the emergency room on 06/17/22 for f evaluation for possible sexual abu Resident #145 Responsible Party was notified on 6/17/22. Resident #145 never returned bac the facility.	hospital urther ise.

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		095015	B. WING		0	C 6/29/2022
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	8:30pm on 5/25/22. If #126] was observed front, back, and unde also reported that [Re with feces on her thig [Resident #126] was the scene and [MD's given to transfer [Res 310-B. Also, [Detection number] was called to After meeting with the staff members the de arrest was made. Ho gave order to transfe (emergency room) via for possible physical to explain what happe cognitive communical dementia, and Alzhei emergency arrive the and left the facility at hospital]" Review of the facility revealed a DOH (Dep Report form that door reported the incident resident-to-resident a non-consensual sexu 05/26/22 at 6:46 PM after the incident). During multiple obset 06/22/22 from approx PM, Resident #108 w	#108] room 112-A at about t was reported that [Resident with feces on his left-hand rmeath his fingernails. It was esident #108] was observed gh and her bed spread. immediately removed from name] notified and order sident #126] to Unit 3 - Room we's name and badge o the facility by the police. e residents and talking to tetective issue report No wever, [MD's name] also r [Resident #108] to ER a 911 for further evaluation abuse. Resident was unable ened due to diagnosis of tion deficit, vascular mer's disease911 e facility at 17:0pm [5:00 PM] 17:28pm [5:28 PM] to [local cartment of Health) Incident umented the facility's staff of alleged alleged inappropriate al touch [sexual abuse] on (approximately 22 hours	F 60	Resident #126 was assessed 6/17/22 by the facility licensed signs of pain or trauma. No app found nor complains of pain rep Resident on 1 on 1 monitoring everyday for safety precaution. monitoring intervention will remain until cleared by the Attending Physician/Designee Psychiatrist/ Designee. Resident #126 was assessed the Psychiatrist, Psych NP, and FNP, for medication review and management on 06/17/22. Mediintervention was updated on 6/ Resident continues to be on 1 and have not acted inappropria will remain on 1 on 1 monitorin everyday.	nurses for any parent injury ported. X 24hrs The and the and the by d behavioral dical 17/22. x 1, 24 hours ately. Resident	09/23/2

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	<b>FIPLF</b>	CONSTRUCTION		D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,				PLETED
							С
		095015	B. WING			06	/29/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 607			F	607	Resident #86, Resident #112, Resident #303,		09/23/2
	During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Agency was notified on 06/26/22, the day after the alleged incident of "physical abuse" [sexual abuse] on 06/25/22, because the evening supervisor failed to make				Resident #304, and Resident #121 wer reassessed by the Unit Managers on 8/17/222 No new incident or occurrences of allegation of abuse observed.	e	
 	him aware of the incid facility's supervisors a Agency aware of any Employee #3 stated,			Resident #145, Resident #108, Reside #86, Resident #112, Resident #303, Resident #304, and Resident #121 did not suffer any negative outcome	ent		
		immediately or within two hours of the incident. Cross Reference 42 CFR 483.12, F600			for not reporting incidences within required time as stipulated by the CMS regulation & requirement to State Agency or for not	9	
	1b. The facility's staff of resident-to-residen non-consensual sexu			conducting interviews and obtaining statements from potential witness of allegation of abuse. Resident #120 no longer residing in the facility and was			
	the State Agency with #145.	nin two hours for Resident			discharged 05/05/22.		
	multiple diagnoses in Disease classified els	dmitted on 02/08/22 with cluding Dementia in other sewhere without Behavioral ive Communication Deficit, scle Weakness.					
	resident to ER (emerge	Physician order] - Transfer gency) for further ossible physical abuse.					
	AM GNA/CNA was do observed the Resider (Resident #126) was	nt in [from] room 310B on top of the Resident					
	the room. Writer calle immediately and the	om 313B and called writer to ed the supervisor other staff on the floor. I the resident (Resident					

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	S FOR MEDICARE &		0.00				<u>D. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	COM	E SURVEY PLETED
		095015	B. WING			C 06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	#126) to his room. Ini monitoring until further assessment was don supervisor and writer tear, no bleeding note any discomfort at this the seen [scene]. Em called on the seen [sc was done by emerger came to a conclusion nearest ER (emerger evaluation per physic party was notified. V// BP 142/67 R 18 O2S/ During a face-to-face 8:45 AM, Employee # was making the surve State Agency) aware resident-to-resident a #145 and Resident # facility's staff informer (State Agency) electro the incident? She stat that the facility's staff aware approximately Cross Reference 42 ( Review of the facility's Process', with a revis documented, interview from potential witness scope of the investiga 2. The facility's staff face	tiated a 1:1 around the clock er notice. A head-to-toe e [for Resident #145] by . No bruises noted, no skin ed. Resident denied pain or a time. Police was called on ergency responders were cene] too. An assessment ncy responders, and they to transfer resident to the ncy room) for further ian's orders. Responsible S (vital signs) T 97.6 P 87 AT 98% Room Air." interview at approximately 42 (DON) stated that she eyor (Representative of the of the incident of lleged abuse with Resident 126. When asked if the d the Department of Health onically information about ted, "No." It should be noted made the State Agency 3 hours after the incident. CFR 483.12, F600 s policy titled, "Investigation ion date of 06/22, w and/or obtain statements ses as determined by the ation ailed to follow their s" policy by not interviewing nts from all potential	F	607	IDENTIFICATION OF OTHERS	e	09/23/2

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		095015	B. WING				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	380 SOUTHERN AVE SE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		۷	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE
F 607	sexual touch [sexual a resident-to-resident a sexual abuse of Reside resident-to-resident in #121, staff physical a staff neglect of Reside 2a. Facility staff failed statements/interviews who might have know resident-to-resident in sexual touch [sexual a Resident #108 was au 12/10/19 with multiple Alzheimer's Disease a 05/25/22 at 8:59 PM [ Assessment, Result F shift at about 8:30pm the nurse that activity #126]sitting at the B his wheelchair and ha [Resident #108] was a happened due to diag communication deficit assessed from head t of pain/discomfort nor No physical signs of t redness, no bruises a buttocks. [MD's name was given to Transfer room) via 911 for furth physical abuse." It shi to transfer Resident #	happropriate non-consensual abuse] for Resident #108; Itercation for Resident #86, dent #112, noident involving Resident buse of Resident #303's and ent #304. d to obtain a from all potential witnesses fledge of the happropriate non-consensual abuse] for Resident #108. dmitted to the facility on e diagnoses including and Major Depression. Situation, Background, form]- "During the evening writer was made aware by director saw [Resident bedside [of Resident 108] in ad feces on his left hand. unable to explain what gnosis of cognitive t. [Resident #108] was to toe by the nurse, no sign facial grimace expressed. rauma observed, no round the perineal area and d] made aware, new order resident to ER (emergency her evaluation for possible ould be noted that the order f108 to ER was not written	F	607	MEASURES TO PREVENT RECURRENCE: The facility Staff Development/ Designe will provide an education /In-service to facility Director of Nursing, ADON, Unit Managers and Supervisors on the process of reporting of incident of unusual occurrences to the State Agency within required time as stipulated by the CMS regulation & requirement. The in-service/education will explain the importance of reporting incidences timely The compliance date for this intervention 9/23/22. The facility Staff Development/Designe will provide education to the facility Unit Managers and Supervisors on the importance of following facility protocol of conducting interviews and obtaining statement from potential witnesses and everyone that w on that shift during an investigation of all incidences of unusual occurrences, The compliance date for th intervention 9/23/22.	of y. ee s	09/23/22
	until 05/26/22 at 4:41	PM after police came to a call for a call of physical					

Facility ID: HCI

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				E CONSTRUCTION		10. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
						С
		095015	B. WING		0	6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SERENIT	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE		
				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	∋ 30	F 607	MONITORING CORRECTI ACTION:	IVE	9/23/22
	resident to ER via 91 possible physical abu 05/26/22 at 3:30 PM [ 3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re [Resident #126 who r was observed sitting bedside of [Resident # 8:30pm on 5/25/22. It #126] was observed w front, back, and unde also reported that [Re with feces on her thig [Resident #126] was the scene and [MD's given to transfer [Res 310-B. Also, [Detectivn number] was called to After meeting with the staff members the de arrest was made. How gave order to transfer (emergency room) via for possible physical a to explain what happe cognitive communicat dementia, and Alzhein emergency arrive the and left the facility at hospital]"	[ADON Note] - "At about ed [two police officers names in the facility who said they abuse for [Resident #108] in eceived report from staff that resided in room 147 bed A in his wheelchair at the #108] room 112-A at about was reported that [Resident with feces on his left-hand rneath his fingernails. It was esident #108] was observed th and her bed spread. immediately removed from name] notified and order sident #126] to Unit 3 - Room ve's name and badge the facility by the police. e residents and talking to tective issue report No wever, [MD's name] also r [Resident #108] to ER a 911 for further evaluation abuse. Resident was unable ened due to diagnosis of tion deficit, vascular mer's disease911 facility at 17:0pm [5:00 PM] 17:28pm [5:28 PM] to [local		The Assistant Director of Net (ADON)/ Designee will com house wide review/audit of a incidences of incidence of u occurrences vial State Agency reporting syst within required time as stipulated by the CMS regul requirement and within 2 ho seriously bodily injury occur weekly times 4, then, monthly times 3 months. The Assistant Director of N (ADON)/ Designee will com house wide review/audit of a incidences of unusual occur to ensure investigation was conducted and potential wit and everyone that work on t are interviewed and statem obtained weekly times 4, then, monthly times 3 month The findings of these audits presented monthly for 3 mo Quality Assurance Performa Improvement (QAPI) comm	plete all unusual eem lation & ours if red. lursing plete all rrences nesses that shift ieent are hs.	

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING		_		C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 2003	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	of the four (4) CNAs [ interviews or stateme During a face-to-face starting at approximat (ADON) stated that the process of investigatin Cross Reference 42 (2) 2b. Facility staff failed statements/interviews who might have know resident-to-resident a Resident #86 was add 08/28/18 with multiple Dementia without Bet Generalized Muscle W Review of a Facility R [DC00010685] dated documented, "Around informed by the smok [Resident #86] was hi #120][Resident #86] [Resident #120] didn't elevator to go to the s #120] approached hir face and promised to himwriter called 91 name] reassured [	eview of the facility's cked documented evidence potential witnesses] nts. interview on 06/28/22 tely 4:00 PM, Employee #3 aey are working on their ing incidents. CFR 483.12, F600 d to obtain a from all potential witnesses vedge of the ltercation for Resident #86. mitted to the facility on a diagnoses including: navioral Disturbances and Veakness. Reported Incident 04/14/22 at 9:09 PM d 11:00 AM writer was ting monitor that it in the face by [Resident 6] stated it all started when t want to ride with me in the smoke patio[Resident in and smacked him [in] his do so each time he [sees] 1 for intervention. [Officer's Resident #86] that he was 0] to the ER for evaluation	F 60	7			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING				C 29/2022
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE		
JERENIT	REHABILITATION AND			W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	32	F	507			
	complained another r who was unprovoked of the neck two days admission to skilled N 04/20/22 at 1:47 PM [ writer and recreation physical altercation b [Resident #120] on 04 expressed that he dow #120] returns to the fa chargesThis writer accompanied [Reside Police Prescient to re charges" Review of facility's inv the following: 04/18/22 [ Employee's monitor]- documented	-					
	[Resident # 120] enter [cursing] and making [Resident #86][Resident #86][Res	red the patio cussing verbal treats [threats] to sident #120] stated nobody etting to youI better not because I got something					
		ew of statement from the as present on the smoking					
	starting at approximation	interview on 06/28/22 tely 4:00 PM, Employee #3 iey are working on their					

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C / <b>29/2022</b>
	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE	<u> </u>	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		,	WASHINGTON, DC 20032		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	<ul> <li>who might have know allegation made by R</li> <li>Resident #112 was at 08/03/20 with diagnos Schizophrenia, Psych Disorder.</li> <li>Review of a Facility R received on 07/19/21 informed by the charge PM) that [Resident #1 (physical therapist) st night, that she is feeli place that if she sees herself"</li> <li>Review of Resident # revealed the following 02/09/21 [Physician's (antidepressant) HCI MG (milligram) give 1 morning for Depression 03/20/21 [Physician's Fumarate (antipsychot tablet by mouth at beau of the set of</li></ul>	ng incidents. I to obtain a from all potential witnesses veldge of a sexual abuse esident #112. dmitted to the facility on ses that included: notic Disorder and Anxiety Reported Incident (FRI) documented, "Writer was ge nurse at 14:40p.m (2:40 112] informed the PT taff that she was raped all ng so horrible about this a gun, she can just kill c112's medical record g: Order] "Sertraline (hydrochloride) Tablet 50 tablet by mouth in the on/Anxiety"	F	607			
	score of 10, indicating	g moderately impaired rs for psychosis, no verbal					

Facility ID: HCI

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING				06/	C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 607	one person physical a transfers, impairment extremities, wheelcha received antipsychotic last 7 days. 07/12/21 at 3:19 PM [ Practitioner Progress seen for f/u (follow up significant for depress lying on the bed, alert self, generally to place at this time" 07/19/21 at 1:43 PM [ "Sexual assault note: report from the ADON Nursing) stating the re was sexually assaulte was in the facility Of the ADON and the SV that the alleged incide due to [Resident #112 from outside of the fac facility being very limit outside visitors have b resident's room. The s will continue to docum that are made by [Res 07/19/21 at 3:52 PM [ informed by the charg [Resident #112] inform was raped all night, th about this place that in just kill herself [Res someone from the con	to total dependence with assist for bed mobility and on both sides for lower ir mobility device and as on a routine basis in the Psychiatric Nurse Note] "The patient was ). She has a history ion, anxiety. She is seen and oriented generally to a, receptive to visit Stable Social Work Progress Note] This worker received a (Assistance Director of esident informed staff she d by several men while she nee the resident spoke to V director it was determined ent could not have happen cility. Due to visitation of the ted do to covid protocols no been allowed to any social work and nursing staff nent any of the statement sident #112]." Nurses Note] "Writer was e nurse at 14:40p.m that ned the PT staff that she iat she is feeling so horrible f she sees a gun, she can	F	607				

Facility ID: HCI

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING			C 06/29/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SERENITY REHABILITATION AND HEALTH CENTER LLC				1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					LD BE COMPLÉTION	
F 607	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH		IPPROPRIATE         DATE	

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING _				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	36	Fe	607			
	Resident #121 was au 02/27/21 with diagnos Schizophrenia, Press Stage 4, Paraplegia, I of Bladder and Schizo Review of a grievance dated 05/27/22 docur (Wednesday) May 25 woke by a strange ma wheelchair @ (at) the screamed and called [Nurse's Name] came for snacks" Review of Resident # Data Set (MDS) date facility staff coded the for Mental Status (BIN no potential indicators or physical behavior so others. 05/25/22 at 2:11 AM [ about 2; 11am a male room 144 A and was Writer asked [Resident touched her, resident touch me, writer aske you have food on the no he was touching th	dmitted to the facility on ses that included: ure Ulcer of Sacral Region Neuromuscular Dysfunction ophrenia. e made by Resident #121 nented, "Wed , 2022 @ (at) 1:30 AM I was an [Resident #126] in a bottom side of my bed. I					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 08/12/2022 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		095015	B. WING					C 29/2022	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATI	E, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	37	F	607					
		s abuse on the grievance d to file an incident report of nt incident.							
	06/22/22 at approxima Employees #6 (Unit 1 Employee #6 stated, ' speak to the resident interviews. I then put	Social Worker) and #3, Once I get a grievance, I and staff involved and get together a packet and it's ocial Services Name] and							
	Employee #3 acknow	ementioned interview, ledged the finding and port should've been done partment of Health)."							
		from all potential witnesses ledge of Resident #303's							
	12/13/21 with diagnos	dmitted to the facility on ses that included: Type 2 sk of Coordination and n.							
	8:30am on Dec. 31st	end of shift rounds at about 2021, writer was informed that during her session this #303] said one of the							
	Review of Resident # revealed the following								

Facility ID: HCI

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
	095015	B. WING			C 29/2022
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
SERENITY REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 607 Continued From page	e 38	F 607	7		
<ul> <li>12/21/21 where facilit Interview for Mental S score of 15, indicating potential behaviors of physical behaviors of physical behaviors of refusal of care, extension one-person physical transfers and person on one side for lower</li> <li>12/31/21 at 6:56 AM During end of shift ro approached by Spee [Resident #303] just is on the hand by a nur [Resident #303's] root happened last night. hit her on her left wrist 12:00AM last night (I injury, and there was discoloration observed question. She denied advised that her com</li> <li>Review of the facility on 06/27/22 lacked d potential witnesses w were interviewed or p</li> <li>During a face-to-face 06/27/22 at 9:14 AM, the finding and made</li> <li>2f. Facility staff failed investigations eviden</li> </ul>	Status (BIMS) summary g intact cognition, no f psychosis, no verbal or rected towards others, no sive assistance with assist for bed mobility, al hygiene and impairment extremity range of motion. [Nurses Note] "Late Entry unds at 8:30AM, writer was ch Therapist, she said nformed her that she was hit se last night. Writer went to m and asked her what She said, the female nurse at around 11:30PM and Dec. 30th 2021). She denied no swelling, or skin d at the alleged skin area in pain. [Resident #303] was plaint will be investigated." s investigation documents ocumented evidence that all ith knowledge of the incident provided a statement. interview conducted on Employee #3 acknowledged no further comment. to implement its policy for ced by failure to interview all knowledge of neglect				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	9 39	F	607			
	11/02/21 with multiple Low Back Pain, Urina Diabetes Mellitus. A Facility Reported In 11/04/21 documented that yesterday night [' did not respond to her	dmitted to the facility on diagnoses that included: ry tract infection (UTI), cident (FRI) received on , "Resident complained 11/03/21] her assigned staff r call light on time when she sistancethat the CNA					
	morning she was assi	was ignoring her dent also reported that this isted to the bathroom but ame to assist her back to					
	Review of Resident # revealed the following						
	ADL self-care perform weakness s/p (status	'[Resident #304] has an hance deficit r/t generalized post) lumbar spinal fusion dent to use bell to call for					
	11/08/21 showed that a Brief Interview for M summary score of 14, no potential behaviors care, required extensi one-person physical a transfers, toilet use ar limitations in range of extremities, used a wa	indicating intact cognition, s of psychosis, no refusal of we assistance with assist for be mobility, nd personal hygiene, no motion for upper and lower alker and wheelchair for hys incontinent of bladder					

Facility ID: HCI

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3)	3 NO. 0938-039 DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		COMPLETED
		095015	B. WING			C 06/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	)E	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	× 40	Гео	7		09/23/22
1 007		s investigation documents	F 60	7 F609		
		no documented evidence		CORRECTIVE ACTION	FOR THE	
		ked with Resident #304 on		AFFECTED RESIDENT	:	
	-	were interviewed or provided		Resident #108 was asse	ssed head	
	statements.			to		
	During a face-to-face	interview on 06/22/22 at		toe by the facility Licens	ed nurse	
		#7 (Unit 1 Nurse Manager)		on		
	acknowledged the fin	dings and provided no		5/26/22, for pain and trau		
	further comments.			apparent injury observed		
	Reporting of Alleged		F 60	9 Resident #108 was transfer		
SS=E	CFR(s): 483.12(c)(1)	(4)		hospital emergency room o	n 5/26/22	
	§483.12(c) In respons	se to allegations of abuse,		further evaluation for possib	ole physical	
		or mistreatment, the facility		abuse. Incident was reporte State	ed to the	
	\$483.12(c)(1) Ensure	that all alleged violations		Agency late, approximately	/ 22 hours	
	involving abuse, negl			after the incident.		
		ng injuries of unknown		Resident #108 returned to	the facility	
		priation of resident property,		from ER/hospital visit on05/	•	
		itely, but not later than 2 tion is made, if the events		Licensed nurse nerformed		
	-	tion involve abuse or result in				
		or not later than 24 hours if				
	the events that cause	the allegation do not involve				
		ult in serious bodily injury, to				
		ne facility and to other the State Survey Agency and				
		ces where state law provides				
	•	-term care facilities) in				
	accordance with State procedures.	e law through established				
	§483.12(c)(4) Report					
		administrator or his or her				
	designated represent accordance with State	ative and to other officials in				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING _				C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revi nine (9) of 67 sample failed to: report allega alleged/witness sexua non-consensual sexua non-consensual sexua survey Agency imme hours of the allegation #145; report the resul State Survey Agency incident for Residents #112, #303 and #304 resident-to-resident in #121. Residents' #10 #303, #304 and #121 The findings included 1. The facility's staff for resident-to-resident a (inappropriate non-co /willful non-consensua State Suvey Agency i two hours of the allega and #145. 1a. Resident #108 wa 12/10/19 with multiple Alzheimer's Disease a Review of the medica following:	n 5 working days of the eged violation is verified a action must be taken. Is not met as evidenced www.and staff interviews, for d residents, facility staff ations of resident-to-resident al abuse (inappropriate al touch /willful al contact) to the State diately or no later than two in for Residents #108 and its of investigations to the within 5 working days of the s' #8, #84, #86, #108, #145, ; and report a neident involving Resident 8, #145, #8, #84, #86, #112, ailed to report allegations of lleged/witness sexual abuse insensual sexual touch al sexual contact) to the mmediately or no later than iation for Residents' #108 as admitted to the facility on a diagnoses including and Major Depression.	F		Resident #145 was assessed head to toe by the facility Licensed nurse on 06/17/22 for pain and trauma, no apparent injury observed. Resider #145 was transfer to the hospital emergency room on 06/17/22 for further evaluation for possible physical abuse. Resident #145 Responsible Party was notified . The incident was reported to State Agency late approximately 3hours after the	ıt	09/23/22
l	, , ,	· · · ·					1

	S FOR MEDICARE &					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING			C
		095015	B. WING			29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				1380 SOUTHERN AVE SE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC	,	WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	signed and dated on Supervisor (Employe evening shift at about aware by the nurse the [Resident #126]sitt Resident 108] in his we his left hand. [Reside explain what happene cognitive communicat was assessed from he sign of pain/discomfor expressed. No physic observed, no redness perineal area and but aware, new order wat to ER (emergency row evaluation for possible be noted that the order to ER was not written after police came to ff physical abuse for Ref 05/26/22 at 3:30 PM 3:30pm writer received and badge numbers] had a call for alleged room 112-A. Writer ref [Resident #126 who re was observed sitting bedside of [Resident 8:30pm on 5/25/22. If #126] was observed front, back, and under also reported that [Ref with feces on her thig	5/31/22 by Nursing e #11) showed, "During the t 8:30pm writer was made hat activity director saw ing at the bedside [of wheelchair and had feces on nt #108] was unable to ed due to diagnosis of tion deficit. [Resident #108] ead to toe by the nurse, no rt nor facial grimace cal signs of trauma s, no bruises around the ttocks. [MD's name] made s given to transfer resident om) via 911 for further le physical abuse." It should er to transfer Resident #108 o until 05/26/22 at 4:41 PM acility after receiving a call of esident #108. [ADON Note] - "At about ed [two police officers names in the facility who said they abuse for [Resident #108] in eceived report from staff that resided in room 147 bed A} in his wheelchair at the #108] room 112-A at about t was reported that [Resident with feces on his left-hand rmeath his fingernails. It was esident #108] was observed ih and her bed spread. immediately removed from	F 609		rses for any rent injury rted. 24hrs he monitoring ed by the d the ehavioral al intervention ht will remain 1 day. Resident	09/23/22

Facility ID: HCI

If continuation sheet Page 43 of 184

SERENTLY REHABILITATION AND HEALTH CENTER LLC     1380 SOUTHERN AVE SE WASHINGTON, D.2 G032       Image: Continue of the process of the proces of the process of the process of the process of the pro	3 NO. 0938-039 DATE SURVEY COMPLETED	(X3) DATE	E CONSTRUCTION	. ,	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DF DEFICIENCIES CORRECTION	TATEMENT C
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During a face-to-face interview on 06/28/22 starting at approximately 4:00 PM, Employee #3 (ADON) stated that the State Survey Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Survey Agency.Resident #86 was reassessed head to toeCross reference 42 CFR 483.12, F600Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.Result of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22.Review of the medical record revealed theResult of the incident investigation report was sent to the State Agency via the reporting portal on 7/14/22.		tinjury			2 hours after the incident).	PM (approximately 22	
<ul> <li>starting at approximately 4:00 PM, Employee #3</li> <li>(ADON) stated that the State Survey Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Survey Agency.</li> <li>Cross reference 42 CFR 483.12, F600</li> <li>1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.</li> <li>Review of the medical record revealed the</li> <li>report was sent to the State Agency via the reporting portal on 7/14/22</li> <li>Resident #86 was reassessed head to toe</li> <li>by the Unit Manager on 8/17/22. There were no negative outcomes. The incident report was sent to the State Agency on 7/14/22.</li> <li>Resident #8 was reassessed head to too by the Unit Manager on 8/17/22for pain and trauma, no apparent injury observed</li> </ul>							
<ul> <li>(ADON) stated that the State Survey Agency was notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Survey Agency.</li> <li>Cross reference 42 CFR 483.12, F600</li> <li>1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.</li> <li>Review of the medical record revealed the</li> <li>the reporting portal on 7/14/22</li> <li>Resident #86 was reassessed head to toe by the Unit Manager on 8/17/22. There were no negative outcomes. The incident report was sent to the State Agency on 7/14/22.</li> <li>Resident #8 was reassessed head to toe by the Unit Manager on 8/17/22 for pain and trauma, no apparent injury observed</li> </ul>		•					
<ul> <li>notified on 05/26/22 because the evening supervisor on 05/25/22 failed to notify the State Survey Agency.</li> <li>Cross reference 42 CFR 483.12, F600</li> <li>1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.</li> <li>Review of the medical record revealed the</li> <li>Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.</li> </ul>	1						
supervisor on 05/25/22 failed to notify the State Survey Agency.Resident #86 was reassessed head to toeCross reference 42 CFR 483.12, F600by the Unit Manager on 8/17/22. There were no negative outcomes. The incident1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.Resident #8 was reassessed head to toe by the Unit Manager on 8/17/22 for pain and trauma,no apparent injury observed.		/14/22	the reporting portal on 7/14/2			. ,	
Survey Agency. Cross reference 42 CFR 483.12, F600 1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the medical record revealed the					•		
Cross reference 42 CFR 483.12, F600by the Unit Manager on 8/17/22. There were no negative outcomes. The incident report was sent to the State Agency on 7/14/22.1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.Resident #8 was reassessed head to toe by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed.		essed head to				•	
Cross reference 42 CFR 483.12, F600were no negative outcomes. The incident1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral 		0/47/00 T				Survey Ageney.	
1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.were no negative outcomes. The incident report was sent to the State Agency on 7/14/22. Resident #8 was reassessed head to too by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed					FR 483 12 F600	Cross reference 42 C	
1b. Resident #145 was admitted on 02/08/22 with multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.       report was sent to the State Agency on 7/14/22.         Resident #8 was reassessed head to too by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed.		nes. The					
multiple diagnoses including Dementia in other Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.report was sent to the State Agency on 7/14/22. Resident #8 was reassessed head to too by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed.					as admitted on 02/08/22 with	1b. Resident #145 wa	
Disease classified elsewhere without Behavioral Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the medical record revealed the Network the medical record revealed the Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the medical record revealed the Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness. Review of the medical record revealed the Disturbances, Cognitive Communication Deficit, and trauma, no apparent injury observed.		tate Agency on					
Disturbances, Cognitive Communication Deficit, and Generalized Muscle Weakness.Resident #8 was reassessed head to too by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observedReview of the medical record revealed theobserved					0	1 0	
and Generalized Muscle Weakness.by the Unit Manager on 8/17/22for pain and trauma,no apparent injury observed							
			observed		I record revealed the	Review of the medica	
following: Result of the incident investigation		vestigation	Result of the incident invest				
report was sent to the State Agency via	1	-				5	

Event ID: FZSW11

Facility ID: HCI

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ATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		095015	B. WING			06	/29/2022
NAME OF PI	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC					
				vv	ASHINGTON, DC 20032		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
							09/23/2
F 609	Continued From page	e 44	F 6	609	Resident #108 was reassessed head	to toe	
	resident to ER (emerg	gency) for further			by the Unit Manager on 8/17/22for pa		
e	examination due to p	ossible physical abuse.			and trauma, no apparent injury observ	ed	
					Result of the incident investigation report was sent to the State Agency v	ia	
	06/17/22 at 7:38 AM	[Nursing Note] - " At 5:00			the reporting portal on 7/14/22	ia	
	AM GNA/CNA was do						
	observed [Resider	nt #126 from] room 310B			Resident #112 was reassessed head	to toe	
	[laying] on top of the	[Resident #145] in room			by the Unit Manager on 8/17/22.		
	313B and called write	er to the room A			Result of the incident investigation	•	
	head-to-toe assessm	ent was done [for Resident			report was sent to the State Agency vi the reporting portal on 7/14/22. Resid		
		and writer. No bruises noted,			suffered no negative outcome from no		
	no skin tear, no bleed	ling noted. Resident denied			reporting the result of incident investig		
	pain or any discomfor	rt at this time. Police was			the State Agency within 5 working day	s.	
	called on the seen [so	cene] An assessment was			Desident #202 was responsed based		
	-	esponders, and they came			Resident #303 was reassessed head the Unit Manager on 8/17/22.	to toe by	
		nsfer resident to the nearest			Result of the incident investigation		
	ER (emergency room	a) for further evaluation"			report was sent to the State Agency vi	a the	
		,			reporting portal on 7/14/22.		
	During a face-to-face	interview at approximately			Resident suffered no negative outcom	e from	
		2 (DON) stated that she			not reporting the result of		
		eyor (Representative of the			incident investigation to the State Agency within 5 working days.		
	State Agency) aware				Agency within 5 working days.		
		illeged abuse with Resident			Resident #304 was reassessed head	to toe by	
		126. When asked if the			the Unit Manager on 8/17/22.	,	
		d the Department of Health			Result of the incident investigation	- 11-	
		onically about the incident?			report was sent to the State Agency vi	a the	
	She stated, "No."				reporting on 7/14/22.		
					Resident #121 was reassessed		
	It should be noted that	at the facility's staff made the			head to toe by the Unit Manager on 8/	17/22.	
	State Survey Agency	aware of the previously			No apparent evidence of		
	mentioned incdient of	f sexual abuse			physical abuse or allegation of abuse. Moving forward any confirmed incider	nce of	
	approximately 3 hour	s after the incident.			allegation of abuse for Resident #121		
					reported timely. The result of the invest	stigation	
	Cross reference 42 C	FR 483.12, F600			was sent to the state agency on 7/14/2 Resident suffered no negative outcom		
	2 Eacility staff failed	to report the results of their			Resident surfice no negative outcom	σ.	
	-	-					
		State Survey Agency within 5					
		ncident for Residents #145,					
	#108, #86, #8, #84 # <sup>.</sup>	117 #3(13 #3(14	1				1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING				C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				13	380 SOUTHERN AVE SE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		w	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	05/26/21 with multiple Schizoaffective Disord and Bipolar Disorder. Review of the FRI dat	admitted to the facility on e diagnoses including der, Delusional Disorder, ed 10/18/21 at 10:39 AM,	F	609	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has potential to be affected.		09/23/22
	arrived at the facility a Room 314 called the hit her neck Assess no bruises, no trauma	PM, to Metropolitan officers and stated that resident in police and stated that some sment was done, no lumps, observed on resident's buse [Employee #31] is avestigation"					
	related to the previous documented evidence	s investigative documents sly mentioned FRI lacked that the facility reported its the State Survey Agency.					
	Cross reference 42 C	FR 483.12, F610					
	investigation of Resid	to report the results of their ent #84's Facility reported o the State Survey Agency of the incident.					
	05/20/21, with multiple Type 2 Diabetes Melli Hemiplegia and Hemi Infarction Affecting Rig Following Cerebral In Organism, Unspecifie Sclerosis, Gastrostom	nitted to the facility on e diagnoses that included: tus Without Complications, paresis following Cerebral ght Dominant Side, Aphasia farction, Sepsis Unspecified d Convulsions, Multiple ny Status and Dysphagia.					
	received on 09/20/21, head to toe assessme	eported Incident (FRI) documented, "A complete ent done Multiple scars to acral area. Redness to					

Facility ID: HCI

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	D: 08/12/2022 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
	095015	B. WING			C / <b>29/2022</b>
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2022
SERENITY REHABILITATION A	ND HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 20032		
	Y STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORF		0(5)
PREFIX (EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
<ul> <li>water, pat dry and each incontinent of leg"</li> <li>Review of the faci showed no docum staff reported the investigation to the During a telephon 07/14/22 at approd#2 (Director of Nu findings and state investigation result 2c. Resident #86 %8/28/18 with diagr without Behaviora Muscle Weakness</li> <li>Review of the FRI documented, "[F#86] in the face"</li> <li>Review of the faci related to the previdocumented evide investigation result 2d. Resident #10 12/10/19 with mult Alzheimer's Disea</li> <li>Review of the FRI documented, "At 3 [Officers names] in a call for alleged at 10 12/10/19 with and the face investigation for the face investigatio</li></ul>	rea washed with soap and l apply skin barrier cream after care, discoloration to left inner lity's investigation documents nented evidence that the facility results of the alleged neglect e State Agency. e interview conducted on ximately, 3:00 PM, Employee rsing) acknowledged the d that they did not send lts to the State Agency. was admitted to the facility on noses that included Dementia I Disturbance and Generalized	F 609	MEASURES TO PREVENT RECURRENCE: The facility Staff Developer/ Design will provide an education/In-service Director of Nursing (DON), Assista of Nursing (ADON), Unit Manager and Supervisors on the process of reporting of incident of unusual occ the State Agency within the requir stipulated by the CMS regulation & requirement and within 2 hours if s injury occurred. The in-service or education will explain the importan incidences within the required tin stipulated by the CMS regulation & requirement. The compliance date for this interv The facility Staff Developer/Design education to facility Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers Supervisors on the importance of t importance of ensuring that results the incident investigation report ar the State Agency via the reporting portal /system within 5 working day incident. The compliance date for this interv 9/23/22. MONITORING CORRECTIVE ACT House wide audit will be conducted Assistant Director of Nursing (ADON)/Designee to ensure report all incidences of unusual occurrence Agency via reporting system timely within 2 hours if seriously bodily in occurred, weekly times 4, then, mor months. The findings of these aud presented monthly for 3 months to Assurance Performance Improver committee.	e to facility int Director s currences to red time as a eriously bodily ince of reporting ne as a rention 9/23/22. The will provide s and he s of re sent to ys of the rention TION: d by ting of ces to the State y and njury inthly times 3 lits will be Quality	09/23/22

Facility ID: HCI

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	-	D HUMAN SERVICES MEDICAID SERVICES	-			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			PLETED	
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENIT	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	of [Resident 108] room on 05/25/22. It was re- was observed with fer [Resident #108] was of thigh and bed spread transferred to Unit 3 . to transfer [Resident # evaluation of possible Review of the facility's related to the previous documented evidence investigation results to Cross reference 42 C 2e. Resident #145 wa multiple diagnoses into Disease classified els Disturbances, Cogniti and Generalized Mus Review of the Facility 06/17/22 at 10:32 AM was informed by the r was observed in bed Room 313B[Reside leave the room [Re no signs of trauma gave orders to transfe ER (emergency room Review of the facility's related to the previous documented evidence	a wheelchair at the bedside m 112 A at about 8:30 PM sported that [Resident #126] ces on his left hand observed with feces on her [Resident #126] was [MD's name] gave orders #108] to ER for further a physical abuse" a investigative documents sly mentioned FRI lacked a that the facility reported its to the State Survey Agency. FR 483.12, F600. As admitted on 02/08/22 with cluding Dementia in other ewhere without Behavioral ve Communication Deficit, cle Weakness. Reported Incident dated 4, documented, "Writer hurse that [Resident #126] with [Resident #145] in ent #126] was redirected to sident #145] was assessed observed[MD's name] ar [Resident #145] via 911 to ) for further evaluation " a investigative documents sly mentioned FRI lacked a that the facility reported its to the State Survey Agency.	F 6	09	House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure that results incident investigation report are sent to the Agency via the reporting portal /system within 5 working days of the incident, weekly times 4, then, monthly the months. The findings of these audits will be present monthly for 3 months to Quality Assurant Performance Improvement (QAPI) common House wide audit will be conducted by Assistant Director of Nursing (ADON)/Designee to ensure that all incidence of allegation of abuse is re- within the required time as stipulated by CMS regulation & requirement. to the S Agency via the reporting portal /system, times 4, then, monthly times 3 months. The findings of these audits will be present monthly for 3 months to Quality Assurant Performance Improvement (QAPI) commons in the reporting portal /system and the present and the second a	he State he imes 3 ented ce nittee. ported the State weekly ented ce	09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	O. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		095015	B. WING			06	C 5/29/2022
	ROVIDER OR SUPPLIER Y REHABILITATION AND	HEALTH CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 609	2f. Resident #112 war 08/03/20 with diagnos Schizophrenia, Psych Disorder. Review of a Facility R received on 07/19/21 informed by the charg PM) that [Resident #1 (physical therapist) st night, that she is feeli place that if she sees herself" Review of the investig no documented evide reported the results o investigation to the St 2g. Resident #303 wa 12/13/21 with diagnos Diabetes Mellitus, Lac Urinary Tract Infection Review of a FRI was documented, "During 8:30am on Dec. 31st by Speech Therapist morning [Resident nurses hit her on her Review of the investig no documented evide reported the results o investigation to the St 2h. Resident #304 wa 11/02/21 with multiple	s admitted to the facility on ses that included: notic Disorder and Anxiety Reported Incident (FRI) documented, "Writer was ge nurse at 14:40p.m (2:40 112] informed the PT taff that she was raped all ng so horrible about this a gun, she can just kill gation documents showed ence that facility staff f the alleged abuse tate Agency. As admitted to the facility on ses that included: Type 2 ck of Coordination and n. received on 01/02/22 end of shift rounds at about 2021, writer was informed that during her session this #303] said one of the hand"	F	609			09/23/22

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) D	DATE SURVEY OMPLETED
		095015	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	Diabetes Mellitus. Review of a FRI recei documented, "Resid yesterday night [11/03 not respond to her ca requested fro (sp) ass (Certified Nurse Aide) calls/requests Resi morning she was ass the staff CNA never of the bed" Review of the investig no documented evide reported the results o investigation to the St During a telephone in 07/14/22 at approxim (Director of Nursing) a and stated that they of investigations to the St 3. Facility staff failed to resident-to-resident in #121. Resident #121 was an 02/27/21 with diagnos Schizophrenia, Press Stage 4, Paraplegia, for Bladder and Schizo Review of a grievance dated 05/27/22 docur (Wednesday) May 25 woke by a strange ma	ived on 11/04/21 dent complained that 3/21] her assigned staff did II light on time when she sistance that the CNA ) was ignoring her ident also reported that this isted to the bathroom but ame to assist her back to gation documents showed ence that facility staff f the alleged abuse tate Agency. terview conducted on ately 3:00 PM, Employee #2 acknowledged the findings lid not send results of their State Agency. to report a heident involving Resident dmitted to the facility on ses that included: ure Ulcer of Sacral Region Neuromuscular Dysfunction ophrenia. e made by Resident #121 mented, " Wed 5,2022 @ (at) 1:30 AM I was	F 60	99		09/23/22

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMF		
		095015	B. WING			06/29/2022		
NAME OF PF	ROVIDER OR SUPPLIER	1	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 609	nurse [Nurse's Name] looking for snacks" Review of Resident # Data Set (MDS) dates facility staff coded the for Mental Status (BIM no potential indicators or physical behavior so others. 05/25/22 at 2:11 AM [ about 2;11am a male room 144 A and was Writer asked [Resident touched her, resident touched her, resident touch me, writer aske you have food on the no he was touching th food on the table, it w table." Review of the "Grieva Decision/Resolution F documented, " Base grievance/alleged abu confirmed" Although confirmed a form, facility staff failed the resident-to-reside During a face-to-face 06/22/22 at approxim Employees #6 (Unit 1 Employee #6 stated,	the nurse. He left. The ] came in and said he was (121's Quarterly Minimum d 05/16/22 showed that e following: a Brief Interview MS) summary score of 15, s of psychosis and no verbal symptoms directed towards [Nurses Note] "Late Entry: At resident wandered into redirected back to his room. Int #121] if the resident stated that no, he did not ad Ms Freeman again, do table, resident answered, he table and there was no ras trash that was on the ance Written Form" dated 05/27/22 ed on these findings, the use case was s abuse on the grievance ed to file an incident report of nt incident. interview conducted on ately 1:00 PM with Social Worker) and #2, "Once I get a grievance, I	F	609	9			
	speak to the resident	and staff involved and get together a packet and it's						

Facility ID: HCI

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE	
		095015	B. WING			C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	380 SOUTHERN AVE SE		
SERENII	REHABILITATION AND	HEALTH CENTER LLC	v	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	51	F 609	F610		09/23/22
	given to [Director of S then goes to the Admi At the time of the afor Employee #3 acknow stated, "An incident re and sent to DOH (Dep Investigate/Prevent/C CFR(s): 483.12(c)(2)- §483.12(c) In respons neglect, exploitation, of must: §483.12(c)(2) Have en violations are thoroug §483.12(c)(3) Prevent neglect, exploitation, of investigation is in prog §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, withir incident, and if the all appropriate corrective	ocial Services Name] and inistration." ementioned interview, ledged the findings and eport should've been done partment of Health)." orrect Alleged Violation (4) se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated. t further potential abuse, or mistreatment while the gress. the results of all idministrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified a action must be taken.		CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The affected Resident #108, was assessed from head to toe by the licensed nurse, no sign of pain/discomfort nor facial grimace expressed. No physical signs of trauma observed, no redness, no bruises around the perineal area and buttocks on 05/25/22. Resident #108 was transfer to the hospital emergency room on 5/26/22 for further evaluation for possible sexual abuse. Licensed nurse performed head to toe assessment on the resident and no negative outcome were found on 5/27/22. Resident was reassessed head to toe by the unit manager/Designee on 8/17/22. No new incident or occurrences of allegation of abuse observed. Resident #86 was reassessed head to toe by the unit manager on 8/17/22. Resident suffered no negative outcome. No new incident or occurrences of allegation of resident to resident altercation or abuse observed.		09/20/22
	by: Based on record revi seven (7) of 67 sampl failed to: conduct thor evidenced by failure to statements from poter Resident #108's alleg inappropriate non-corr	o interview and/or obtain ntial witnesses for: ation of resident-to-resident				

Facility ID: HCI

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	-	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
		095015	B. WING _			06	C 6/29/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	<b>YREHABILITATION AND</b>	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	resident-to-resident a allegation of staff-to-r Resident #112's alleg Resident #303's alleg physical abuse; Resid staff neglect; and con Residents #108, #86, #121. The findings included Review of the facility's Abuse", with a revisio sexual abuse as " n contact of any type wi not limited to sexual h sexual assault" Review of the facility's Process", with a revisio documented, "intervisid statements from pote determined by the soc 1. Facility staff failed investigations evidence and/or obtain statements for Residents #108, # #304. 1a. The facility's staff investigate an allegati inappropriate non-cor [sexual abuse] for Re Resident #108 was an 12/10/19 with multiple	Itercation; Resident #8's esident physical abuse; ation of sexual abuse; jation of staff-to-resident dent #304's allegation of iduct an investigation of iduct an investigation of lent-to-resident incident. , #8, #112, #303, #304, : s policy titled, "Prohibition of in date of 05/22, defined ion-consensual sexual ith a resident includes but is narassment coercion or s policy titled, "Investigation ion date of 06/22, <i>view</i> and/or obtain ntial witnesses as ope of the investigation" to conduct thorough ced by failure to interview ents from potential witnesses 86, #8, #112, #303 and failed to thoroughly ion of resident-to-resident nsensual sexual touch sident #108. dmitted to the facility on	F	510			09/23/22

If continuation sheet Page 53 of 184

CENTER STATEMENT (		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	FORM OMB NO (X3) DATE	0: 08/12/2022 MAPPROVED 0. 0938-0391 SURVEY LETED
		095015	A. BUILDIN B. WING	1G			C
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	06/	29/2022
	Y REHABILITATION AND	HEALTH CENTER LLC		13	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Assessment, Result F shift at about 8:30pm the nurse that activity #126]sitting at the k his wheelchair and ha [Resident #108] was c happened due to diag communication deficit assessed from head t of pain/discomfort nor No physical signs of t redness, no bruises a buttocks. [MD's name was given to Transfer room) via 911 for furth physical abuse." It shi to transfer Resident # until 05/26/22 at 4:41 facility after receiving abuse for Resident #1 05/26/22 at 4:41 PM [ resident to ER via 91 <sup>2</sup> possible physical abu 05/26/22 at 3:30 PM [ 3:30pm writer receive and badge numbers] had a call for alleged room 112-A. Writer re [Resident #126 who r was observed sitting i bedside of [Resident # 8:30pm on 5/25/22. It #126] was observed v front, back, and under	[Situation, Background, Form]- "During the evening writer was made aware by director saw [Resident bedside [of Resident 108] in ad feces on his left hand. unable to explain what gnosis of cognitive t. [Resident #108] was to toe by the nurse, no sign r facial grimace expressed. rauma observed, no round the perineal area and e] made aware, new order r resident to ER (emergency her evaluation for possible ould be noted that the order #108 to ER was not written PM after police came to a call for a call of physical 108 [Physician Order] transfer 1 for further evaluation for	F 6	510	Resident #8 was reassessed heat toe by the Unit manager on 8/17/2 No new incident or occurrences of allegation of staff to resident physical abuse observed. Resident #8 suffered no negative outcome from not conducting thor investigation and by not interview and or obtaining statements from potential witnesses and everyone work on that shift. Resident #112 was reassessed he toe by the Unit manager on 8/17/2 No new incident or occurrences of allegation of physical or sexual abuse observed. Resident #112 suffered no negative outcome from not conducting thorough investigation and by not interviewing and or obtaining statements all from potential witnesses and everyone that work on that shift	22 f rough ving all that ead to 22 f ve	09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC				
				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 610	with feces on her thig [Resident #126] was it the scene and [MD's i given to transfer [Res 310-B. Also, [Detectiv number] was called to After meeting with the staff members the dei arrest was made. How gave order to transfer (emergency room) via for possible physical a to explain what happe cognitive communicat dementia, and Alzhein emergency arrive the and left the facility at hospital]" Review of the staff as had two licensed nurs working on evening si of 05/25/22. However investigative report la of the four (4) CNAs [ interviews or stateme During a face-to-face starting at approximat (ADON) stated that th process of investigatin Cross reference 42 C 1b. The facility's staff investigate an allegat altercation for Reside	h and her bed spread. immediately removed from name] notified and order ident #126] to Unit 3 - Room /e's name and badge to the facility by the police. e residents and talking to tective issue report No wever, [MD's name] also r [Resident #108] to ER a 911 for further evaluation abuse. Resident was unable ened due to diagnosis of tion deficit, vascular mer's disease911 facility at 17:0pm [5:00 PM] 17:28pm [5:28 PM] to [local signment revealed Unit 1 ses and four (4) CNAs hift (3:00 PM to 11:00 PM) r, review of the facility's cked documented evidence potential witnesses] nts. interview on 06/28/22 tely 4:00 PM, Employee #3 ney are working on their ng incidents. CFR 483.12, F600 and F607 failed to thoroughly ion of resident-to-resident	F 61	Resident #303 was reassessed head by the Unit manager on 8/17/22 No new incident or occurrences of allegation of staff to resident physical abuse observed. Resident #303 suffered no negative outcome from not conducting thorou investigation and by not interviewin and or obtaining statements from all potential witnesses and everyone that works on that shift. Resident #304 was reassessed head by the Unit manager on 8/17/22 No new incident or occurrences of allegation of neglect from staff or abuse observed. Resident #303 suffered no negative outcome from not conducting thorou investigation and by not interviewin and or obtaining statements from all potential witnesses and everyone that works on that shift.	igh g d to toe igh g	09/23/22

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/12/2022 M APPROVED D. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		095015	B. WING				C / <b>29/2022</b>
NAME OF PR	OVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Generalized Muscle V Review of the medica following: 04/19/22 at 11:25 PM complained another reveal who was unprovoked of the neck two days a admission to skilled N 04/20/22 at 1:47 PM [ writer and recreation of physical altercation be [Resident #120] on 04 expressed that he doe #120] returns to the fa chargesThis writer accompanied [Reside Police Prescient to rep charges" Review of facility's inv the following: 04/18/22 [ Employee's monitor]- documented with [Resident #86] ar [Resident #120] ente [cursing] and making [ Resident #86][Res can't stop me from ge catch in the elevator for your [expletive]"	diagnoses including: havioral Disturbances and Veakness. I record showed the [MD Note] - "Resident esident [Resident # 120] struck him on the right side agoPlan continue H (nursing home)" Social Work Note] - "The director was informed of a etween [Resident #86] and k/14/22[Resident #86] es not feel safe if [Resident holity] want to press and activities director nt #86] to the 7th District bort incident and press restigative report showed s #27's statement - smoke l, "I was on the smoke patio nd [another resident] when red the patio cussing verbal treats [threats] to ident #120] stated nobody tting to youI better not because I got something	F	610	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility hav the potential to be affected.	e	09/23/22

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER		1	S	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			880 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	56	F	610			09/23/22
		s present on the smoking			MEASURES TO PREVENT RECURR	ENCE:	
	(ADON) stated that th process of investigatin 1c. The facility's staff investigate an allegati physical abuse for Re Resident #8 was adm 05/26/21 with multiple	interview on 06/28/22 ely 4:00 PM, Employee #3 ey are working on their ng incidents. failed to thoroughly on of staff-to-resident sident #8. itted to the facility on e diagnoses including der, Delusional Disorder,			The facility Staff Development/ Designee will provide education to the facility Director of Nursing (DON), Assi Director of Nursing (ADON),Unit Mana and Supervisors on the importance of following facility protocol by ensuring that investigation is thorough conducted, and all potential witnesses and all staff present are interviewed and statements are obtained. during an investigation of all incidences of unusual occurrences	istant igers ly	
	to Metropolitan officer stated that resident in and stated that some was done, no lumps, i observed on resident" [Employee #31] is sus investigation" Review of the medica following: 08/25/21 [Minimum D Resident #8 had a Bri Status summary score resident's cognition w Further review reveals for hallucinations, dela	, documented, "At 9:13 PM, s arrived at the facility and Room 314 called the police hit her neck Assessment no bruises, no trauma s neck The alleges abuse spended pending I record revealed the ata Set - Quarterly] showed ef Interview for Mental e of "11" indicating the as moderately impaired. ed the resident was coded usions, verbal behavior ward others and receiving			MONITORING CORRECTIVE ACTION The Assistant Director of Nursing (ADON)/ Designee will complete house wide review/audit of all incidences of unusual occurrences to ensure that investigation is thoroughly conducted, a all potential witnesses and all staff press are interviewed and statements are obtained during an investigation of all incidences of unusual occurrences wee times 4, then monthly times 3 months. The finding of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	e and sent	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION		NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	` '			· · ·	MPLETED	
		095015	B. WING			C		
	ROVIDER OR SUPPLIER	000010	STREET ADDRESS, CITY, STATE, ZIP COL			06/29/2022		
		HEALTH CENTER LLC		1380	SOUTHERN AVE SE HINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 610	Continued From page	o 57		240			09/23/2	
1 010			FC	610				
		/ [Nursing Note]- "At 9:13 n Officers arrived [to] the						
	· · ·	e resident in room 314 called						
	and stated someor							
		ne no lumps, no bruises, no						
		resident's neck The						
	alleged abuser [emp	loyee's name] is suspended						
	pending investigation	ı"						
	10/14/22 at 11:15 AN	/ [ADON Note] - " Writer						
		or Charge Nurse met with						
		inquire] from resident her						
		n for to speak to the police						
	officer yester. Reside	ent said she could not						
	-	e police. Resident said with a						
		someone hit me on my neck						
	-	roup home and I was taken						
		pitalsomeone has been						
		her bank accountnow ing her to pay back the						
	money The resider							
		resident was hit while in the						
		name] notified order given						
		resident with behavioral						
	disturbance and con	fabulation [known as honest						
	lying]"							
	Review of the facility	's investigative report						
	showed the following							
	10/31/21 at 9:13 PM	[ Assigned Nurses						
		he nurse on duty when the						
		called the police and told						
		er on the head. The police						
	was [were] here and	I did an investigation."						
	10/14/21 [Employee	#31's statement - accused						
		e working on Wednesday,						
		o working on wouldoudy,						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		095015	B. WING				C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	manner I would ner anyone to ever think to a woman, a defensive is [in] this incident set measures put in place Employee worked in to Department Review of the Unit 3's 10/13/22 showed the three (3) licensed nur shift two (2) licensed However, review of the report lacked docume nurses and 6 CNAs [] interviews or stateme During a face-to-face starting at approximation	y, physically, and/or in other ver want my family and/or that I would put my hands on e [sp] one at that My goal as precedent to have safety e to protect staff members." the Activities/Recreation s assignment sheet for following staff: Dayshift ses and 3 CNAs. Evening nurses and 3 CNAs, he facility's investigative ented evidence of 4 licensed botential witnesses] nts. interview on 06/28/22 tely 4:00 PM, Employee #3 hey are working on their	F	610			
	investigation on Resid allegation evidenced statements/interviews who might have know	from all potential witnesses /ledge of the incident. dmitted to the facility on					
	Schizophrenia, Psych Disorder Review of a Facility R received on 07/19/21	notic Disorder and Anxiety Reported Incident (FRI) documented, "Writer was ge nurse at 14:40p.m (2:40					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING				06/	C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
				13	880 SOUTHERN AVE SE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		W	ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 7 MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 610	night, that she is feeling	aff that she was raped all ng so horrible about this a gun, she can just kill 112's medical record	F 6	10				
	MG (milligram) give 1 morning for Depressio 03/20/21 [Physician's	(hydrochloride) Tablet 50 tablet by mouth in the on/Anxiety"						
	tablet by mouth at bee Quarterly Minimum D 05/04/21 where that fill Interview for Mental S score of 10, indicating cognition, no indicator or physical behaviors extensive assistance one person physical a transfers, impairment extremities, wheelcha received antipsychotic last 7 days. 07/12/21 at 3:19 PM [ Practitioner Progress seen for f/u (follow up significant for depress lying on the bed, alert self, generally to place at this time"	time for Schizophrenia" ate Set (MDS) dated acility staff coded: ta brief tatus (BIMS) summary moderately impaired s for psychosis, no verbal directed to others, to total dependence with assist for bed mobility and on both sides for lower ir mobility device and cs on a routine basis in the Psychiatric Nurse Note] "The patient was						

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
U PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMPLETED
		095015	B. WING		C 06/29/2022
IAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
BERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE TE APPROPRIATE DAT
F 610	Continued From page		F 61	o	
	report from the ADON	This worker received a I (Assistance Director of esident informed staff she			
	was sexually assaulte	ed by several men while she nce the resident spoke to			
	that the alleged incide	V director it was determined ent could not have happen 2] stating the men came			
	from outside of the fa facility being very limit	cility. Due to visitation of the ted do to covid protocols no			
		social work and nursing staff nent any of the statement			
	informed by the charg	[Nurses Note] "Writer was ge nurse at 14:40p.m that			
	was raped all night, the about this place that it	ned the PT staff that she nat she is feeling so horrible f she sees a gun, she can			
	someone from the co	sident #112] said "that mmunity has been following : homes and also followed			
	raping her and touchi	ospitals that she been to ng her inappropriately". resident of her safety while			
	said the individual do	e facility. [Resident #112] es not work in this facility e the mane of any individual.			
	NP (Nurse Practitione Resident's RP (repres	er)was notified			
	to monitor resident for				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		095015	B. WING				C / <b>29/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER		1	:	STREET ADDRESS, CITY, STATE, ZIP CODE			
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 610	Thorough assessmer team members on fol of rape. Facility well s security staff, staff ma visitors/guests do not authorization. Facility comment by patient Review of the facility's on 06/23/22 lacked do show that facility staff all staff that might hav incident. During a face-to-face 2:15 PM, Employee # and made no further of 1e. Facility staff failed investigation of Resid physical abuse by an failure to obtain states potential witnesses w the incident. Resident #303 was an 12/13/21 with diagnos Diabetes Mellitus, Lac Urinary Tract Infection A FRI was received of documented, "During 8:30am on Dec. 31st	t done by multi-disciplinary low up of patient comment secured and monitored by aking frequent rounds, enter facility without prior protocols followed on this " s investigation documents ocumented evidence to f obtained statements from we knowledge of the alleged interview on 06/23/22 at 3 acknowledged the finding comment. It to conduct a thorough lent #303's allegation of employee evidenced by ments/interviews from all ho might have knowledge of dmitted to the facility on ses that included: Type 2 ck of Coordination and n. n 01/02/22 that end of shift rounds at about 2021, writer was informed that during her session this #303] said one of the hand"	F	610				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/12/2022 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		095015	B. WING			C 6/29/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP	CODE	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From page	62	F 610			
	score of 15, indicating potential behaviors of physical behaviors of refusal of care, extens one-person physical a transfers and persona on one side for lower 12/31/21 at 6:56 AM [ During end of shift rou approached by Speec [Resident #303] just in on the hand by a nurs [Resident #303's] roo happened last night. S	y staff coded: a brief btatus (BIMS) summary g intact cognition, no psychosis, no verbal or rected towards others, no sive assistance with assist for bed mobility, al hygiene and impairment extremity range of motion. Nurses Note] "Late Entry unds at 8:30AM, writer was ch Therapist, she said nformed her that she was hit we last night. Writer went to m and asked her what She said, the female nurse t around 11:30PM and				
	injury, and there was discoloration observe question. She denied advised that her comp Review of the facility's on 06/27/22 lacked do potential witnesses w were interviewed or p During a face-to-face 06/27/22 at 9:14 AM, the finding and made 1f. Facility staff failed allegation on neglect evidenced by failure t	d at the alleged skin area in pain. [Resident #303] was blaint will be investigated." is investigation documents bocumented evidence that all ith knowledge of the incident rovided a statement. interview conducted on Employee #3 acknowledged no further comment. to thoroughly investigate an for Resident #304				

If continuation sheet Page 63 of 184

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
		095015	B. WING				29/2022
NAME OF P	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	who might have know Resident #304 was a 11/02/21 with multiple Low Back Pain, Urina Diabetes Mellitus. A Facility Reported In 11/04/21 documented that yesterday night [ did not respond to he requested fro (sp) ass (Certified Nurse Aide calls/requests Res morning she was ass the staff CNA never of the bed" Review of Resident # revealed the following 11/02/21 [Care Plan] ADL self-care perform weakness s/p (status Encourage the res assistance." An Admission Minimu 11/08/21 showed that a Brief Interview for M summary score of 14 no potential behavior care, required extens one-person physical a transfers, toilet use a limitations in range of extremities, used a w	Aledge of the incident. dmitted to the facility on a diagnoses that included: iny tract infection (UTI), acident (FRI) received on d, "Resident complained 11/03/21] her assigned staff r call light on time when she sistancethat the CNA ) was ignoring her ident also reported that this isted to the bathroom but ame to assist her back to 304's medical record g: "[Resident #304] has an nance deficit r/t generalized post) lumbar spinal fusion ident to use bell to call for Im Data Set (MDS) dated f facility coded the following: Anticating intact cognition, s of psychosis, no refusal of ive assist for be mobility, and personal hygiene, no i motion for upper and lower alker and wheelchair for	F	610			
	the bed" Review of Resident # revealed the following 11/02/21 [Care Plan] ADL self-care perform weakness s/p (status Encourage the res assistance." An Admission Minimu 11/08/21 showed that a Brief Interview for N summary score of 14 no potential behavior care, required extens one-person physical a transfers, toilet use a limitations in range of extremities, used a w	304's medical record g: "[Resident #304] has an hance deficit r/t generalized post) lumbar spinal fusion ident to use bell to call for Im Data Set (MDS) dated if acility coded the following: Mental Status (BIMS) , indicating intact cognition, s of psychosis, no refusal of ive assistance with assist for be mobility, nd personal hygiene, no i motion for upper and lower alker and wheelchair for ays incontinent of bladder					

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391				
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SU COMPLET					
		095015	B. WING				29/2022				
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1					
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE				
F 610	Continued From page	∋ 64	F	610							
	on 06/22/22 showed that the staff who wor	s investigation documents no documented evidence ked with Resident #304 on were interviewed or provided									
	12:55 PM, Employee	interview on 06/22/22 at #7 (Unit 1 Nurse Manager) ding and provided no further									
	2. Facility staff failed resident-to-resident ir #121.	to investigate a ncident involving Resident									
	02/27/21 with diagnos Schizophrenia, Press	ure Ulcer of Sacral Region Neuromuscular Dysfunction									
	about 2; 11am a male room 144 A and was Writer asked [Reside touched her, resident touch me, writer aske you have food on the no he was touching th	[Nurses Note] "Late Entry: At e resident wandered into redirected back to his room. nt #121] if the resident stated that no, he did not ed Ms Freeman again, do table, resident answered, ne table and there was no was trash that was on the									
	dated 05/27/22 docur (Wednesday) May 25 woke by a strange ma wheelchair @ the bot	5, 2022 @ (at) 1:30 AM I was an [Resident #] in a									

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/12/2022 1 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	-	(X3) DATE COMP	SURVEY LETED
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610 F 625 SS=E	looking for snacks" Review of Resident # Data Set (MDS) dated facility staff coded the for Mental Status (BIM no potential indicators or physical behavior so others. Review of the "Grieva Decision/Resolution F documented, " Base grievance/alleged abu " Although confirmed at form, facility staff faile as resident-to-resident During a face-to-face 06/22/22 at approxima Employees #6 (Unit 1 Employee #6 stated," speak to the resident interviews. I then put given to [Director of S then goes to the Adm At the time of the afor Employee #3 acknow stated, "Based on the Resident's Name] was not a safety concern."	I came in and said he was 121's Quarterly Minimum 05/16/22 showed that a following: a Brief Interview MS) summary score of 15, a of psychosis and no verbal symptoms directed towards ance Written Form" dated 05/27/22 a on these findings, the use case was confirmed s abuse on the grievance a to investigate the incident at incident of abuse. interview conducted on ately 1:00 PM with Social Worker) and #3, "Once I get a grievance, I and staff involved and get together a packet and it's social Services Name] and inistration." rementioned interview, ledged the finding and e staff statements, [accused s looking for food and it was oblicy Before/Upon Trnsfr	F 6	10			

Facility ID: HCI

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TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     DATE	STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
IMME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZIP CODE       SERENTY REHABILITATION AND HEALTH CENTER LLC     138 SOUTHERN AVE SE       WASHINGTON, DC 20032     WASHINGTON, DC 20032       (PA) ID     EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID       F 625     Continued From page 66 §4483.15(d) Notice of bed-hold policy and return- gates in the resident or resident or a hospital or the resident or resident representative that specifies.     F 625     F625     CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency.     09/23/2       (i) The duration of the state bed-hold policy, if any, during which the resident to presentative that specifies.     F 625     F625     CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency.     Resident #35,#54,#93,#97,#110 and #84 were reassessed from head to toe on 817/122 by Unit Manager/ Designee. ResidentR suffere no negative outcome. ResidentR suffere no negative outcome. ResidentR suffere no negative outcome. ResidentR sufferent on cannot the resident to return, and (iv) The ursing facility spolicies regarding bed-hold policy, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.     S483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or threapeutic leave, a nursing facility must provide to the resident and the			095015	B. WING			-	
SERENTY REHABILITATION AND HEALTH CENTER LLC     1380 SOUTHERN AVE SE WASHINGTON, DC 20032       (M) ID TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH EDRIFELINCY MUST BE PRÉCEDEDE DE Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID IFREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH EDRIFECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OOM/CET DEFICIENCY       F 625     Continued From page 66 \$483.15(d)(1) Notice before transfer. Before a nursing facility must provide written information to the resident or esident to a hospital or the resident or representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility: (ii) The resurve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The runsing facility spolicies regarding bed-hold polics, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.     S483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident to provide a the appropriate provide of the resident to paragraph (e)(1) of this section.     S483.15(d)(2) Each-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the     S483.15(d)(2) Each-hold notice upon transfer. At the time provide to the resident and the     S483.15(d)(2) Each-hold notice upon transfer. At the time provide to the resident and the     S483.15(d)(2) Each-hold notice upon transfer. At the time of the approvide to the resident and the     S483.15(d)(2)	NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	25/2022
(M) 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE     OST CARTER (EACH OFFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     DEFICIENCY       F 625     Continued From page 66 §483.15(d)(1) Notice of bed-hold policy and return- §4431.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;     F 625     F625     CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility canot retroactively correct this deficiency. Resident #35,#54,#93,#97,#110 and #84 were reassessed from head to toe on 8/17/22 by Unit Manager/ Designer. ResidentSuffered no negative outcome. ResidentSuffered no negative outcome. Resident Responsible party will be given the updated bed hold policy by 09/23/22.       (ii) The reserve bed payment policy in the state plan, under § 447.40 of this schapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the					1	380 SOUTHERN AVE SE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMMENTE DATE         F 625       Continued From page 66 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident appendent to a transing facility;       F 625       F625       CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The facility cannot retroactively correct this deficiency. Resident #35,#54,#93,#97,#110 and #84 were reassessed from head to toe on 8/17/22 by Unit Manager/ Designee. Residents suffered no negative outcome. Resident party will be given the updated bed hold policy by 09/23/22.         (ii) The runsing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the       Image: F 625	SERENITY	REHABILITATION AND	HEALTH CENTER LLC					
<ul> <li>\$483.15(d) Notice of bed-hold policy and return- \$483.15(d) (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- () The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
<ul> <li>\$483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</li> <li>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</li> <li>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</li> <li>(iv) The information specified in paragraph (e)(1) of this section.</li> <li>\$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for herapeutic leave, a nursing facility must provide to the resident and the</li> </ul>	F 625	- 15		F	625	F625		09/23/2
specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, for six (6) of 67 sampled residents, facility staff failed to provide written notice of the facility's bed-hold policy to residents or their representative(s). Residents' #35, #54, #93, #97, #110 and #84. The findings include: 1. Resident #35 was re-admitted to the facility on		§483.15(d)(1) Notice nursing facility transfe the resident goes on nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing faciliti bed-hold periods, wh paragraph (e)(1) of the resident to return; and (iv) The information s of this section. §483.15(d)(2) Bed-hold the time of transfer of hospitalization or the facility must provide the resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on record rev (6) of 67 sampled residents or Residents' #35, #54, The findings include:	before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if e resident is permitted to sidence in the nursing bayment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d specified in paragraph (e)(1) old notice upon transfer. At f a resident for rapeutic leave, a nursing to the resident and the ve written notice which of the bed-hold policy oh (d)(1) of this section. T is not met as evidenced iews and interviews, for six sidents, facility staff failed to e of the facility's bed-hold their representative(s). #93, #97, #110 and #84.			AFFECTED RESIDENTS: The facility cannot retroactively corre this deficiency. Resident #35,#54,#93,#97,#110 and #84 were reassessed from head to toe on 8/17/22 by Unit Manager/ Designee. Residents suffered no neg outcome. Resident/Responsible par given the updated bed hold policy	ative	

Facility ID: HCI

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С 095015 B. WING 06/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1380 SOUTHERN AVE SE** SERENITY REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 09/23/22 **IDENTIFICATION OF OTHERS** F 625 WITH THE POTENTIAL TO BE Continued From page 67 F 625 AFFECTED: 03/15/22 with diagnoses including Pneumonia, All residents residing in the facility have Type 2 Diabetes Mellitus, Dependence on Renal the potential to be affected. Dialysis, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarct without MEASURES TO PREVENT Residual Deficits, and Dysphagia. **RECURRENCE:** Staff Development/Designee will provide education/in-service to the facility A Quarterly Minimum Data Set (MDS) dated Admission Director/ Designee on the 04/11/22 showed in Section C (Cognitive importance of providing the bed hold policy Patterns) that facility staff documented the to the resident and/or responsible party/ resident as having a Brief Interview For Mental designee within stipulated time by CMS Status Summary Score (BIMS) of "15," indicating requirement and regulation. intact cognition. MONITORING CORRECTIVE ACTION: Review of Resident #35's clinical record revealed: Director of Admission/Designee will conduct house wide audit to ensure 03/11/22 Transfer/Discharge Report documented: that responsible parties "Resident returned from dialysis at 4:30 PM with are notified or provided with a copy shortness of breath, chest congestion/discomfort, of the bed hold policy when a resident elevated blood pressure, low oxygen level (88%), is out of the facility and update them and temperature 100.5." in writing of the bed hold days and ensure documentation of bed 03/11/22 at 4:40 PM [Physician's Order] directed, hold policy and bed hold days in the "Transfer patient to the hospital for further resident medical record, weekly times evaluation and treatment one time a day for SOB 4, then, monthly times 3 months. Any issues (shortness of breath), chest discomfort, elevated found will be corrected by 9/23/22. BP (blood pressure), low oxygen saturation." The findings of these audits will be presented monthly for 3 months to 03/11/2022 at 6:58 PM, [Nurses Notes/Late Quality Assurance Performance Improvement (QAPI) committee . Entry]: " ...Resident returned from dialysis center ...went straight to bed to relax ...resident was observed with shortness of breath, chest congestion/discomfort, hypertension, and low oxygen level...Resident was transferred to [Local Hospital] ... [Name of Responsible party] made aware of the change in condition and hospital transfer ... Resident was transferred to ER (Emergency Room) with the following documents: Physician order, Diagnoses and Allergies, Recent Vital signs, Face sheet, Copy of Advance directive, Copy of Comprehensive Care Plan

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: HCI

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT		NSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		005045					С
		095015	B. WING	0705	ET ADDRESS, CITY, STATE, ZIP CODE		06/29/2022
NAME OF PI	ROVIDER OR SUPPLIER				SOUTHERN AVE SE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			SHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
							09/23/22
F 625			F 6	525			
		bs, E-Interact printed and apid COVID-19 test result."					
	A review of Resident #35's medical record						
		ted evidence that facility staff					
	provided the resident						
	· ·	ritten information that bed hold policy when					
	Resident #35 transfer						
	During a face-to-face	interview on 06/23/22 at					
	10:36 AM, when aske	ed to provide written					
		bw that the bed hold policy					
	-	dent #35 or the resident's oyee #29(Social Worker)					
	stated, "I checked an						
	2. Resident #54 was						
		oses including, Pneumonia,					
	Type 2 Diabetes Mell	Pulmonary Disease (COPD),					
		n, and Dementia in Other					
	Diseases Classified E						
	Behavioral Disturban	ce.					
	A Quarterly Minimum	Data Set (MDS) dated					
	04/25/22 showed in S						
	Patterns) that facility						
		Brief Interview for Mental re (BIMS) of "03," indicating					
	· ·	severely impaired cognition.					
	Review of Resident # revealed:	54's medical record					
		Report dated 04/13/22					
	status observed [a] la emesis on bed linens	Complaint: Change in mental arge quantity of green					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETE C		
		095015	B. WING	 	06	5/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE			
SERENIT	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Continued From page 04/13/22 at 2:49 PM "ER transfer for green elevated temperature condition." 04/13/22 at 4:00 PM "During shift rounds a a large quantity of green linen and on the floor resident was] observed weakness, [ and] con Practitioner] made aw [the] resident to be tra [Resident Representation made awareThe for accompanied [the] re result negative, verified sheet, advance direct Recent labs, history at goals, and bed hold p 05/15/22 at 2:00 AM, Assessment (SBAR). Situation:at about 'change in mental stat send out the resident Mental status or neur responsedifficult to of Resident#54's Rep 05/15/22 at 2:25 AM, (Department of Healt	2.SC IDENTIFYING INFORMATION) (Physician's Order] directed, in emesis, tachycardia, i, generalized change in (Nurses Note] documented, at 2 PM, the writer observed een emesis on resident's bed Upon assessment, [the ed with general body fusion[Name of Nurse vare and gave [an]order for ansferred to hospital, RP ative's Name] [was] also llowing documents sident, Covid test done, ed by two nurses, Face tive, list of medications. and physical, care plan policy." a [Situational, Background, Communication Tool] "	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)			
	transfer is for therape facility's bed-hold poli bed-hold days is: " 0.	rred to a hospital or the putic leave, attached is this icy. Your available number of " Of note, no bed hold <i>i</i> thin or attached to this					

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		095015	B. WING				C / <b>29/2022</b>		
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RRECTIVE ACTION SHOULD BE COM			
F 625	form. During a face-to-face 10:36 AM, Employee that the facility staff in policy on the DOH (D of Discharge Transfer was shared with Resi Employee #29 offered provided no document bed hold policy that fa Resident #54 or the row when the resident tran 04/13/22 and Review of Resident # documented evidence provided written inform facility's bed hold poli resident transferred to 05/15/22. 3. Resident #93 was a 12/11/18 with multiple Unspecified Convulsion Hemiplegia following Right Dominant Side, Status, Unspecified D Disturbance, Narcole Type 2 Diabetes Mellion A Quarterly Minimum 04/12/22 showed that Patterns), facility staff #93's Brief Interview F Score (BIMS) as a mit that the resident was interview questions an	interview on 06/23/22 at #29 (Social Worker) stated included the facility's bed hold epartment of Health) Notice or Relocation Form, which dent #54's representative. d no further comment and ited evidence of a separate acility staff provided to esident's representative insferred to the hospital on #54's medical record lacked e that the facility staff mation that specified the cy to Resident #54 when the pothe hospital on 04/13/22 or admitted to the facility on e diagnoses, including, ons, Parkinson's Disease, Cerebral Infarct Affecting Aphasia, Gastrostomy Dementia without Behavioral psy Without Cataplexy and itus. Data Set (MDS) dated t in Section C (Cognitive f documented Resident For Mental Status Summary inus (-) symbol; indicating	F	625					
	Hemiplegia following Right Dominant Side, Status, Unspecified D Disturbance, Narcole Type 2 Diabetes Melli A Quarterly Minimum 04/12/22 showed that Patterns), facility staff #93's Brief Interview F Score (BIMS) as a mi that the resident was	Cerebral Infarct Affecting Aphasia, Gastrostomy Dementia without Behavioral psy Without Cataplexy and itus. Data Set (MDS) dated t in Section C (Cognitive f documented Resident For Mental Status Summary inus (-) symbol; indicating unable to answer the							

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	9 71	F	625			
	A review of Resident revealed:	#93's medical record					
		l [Physician's Order] dent to nearest Emergency or uncontrollable seizure."					
	during round[s] at the verbally responsive. <i>A</i> responded to a code observed in bed unre	ident was received in bed start of shift alert and At 11 AM, [the] writer blue[the] resident was sponsive, having [a]					
	generalized tonic-clor Physician] made awa transfer resident to El	-					
	(Department of Health Transfer or Relocation are being transferred is for therapeutic leav bed-hold policy. Your bed-hold days is: 'will	I, a document entitled "DOH h) Notice of Discharge n Form," read: ",,, (5) If you to a hospital or the transfer re, attached is this facility's available number of attached (sp,).' Of note, d policy attached to this					
	provided the resident representative with w	ed evidence that facility staff or the resident's ritten information that bed hold policy when					
	10:36 AM, Employee	interview on 06/23/22 at #29 (Social Worker) stated, not find documentation to					

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	resident or the reside 4. Resident #97 was a 08/28/20 with multiple Chronic Obstructive F Type 2 Diabetes Mell Stage 3, Congestive I Non-Alzheimer's Dem and Signs Concerning A Quarterly Minimum 09/14/21 showed that (Cognitive Patterns)/E Status Summary Sco that the resident had impairment. A review of Resident revealed: [Face Sheet] docume #97] Responsible par 07/07/21 at 11:41 PM "NP reviewed lab re received from NP to t nearest ER (Emerger ambulance for abnorr indicators) elevated E (representative) notifi hospital resident was following copies were resident: Physician's diagnosis/allergiesa	Id policy was provided to the nt's representative." admitted to the facility on a diagnoses, including, Pulmonary Disease (COPD), itus, Chronic Kidney Disease Heart Failure, nentia and Other Symptoms g Food and Fluid Intake. Data Set (MDS) dated t facility staff left Section C Brief Interview For Mental re (BIMS) of "08," indicating moderate cognitive #97's medical record ented: [Name of Resident ty. I [Nurses Note] documented esults at 6:30 PM, order ransfer resident to the hoy Room) via regular mal lab AKI (acute kidney BUN/CreatinineRP ed of pick up, and the transferred toThe e sent to the hospital with the order, advance sive care planA copy of	F	625			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE COMF	
		095015	B. WING				29/2022
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
SERENITY	SERENITY REHABILITATION AND HEALTH CENTER LLC				1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 625	altered mental status (left lower quadrant) a 09/14/21 at 12:20 PM documented, "Asked (immediately) Reside Altered Mental Status (right upper quadrant Room) transfer for fur treatment." 09/14/21 at 2:06 PM, Assessment (RN-Reg Appearance (LPN- Lie Request] (SBAR)- Ph Practitioner)/PA (Phys Communication Tool of Resident was observe Status, and Severe a Person contacted: Representative] unab 09/20/21 at 8:21 PM [ "Write(r) received a c Hospital]that reside During a face-to-face 10:36 AM, Employee "I could not find the b that resident. The res The resident expired On 06/27/22 at 11:00 requested the entire of #97 and asked explic documentation that s	ransfer for resident with and severe distended LLQ abdomen." I [Nurse Practitioner Note]: to evaluate resident 'STAT' int in bed. DrowsyA. due to? R/o (rule-out) RUE ) mass. P. ER (Emergency ther evaluation and a [Situational, Background, gistered Nurse) or censed Practical Nurse) and ysician/NP(Nurse sician's Assistance) documented: " [the] ed with Altered Mental abdominal distention [Name of Resident #97's le to reach voicemail full" fNurses Note] documented, all from [Nurse at Local ent expired at 7:28 PM." interview on 06/23/22 at #29 (Social Worker) stated, ed hold policy documents for ident's record is closed." in September 2021.	F	625	5		
		ded to Resident#97 when					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING		_		C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page 07/07/21 and 09/14/2 A review of Resident :		F 625				
	and transfer documer #29 showed no docur staff provided the resi that specified the faci	nts provided by Employee nented evidence that facility dent with written information lity's bed hold policy when sferred to the hospital on					
	#110's or their represe	to provide to Resident entative(s) written notice of hen she was transferred to					
	11/08/19 with diagnos Osteoarthritis, Type 2	Diabetes Mellitus, bisease and Dysphagia. 110's medical record					
	04/26/22 at 4:37 PM [ 12:30pm writer was c doing her regular rour left toe is infected. NF aware, assessed resi transfer resident to Ef						
	04/26/22 at 9:50 PM [ call made to [Hospital admitted"	Nurses Note] "At 9:45pm Name] resident is					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		095015	B. WING				_ 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	9 75	F	625			
	showed facility staff d Interview for Mental S	(MDS) dated 05/20/22 locumented: a Brief Status (BIMS) summary g moderately impaired					
	bed-hold policy provid representative for the	de a copy of the written ded to Resident #110 or their hospitalization on 04/26/22, le to provide the document.					
	06/24/22 at 12:04 PM Social Worker) stated happened. I can only policy for 2021. I can'	find the notice of bed hold t find one for the most . It must've have been					
	notice of the facilities #84 and the Resident	nen Resident #84 was					
	05/20/21, with multipl Type 2 Diabetes Mell Hemiplegia and Hem Infarction Affecting Ri Following Cerebral In Organism, Unspecifie	mitted to the facility on e diagnoses that included: itus Without Complications, iparesis following Cerebral ght Dominant Side, Aphasia farction, Sepsis Unspecified ed Convulsions, Multiple ny Status and Dysphagia.					
	(MDS) dated 02/18/2	rly Minimum Data Set 2, revealed that the facility ing: Section C (cognitive					

Facility ID: HCI

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		MEDICAID SERVICES	(X2) MI II TIE	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · ·	OMPLETED
						С
		095015	B. WING			06/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	Continued From page	76				09/23/22
1 025			F 62	25		
	Status be Conducted	Brief Interview for Mental ? "NO"				
		an orders showed the Resident returned from				
	Review of the nurse's the following:	progress notes revealed				
	bright red blood satur care at 1:30 PM. Ass bleeding from her vag practitioner) was notif	"Resident was observed with rated brief during incontinent essment revealed profuse ginaNP (nurse fied and oder (sp) given to R (Emergency room)"				
	again vomiting large a emesis and continuou from both nostrils9 arrived at resident be	"resident was observed amount of coffee ground usly bleeding fresh red blood 11 was called, paramedics dside at 5PM assessed unit with resident to (Hospital				
	with dislodged G-(Ga medication administra replace G-tube unabl resistance. Resident aware and give order ER for G-tube replace and EMT arrived at 8	"nurse observed resident strostomy)Tube during ationwriter attempt to e on two attempts with with (Hospice name) made to send resident to nearest ement911 call at 7:55pm :05 pm bed side ad resident was transfer"				
		ted evidence in the medical he bed hold policy being esident representative.				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	OMPLETED
		095015	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		00/29/2022
	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
E 625	Continued From page	~ 77	F 00	-		09/23/2
F 625	A face-to-face intervie 06/24/22 at 11:57 AM (Licensed Social wor documented evidenc resident representation facilities bed hold pol hospitalizations. Emp provide any document cannot find the 6-108	ew was conducted on 1 with Employee #29 ker) the surveyor asked for e that the resident or	F 62	5		
F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The fa implement a comprel care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefr- medical, nursing, and needs that are identifi assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the r- under §483.10, include treatment under §483. (iii) Any specialized s	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized is the nursing facility will	F 65	6 F656 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #150 was reassesse from head to toe by Unit Mana /Licensed Nurse on 8/17/22 Resident suffered no negative A comprehensive care plan wa developed on 8/10/22 to addre use of Plavix (anticoagulant) . Resident #354 was reassesse from head to toe by Unit Mana /Licensed Nurse on 8/17/22 Resident suffered no negative outcome Care plan intervention was implemented on management central line insertion site on 6/ Dressing to the central line ins site was changed immediately being notified on 6/14/22 by the licensed nurse.	outcome. as ess d ager of the 14/22. ertion	

Facility ID: HCI

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	0. 0938-039 SURVEY LETED
		095015	B. WING				29/2022
	ROVIDER OR SUPPLIER Y REHABILITATION AND	HEALTH CENTER LLC		13	TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	findings of the PASAF rationale in the reside (iv)In consultation wit resident's representat (A) The resident's good desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident's community was assess local contact agencie entities, for this purpor (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record revi- two (2) of 67 sampled failed to: (1) develop to address Resident # (anticoagulant) and (2 intervention for charge line dressing. The findings included 1. Facility staff failed comphrehensive care use of Plavix. Resident #150 was a 03/08/22 with the mul Peripheral Vascular D Atherosclerosis due to Review of the medication	RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and efference and potential for illities must document is desire to return to the ssed and any referrals to is and/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced iew and staff interviews, for d residents, facility staff a comprehensive care plan #150's use of Plavix 2) implement the care plan ging Resident #354's central it to develop a a to address Resident #150's dmitted to the facility on ltiple diagnoses including Disease and Coronary o Lipid Rich Plasma.	F	656	IDENTIFICATION OF OTHERS WITH T POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	ſΗΕ	09/23/22

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		095015	B. WING		C 06/29/2022	
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SEDENITY	REHABILITATION AND		1	380 SOUTHERN AVE SE		
SERENIII	REPADILITATION AND		۱ N	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
				F656		09/23/22
F 656	Continued From page	979	F 656			09/23/22
	"Plavix [anticoagulant	] 75 mg (milligrams) give		MEASURE TO PREVENT RECURREN	ICE:	
		th one time a day for PAD		The facility Staff Development will		
	(Peripheral Arterial Di	sease)."		provide education/in-services to all		
	Deview of Devide ( 1			facility licensed nurses on the importance of :		
		150's comprehensive care nted evidence the of a care		1. Developing comprehensive		
		sident's use of Plavix.		care plan to address the needs of the		
				resident.		
	During a face-to-face	interview on 06/28/22 at		2. Implementation of the care plan interventions to address / meet the		
		21 (RN/Unit Manager)		needs of the residents		
		oversight, and she would		This will be completed by 0/22/22		
	of Plavix.	o address the resident's use		This will be completed by 9/23/22.		
	2. Facility staff failed t	o implement the care plan				
	-	ging Resident #354's central				
	line dressing every se	even (7) days.				
	According to the Cent	ers for Disease Control				
		ressings used on short-term				
		catheter) sites at least every				
	7 days"					
	https://www.cdc.gov/ii i/index.html#rec6	nfectioncontrol/guidelines/bs				
	During an observatior Resident #354 was ol	n on 06/14/22 at 10:40 AM,				
		iotics via a peripherally				
		ter (PICC). The resident				
	-	they needed to change the				
	•	een changed since it was				
		Upon closer observation, ed to have the date "6/6/22"				
	in bold, black ink.					
	Review of Resident #					
	revealed the following	l.				

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING			C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE		
	1		V	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Resident #354 was au 06/10/22 with diagnos and Inflammatory Rea Joint Prosthesis. Care Plan focus areal right upper line picc lin documented " Interv transparent dressing of days Monitor right of shift" 06/11/22 at 10:43 AM "Late EntryAdmitted and left shoulder surg 06/11/22 [Physician's arm and call MD (med Practitioner) for bleed symptoms) of infectio complications every s The evidence showed change the transpare #354's insertion site of the care plan. During a face-to-face 06/14/22 at 11:10 AM Nurse) acknowledged didn't notice that the of changed. I will change Care Plan Timing and CFR(s): 483.21(b) Comprehe	dmitted to the facility on sees that included: Infection action Due to Other Internal "[Resident #354] has an ne" initiated on 06/10/22 ventions: Change on insertion site every 7 upper line picc line q (every) [Nurses Progress Note] d with right upper picc line gical wound" Order] "Observe right upper dical doctor)/NP (Nurse ing, swelling s/s (signs and n or any IV related hift" d that facility staff failed to nt dressing to Resident every 7 days as specified in interview conducted on , Employee #5 (Registered d the finding and stated, "I dressing was due to be e it today." I Revision (i)-(iii)	F 656	MONITORING CORRECTIVE ACTION: The Unit Manager/ Designee will complete house wide review/audit of al residents on Anticoagulant therapy. Audit will be done weekly times 4, then, monthly times 3 months. Any negative findings will be corrected by 9/23/22. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee. The Unit Manager/ Designee will complete house wide review/audit of all residents to identify potential residents with an Intravenous line to ensure that the licensed nurses implement the care plan intervention for changing resident intravenous line insertion site dressing according to the plan of care and as needed.Audit will be done weekly times 4, then, monthly times 3 months. Any negative findings will be corrected by 9/23/22. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.		09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/12/2022 MAPPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		095015	B. WING				C 6/29/2022	
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	the comprehensive a (ii) Prepared by an in- includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on record rev one (1) out of 67 sam failed to revise Resid care plan reflect the r be discharged. The findings include: Review of the facility Team Meeting (IDT) ( 02/22 documented, " Name] to develop and	<ul> <li>7 days after completion of ssessment.</li> <li>terdisciplinary team, that nited toysician.</li> <li>e with responsibility for the</li> <li>responsibility for the</li> <li>and nutrition services staff.</li> <li>cticable, the participation of resident's representative(s).</li> <li>be included in a resident's participation of the resident of the resident of the resident of the resident of the resident.</li> <li>resentative is determined e development of the</li> <li>restaff or professionals in ined by the resident's needs e resident.</li> <li>ised by the interdisciplinary ssment, including both the quarterly review</li> <li>T is not met as evidenced</li> <li>iew and staff interview, for npled residents, facility staff ent #124's comprehensive resident's preference to not</li> </ul>	F	657	F657 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct this deficiency Resident #124 was discharged from the facility 07/1/2022. Resident suffered no negative outcor IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected.	ne	09/23/22	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE		
	-			WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	Continued From page	82	F 657	F657		09/23/22
	includes the instruction effective and person-of professional standard	centered care that meet		MEASURE TO PREVENT RECURRENCE:		
	Resident #124 was ad 04/21/21 with diagnos Walking, Hypothyroidi and Dysphagia. Review of Resident # revealed the following Care Plan focus area expectation for discha community" initiated of " 05/2/22 IDT meetin reviewed and updated of care)" 02/01/22 at 3:27 PM [ "Care Plan Note: IDT Meeting was held on are no plans for disch will continue to be a lo facility" 05/03/22 at 11:27 AM Note] "The clinical/IDT resident's care plan. S Nursing, Dietitian, Re attendance. Resident meetingThere were update, this worker w resident to assist with are no plans for disch will continue to be a lo facility"	dmitted to the facility on ses that included: Difficulty ism, Hypertension, Anemia 124's medical record :: "[Resident #124's] goal and arge is to return back to the on 04/22/21, documented, ng held today. Care plan d. Continue with POC (plan Social Work Progress Note] (interdisciplinary team) behalf of residentThere arge at this time, resident ong term care resident in the [Social Work Progress T team met to review Social worker, Activity, hab services were in chose not to attend the no changes since the last ill continue to work with the any needs or issues. There arge at this time, resident ong term care resident in the		The facility Staff Development will provide education/in-services to the f social worker on the importance of ensuring resident comprehensive care plan is revised t resident preferences not to be discharged and to remain in Long Te This will be completed by 9/23/22 MONITORING CORRECTIVE ACTION: The Director of Social Service/ Desig complete house wide review/audit of residents to identify any residents wit preference not to be discharged, and that the comprehensive care plan ref resident's preference to remain in lor care. Any issue found during this auc corrected by 9/23/22. The audit will b conducted weekly times 4, then, mor 3 months. The findings of these audits will be pr monthly for 3 months to the Quality A Performance Improvement (QAPI) co	nee will all h the ects the g term it will be e thly times esented ssurance	
	05/14/22 Quarterly Mi	nimum Data Set (MDS)				

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUC	TION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	IG			
		095015	B. WING _			C 06/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHE			
				WASHINGTO	ON, DC 20032		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page	e 83	F	57			09/23/2
		coded: a Brief Interview for					
		) summary score of 15,					
	indicating intact cogn	· •					
		or physical behavioral owards others, independent					
		d off the unit and no active					
		or the resident to return to					
	the community.						
	The evidence showe	d that facility staff failed to		CORREC	F676 CTIVE ACTION FOR		
		I's care plan to reflect that			ECTED RESIDENTS:		
		the longterm care facility.			y cannot retroactively correct		
				this defic Resident#	#84 received a shower		
		e interview on 06/16/22 at e #6 (Unit 1 Social Worker)		immediat	ely on 6/23/22 after being		
	stated, "Discharge wa			notified an	nd was ted accordingly. Resident		
	-	lized a desire to leave the			sessed by the Unit		
		original goal (discharge)			Designee on 8/17/2022		
		dmitted here, it (care plan)			suffered no negative outcome e assisted with		
	wanted to be long ter	anged to say that she m care "		Activity of	Daily Living including		
F 676	-	(ADLs)/Mntn Abilities	F	bathing ai	nd all the care provided. Il be documented in the		
SS=D		(b)(1)-(5)(i)-(iii)			medical record ongoing.		
	§483.24(a) Based on	the comprehensive		Resident	#4 received a shower		
		dent and consistent with the		immediat	ely on 6/28/22 after being		
		choices, the facility must		notified an	nd was ted accordingly. Resident		
		y care and services to			sessed by the Unit		
		it's abilities in activities of		Manager/	Designee on 8/17/2022		
		ninish unless circumstances nical condition demonstrate			suffered no negative outcome e assisted with	).	
		was unavoidable. This		Activity of	Daily Living including		
	includes the facility e	nsuring that:			nd all the care provided. Il be documented in the		
	8483 24(a)(1) A resid	lent is given the appropriate			medical record ongoing.		
		es to maintain or improve his					
		out the activities of daily					
		e specified in paragraph (b)					

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WING				C / <b>29/2022</b>
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		138	REET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	of this section §483.24(b) Activities of The facility must provi- accordance with para- activities of daily living §483.24(b)(1) Hygien grooming, and oral ca §483.24(b)(2) Mobility including walking, §483.24(b)(3) Elimina §483.24(b)(3) Elimina §483.24(b)(4) Dining- snacks, §483.24(b)(5) Commi- (i) Speech, (ii) Language, (ii) Other functional ca This REQUIREMENT by: Based on observation residents, facility staff residents are given the services to maintain of carry out activities of documented evidence provided with ADL (activity)	of daily living. ride care and services in agraph (a) for the following g: the -bathing, dressing, are, y-transfer and ambulation, ation-toileting, -eating, including meals and unication, including communication systems. T is not met as evidenced an, record review, staff and two (2) of 67 sampled f failed to ensure that he appropriate treatment and or improve their ability to daily living by not providing that residents were stivities of daily living) care jiene care on multiple days. #4).	F 6		IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED: All residents residing in the facility hav potential to be affected.		09/23/22

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI		ONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	PLETED
							С
		095015	B. WING			06	/29/2022
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	( REHABILITATION AND	HEALTH CENTER LLC			) SOUTHERN AVE SE SHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
							09/23/22
F 676			F 67				
	evidence of bathing F days during the mont	Resident #84 on multiple h of May 2022.			MEASURE TO PREVENT RECURRENCE:		
	received by DOH (De 09/20/21, concerning A complete head to Multiple scars to left u Redness to perineal / incident is categorize Resident/Patient Neg Resident #84 was ac 05/20/21, with multipl Type 2 Diabetes Mell Hemiplegia and Hem Infarction Affecting Ri	d as an allegation of lect. dmitted to the facility on le diagnoses that included: itus Without Complications, iparesis following Cerebral ight Dominant Side, Aphasia		e n ir o d	The facility Staff Developer will proveducation/in-services to the facility liburses and nursing assistants on the mportance of assisting and providing f Daily Living (ADL) and importance focumentation of care provided for the sidents. This will be completed by	censed e g Activity e of the	
	Organism, Unspecifie Sclerosis, Gastroston Review of the Quarte (MDS) dated 02/18/2 staff coded the follow Section C (Cognitive Interview for Mental S Section G (Functiona	Patterns): "Should a Brief Status be Conducted? "NO" I Status): Bed Mobility,					
	physical assist" Trans requiring "Two-perso	e assistance" requiring I assist" xtensive assistance" n physical assist" dence" airment on one side"					

Facility ID: HCI

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TATEMENT	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE		CONSTRUCTION	(X3) DATE	0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
							С
		095015	B. WING			06/	29/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		13	380 SOUTHERN AVE SE		
021121111				W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 676	Continued From page	- 96	<b>F</b> 07	70			09/23/2
F 070	Continued From pag	e oo	F 67	/6		-	
	Review of the physic	ians' orders showed the			MONITORING CORRECTIVE ACTION		
		Adjust to nursing home			The Unit Manager/Designee will conduc		
		good nutritional status and			house wide review/audit to identify resid		
		ve physical function; Meet			that require ADL assistance including b		
	-	ly living) needs daily"			and ensure that the appropriate assista provided. This audit will be completed v		
					times 4, then, monthly times 3 months.	reenay	
		lan with a focus area of					
	"[Resident #84] has a				The Unit Manager/Designee will		
	-	/t (related to) Hemiplegia and			conduct house wide review/audit of res and ensure that Activity of Daily Living		
	•	g cerebral infarction affecting			care provided are documented in		
	right dominant side, a				the resident medical records accurately		
		, included the following dent #84) requires 2 staff			audit will be conducted weekly times 4,	then,	
		sfers the resident is totally			monthly times 3 months. The findings of these audits will be pres	ontod	
	dependent on staff to	-			monthly for 3 months to Quality Assura	nce	
		ent #84] requires total			Performance Improvement (QAPI) com		
		onal hygiene care The					
	resident is totally dep	pendent on staff for dressing					
	"						
	Review of the docum	ent titled "Documentation					
		hich is part of the electronic					
		the CNA's (Certified Nurse					
		L and other care that they					
	,	05/01/22 to 05/31/22, shows					
	•	cumented evidence of					
		pathed on the following					
	dates:						
	05/11/22, 05/14/22, 0 and 05/29/22	05/15/22, 05/16/22, 05/17/22,					
		interview conducted on /i, Employee #33 (Unit					
		stated "Its not documented"					
		wledged the findings and					
	made no further com						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 676	<ol> <li>Facility staff failed t evidence of bathing R in May and June 2022</li> <li>Resident #4 was adm 05/23/22 with multiple Pressure Ulcer Sacra Diabetes Mellitus with Legal Blindness as D Glaucoma, and Musc</li> <li>Review of the Admiss (MDS) dated 05/27/22 staff coded the following Section C (Cognitive Mental Status (BIMS) Indicating severely im Section G (Functional "Extensive assistance physical assist"</li> <li>Transfer, "Activity did Dressing, "Total depe "One-person physical Toilet Use, "Total depe "Two-person physical Personal hygiene, "Total Personal hygiene, "Total Come-person physical Bathing, "Total depen Upper extremity "Impa Section H (Bladder ar Catheter Urinary Continence "A Section M (Skin Cond</li> </ol>	to provide documented Resident #4 on multiple days 2. hitted to the facility on e diagnoses that included: I Region Stage 4, Type 2 h Unspecified Complications, efined in USA, Unspecified le Weakness. sion Minimum Data Set 2, revealed that the facility ing: Patterns): Brief Interview for 9 Summery Score "02" hpaired cognition. I Status): Bed Mobility, e" requiring "Two-person not occur" ndence" requiring assist" endence" requiring assist" otal dependence" requiring assist" dence" airment both sides" airment on both sides" airment on both sides" hd Bowel): Indwelling	F	676			

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	
		095015	B. WING				29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 676	pressure ulcers that w one (1) unstageable p admission and moistu Review of the physica following: 05/21/22, " daily Living) needs da Review of the care pla "[Resident #4] ADL se physical limitations, w mental status" initi the following intervent Bathe/Shower as need hygiene, grooming, da as needed" Review of the docume Survey Report v2" wh health record where the Aides) document ADL provide dated 05/21/2 there was no docume #4 being bathed on the 05/22/22, 05/24/22, 00 06/25/22, 06/26/22 ar On the above dates st Applicable) or RN (Ref An observation and fac conducted on 06/27/2 stated "They are shor come to give me a bas During a face-to-face 06/28/22 at 10:37 AM	vere present on admission, pressure ulcer present on ure associated skin damage. ans' orders revealed the Meet ADL (activities of aily" an with a focus area of: elf-care deficit related to isual impairment, change in ated on 05/23/22, included tions: "Assist to dedAssist with daily ressing, oral care and eating ent titled "Documentation hich is part of the electronic he CNA's (Certified Nurse and other care that they 22 to 6/28/2022, shows that ented evidence of Resident he following dates: 05/29/22, 06/07/22, hd 06/28/22 taff documented NA (Not esident Not Available). ace-to-face interview were 22 at 1:15 PM, Resident #4 t, and they do not always tth." interview conducted on l, Employee #3 (Assistant tated, "She (Resident #4)	F	676			

Facility ID: HCI

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY
		095015	B. WING		0	C 6/ <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 676	Continued From page	89	F 676			09/23/22
F 677	Employee #3 acknow documented evidence on multiple days in M ADL Care Provided for	ledged that there was no e that staff bathed resident		F677 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #4,#19 #84,#93 ADL care including shower were given immediately after being notified and	document was	
SS=D	<ul> <li>§483.24(a)(2) A resid out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by:</li> <li>Based on record revit three (4) of 67 sampling failed to ensure that maintain personal hyg #84 and #93.</li> <li>The findings included</li> <li>1. Facility staff failed the evidence of bathing Failed the evide</li></ul>	<ul> <li>is not met as evidenced</li> <li>ews and interviews, for</li> <li>ed residents, facility staff</li> <li>esidents who were unable to</li> <li>out activities of daily living</li> <li>d services necessary to</li> <li>giene. Residents' #4, #19,</li> <li>:</li> <li>to provide documented</li> <li>Resident #4, who is</li> <li>r ADL care, on multiple days</li> <li>2.</li> <li>hitted to the facility on</li> <li>e diagnoses that included:</li> <li>I Region Stage 4, Type 2</li> <li>n Unspecified Complications,</li> <li>efined in USA, Unspecified</li> <li>le Weakness.</li> <li>bion Minimum Data Set</li> <li>2, revealed that the facility</li> </ul>		completed accordingly. Residents were reassessed by by the Unit Manager/Designee on 8/17/22 Resident suffered no negative outcoor Residents will be assisted with Activity of Daily Living including bathing , and all the care provided will be documented in the residents' medical record ongoing.		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 08/12/2022 RM APPROVED IO. 0938-0391	
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		095015	B. WING			C 06/29/2022		
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC	I	1380	EET ADDRESS, CITY, STATE, ZIP CODE ) SOUTHERN AVE SE SHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 90	F	677			09/23/22	
	Mental Status (BIMS) Indicating severely in Section G (Functiona "Extensive assistance physical assist" Transfer, "Activity did Dressing, "Total depe "One-person physica Toilet Use, "Total depe "Two-person physica Personal hygiene, "To "One-person physica Bathing, "Total deper Upper extremity "Imp Lower extremity "Imp Section H (Bladder an Catheter Urinary Continence "A Section M (Skin Cond coded that resident h pressure ulcers that w one (1) unstageable admission and moistin Review of the physicia	I Status): Bed Mobility, e" requiring "Two-person I not occur" endence" requiring I assist" bendence" requiring I assist" otal dependence" assist the state of the state						
	"[Resident #4] ADL s physical limitations, v mental status" initia the following intervent	an with a focus area of: elf-care deficit related to risual impairment, change in ated on 05/23/22, included tions: "Assist to ededAssist with daily						

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WING				C 29/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
				1:	380 SOUTHERN AVE SE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		W	ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page hygiene, grooming, dr as needed" Review of the docume Survey Report v2" wh health record where th Aides) document ADL provide dated 05/21/2 documented evidence bathed on the followin 05/22/22 05/24/22 05/29/22 06/07/22 06/25/22 06/26/22 06/28/22 On the above dates s Applicable) or RN (Re An observation and fa conducted on 06/27/2 stated, "They are sho come to give me a ba During a face-to-face 06/28/22 at 10:37 AM Director of Nursing) s was available the staf appropriately."	e 91 ressing, oral care and eating ent titled "Documentation nich is part of the electronic he CNA's (Certified Nurse and other care that they 22 to 6/28/2022, showed no e of Resident #4 being ng dates: taff documented NA (Not esident Not Available). ace-to-face interview were 22 at 1:15 PM, Resident #4 rt, and they do not always th." interview conducted on l, Employee #3 (Assistant tated, "She (Resident #4)		677			09/23/22	
	on multiple days in Ma 3. Facility staff failed t evidence of bathing R	ay and June 2022. to provide documented						

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		095015	B. WING		C 06/29/2022		
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
			1	380 SOUTHERN AVE SE			
SERENIII	REHABILITATION AND	HEALTH CENTER LLC	v	VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 677	Continued From page during the month of M		F 677	F677 MEASURE TO PREVENT RECURRENCE:		09/23/22	
	received by DOH (De 09/20/21, concerning A complete head to	d as an allegation of		The facility Staff Developer will provide education/in-services to the facility licen- nurses and nursing assistants on the im of assisting and providing Activity of Daily Living (ADL) to residents who ar to independently carry out activities of da (ADLs) and the importance of accurate documentation of care provided for the r by 09/23/22.	oortance e unable aily living esidents		
	05/20/21, with multiple Type 2 Diabetes Melli Hemiplegia and Hemi Infarction Affecting Rig Following Cerebral Int Organism, Unspecifie Sclerosis, Gastrostom Review of the Quarter (MDS) dated 02/18/22 staff coded the followi Section C (Cognitive I Interview for Mental S Section G (Functional "Extensive assistance	2, revealed that the facility ng: Patterns): "Should a Brief status be Conducted? "NO" Status): Bed Mobility, " requiring "One-person offer, "Extensive assistance" offer, "Extensive assistance" assistance" requiring assist" stensive assistance" offensive assistance" offensive assistance offensive assistance offensive assistance offensive assistance assist" stensive assistance offensive assistance		Charge nurses will ensure the nursing a are providing ADL's which include but no to shower/bath, shaving, grooming and p hygiene to the residents as indicated du shift. Any issues found will be corrected 9/23/22. Random rounds will be conducted week supervisors to ensure that the residents given showers on their schedule date. <i>A</i> issues found will be corrected by 9/23/22	ot limited bersonal ring their by ly by are any		
		ans' orders showed the djust to nursing home					

Facility ID: HCI

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		<u>O. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
					C	
		095015	B. WING			/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE		
				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From pag	e 93	F 67	F677		00/00/0
1 0//		good nutritional status and	F 07			09/23/2
		ve physical function; Meet				
	· ·	ly living) needs daily"				
		·		ACTION: The Unit Manager/Designee w	vill conduct	
	-	lan with a focus area of		house wide review/audit to ide	entify residents	
	"[Resident #84] has a	an ADL self-care /t (related to) Hemiplegia and		who are unable to independer activities of daily living (ADLs)		
		g cerebral infarction affecting		facility staff provide necessary		
		adult failure to thrive"		maintain residents' personal h	ygiene and	
		, included the following		that services provided are acc documented in the residents' r		
		dent #84) requires 2 staff		Any issue found during this re		
	dependent on staff to	nsfersthe resident is totally		be corrected by 9/23/22.		
		ent #84] requires total		This audit will be conducted w then, monthly times 3 months.		
		onal hygiene care The		of these audits will be present	ed monthly for	
	resident is totally dependent on staff for dressing			3 months to Quality Assurance		
	"			Improvement (QAPI) committe	ee.	
		nent titled "Documentation				
		hich is part of the electronic				
		the CNA's (Certified Nurse				
		L and other care that they 05/01/22 to 05/31/22, shows				
	•	cumented evidence of				
		pathed on the following				
	dates:					
	05/11/22					
	05/14/22					
	05/15/22					
	05/16/22					
	05/17/22 05/29/22					
	-	e interview conducted on				
		I, Employee #33 (Unit stated, "Its not documented."				
		wledged the findings and				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	TE SURVEY MPLETED
		095015	B. WING		l a	C 6/29/2022
				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE		
SERENII	Y REHABILITATION AND	HEALTH CENTER LLC		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	94	F 67	7		09/23/22
		to provide Resident #19 with sistance on his shower days.				
	12/29/2016 with diag Dementia without Bel Amenia, Peripheral V Hypertension, Catara	navioral Disturbance, ascular Disease,				
	Completed 4/13/2022 having a BIMs score moderately impaired Cognitive Patterns. Status, the resident w	rterly Minimum Data Set the resident was coded as of "11" indicating that he has cognition Under Section C Under Section G Functional /as coded as requiring with one person assistance ne.				
	According to the phys 01/02/2021 directs, "F twice a week every ni [Thursday]"	Resident may take shower				
	11:01 AM with the res #19 she statedI ha grooming him [Reside	interview on 6/22/22 at sponsible party for Resident ve to tell the staff about ent #19]They tell me they ut they don't shave him. I hem to shave him"				
	unshaven. During a face-to-face	wheelchair in his room and interview on 6/22/22 at AM with Resident #19 he				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 2003	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page supposed shave me o were supposed to do	on my shower days. They	F 677				
	Review of the skin sw show the following: 6/16/22, 6/22/22 - res 6/20/22- bed bath give						
		N, a certified nurse aide on e would shave Resident					
	Resident #19 who is u	ce that facility staff shaved unable to grooming himself om the staff on his shower					
	During a face-to-face 10:53 AM with the En acknowledged the fine						
	evidence that assista	to provide documented nce was provided to a ependent upon facility staff nal hygiene.					
	12/11/18 with multiple Unspecified Convulsion Hemiplegia following Right Dominant Side, Status, Unspecified D Disturbance, Narcole Type 2 Diabetes Mellion						
	04/12/22, revealed in	Data Set (MDS) dated Section C (Cognitive					

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					RINTED: 08/12/2022 FORM APPROVED MB NO. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			X3) DATE SURVEY COMPLETED
	095015	B. WING			C 06/29/2022
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE	
SERENITY REHABILITATION AND HE	EALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 20032		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
<ul> <li>Book on Unit 2 revealed bath/shower days were during the night shift.</li> <li>Review of Resident #93 revealed:</li> <li>[Care Plan] initiated on 0 "[Resident #93] has an A r/t (related to) limited mod healthcare status related Goal: Assist [Name of R Interventions:Assist related bathing/showersAssist hygiene and oral care."</li> <li>Skin Sweep Observation 05/31/22 documented th Resident #93 a bed bath and 05/16/22.</li> <li>Skin Sweep Observation 06/29/22 (last day of surfacility staff gave Resided day; 06/09/22.</li> <li>Certified Nurse's Assistata Survey Report for May 2</li> </ul>	<ul> <li>w For Mental Status</li> <li>a, documented that the answer the interview</li> <li>re cognitive impairment.</li> <li>I Status), facility staff</li> <li>#93 required extensive</li> <li>ff person for personal ance for bathing.</li> <li>a review of the Shower</li> <li>d that Resident #93's</li> <li>Mondays and Thursdays</li> <li>'s medical record</li> <li>03/05/21 with Focus:</li> <li>ADL (assisted daily living)</li> <li>obility decline in</li> <li>d to Parkinson's disease.</li> <li>Resident with</li> <li>st resident with personal</li> <li>in Sheets for 05/01/22 to the for 05/01/22 to the for 05/09/22, 05/12/22,</li> <li>in Sheets for 06/01/22 to the fo</li></ul>	F 677			

Facility ID: HCI

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING			C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677 F 684 SS=E	bath for Resident #93 05/15/22. Certified Nurse's Assis Survey Report for Jun staff failed to docume Resident #93 on 06/1 During a face-to-face 11:51 AM, Employees Nursing (ADON), ack failed to document tha personal hygiene to R June. The employees provided baths and pe #93, they should have was done on the resid Observation Sheets a Survey Reports." Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fun applies to all treatment facility residents. Base assessment of a resid that residents receive accordance with profe practice, the compreh care plan, and the residents	for Resident #93 on o note that they offered a on 05/13/22, 05/14/22 and stant (CNA) Documentation he 2022 revealed that facility int they provided a bath for 0/22. interview on 06/23/22 at #3, Assistant Director of nowledged that facility staff at they provided baths and tesident #93 in May and stated, "When the CNAs ersonal hygiene to Resident e documented that the care bent's Skin Sweep nd the CNA Documentation are ndamental principle that at and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of ensive person-centered	F 67	F684 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident#126 was reassessed by the U Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's comprehensive care plan wa updated on 6/17/22 including the exhibit inappropriate sexual behavior and interventions are now in place.	s	09/23/22
	interviews, for 13 of 6	ns, record reviews, and staff 7 sampled residents, facility hat residents received				

Facility ID: HCI

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			()(0)				D. 0938-039
ATEMENT OF DEFICIE D PLAN OF CORRECT	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
			A. BOILDII	<u> </u>	с		
095015		B. WING				/29/2022	
IAME OF PROVIDER C	R SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		1 00	
	EHABILITATION AND HEALTH CENTER LLC			1380 SOUTHERN AVE SE			
	LITATION AND	HEALTH CENTER LLC		V	VASHINGTON, DC 20032		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
treatme plan or standar provide compre beavior subject provide service nurse p psychia [wande #126; e and acc #32 wit by the p prescrif splint) a compre physicia medica changir every s Reside physicia residen Reside suppler physicia residen Reside suppler physicia residen Reside suppler physicia residen Reside	in accordance ds of practice care in accord hensive care , subsequently ed to non-con- Resident #28 s as ordered b ractitioner's re- tric consult for ing in resident surate skin ass nestorative no bysician; pro- bed rehabilitat is specified in hensive care an's order whet tion; follow the g Resident #2 even (7) days at #138 accord an's order to c ts' room every at #102; not pl at #102; not pl at #102; not pl at #102; not pl at #138 accord an's order to c ts' room every at #102; not pl at #138, admini nental oxygen an; and admin at #250 in acc Residents' #14 354, #138, #1 dings included of the policy ' 02/22 docum	er the comprehensive care e with professional as evidenced by failure to: dance with Resident #126's plan for inappropiate sexual y Resident #145 was senual sexual contact; with restorative nursing by the physician; follow the ecommendation for a r behavioral disturbances tts' rooms] for Resident nt #11 received a complete sessment; provide Resident wide Resident #95 with her ive equipment (right hand the resident's plan; follow Resident #133's en administering pain e care plan interventions for 854's central line dressing ; turn and reposition ding to care plan; follow a omplete a sign in sheet in r time care is rendered for lace 2 incontinent briefs on ster Resident #54's as ordered by the ister pain medication to ordance with the physician's 5, #28, #126, #11, #32, #95, 02, #85, #54 and #250.	F	84	Resident#28 was reassessed by the Un Manager/Designee on 8/17/22 Resident suffered no negative outcome. Resident's right resting hand was applied immediately and psychiatr consult was completed after being notii 7/19/22. The Unit manager will ensure t Resident #28 receives right resting har as ordered by the physician.	splint ic ied on hat	09/23/2

Facility ID: HCI

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AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COME         NAME OF PROVIDER OR SUPPLIER       B. WING       06/         SERENITY REHABILITATION AND HEALTH CENTER LLC         STREET ADDRESS, CITY, STATE, ZIP CODE       1380 SOUTHERN AVE SE         WASHINGTON, DC 20032       WASHINGTON, DC 20032         (K4) JD       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       CROSS-REFERENCE TO THE APPROPRIATE         Kegoulatory or LSC IDENTIFYING INFORMATION)       PREFIX       CROSS-REFERENCE TO THE APPROPRIATE         Skilled OT (Occupational Therapy) or PT       (Physical Therapy) services Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care planRestorative nursing care is performed for those residents who require such service initiate point click care list for each resident placed on program"       Resident#11 was reassessed head to toe including a skin assessment by the licensed nurse on 8/17/22. Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions.         Review of the policy "Pain Management" revised 02/22, documented, "The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated"       Review of the policy "Medication/Treatment         Review of the policy "Medication/Treatment       Review of the policy "Medication/Treatment       Review of the policy "Medication/Treatment	TE SURVEY MPLETED C 16/29/2022 (X5) COMPLETION DATE 09/23/22
095015         B. WING         Official           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         1380 SOUTHERN AVE SE         WASHINGTON, DC 20032         1380	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SERENITY REHABILITATION AND HEALTH CENTER LLC         STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 684         Continued From page 99 skilled OT (Occupational Therapy) or PT (Physical Therapy) services Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care planRestorative nursing care is performed for those residents who require such service initiate point click care list for each resident placed on program"       F 684       Resident#110 was reassessed head to toe including a skin assessment by the licensed nurse on 8/17/22. Resident#11 was reassessed head to toe including a skin assessment by the licensed nurse on 8/17/22. Resident suffered no negative outcome.         Review of the policy "Pain Management" revised 02/22, documented, "The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated"       Review of the policy "Medication/Treatment	(X5) COMPLETION DATE
SERENITY REHABILITATION AND HEALTH CENTER LLC         WASHINGTON, DC 20032           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           F 684         Continued From page 99 skilled OT (Occupational Therapy) or PT (Physical Therapy) services Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care planRestorative nursing care is performed for those residents who require such service initiate point click care list for each resident placed on program"         F 684         Resident#1146 was reassessed head to to by the Unit Manager/ Designee on 8/17/22 Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions.           Review of the policy "Pain Management" revised 02/22, documented, "The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated"         Resident suffered no negative outcome.	COMPLETION
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 684       Continued From page 99 skilled OT (Occupational Therapy) or PT (Physical Therapy) services Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care planRestorative nursing care is performed for those residents who require such service initiate point click care list for each resident placed on program"       F 684       Resident#1126 was reassessed head to toe by the Unit Manager/ Designee on 8/17/22 Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions.         Review of the policy "Pain Management" revised 02/22, documented, "The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated"       Review of the policy "Medication/Treatment         Review of the policy "Medication/Treatment       Review of the policy "Medication/Treatment       Review of the policy "Medication/Treatment	COMPLETION
F 684Continued From page 99F 684skilled OT (Occupational Therapy) or PT (Physical Therapy) services Our facility has an active program of restorative nursing which is developed and coordinated through the resident's care planRestorative nursing care is performed for those residents who require such service initiate point click care list for each resident placed on program"F 684to toe by the Unit Manager/ Designee on 8/17/22 Resident#126 was last seen by Psychiatry Nurse Practitioner on 8/10/2022. Resident remains on 1 on 1 monitoring 24 hrs/ daily for safety precautions.Review of the policy "Pain Management" revised 02/22, documented, "The licensed nurse will obtain order from the attending physician/designee for pain management and administer the order as indicated"Review of the policy "Medication/TreatmentReview of the policy "Medication/TreatmentReview of the policy "Medication/TreatmentReview of the policy "Medication/Treatment	09/23/22
Administration Record and Initials" revised 03/22         documented, " Prior to administration of         medication and treatment, the licensed nurse         assigned to the resident must check and         validated the ten Rights of Medication which         includes right assessment, right evaluation         Licensed nurses will administer medication and         treatment to residents following the physician         orders"         1. The facility's staff failed to provide care in         accordance with Resident #126's comprehensive         care plan for inappropiate sexual beavior,         subsequently Resident #145 was subjected to         non-consenual sexual contact;         Resident #126 was admitted to the facility on         05/07/21 with multiple diagnoses including Major         Depressive Disorder and Dementia without         Behavioral Disturbances.         Review of the medical record revealed the	

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION IDENTIFICATION NUMBER:		· /	A. BUILDING			PLETED
		095015	B. WING			C 06/29/202	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	REHABILITATION AND	HEALTH CENTER LLC		13	80 SOUTHERN AVE SE		
OERENT				W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
							09/23/22
F 684		[Psychiatric NP Note] -	F 68		The affected Resident #32 is now receiving restorative services as ordered by the physician. Resident was reassessed from head to toe on 08/17/22 by the licensed		
	adjust medications fo He was counseled a other people's persor others inappropriately	uate mental status and or behavioral disturbances about the risk of invading nal spaces or touching y. He was also encouraged oles' personal spaces and			nurse and did not suffer any negative outcome. The affected Resident #95 right resting hand splint was applied immediately. Resident was re-evaluated by Occupational therapy on 8/11/22		
	not to touch anyone in receptiveHis Sertra increased to 50 mg (r depression and comp	nappropriately; and he was alin [antidepressant]was milligrams) to control his			assessed from head The Unit Manager/Designee, will ensure that Resident #95 receives resting hand splint as ordered by the physician ongoing.		
	#126] have a problem residents act character sexual behavior relater residents and/or staff	wing: Focus Area- [Resident natic manner in which erized by inappropriate ed to; resident touches other inappropriately. other residents if unable to			Resident #133 was reassessed from head to toe on 08/17/22 by the licensed nurse, Resident to receive medications according to the parameters and as order the physician. Resident did not suffer any negative outcome. The assigned nurse wa educated immediately on administration of pain medication as ordered by the physicia according to the parameters	as f	
	"At about 5:40 AM [Resident #126] was [Resident #145]MI #145] to ER for fur name and Detective's interviewed writer, [R	[Nursing Supervisor's Note] - writer was informed by nurse observed in bed with 0 order to transfer [Resident ther evaluation[Officer's s name] the detective esident #126], assigned y will continue with their					
	Request]- "Writer v that [Resident #126] v	Background, Assessment, vas informed by the nurse was observed on bed with 313B [Resident #145]"					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED 8 NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION (X3) E		DATE SURVEY COMPLETED
		095015	B. WING			06/29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIF 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 684	06/17/22 [assigned C started rounds, when noticed [Resident #14 opened the door and on top of [Resident # 06/17/22 [assigned LI writer was called by [ observed a resident	s investigative report g employee statements: NA] - "At 5:45 AM I I came around the corner, I I5's room] door closed, I saw [Resident #126] naked 145]." PN] - "Around 5:40 AM CNA] to room 313B t in [from] Room 310B p of the resident in room	F 68	34		09/23/22
	starting at approximat (Unit Manager) stated recently moved to her inappropriately touchi first floor. The employ provided education to inappropriate behavio not have documented provided. The employ monitored [Resident # positioned near his ro asked with those inter your staff ensure Res Resident #126's sexu non-consensual sexu did not provide an ans Cross Reference 42 ( 2. The facility's staff factors	staff about Resident #126 or? said, "Yes", but she did l evidence of the education wee stated that staff #126] hourly and was from. The employee was rventions in place how did ident #145's safety from al behavior [willful al contact]? The employee swer.				

Event ID: FZSW11

Facility ID: HCI

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 08/12/2022 FORM APPROVED B NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		095015	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	10/28/20 with multiple Contracture of Left Ha Hemiparesis following Affecting Left Non-Do Coordination and Wea Review of the medica following: 04/05/22 [Quarterly M that restorative service inducating the resient restorative nursing se assessment. 04/06/22 [physician of OT (occupational ther achieved highest prace on RNP (restorative n (times) a week for 15 Review of the compre- the following. Focus area - Residen resting/hand splinting, upper extremity to pre- contracture Intervention - Discont redness, swelling, bru- staff will assist with da Observations on 06/1 approximately 10:00 / showed Resident #28	mitted to the facility on e diagnoses including and, Hemiplegia and g Cerebral Infarction minant Side, Lack of akness. I record revealed the linimum Data Set] revealed es was not coded was not receiving rvices at the time of the rder] - "Discontinue skilled apy) as a patient has stical level. Patient will start ursing program) 3-5 x minutes. Thensive care plan showed t on restorative nursing for /palmar guard to the left event further left-hand inue and refer back to OT if ising notedrestorative aily exercise as per order.	F 684	Resident #354 PICC line dressi changed immediately on 6/14/2 notified. Resident was reassess to toe on 08/17/22 by licensed b suffered no negative outcomes. Resident #138 is being encoura to turn and reposition every two tolerated and is ongoing. Reside reassessed from head to toe or licensed nurse. Resident did no negative outcome. CNA is being proper documentation every tim provided. Resident #102 was reassessed toe on 08/17/22 by licensed nur suffered no negative outcome. The resident care sign-in sheet immediately implemented. Staff when care is rendered.	2 after being sed from hea burse and aged/assisted hours and a ent 0.08/17/22 by of suffer any g educated on he care is d from head to rse. Resident was	d d is / in

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING \_\_\_\_ С 095015 B. WING 06/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1380 SOUTHERN AVE SE** SERENITY REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 09/23/22 F 684 Continued From page 103 F 684 The affected Resident #85 was During a face-to-face interview on 06/23/22 at immediately provided with one incontinent brief as standard of care. approximately 4:30 PM, Employee #3 (ADON) Resident was reassessed from head stated that the resident was not receiving to toe on 08/17/22 by licensed nurse. restorative nursing services because his name Resident did not suffer any was accidentally omitted from the facility's list of negative outcome. residents on the restorative nursing program. The The affected Resident #54 oxygen therapy employee stated that he would ensure resident was administered in accordance start services on 06/24/22. with physician order and parameters on 6/23/22 Resident was reassessed from head 3. The facility staff failed to follow the nurse to toe on 08/17/22 by Unit practitioner's recommendation for a psychiatric Manager/Designee, consult for behavioral disturbances [wandering in Resident #54 did not suffer any residents' rooms] for Resident #126. negative outcome. Resident #126 was admitted to the facility on The affected Resident #256 was 05/07/21 with multiple diagnoses including Major administered pain medication as ordered by the physician and parameters. Depressive Disorder and Dementia without Resident was reassessed from head Behavioral Disturbances. to toe on 08/17/22. Resident did not suffer any negative outcome. Review of the medical record Education was provided to the assigned licensed nurse on medication administration 06/13/22 at 1:47 PM [Nursing Note] - "...at 1200 according to physician orders and [12:00 PM] resident was observed wandering and parameters. pacing the hallway with his wheelchair, entering other resident's room, resident was redirected at all times by staff. NP (nurse practitioner) ... notified, recommends to monitor and redirect as required and psych consult for behavioral disturbances ... " Review of progress notes, consults, medication administration record. and treatment administration records from 06/13/22 to 06/17/22 lacked documented evidence that Resident #126 was evaluated by psych for behavioral disturbance of wandering in other residents' room [uninvited]. During a face-to-face interview on 06/21/22

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		MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		3	· · · ·	COMPLETED
						С
095015		B. WING	· · · · · · · · · · · · · · · · · · ·		06/29/2022	
NAME OF P			STREET ADDRESS, CITY, STATE, Z	P CODE		
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
						09/23/22
F 684			F 68	4		
	(Unit Manager)stated was not done. It should be noted tha in Resident 145's roo	tely 1:30 PM, Employee #21 I that the psych evaluation at Resident #126 wandered om on 06/17/22, and he sensual sexual contact with		IDENTIFICATION OF OT WITH THE POTENTIAL AFFECTED. All the residents in the fac potential to be affected.	TO BE	
	Cross Reference 42	CFR 483.12, F600				
	received treatment ar professional standard by failure to conduct skin assessment.	to ensure Resident #11 nd care in accordance with ds of practice as evidenced a complete and accurate mitted to the facility on				
	06/17/19 with diagnos	5				
	Review of Resident # revealed the following					
	04/18/22 showed tha resident as: severely potential indicators of not exhibited, extensi person physical assis dressing, toilet use an impairment on one si extremities, wheelcha incontinent of bladde	a Data Set (MDS) dated t facility staff coded the the cognitively impaired, no f psychosis, rejection of care ive assistance with one st for bed mobility, transfer, nd personal hygiene, de for upper and lower air for mobility device, always r, frequently incontinent of re injury, wounds and or				

Facility ID: HCI

If continuation sheet Page 105 of 184

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVEI 0. 0938-039
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, í			E SURVEY IPLETED
		095015			C 5/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
				1	380 SOUTHERN AVE SE	
SERENITY	REHABILITATION AND	HEALTH GENTER LLC		V	NASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page	e 105	F	684		09/23/22
	skin assessment by L	icensed Nurse every day				
		sday), Sat (Saturday)"			MEASURE TO PREVENT RECURRENCE:	
		05/05/22 showed [Resident				
		pressure ulcer development			The facility Staff Developer will	
	· · · ·	e process, limited mobility and protocols for the			provide education for the licensed	
	• •	nent of skin breakdown			nursing staff to ensure that residents	
		sturizer applied daily to my			received treatment and care per the comprehensive care plan and in	
	skin"				accordance with professional	
					standards of practice. The education will also	
		n Assessment -Licensed			include how to conduct a complete and accurat	
	Nurse] "Complete	No new skin issue."			skin assessment. Training will be completed by 09/23/22.	
	06/17/22 at 8:51 PM	[Skin Observation Tool			The facility Staff Developer/Designee will provid	10
	· /-	cumented, "right thigh (rear)"			education to the facility licensed nurses on the	10
		bserved a skin intergrity			importance of implementing the care plan	
	issue.				intervention for changing resident intravenous	
	06/17/22 at 8.51 DM	[Situation Background			line insertion site dressing. Training will be completed by 9/23/22.	
		t (SBAR)] " Situation				
	•	ith wound on right thigh			The facility Staff Developer/	
		tinent care at 8:45 pm, writer			Designee will provide education to the facility nursing staff (licensed nurses and Nursing	
	was notified by CNA	(Certified Nurse Aide) of			Assistants) on the importance of ensuring that	
		esident's right thigh (rear)			residents with limited range of motion received	
	( <b>U</b> )	centimeters) X W (width) =			appropriate treatment and services to prevent	
	0.6cm. scanty drainag	ge noted from site"			further decrease in range of motion and educate staff on the importance of providing restorative	
	06/21/22 [Tisque Ana	lytics] "Wound Location:			nursing services as ordered by the physician.	
		Wound status - new.			Training will be completed by 09/23/22.	
		es. Etiology - abscess"			In-service will be provided by Staff	
					Development /designee to all facility staff	
		ew was conducted on			about care plan intervention in place for	
	06/27/22 at 10:55 AM				residents with sexual behavior, behavior	
		ho completed the weekly			with the potential to abuse others, and wandering behavior.	
		ed 06/16/22. When asked sment she documented as				
		e #8 stated, "I couldn't do a				
		because the resident				

Facility ID: HCI

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING _				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE		
				N	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	The night shift got her the chair. I document able to see." Employed did not observe Resid part of the weekly skii completed on 06/16/2 The evidence showed ensure Resident #11 in accordance with pr practice. 5. Facility staff failed to restorative nursing se physician. Resident #32 was add 03/27/20 with multiple Muscle Weakness, C Alzheimer's Disease. Review of Resident # revealed the following A Quarterly Minimum 05/13/22 where staff of moderately impaired of assistance with two p bed mobility, transfers hygiene, range of mor lower extremities, who received occupationa 04/11/22 to 05/13/22. 05/13/22 [Occupation Summary] " Dischar Recommendations: R	<ul> <li>bed for the assessment.</li> <li>r washed, dressed and into ed just on the parts I was be #8 further stated that she lent #11's rear thigh area as in assessment she?</li> <li>d that facility staff failed to received treatment and care of essional standards of</li> <li>to provide Resident #32 with rivices as ordered by the</li> <li>mitted to the facility on ediagnoses that included: erebral Infarct and</li> <li>32's medical record g:</li> <li>Data Set (MDS) dated coded the resident as cognition, extensive ersons physical assist for s, toilet use and personal tion impairment on both eelchair mobility device and I therapy (OT) services from</li> </ul>	F	584	MONITORING CORRECTIVE ACTION: MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/De- will conduct house wide audit to identify p residents with sexual behavior to ensure proper comprehensive care plan and interventions are in place in accordance professional standards of practice. Audit done weekly times 4, then monthly times months. The facility ADON/Designee will complete wide review/audit of all facility residents to potential residents with limited range of m ensure residents receive restorative nurs services including the application of splim prevent further decrease in range of moti audit will be conducted weekly times 4, th monthly times 3. All findings will be correct Assistant Director of Nursing (ADON)/De- will conduct house wide audit to identify p residents on pain management to ensure assessment is completed and residents a treated in accordance with the Physician' and parameters. This audit will be conduc weekly times 4, then monthly times 3 monti- findings will be corrected. The Unit Manager/ Designee will complete house wide review/audit of residents to identify residents with Intravenous line to ensure that care plans interventions are properly implemented in care of the intravenous line insertion site dressing. This audit will be conducted we times 4, then monthly times 3 months. All will be corrected. The Unit Manager/ Designee will complete wide review/audit of all residents to identify residents to identify residents with Intravenous line to ensure that care plans interventions are properly implemented in care of the intravenous line insertion site dressing. This audit will be conducted we times 4, then monthly times 3 months. All will be corrected. The Unit Manager/ Designee will complete wide review/audit of all residents to identify residents with behavioral problems have consult and being seen by the Psychatris Designee. This audit will be conducted we times 4, then monthly times 3 months. All will be corrected.	otential that the with will be 3 bound bou	09/23/22

Facility ID: HCI

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING \_\_\_\_ С 095015 B. WING 06/29/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1380 SOUTHERN AVE SE** SERENITY REHABILITATION AND HEALTH CENTER LLC WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 09/23/22 F 684 The Unit Manager/ Designee will complete F 684 Continued From page 107 house wide review/audit of all weekly skin of performance and in order to prevent decline, assessments to ensure that the weekly skin development of and instruction in the following assessments are accurate and complete. All RNPs has been completed with the IDT negative findings will be corrected by 9/23/22. (interdisciplinary team): ROM (range of motion) This audit will be conducted weekly times 4, then active ... " monthly times 3 months The Unit Manager/ Designee will complete a 05/13/22 [Physician's Order] "D/C (discharge) review/audit of ADL care signing sheet in from OT services as highest functional level resident room to ensure ADL is provided on achieved. Pt (patient) to start on RNP for every shift according to physician order and the 3-5x/week to maintain function." signing sheet is visible in the resident room and signed by nursing assistant and licensed nurses. Review of the "Restorative Nursing Program This audit will be conducted weekly times 4, then monthly times 3 months. Resident List "provided to the surveyor on 06/21/22 at 9:20 AM, did not include Resident The Unit Manager/ Designee will complete house #32 as receiving RNP. wide review/audit of all incontinent residents to ensure that residents are provided with one During a face-to-face interview on 06/21/22 at incontinent brief as standard of care. This audit 9:26 AM, Employee #10 (Rehab Manager) stated, will be conducted weekly times 4, then monthly "[Resident #32] had no issues or complaints times 3 months. when we saw him during the latest round of OT. Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify potential He (Resident #32) participated and made residents on oxygen therapy to ensure oxygen is consistent progress. He was d/c to restorative administered to residents in accordance with the nursing. Education was provided to the nursing Physician's order and parameters. This audit will staff on the techniques and ROM to provide." be conducted weekly times 4, then monthly times 3 months. All findings will be corrected. Review of Resident #32's medical record on 06/21/22 showed there was no documented The Unit Manager/ Designee will complete house wide review/audit of all residents to evidence that restorative nursing services were identify residents with inaccurate comprehensive being provided since discharge from OT, plan of care to ensure that residents receive approximately 6 weeks (05/13/22 to 06/21/22). treatment in accordance to professional standards of practice. This audit will be During a face-to-face interview on 06/21/22 at conducted weekly times 4, then monthly times 3 10:38 AM, Employee #3 (Assistant Director of months. Nursing (ADON)/RNP Program Manager) acknowledged the finding and stated, "It was an The findings of these audits will be presented monthly for 3 months to Quality Assurance oversight on my part." Performance Improvement (QAPI) committee. 6. Facility staff failed to provide Resident #95 with her prescribed rehabilitative equipment (right

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: HCI

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 08/12/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING		_	06/2	C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #95 was obs the head of her bed th hand splint for 6-8 hor this observation, a rig hanging on the wall a plastic bag. During a face-to-face time of the observation Nurse Aide) stated, "T restorative aide applie During observations of 06/24/22 at 3:54 PM, the right hand splint. Resident #95 was add 11/16/18 with multiple Muscle Weakness, Co	ied in the resident's olan. In on 06/14/22 at 10:31 AM, served in bed with a sign at hat directed "Apply right urs daily" At the time of ht hand splint was noted above the bed in a clear, interview conducted at the n, Employee #9 (Certified The therapist or the es and removes the splint." on 06/21/22 at 12:16 PM and Resident #95 not wearing mitted to the facility on a diagnoses that included: erebral Vascular Disease, itus and Hypertension. 95's medical record	F 68		DEFICIENCY)		09/23/22
	06/02/21 [Physician's splint"	Order] "Right resting hand					
	restorative nursing for motion) to bilateral ex hand splint for 6-8hrs contractures Restor daily exercises as per	rative staff will assist with order"					
	A Quarterly MDS date	ed 05/31/22 showed facility					

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	ON	IB NC	APPROVED 0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· ,	A. BUILDING			COMPLETED	
		095015	B. WING			06/29/2022		
					STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE	Ξ		
SERENIT	( REHABILITATION AND				WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 684	with two persons phy toilet use and person impairment on both s extremities and receiv 04/19/22 to 05/31/22. 06/01/22 [Occupation Summary] " Discha RNP to facilitate pa level of performance decline, development following RNPs has b : bed mobility and R ( brace care" Review of the "Resto Resident List" docum on 06/21/22 at 9:20 A as receiving RNP for splint. Review of Resident # there was no docume staff was applying the specified by the phys During a face-to-face 06/24/22 at approxim acknowledged the fin comments. 7. Facility staff failed physician's order whe medication.	ent #95 as severe totally dependent on staff sical assist for bed mobility, al hygiene; range of motion ides for upper and lower ved OT services from al Therapy Discharge rge recommendations: tient maintaining current and in order to prevent of and instruction in the been completed with the IDT right) H (hand) splint or rative Nursing Program ent provided to the surveyor M, did not list Resident #95 the right hand resting hand 95's medical record showed ented evidence that facility e right hand splint as ician's order and care plan. interview conducted on ately 4:00 PM, Employee #3 dings and made no to follow Resident #133's	F	68	4			09/23/22
		amitted to the facility on ses that included: Pain in						

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING _				C / <b>29/2022</b>
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	on 06/15/22 at 8:46 A that his pain level was Employee #11 (Regis proceeded to adminis pain reliever) - APAP (milligram) 1 tablet by Review of Resident # revealed the following 05/27/22 [Physician's pan reliever) Patch 72 (micrograms)/HR (ho transdermally one tim pain management an 05/28/22 [Physician's (pain reliever) Tablet mouth one time a day wound care" 05/30/22 [Physician's "Oxycodone-Acetami (Percocet) (Give 1 tal day for Pain [level of A Significant Change dated 06/06/22 show Brief Interview for Me score of 15, indicating intact cognitive respo and PRN (as needed experienced pain occ	Kidney Failure. administration observation M, Resident #133 stated s "6" on a scale of 1 to 10. stered Nurse) then ster Oxycodone (narcotic (Acetaminophen) 5-325 MG y mouth to Resident #133. additional record g: Order] "Fentanyl (narcotic 2 Hour 25 MCG ur) Apply 1 patch he a day every 3 day(s) for d remove per schedule" Order] "Acetaminophen 500 MG Give 2 tablet by y for Pain 30 minutes prior to Order] nophen Tablet 5-325 MG blet by mouth two times a ] 7-10" Minimum Data Set (MDS) ed that facility staff coded: a intal Status (BIMS) summary g that the resdeint had an nse, received scheduled ) pain medication and	F 6	584			09/23/22

Facility ID: HCI

If continuation sheet Page 111 of 184

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT		CONSTRUCTION	OMB NC	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
		005045					С
		095015	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	06/	29/2022
NAME OF PI	ROVIDER OR SUPPLIER				REETADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
							09/23/22
F 684	Continued From page	e 111	F	684			
		algesic medications as . Review for pain medication					
	Review of the June 2	022 Medication					
		d (MAR) showed that facility					
		ycodone-Acetaminophen					
	Tablet 5-325 MG 1 ta	blet as followed:					
	06/01/22 at 9:00 AM	and 6:00 PM - Pain level =5					
		and 6:00 PM Pain level =0					
		Pain level =6 and 06/04/22					
	at 6:00 PM Pain level	= 4					
		and 6:00 PM Pain level =0					
		Pain level =2 and 06/06/22					
	at 6:00 PM Pain level	and 6:00 PM Pain level =3					
		and 6:00 PM Pain level =0					
		and 6:00 PM Pain level =0					
	06/10/22 at 9:00 AM	Pain level =2 and 06/10/22					
	at 6:00 PM Pain level						
		and 6:00 PM Pain level =0					
		and 6:00 PM Pain level =0 and 6:00 PM Pain level =0					
		Pain level =2 and 06/14/22					
	at 6:00 PM Pain level						
	06/15/22 at 9:00 AM	Pain level =6 and 06/15/22					
	at 6:00 PM Pain level						
	06/16/22 at 9:00 AM	Pain level =4					
	-	interview conducted on					
	06/16/22 at 9:45 AM,	· ·					
	acknowledged the fin	isk, he (Resident #133) says					
		er but I know it's not possible					
	-	ng on medically. He has a lot					
	of wounds. I know the	e pain level he's saying is not					
	possible."			1			1

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) D	DATE SURVEY OMPLETED
		095015	B. WING				C 06/29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC	- 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	follow the physician's Resident #133's narce evidenced by licensed Percocet when the re- than 7 on the pain sca 8. Facility staff failed interventions for char- central line dressing of According to the Cem (CDC), "Replace dr CVC (central venous 7 days" https://www.cdc.gov/i i/index.html#rec6 During an observation Resident #354 was o intravenous (IV) antib- inserted central cathe- stated, "I told the staff dressing. It has not be put in in the hospital." the dressing was note in bold, black ink. Review of Resident # revealed the following Resident #354 was a 06/10/22 with diagnos and Inflammatory Re- Joint Prosthesis.	d that facility staff failed to order for administering otic pain medication d staff administering sident's pain level was less ale. to follow the care plan aging Resident #354's every seven (7) days. ters for Disease Control essings used on short-term catheter) sites at least every nfectioncontrol/guidelines/bs n on 06/14/22 at 10:40 AM, bserved receiving iotics via a peripherally eter (PICC). The resident f they needed to change the een changed since it was ' Upon closer observation, ed to have the date "6/6/22"	F	684	4		09/23/22

Facility ID: HCI

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-		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
		095015	B. WING				29/2022
NAME OF PROVIDER OR SU	PPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY REHABILITA	TION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE NASHINGTON, DC 20032		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
every 7 day (every) shift 06/11/22 at "Late Entry and left sho 06/11/22 [Pl arm and cal Practitioner symptoms) complication The evidend change the #354's inset the care pla During a fac 06/14/22 at Nurse) ackr didn't notice changed. I v 9. The facili Resident #1 08/20/21, w Chronic Res Diabetes Ma Pressure UI Weakness a and Mobility	10:43 AM Admitte ulder surg hysician's I MD (me ) for bleed of infections is every s ce showed transpare tion site of n. ce-to-face 11:10 AM iowledged that the of will chang ty staff fail 38 accord 38 was a ith multipl spiratory I ellitus with cer of Sa and Unspir do 5/17/2	dressing on insertion site tor right upper line picc line q I [Nurses Progress Note] ed with right upper picc line gical wound" • Order] "Observe right upper dical doctor)/NP (Nurse ding, swelling s/s (signs and on or any IV related shift" d that facility staff failed to ent dressing to Resident every 7 days as specified in Interview conducted on I, Employee #5 (Registered d the finding and stated, "I dressing was due to be	F	684			

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,				PLETED
							С
		095015	B. WING			06/	29/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE		
	I				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page Section C (Cognitive Mental Status (BIMS) indicating intact cogni Section G (Functiona "Limited assistance" r physical assist", trans requiring "One-person "Limited assistance" r physical assist" Personal hygiene "Ex requiring "One-person Bathing "Total depend Mobility devices "Whe Section M (Skin Cond the resident as having pressure ulcer Review of the care pla a focus area of "[Resi (Activities of Daily Liv related to respiratory Interventions included to reposition frequent Review of the TAR (T Record) dated from 0 lacked documented s and repostioning of R	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	Survey Report v2" wh health record where t Aides) document ADL	ent titled "Documentation nich is part of the electronic he CNA's (Certified Nurse _ care including turning and ts dated 05/15/22 through					

Facility ID: HCI

If continuation sheet Page 115 of 184

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 08/12/2022 FORM APPROVED B NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		095015	B. WING			C 06/29/2022		
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		138	REET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	facility staff turned or on the following days 05/15/22 05/24/22 05/26/22 05/28/22 05/29/22 05/31/22 06/01/22 06/04/22 06/09/22 06/11/22 06/15/22 06/15/22 06/18/22 06/20/22 06/21/22 06/26/22 Facility staff either do indicates "no" the res repositioned or they of indicates not applicate During a face-to-face 06/27/22 at 10:30 AM Director of Nursing) s repositioning) are sup Resident's care is a p 10. Facility staff failed to complete a sign-in room every time care Review of a Complain (Department of Health "[Resident #102] says	documented evidence that repositioned Resident #138 : : : : : : : : : : : : : : : : : : :	F	684				

If continuation sheet Page 116 of 184

	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED NO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		095015	B. WING			C 06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 684	addressed during a ca Resident #102 was an 07/30/20, with multipli- the following: Adult Fa Ulcer of Sacral Regio Unspecified Joint, Co Contracture Left Knee Malnutrition and Muso Review of the Quarter (MDS) dated 06/02/22 coded the following: Section C (Cognitive Mental Status Summa intact cognition. Section E (Behavior): -Presence & Frequen exhibited Section G (Functional "Extensive Assistance physical assist" Transfer "extensive as "Two-person physical Dressing "Extensive a "Two-person physical Eating "Supervision" n	Some of this issues were areplan meeting" dmitted to the facility on e diagnoses that included ailure to Thrive, Pressure n, Stage 3, Contracture ntracture Right Knee, e, Moderate Protein Calorie cle Weakness. rly Minimum Data Set 2, revealed facility staff Patterns): Brief Interview for ary Score "15" indicating Rejection of Care cy "0" Behavior not I Status): Bed mobility e" requiring "Two-person ssistance" requiring assist" assistance" requiring assist" requiring "Set-up help only" assistance" requiring "One st"	F 68	34			

Event ID: FZSW11

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		095015	B. WING				29/2022
NAME OF P	ROVIDER OR SUPPLIER	L	_	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	room each time care Observation of reside 06/24/22 at approxim did not observe a sign During a face-to-face 06/24/22 at approxim (Assistant Director of surveyor where was t fill in after care is rend "I cannot find it at the 11. The facility staff fa comprehensive and p in accordance with pr placing 2 incontinent Review of a Facility F received by DOH (De 06/17/22, concerning "During incontinent the assigned CMA [C of a new open area Resident #85 was ad 09/18/18, with multipl the following: Other S	n physical assist" dence" ans' orders revealed: n signing sheet in residents' is rendered" ent's room was conducted on ately 12:30 PM, the surveyor in sheet for ADL care. interview conducted on ately 1:00 PM, Employee #3 Nursing) when asked by the he sign in sheet for staff to dered? Employee #3 stated bedside." alled to provide person-centered care that is ofessional standards by briefs on Resident #85. Reported Incident (FRI) epartment of Health) on Resident #85, documented /perineal care at 4:00 pm by NA] staff , writer was notified	F	684			
	-	conducted on 06/27/22 at 35 was observed in bed and					

		MEDICAID SERVICES	(X2) MI II 1		E CONSTRUCTION		D. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	PLETED	
							С	
		095015	B. WING	_		06/29/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 118	É F	684				
		e. Resident was observed						
	Review of the Quarterly Minimum Data Set (MDS) dated 04/11/22, revealed that facility staff coded the following: Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) summary score "99" indicating resident unable to complete the interview. Section G (Functional Status): Toilet Use							
	"Extensive assistance physical assist"	e" required "One-person (tensive assistance" required						
	toileting program bee admission/entry or re	entry since urinary ed in this facility?" "No" Always incontinent"						
	06/27/22 at 4:20 PM, Manager 3rd floor) ac stated "That's not our	cknowledged the finding and practice." d to administer Resident #54						
	01/08/21 with diagno							
		n on 06/23/22 at 12:12 PM, /ake, resting comfortably,						

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C 1 <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	<ul> <li>with non-labored breareceiving supplement nasal cannula at a rate</li> <li>A Quarterly Minimum 04/25/22 showed in SPatterns) that facility resident as having a EStatus summary scort that the resident had In Section G (Functio documented that Resassistance with one p for bed mobility and w required assistance fit transfers. ADD O2 see Review of Resident #revealed:</li> <li>05/20/22 [Physician's (oxygen) at 2 L(liters) (shortness of breath)</li> <li>05/22/22 [Care Plan] has diagnosis of COF bronchopneumonia; nebulizer treatments a ordered."</li> <li>A review of Resident the follow levels from 06/23/22: air; 5:24 AM, 98% or on oxygen via nasal compared the follow levels for other for the follow levels for the f</li></ul>	athing. The resident was al humidified oxygen via te of 5 liters per minute. Data Set (MDS) dated Section C (Cognitive staff documented the Brief Interview for Mental e (BIMS) of "00," indicating severely impaired cognition. nal Status), facility staff ident #54 required extensive person physical assistance vas totally dependent and rom one staff person for action. 54's medical record Order] directed, "O2 /min(minute) for SOB or respiratory distress." Focus area: [Resident # 54] PD exacerbation, acute Interventions:Give and oxygen therapy as 54's Vital Signs Report wing oxygen saturation at 2:06 AM, 98% on room in room air; 10:42 AM, 97%	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING			( 06/:	_ 29/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE	-	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	<ul> <li>#54 was receiving 5 li The employee then st is too high," and the e resident's oxygen rate</li> <li>13. Facility staff failed Resident #256 in acco order.</li> <li>Resident #256 was ac 06/10/2022 with diagr Osteoarthritis of Hip, I of Bladder and Clostri</li> <li>According to the physion 06/12/2022 the reside</li> <li>HCI (used to relieve m severe pain) 50 mg of hours as needed for pain Review of the controll record for Resident #2 receive Tramadol 50 me every 8 hours as needed and count received fr</li> <li>Review the physician 50 mg take 1 tablet by needed for pain 6-10.</li> <li>Review of the Medicaa (MAR) showed that a that she gave Resided 06/13/22 at 17:07 how level recorded; and on</li> </ul>	cknowledged that Resident ters of oxygen per minute. ated, "Oh, the oxygen level imployee turned down the e to 2 liters oxygen. to administer Tramadol to ordance with the physician's dmitted to the facility on noses that included Neuromuscular Dysfunction dium Difficile. ician's order dated ent is to receive Tramadol noderate to moderately ne tablet by mouth every 8 vain 6-10 in scale. ed drug administration 256 showed she was to mg one tablet by mouth ded for pain 6-10 in scale; om the pharmacy was 30. s order directed, "Tramadol y mouth every 8 hours as " tion Administration Record facility staff nurse signed nt #250 Tramadol on vever there was no pain n 06/16/22 at 11:12 facility	F 684				
		n 06/16/22 at 11:12 facility ident's pain level as 5 of 10.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED IO. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		095015	B. WING		0	C 6/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page		F 68	84		
		ned that they removed the I) and administered it to the ing dates:				
	06/16/22 at 11:12 AM the recorded pain leve	1 tab was given - however el was 5				
	approximately 11:00 A the documents and ad					
F 686 SS=E	Treatment/Svcs to Pro CFR(s): 483.25(b)(1)(	event/Heal Pressure Ulcer ′i)(ii)	F 68	86		
	resident, the facility m (i) A resident receives professional standard	re ulcers. hensive assessment of a nust ensure that-				
	demonstrates that the (ii) A resident with pre necessary treatment a with professional stan	and services, consistent idards of practice, to /ent infection and prevent				
	This REQUIREMENT by: Based on observation interviews, for five (5) facility staff failed to e received care consist standards of practice	n, record review and staff of 67 sampled residents, nsure that residents ent with professional for pressure ulcers as b: perform weekly skin				

Facility ID: HCI

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1380 SOUTHERN AVE SE		
SERENIII	(REHABILITATION AND	HEALIH CENTER LLC	,	WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 686	<ul> <li>(2) residents at an ad #4, #56, #84, #138, a</li> <li>The findings included</li> <li>1. Facility staff failed assessments for Res</li> <li>Resident #4 was adr 05/23/22 with multiple</li> <li>Pressure Ulcer Sacra</li> <li>Diabetes Mellitus with and Muscle Weaknes</li> <li>Review of the Admiss (MDS) dated 05/27/2</li> <li>staff coded the follow</li> <li>Section C (Cognitive Mental Status (BIMS) indicating severely in</li> <li>Section G (Functiona "Extensive assistance physical assist"</li> <li>Dressing, "Total depe"</li> <li>"One-person physica</li> <li>Personal hygiene, "To "One-person physica</li> </ul>	uired pressure ulcers for two lvanced stage. (Residents' and #257) I: to perform weekly skin ident #4. mitted to the facility on e diagnoses that included: al Region Stage 4, Type 2 h Unspecified Complications, ss. sion Minimum Data Set 2, revealed that the facility ring: Patterns): Brief Interview for ) Summary Score "02" hpaired cognition. Il Status): Bed Mobility, e" requiring "Two-person endence" requiring I assist" hendence" requiring I assist" total dependence" requiring I assist" Lower extremity "Impairment and Bowel): Indwelling	F 686	F686 CORRECTIVE ACTION FOR	ed nurse, e. d skin erved. e. d toe 22 by erved. e. d to toe 22 by erved. e. d to toe 22 by erved. e. d to toe 22 by erved. e. d to sheet ensed ment 22 sed nurse kin	09/23/2

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED O. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		095015	B. WING		06	C / <b>29/2022</b>
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	Section M (Skin Cond coded that resident h pressure ulcers that v one (1) unstageable p admission and moistu Review of the physici following: 05/21/22 "Weekly skin nurs day shift every 05/23/22 "Wound to r normal saline apply n dressing every day shift cleanse with normal s honey and covered (s daily. Every day shift. Review of the care pl "admitted with Pressu unstageable wound to immobility, incontiner sacral" initiated on 05 following intervention treatment as ordered Resident #4's medicae evidence that facility s assessments from 06 ordered by the physic During a face-to-face 06/28/22 at approxim #3 (Assistant Director	ditions): The facility staff as two (2) stage three vere present on admission, pressure ulcer present on ure associated skin damage. ans' orders revealed the in assessment by licensed y fri (Friday)." ight buttock: cleanse with hedihoney and cover with dry hift." um Unstageable wound saline, pat dry apply Medi sp) with bordered gauze " an with a focus area of: ure Ulcer to sacral oright buttock r/t (related to) ice, Stage 4 pressure to b/24/22, included the s: "Administer preventive by physician" al record lacked documented staff conducted weekly skin by following of 28/22, as cian. interview conducted on ately 12:30 PM, Employee of Nursing) acknowledged id, "They [Weekly Skin	F 686	5 F686 IDENTIFICATION OF OTHERSWITH POTENTIAL TO BE AFFECTED: All the residents in the facility have th potential to be affected.		09/23/22

Facility ID: HCI

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	9 124	F	686	F686		09/23/22
	performed ongoing sk Resident #56, subsect developed a pressure was first observed at Resident #56 was rea 08/30/19 with diagnos Vascular Disease, an Pulmonary Disease. The physician's order "weekly skin assessm day shift every [Wedr Review of the Admiss (MDS) dated 04/06/22 staff coded the follow Section C (Cognitive Mental Status (BIMS) indicating severely im Section G (Functiona assistance" requiring assist" for Bed mobil hygiene. Upper and lower extra sides" Section M (Skin Cond coded that resident has pressure ulcer; the re ulcers, is on a pressure ulcers of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of the comparison of	auently the resident a ulcer to his left heel that a Stage 3. admitted to the facility on ses that included Peripheral d Chronic Obstructive a dated 08/30/19 directed, nent by licensed nurse every nesday]" dion Minimum Data Set 2, revealed that the facility ing: Patterns): Brief Interview for Summary Score "04" apaired cognition. I Status): "Extensive "Two-person physical ity, Transfer, and Personal emity "Impairment both ditions): The facility staff as one (1) stage three sident is at risk for pressure re reducing device for bed,			MEASURE TO PREVENT RECURRENCE: The facility Staff Developer/designee w provide education/ in-services to the facilicensed nurses to ensure residents red care consistent with professional standar practice and importance of completing a assessments and implementing ongoin assessment as ordered by physician. T be completed by 9/23/22. MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit to identify residents that are missing that facility licensed nurses failed to implement we skin assessment and documentation as ordered by the physician; and ensuring Residents receive care consistent with professional standards of practice. Any found during this audit will be addresse 09/23/22 The findings of these audits will be prese monthly for 3 months to Quality Assurat Performance Improvement (QAPI) com	elity eive ards of skin g skin his will ekly issue d by ented nce	

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/12/2022 RM APPROVED NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		095015	B. WING			C 6/29/2022
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, 2		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 686	shift." Review of the Tissue J 05/25/21 revealed: loc status-healed; Etiolog Review of the Skin Sv showed the following: 04/04/22 - Skin inspec blank (indicating the r areas to his skin). Th certified nurse aide ar signature indicating the resident's skin. 04/07/22 - Skin inspec blank (indicating the r areas to his skin). Th certified nurse aide ar indicating the licensed resident's skin. 04/11/22- Skin inspec blank (indicating the r areas to his skin). Th certified nurse aide ar signature indicating the r areas to his skin). Th certified nurse aide ar signature indicating the observed the resident 04/14/22- Skin inspec blank (indicating the r areas to his skin). Th the certified nurse aide nurse signed indicatin resident's skin.	t for pressure relief every Analytics form dated cation - left heel; wound y-Blister. weep/Shower sheets cted and shows - was left esident had no new open e sheet was signed by the nd lacked a licensed nurse's nat she observed the cted and shows - was left esident had no new open e sheet was signed by the nd the licensed nurse d nurse observed the tted and shows - was left esident had no new open e sheet was signed by the nd the licensed nurse d nurse observed the	F 686			09/23/22
	-	esident had no new open				

Facility ID: HCI

If continuation sheet Page 126 of 184

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095015	B. WING		_		C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	certified nurse aide ar signature indicating the observed the resident Review of the skin assisterevealed "Reopend normal saline, pat dry cover with dry dressin Review of the Tissue 04/19/22, revealed: "In wound acquired- 04/1 slough-40%, Depth 0. status- reopened; Etic The physician's order "Wound to left heel (Finormal saline, pat dry cover with dry dressin Although the Tissue A that the pressure ulce on 04/18/22, there is a the medical record of 04/19/22. During a face-to-face #41 (Wound Nurse) of stated, "He [Resident prone to blisters. The Tissue Injury) and is r ulcer), it is clean." There was no evidence performed ongoing as #56's left heel, subset	e sheet was signed by the ad lacked a licensed nurse's nat a licensed nurse had not 's skin. sessment dated 04/19/22 ed left heel, cleanse with and apply medi honey and g" Analytics form dated boation - left heel; Date 8/2022; granulation - 60%, 10 centimeter; wound blogy-pressure stage 3" dated 04/19/22 directed, Reopened): Cleanse with y and apply medi honey and g" analytics form documented r on the left heal re-opened no documented evidence in treatment orders until interview with Employee n 06/21/22 at 1:09 PM she #56] has bunions and is eleft heel was a DTI (Deep now a stage 3 (Pressure exe that a licensed nurse sessments of Resident quently his left heal wound served on 04/18/22, as a	F 68	5			

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095015	B. WING			_		C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 200	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	127	F	686				
		ith Employee #2 (Director of at 10:46 AM, she reviewed ade no comment.						
	3. Facility staff failed t assessment for Resid	o perform weekly skin ent #84.						
	received by DOH (De 09/20/21, concerning A complete head to	eported incident (FRI) partment of Health) on Resident #84 documented " toe assessment done upper back and sacral area. sacral, area"						
	05/20/21, with multiple Type 2 Diabetes Melli	mitted to the facility on e diagnoses that included: tus Without Complications, paresis following Cerebral						
	Review of the Quarter (MDS) dated 02/18/22 coded the following:	rly Minimum Data Set 2, revealed that facility staff						
		Patterns): "Should a Brief itatus be Conducted? "No" s not assessed.						
		Status): Bed Mobility, " requiring "One-person						
	Transfer, "Extensive a "Two-person physical							
	Toilet use, "Extensive "One-person physical	· •						

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		095015	B. WING				0 29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Personal hygiene, "E: requiring "One-person Bathing "Total depend Upper extremity "Imp Lower extremity "Imp Section M (Skin Cond resident as being at r ulcers/injuries and as pressure ulcer that wa admission. Review of the physici following: 04/06/22, " licensed nurse day (Wednesday)" Review of the care pl "[Resident #84] has p integrity r/t (related to date of 05/23/22, had "Treatment to be dom The medical record la that weekly skin asse the following dates: 0 to 05/03/22 and 05/05 During a face-to-face 06/23/22 at 3:00 PM, Manager 2nd floor) ar and stated "A nurse g and whatever they set	xtensive assistance" n physical assist" dence" airment on one side" ditions): Facility staff coded isk of developing pressure having one (1) unstageable as not present on an's orders revealed the Weekly skin assessments by y shift every Wed an with a focus area of botential impairment to skin o) fragile skin" initiated I the following interventions e per MD order," acked documented evidence essments were completed on 4/06/22 to 4/19/22, 04/21/22 5/22 to 06/21/22. interview conducted on Employee #33 (unit cknowledged the findings goes and checks the skin ee they document."	F	586			
	-	to perform weekly skin					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 // APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		095015	B. WING				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1380 SOUTHERN AVE SE		
SERENIII	REHABILITATION AND	HEALTH CENTER LLC			WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	2 129	F	686	6		
	Resident #138 was at 08/20/21 with multiple Chronic Respiratory F Diabetes Mellitus with Pressure Ulcer of Sac Weakness and Unspe- and Mobility. Review of the Quarter (MDS) dated 05/17/22 coded the following: Section C (Cognitive Mental Status (BIMS) indicating intact cogni Section G (Functional "Limited assistance" r physical assist" Transfer "Limited ass "One-person physical Toilet use "Limited ass "One-person physical Personal hygiene "Ex requiring "One-persor Bathing "Total depend Mobility devices "Whe Section M (Skin Cond the resident as having pressure ulcer Review of the physical following: 08/20/21, d assessment by licens (Tuesday)"	dmitted to the facility on diagnoses that included, Failure with Hypoxia, Type 2 n Diabetic Neuropathy, cral Region Stage 3, Muscle ecified Abnormalities of Gait rly Minimum Data Set 2 revealed that facility staff Patterns): Brief Interview for summary score "15" ition. I Status): Bed mobility requiring "One-person istance" requiring assist" sistance" requiring assist" tensive assistance" n physical assist" dence" eelchair" ditions): Facility staff coded g one (1) stage three ans' orders revealed the					
		b) fragile skin, decreased ted of 08/21/21, had the					

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		095015	B. WING				29/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 686	following interventions per order" The medical record la evidence that the faci assessments for Resi through 05/30/22. During a face-to-face 06/27/22 at 10:30 AM Director of Nursing) w assessments were per resident and where w #3 acknowledged the further comment. 5. Facility staff failed for received care consist standards of practice of a pressure ulcer (S Resident #257 was are 11/19/21 with diagnoss Osteomyelitis of Left A Diabetes Mellitus with Vascular Disease. Review of Resident # revealed the followings 04/06/22 at 10:09 AM "Resident re-admitt diabetic ulcer, absent	s " Treatment to be done acked any documented lity staff did weekly skin ident # 138 from 05/07/22 interview conducted on l, Employee #3 (Assistant vas asked if weekly skin erformed in May 2022 for the ere they located? Employee findings and made no to ensure Resident #257 ent with professional to prevent the development itage 3). dmitted to facility on ses that included: Acute Ankle and Foot, Type 2 n Foot Ulcer and Peripheral 257's medical record	F	68				
	"Resident re-admit diabetic ulcer, absend necrotic tissue measu 1.71cm, left second to	ted on 04/06/22 with left foot ce of left toe, right lateral foot						

Facility ID: HCI

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	: 08/12/2022 APPROVED . 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		(X3) DATE S COMPL	SURVEY _ETED
	095015	B. WING		_	06/2	; 29/2022
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SERENITY REHABILITATION AND HE	EALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 200	)32		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 Continued From page 1 Review of physician's of following: 04/06/22 "Weekly skin a nurseday shift every V	rders revealed the assessment by licensed	F 68	6			
04/06/22 "Apply moistur lubrication every day sh Care Plan updated on 0 has potential for pressu (related to) decreased r incontinence Monitor, any changes in skin sta weekly and as needed b Care Plan updated on 0 has an ADL (activities o performance deficit r/t g totally dependent on sta twice weekly and as need inspection. Observe for scratches, cuts, bruises 06/01/22 [Weekly Skin A skin impairment: none . not observe any skin int Resident #257. A Quarterly MDS dated staff coded: moderately rejection of care, extens person physical assist fo personal hygiene, impai lower extremities, alway and bladder, 2 unstages	rizing lotion daily for skin ift" )4/13/22 " [Resident #257] re ulcer development r/t nobility, fragile skin and /document/report PRN tus Skin assessment by licensed nurse" )4/13/22 [Resident #257] f daily living) self-care generalized weakness aff to provide bath/shower cessary requires skin redness, open areas, and report changes" Assessment] "Describe " indicating the nurse did tegrity concerns for 06/03/22 where facility impaired cognition, no sive assistance one or bed mobility and irment on both sides for					

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	06/06/22 at 2:51 PM   Assessment, Reques wound on coccyx D 2:45 pm, writer was m Nurse Aide) staff assi opening area on cc L=0.87cm X W= 0.55 noted from sites" 06/06/22 at 2:51 PM   Coccyx wound 0.87 06/07/22 at 10:40 AM Comprehensive skin a sacrum stage 3 press 06/10/22 at 1:02 PM   Note] " Pressure ul 0.87 cm width 0.55 cr acquired" Review of the form "L List" (not dated) provi 06/23/22 showed that schedule for a bath/sl Thursday. During a face-to-face 11:05 AM, Employee stated, "Skin sweep a scheduled shower da completed by the CN sheet, then it [skin sw done."	Situation, Background, t] "Situation: Observe uring incontinent care at otified by CNA (Certified gned to resident of an occyx which measure cm. Moderate drainage Skin Observation Tool] " cm 0.55cm" I [Skin/Wound Note] " and wound evaluation oure ulcer" Wound/Pressure Ulcer cer/Stage 3 sacrum length in depth 0.1 cm in house Unit 3 Resident Bath/Shower ded to the surveyor on t Resident #257 was on the hower every Monday and interview on 06/23/22 at #12 (Registered Nurse) issessments are done on ys. A skin sweep form is A and nurse. If there's no reep assessment] wasn't 257's medical record lacked	F	686			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING			06/	) 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
	SLIMMARY ST	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	K	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	133	F	686			
	bath/shower day.						
	-	ocumentation showed that ed a bed bath (BB) every 06/05/22.					
	(TAR) showed that fac area that directed, "A for skin lubrication eve	ent Administration Record cility staff initialed in the oply moisturizing lotion daily ery day shift" from 06/02/22 ndicating that the task was					
	(06/02/22 to 06/05/22 failed to document an Resident #257's skin.	that for a period of 4 days ), the facility's nursing staff d report any changes in Subsequently, Resident ith a Stage 3 pressure ulcer 06/22.					
F 688 SS=D	11:39 AM, Employee acknowledged the fine should not be found w stages (Stage 3). The document and report Nursing staff have be documenting on the S shower days. If the re shower or the skin sw documented on the for Increase/Prevent Dec	ding and stated, "Resident's vith wounds at advanced CNA's and nurses know to any changes to the skin. en educated on skin Sweep Sheet on sident refuses the bath, eep, it should be rm and in a [nurse's] note." rease in ROM/Mobility	F	688			
	resident who enters the	ility must ensure that a ne facility without limited not experience reduction in					

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		095015	B. WING _				/29/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI> TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A resid motion receives appro- services to increase r prevent further decrea §483.25(c)(3) A resid receives appropriate a assistance to maintail the maximum practica reduction in mobility is This REQUIREMENT by: Based on observatio interview for three (3) residents, facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of motion. Facility staff with limited range of r appropriate services fo of appropriate services fo	es the resident's clinical es that a reduction in range ble; and ent with limited range of opriate treatment and ange of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. is not met as evidenced n, record review and staff out of 67 sampled f failed to ensure residents motion received the to maintain or improve range ff failed to show evidence ng services were provided hat a resident received and multi-podus boots as tian to prevent worsening ints' #32, #95, and #102)	F6	\$88	CORRECTIVE ACTION TO THE AFFECTED RESIDENT: The facility cannot retroactive correct this deficiency. The affected Resident #32 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident clinically stable Resident #32 did not suffer a negative outcome. The affected Resident #95 was assessed from head to toe on 08/17/22 by Unit Manager/Designee, Resident is clinically stable.Resident # currently on Occupation The started 08/11/22. Resident #95 did not suffer a negative outcome.	as t#32 any as t #95 95 rapy	09/23/22

Facility ID: HCI

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMF	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 688	<ul> <li>initiate point click care placed on program</li> <li>1. Facility staff failed received appropriate maintain mobility evic restorative nursing sephysician.</li> <li>Resident #32 was ad 03/27/20 with multiple Muscle Weakness, C Alzheimer's Disease.</li> <li>Review of Resident # revealed the following A Quarterly Minimum 05/13/22 where staff cognition, extensive a physical assist for beuse and personal hygimpairment on both lomobility device and re (OT) services from 04</li> <li>05/13/22 [Occupation Summary] " Discha Recommendations: F Program)to facilitation of performance and in development of and i RNPs has been comp (interdisciplinary team active"</li> <li>05/13/22 [Physician's</li> </ul>	e list for each resident " to ensure Resident #32 services and assistance to denced by failure to provide ervices as ordered by the mitted to the facility on e diagnoses that included: cerebral Infarc and #32's medical record g: Data Set (MDS) dated coded: moderately impaired assistance with two persons d mobility, transfers, toilet giene, range of motion ower extremities, wheelchair eceived occupational therapy 4/11/22 to 05/13/22. hal Therapy Discharge rge Status and RNP (Restorative Nursing te maintaining current level n order to prevent decline, nstruction in the following	F 68	<sup>38</sup> IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents in restorative have potential to be affect		09/23/2

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	СОМ	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 688	3-5x/week to maintain Review of the "Resto document provided to 9:20 AM, did not list F RNP. During a face-to-face 9:26 AM, Employee # "[Resident #32] had r when we saw him du He (Resident #32) pa consistent progress. I nursing. Education w staff on the technique Review of Resident # 06/21/22 showed no restorative nursing se since discharge from (05/13/22 to 06/21/22 During a face-to-face 10:38 AM, Employee Nursing (ADON)/RNF acknowledged the fin oversight on my part. 2. Facility staff failed received appropriate maintain mobility evic resident's prescribed (right hand splint). During an observation Resident #95 was ob the head of her bed to hand splint for 6-8 ho	n function." rative Nursing Program" to the surveyor on 06/21/22 at Resident #32 as receiving e interview on 06/21/22 at #10 (Rehab Manager) stated, no issues or complaints ring the latest round of OT. urticipated and made He was d/c to restorative as provided to the nursing es and ROM to provide." #32's medical record on documented evidence that ervices were being provided OT, approximately 6 weeks e). interview on 06/21/22 at #2 (Assistant Director of P Program Manager) ding and stated, "It was an	F 68	<ul> <li>8 F688</li> <li>MEASURES TO PREVENT RECURRENCE: The facility Staff Developer/ Designee will provide an ed in-service to facility nursing The education will explain th ensuring that residents with motion received appropriate services to prevent further of of motion by 9/23/22.</li> <li>MONITORING CORRECTIN ACTION: The facility ADON/Designed complete house wide review facility residents to identify p residents with limited range the facility's staff failed to er appropriate treatment and s prevent further decrease in weekly times 4, then, month months.</li> <li>The findings of these audits monthly for 3 months to Qua Performance Improvement committee.</li> </ul>	ucation/ staff. he importance of limited range of treatment and decrease in range /E will v/audit of all of motion that hsure received ervices to range of motion hy times 3 will be presented ality Assurance	09/23/22

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		095015	B. WING			06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE :D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 688	above the bed in a cle During a face-to-face time of the observation Nurse Aide) stated, "T restorative aide applie During observations of 06/24/22 at 3:54 PM, not be wearing the rig observation, the right the head of her bed, i Resident #95 was add 11/16/18 with multiple Muscle Weakness, C Type 2 Diabetes Melli Review of Resident # revealed the following 06/02/21 [Physician's splint" 04/12/22 [Revised Ca restorative nursing for motion) to bilateral ex hand splint for 6-8hrs contractures Restor daily exercises as per A Quarterly MDS date facility staff coded the cognitive impaired, to two persons physical use and personal hyg	ear, plastic bag. interview conducted at the on, Employee #9 (Certified The therapist or the es and removes the splint." on 06/21/22 at 12:16 PM and Resident #95 was noted to ght hand splint. At each hand splint was observed at n a clear, plastic bag. mitted to the facility on a diagnoses that included: erebral Vascular Disease, itus and Hypertension. 95's medical record g: Order] "Right resting hand are Plan] "[Resident #95] on r PROM (passive range of ttremities right resting to prevent right hand rative staff will assist with r order" ed 05/31/2022 showed a Resident #95 as severe tally dependent on staff with assist for bed mobility, toilet giene; range of motion ides for upper and lower ved OT services from	F 6	88		09/23/22

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C /29/2022
NAME OF PI	ROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page		F	688	3		09/23/22
	Summary] " Dischar RNP to facilitate pa level of performance decline, development following RNPs has b	al Therapy Discharge rge recommendations: tient maintaining current and in order to prevent of and instruction in the een completed with the IDT: ght) H (hand) splint or brace					
	document provided to	rative Nursing Program" o the surveyor on 06/21/22 at Resident #95 as receiving d resting hand splint.					
	no documented evide	95's medical record showed ence to show that facility staff t hand splint as specified by and care plan.					
		interview conducted on ately 4:00 PM, Employee #2 dings and made no					
	restorative nursing se ensure that the Resid prescribed orthotics a	to show evidence that rvices were provided and lent #102, received and multi-podus boots as cian to maintain or improve					
	07/30/20, with multipl the following: Adult Fa Ulcer of Sacral Regio Unspecified Joint, Co	e, Moderate Protein Calorie					

Facility ID: HCI

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DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. DOILDIN				C
		095015	B. WING				29/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			80 SOUTHERN AVE SE		
				VV/	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	9 139	F 6	88			
		rly Minimum Data Set 2, revealed facility staff					
		Patterns): Brief Interview for ary Score "15" indicating					
	Section E (Behavior): -Presence & Frequen exhibited						
		l Status): Bed mobility e" requiring "Two-person					
	Transfer "extensive as "Two-person physical						
	Dressing "Extensive a "Two-person physical						
	Eating "Supervision" I	requiring "Set-up help only"					
	Toilet use "Extensive -person physical assis	assistance" requiring "One st"					
	Personal Hygiene "Ex requiring "One-persor						
	surface transfer "Not with staff assistance" Upper extremity "no in	tions and walking Surface to steady only able to stabilize mpairment" airment on both sides"					
	Section K (Swallowing Swallowing Disorder						

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		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	LE CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>				PLETED
							с
		095015	B. WING			06/	/29/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE		
-	-				WASHINGTON, DC 20032		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IV	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 000			_				
F 688	Continued From page	e 140	F	688	8		
	Section O (Special Tr	eatments, Procedures, and					
		Therapy start date was					
		o end date was coded. The					
		physical therapy was coded					
	"0168" minutes						
	Review of the physici	ans' orders revealed the					
	following:						
	-						
		to wheelchair by nursing as					
	tolerated to improve in	nteraction with environment"					
	11/23/21 "LE ( Left Ex	<pre>ktremity) orthotics: R (Right)</pre>					
		and B/L ankle multi-podus					
		o 6 hours or to patients'					
		sessments completed pre iscontinue) use if patient					
		es in skin integrity occur."					
	04/03/22 "Discontinue						
	functional mobility. Pa	ctical level in ADL's and					
	•	Program) 5-6x/week for 15					
	minutes"	<b>C</b> ,					
	Deview of the same of						
	"[Resident #102] has	an with a focus area of alteration in					
		is r/t (related to) contracture					
	of the bilateral knees.	" date revised 06/02/2022					
	-	rventions: "Anticipate and					
		call light is within reach and					
		all requests for assistance."					
	Review of a documer	nt titled "Physical Therapy					
		e section titled "Summary					
		ue service dated signed					
	06/21/22 at 3:04 PM s continue services : C						

Facility ID: HCI

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		MEDICAID SERVICES				D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY PLETED
		095015	B. WING		06	C / <b>29/2022</b>
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
BERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 688	Continued From pag	e 141	F 68	8		
	13	necessary in order to				
		sistive device, develop and				
		prative nursing program)				
		areness, enhance rehab				
	potential, increase co	•				
		rease functional activity				
	(range of motion) and	E (lower extremity) ROM				
	(range of motion) and					
	Review of the docum	ent titled "Documentation				
	survey report v2" fror	n June 1, 2022, through				
		ments care provided to				
	residents revealed in	the section titled				
		wed resident did not receive				
	-	or active range of motion of				
	bilateral lower extrem	nity on the following dates:				
	06/02/22					
	06/06/22					
	06/07/22					
	06/16/22					
	06/17/22					
	06/20/22					
	06/23/22					
		cuments resident receiving or bed mobility getting out of				
		o wheelchair for 4 hours				
		s not done on the following				
	days:	5				
	06/01/22					
	06/02/22					
	06/06/22					
	06/07/22 06/16/22					
	06/17/22					
	06/20/22					
	06/23/22					
		cuments "Resident on				
		for splinting to right knee with	1			1

Facility ID: HCI

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		095015	B. WING		C 06/29/2022		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	_	
SERENIT	REHABILITATION AND	HEALTH CENTER LLC		13	380 SOUTHERN AVE SE		
021121111				W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688 F 689 SS=D	this task was not perf days: 06/01/22 06/02/22 06/03/22 06/06/22 06/06/22 06/07/22 06/16/22 06/16/22 06/23/22 For all the above-mer either left the space b which means "Not Ap documentation. A face-to-face intervie 06/24/22, at 2:40 PM Director of Nursing) h aide does the restora applies the orthotics, challenges sometime The surveyor went or about what the "NA" r and he stated it mean done in error" Employee #3 acknow Free of Accident Haza CFR(s): 483.25(d)(1) for the facility must ensu §483.25(d) (1) The rest	pods boot. Don after ff at bedtime" showed that formed on the following ntioned sections facility staff plank or documented "NA" oplicable" according to the ew was conducted on with Employee #3 (Assistant the stated "The restorative tive nursing program and I know we have some s they assist the unit" in to question Employee #3 meant in the documentation, at "Not available and it was reledged the findings ards/Supervision/Devices (2)		688	F689 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT The facility cannot retroactively correct this deficient practice. Resident#124 did not returned to the facility from Leave Of Absence . Resident #124 was discharged from the facility on 07/1/2022. Resident #135 was assessed from head to toe done by a licensed nurse on 11/20/21 post fall medicated for complaint of pain. X-ray ordered for complaint of to the right hip on 11/20/21, result of X-ray was negative for fracture and no acute changes noted. Resident #135 was reassessed from head to toe on 08/17/22 by the licensed nurse Resident did not suffered any negative outcom Resident #35 was assessed from head to toe on 05/20/22 by the licensed nurse post fall . No complaint of pain or apparent injury sustained. The resident is now provided with adequate supervision when leaving and returning from dialysis. Resident #35 was reassessed from head to toe on 08/17/22 by the licensed nurse Resident did not suffered any negative outcom Education was immediately provided to the assigned staff with regards to providing prope assistance during care transfer.	ne.	09/29/2

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 08/12/2022 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE SURVEY COMPLETED	
		095015	B. WING			0	C 6/29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		13	REET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHERN AVE SE ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	§483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on record revision facility staff failed to estimate and supervision to pro- as evidenced by the foresident that left the foresident that left the foresident while bein facility; and one resid assistance from one estimate and supervision to pro- as evidenced by the foresident that left the foresident while bein facility; and one resid assistance from one estimation assistance form one estimation for an assistance for an assistance for an assistance for a leave of destination, responsite and any special instru- on LOA form resider return back to facility note must be complete event in the resident for Review of the policy, revised 05/22 docume [Facility Name] to pro- our residents. The face will provide strategies of falls Procedure as communicate patiencaregivers. Develop i	esident receives adequate stance devices to prevent is not met as evidenced iew and staff interviews, ensure that three (3) of 67 ceived adequate monitoring event avoidable accidents following occurrences: one acility without staff lent who fell out of her og escorted back into the ent who fell after receiving staff person during a #124, #135, #35). : 'Leave of Absence (LOA) for n 05/22 documented, "For if absence Time, date, ole party, expected return uction must be documented ents who go on LOA, must prior to midnight Progress ted stating the timeline of medical record." "Mobility and Falls" ented, " It is the policy of vide a safe environment for cility falls prevention initiative sto decrease the number and Implementation	F	689			09/23/22

Facility ID: HCI

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1G			
		095015	B. WING				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
SERENITY	Y REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 690		- 444					09/23/2
F 689	Resident #124, who I knowledge on 06/13/2 AM.	eft the facility without staff 22 at approximately 10:30	F 6	89	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.		
	06/13/22 documented PM), writer was inforr supervisor that [Resid while she did her well rounds on the unit. Re nurse (evening shift s the facility on LOA at notify the MPD (Metro via 911 at 08:40pm building and returned (Department of Healt notified"	ported Incident (FRI) dated d, "At about 17:10 pm (5:10 med by the on-coming shift dent #124] is not in her room Iness check and routine eport received from the supervisor) that resident left about 10:36a.m. Writers opolitan Police Department) .The police officer exited the at 09:35p.mThe DOH h) and Ombudsman were					
	04/21/21 with diagnos	dmitted to the facility on ses that included: Difficulty lism, Hypertension, Anemia					
	During a tour of room 129 on 06/14/22 at approximately 11:20 AM, Resident #124 was not in the room. The bed was made, no personal effects were noted at the bedside or in the bedside drawer and no clothes were noted in the closet- just 4 (four) empty hangers.						
	revealed the following 05/07/21 [Physician's	#124's medical record g: order] "May be up as ad lib (leave of absence) with					
	to confirm that the res	order] "Check every 1 hour sident is physically in the ' for Hallway, "DR" for Dining					

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-0391
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	1PLETED
		095015	B. WING			C 6/29/2022
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		5/29/2022
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE	•	
	0.000			WASHINGTON, DC 2003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
						09/23/2
F 689	Room, "RM" for Room "SC" for Smoking Pat A Quarterly Minimum 05/14/22 showed faci Interview for Mental S score of 15, indicating potential for psychosi behavioral symptoms refusal of care, indep and off the unit, no im and no active dischar to return to the comm June 2022 [Medicatio (MAR)]: facility staff in Resident #124 receiv AM medications on 00 June 2022 [Treatmen (TAR)]: facility staff do "absent from home" fi 06/13/22 at 5:00 PM i "check every 1 hour t physically in the facility Review of the "24 Ho revealed that facility s Resident #124 had le Review of the Unit 1 s lacked documented e signed out to leaving 06/13/22 at 9:28 PM   17:10pm, writer was i shift supervisor that [I room while she did he	n, "OF" for Out of Facility, tio, and "IB" for In-bed" Data Set (MDS) dated lity staff coded: a Brief Status (BIMS) summary g intact cognition, no s, no verbal or physical directed towards others, no endent for locomotion on npairment in range of motion ge planning for the resident nunity. Administration Record hitialed to indicate that ed all her scheduled 9:00 6/13/22. Administration Record bocumented "3", meaning rom 06/13/22 at 11:00 AM to in the area that directed, o confirm that the resident is ty." ur Report" on 06/14/22 staff did not document that off LOA on 06/13/22.	F 68	RECURRENCE: RECURRENCE: Staff Developer/Des education/in-service importance of follow Leave of Absence (I ensuring documenta on LOA by 09/23/22 Staff Developer/Des provide education/in facility Nursing licen Assistants on how to assistance to reside completed by 09/23, The facility Staff Dev provide education/in staff on importance receive adequate m	signee will provide to all facility staff on the ring the facility policy on LOA) and ation of resident that left signee will -service to the sed nurses and Nursing o provide proper transfer ints. This will be /22. veloper/Designee will n-service to all the facility of ensuring resident onitoring and supervision a accidents and potential	

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	S FOR MEDICARE & I					<u>0. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		095015	B. WING			С
	ROVIDER OR SUPPLIER	095015		STREET ADDRESS, CITY, STATE, ZIP CODE		/29/2022
NAME OF F	ROVIDER OR SOFFLIER			1380 SOUTHERN AVE SE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	the nurse [Nurse Sup facility on LOA at abo the resident's chart to resident had no conta contact in her records Name] and the APS MPD" 06/13/22 at 11:16 PM Assessment Request (5:10 PM), writer obse in her room during dir during start of shift, w resident left the facilit During routine check observed that residen Resident is self R/P w emergency contact or MPD arrived at 08: informationOfficer s considered a missing her cognitive status, r not to leave the facilit Review of the progress note that was created with an effective date documented, "Late Ep oriented x3, received Tolerated all due med concerns noted. Resi at 10:30 am in stable (resident representati During a face-to-face	ervisor] that resident left the but 10:36a.m. Writer review o get her contact number but act number nor emergency s Writer notify [Physician's S was called Writer notify I [Situation Background : (SBAR)] "Situation: 17:10 erved that resident was not oner At 15:00 (3:00 PM) writer received report that y on LOA at 10:30am at 17:10 (5:10 PM), writer nt was not in her room with no contact nor n her chart Writer notified 45p.m, reviewed resident's said resident is not person at this time base on resident has no restriction y" ss notes showed a nurses to n06/14/22 at 7:41 AM of 06/13/22 at 3:36 AM that ntry Resident is alert and sitting up in bed this am. dications this am with no dent left the facility on LOA condition. She is self RP ive)"	F 689		house wide on Leave of he facility LOA ocumentation f house wide quiring two - to ensure that ssistance. This times 4, then, f house wide that residents and e accidents imes 3 months.	09/23/22

Facility ID: HCI

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		<u>NO. 0938-0391</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	• •	G	· · ·	MPLETED
		095015	B. WING			C
	ROVIDER OR SUPPLIER	000010		STREET ADDRESS, CITY, STATE, ZIP CODE	(	6/29/2022
	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	Continued From page	• 147	F 68	39		09/23/2
	further stated, "Anytin facility whether for a r LOA, it should be doo	ne a resident leaves the nedical appointment or sumented on the 24 hour progress note in PCC (point				
	During a face-to-face interview on 06/14/22 at 2:57 PM with Employeess #17 (Security Officer) and #18 (Security Supervisor), Employee #17 stated that she let Resident #124 out of the building by pushing a button (this button opens and closes the sliding door at the front entrance). Employee #17 further stated, "She (Resident #124) did not sign out. She appeared to be a visitor. I only know of one caucasian resident here. It was my first time seeing her (Resident #124)."					
Security footage was not unavailable for the time of the interview. Employee #18 "The cameras are set up for 24 hour de the video and she [Resident #124] had tote bag. She walked out the front door the parking lot to Southern Avenue."	ew. Employee #18 stated, : up for 24 hour delete. I saw esident #124] had a black out the front door, through					
	AM, Employee #5 (As 06/13/22 day shift), st administration at appr Resident #124 mention going to leave the fac something. Employee know that the residen the time. When I finish did not know she had	oned to her that she was ility to take care of #5 further stated, "I did not t had left the facility or even hed my shift at 3:30 PM, I left. It was not until I ne evening shift nursing				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C / <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC			1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 689	the last time I saw he told her when I gave I morning (approximatil doesn't get any scheo medications." The evidence showed follow its policy for re- result, Resident #124 at approximately 10:3 knowledge. During a face-to-face #1 (Administrator) and 06/15/22 at 11:08 AM the finding. It should be noted that after leaving), Reside facility nor was she ev 2. Facility staff failed the with adequate assistat transfers which result Resident #135 was and 07/28/21 with diagnos Coordination and Mus A FRI received on 11/ 11am CNA (Certified shower, took her to he bed, resident's legs g lower her on the floor entering resident's roo on the floor in a sitting CNA explained what I	r (Resident #124) was and I her medications in the ey 10:15 AM). The resident duled afternoon d that facility staff failed to sidents going on LOA. As a left the facility on 06/13/22 30 AM without staff interview with Employees d #2 (Director of Nursing) on I, they both acknowledged at as of 06/29/22 (16 days nt #124 did not return to the ver located. to provide Resident #135 ance of two persons for red in a fall. dmitted to the facility on ses that included: Lack of scle Weakness. /22/21 documented, " At ed Nurse Aide) gave her er room, try to assist her in ave up, and the CNA help and call for the writer. Upon om, resident was observed g position beside her bed; had happened to the writer. sident complained pain to	F	689	9		09/23/22

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				(X3) DATE COMP	SURVEY PLETED
		095015	B. WING			-		C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 2003	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 689	redness, resident was made comfortable" Review of Resident # revealed the following 07/28/21 [Physician's of every shift" 7/28/21 [Physician's of every shift" 10/27/21 [Quarterly F Assessment/Evaluation A Quarterly Minimum 11/01/21 showed that following: A brief Inte (BIMS) summary scot moderately impaired of extensive assistance assist for transfers, in lower extremities and recentry or prior asses 11/20/21 at 11:10 AM received from assigned that resident was eas CNA during transfer fur resident in bed alert a move all extremities, or right lower extremity, administered by assign (Nurse Practitioner) in and gave new order fur extremity"	ge from ears, nose, eyes, no a assisted to her bed and 135's medical record g: Order] "Fall precaution Drder] "Low bed for safety all Risk on] "Moderate Risk" Date Set (MDS) dated facility staff coded the riview for Mental Status re of 08, indicating cognition, no refusal of care, with two persons physical spairment on one side for no falls since admission, sment. [Nurses Note] "Report ed nurse around 11:44 am ed on by floor by assigned rom chair to bed. Met and oriented x 3. Able to c/o (complained of) pain to pain med (medication) gned nurse and effective. NP of facility, reassess resident or x-ray to right lower	F	689				
	11/20/21 [Physician's	Order] "x-ray- Right hip c/o						

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	
		095015	B. WING				29/2022
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE NASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	resident what had had the assign CNA was to her legs gave up and floor." 11/21/21 at 4:59 PM [ "review X-ray result changes negative for Care Plan created on has ADL (activities of performance deficit r/ balance The reside participation with tran During a telephone in PM, Employee #23 (a stated, "I was transfer shower chair to the bo called the nurse to co get her (Resident #13) transferred her by my she needed 2 people The evidence showed provide Resident #13 of two persons for tran During a face-to-face 06/24/22 at 12:37 PM Manager) acknowled	one time" Nurses Note] "Writer ask ppened, she stated that as rying to assist her in bed, she help lower her on the Nurse Practitioner Note] s done last nightNo acute for fracture" 07/29/21 "[Resident #135] daily living) self-care t (related to) impaired ent has requires (2) staff sfers." Iterview on 06/24/22 at 12:35 assigned CNA on date of fall) rring the resident from the ed when her legs gave out. I ome in and she helped me 85) back in bed. I always reself, I was not aware that for transfers."	F	689			
	3. Facility staff failed supervision for Reside	to provide adequate ent #35, who sustained a fall while being asssited by staff.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING				C 29/2022
NAME OF PI	ND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING       095015     B. WING       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SERENITY REHABILITATION AND HEALTH CENTER LLC     1380 SOUTHERN AVE SE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX			TREET ADDRESS, CITY, STATE, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC					
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	9 151	F	689			
	03/15/22 with diagnos on Renal Dialysis, Pe Ischemic Attack (TIA) without Residual Defi A Quarterly Minimum 04/11/22 showed in S Patterns) that facility resident as having a B	ses including Dependence rsonal History of Transient , and Cerebral Infarct cits. Data Set (MDS) dated Section C (Cognitive staff documented the Brief Interview For Mental					
	intact cognition. Secti facility staff document a wheelchair for mobi assistance with one p for transfers, and requ	on G (Functional Status), ted that Resident #35 used lity, required extensive person physical assistance uired supervision for setup					
		#35's medical record					
	returnedat 1600 (4 dialysis. CNA (Certifie informed writer, that s resident from the tran facility. CNA stated , t taken from the van ar around to take [the] re [the] resident slid out the ground in a sitting assisted back into her and brought to the un bed and assessed no	00 PM) via wheelchair from ed Nurse's Assistant) she went to escort [the] sportation van back into the that after [the] resident was					
	slid out of the wheeld	hair in a sitting position on uce falls[Resident #35] will					

Facility ID: HCI

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	COM	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
AME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C		
	REHABILITATION AND			1380 SOUTHERN AVE SE		
	REHADIEMATION AND			WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
						09/23/2
F 689	Continued From page	e 152	F 68	99		
	minimize[the] risk for	fallsInterventions: Provide				
	assistance to transfe					
		s investagative resport				
	revealed the following	g statements:				
	05/20/22 [Employee :	#35 -CNA] documented,				
	"Resident went for di	-				
		turn to the facility] escort				
		e and writer [Employee				
		that resident slipped out of				
	the wheelchair into a			F697		
	transferring her into t	ne facility"		CORRECTIVE ACTION F		
	05/20/22 [Employee :	#36 - CNA] documented,		THE AFFECTED RESIDE	NI:	
		back from dialysis when		The facility cannot retroact	tively	
		assist her on the wheelchair		correct this deficiency.		
	to the build[ing]. [Res	ident #35] slide off the		Pagidant #104 pain madia	otion was	
		to reposition [Resident #35]		Resident #104 pain medic administered immediately		
	back in her wheelcha	ir. Nurse was informed."		parameters and physician	orders after being	
	During a face to face	interview on 06/28/22 at		notified and assigned licer		
		interview on 06/28/22 at #35 reported, "I was coming		immediately educated on a administration process and		
		fore I fell. The van driver got		reconciliation process. Re		
		e escorts were waiting at the		reassessed head to toe or		
		One of the escorts was		did not suffer any negative	e outcome.	
		ouilding, talking to another		Resident #133 was immed	liately given pain	
	escort when I slid out			medication per physician of	orders. This in	
		as not paying attention. I ports helped me get back into		ongoing. Licensed nurse v		
		ought me back upstairs."		proper administration of m accurate documentation. F		
	ing onen, and one bro	agin no such apotallo.		reassessed from head		
	During a face-to-face	interview on 06/28/22 at		to toe on 08/17/22 by lice		
	11:17 AM Employee	#3, (Assistant Director of		Resident suffered no nega	auve outcome.	
	Nursing) acknowledg	ed the finding.				
	Pain Management		F 69	17		
SS=D	CFR(s): 483.25(k)					
						1

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		095015	B. WING			C / <b>29/2022</b>
				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE		
SERENIT	(REHABILITATION AND			WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	The facility must ensuprovided to residents consistent with profess the comprehensive per and the residents' goat This REQUIREMENT by: Based on observation interview, for two (2) of facility staff failed to per accordance with the per #104 and #133. The findings included Review of the policy " 02/22, documented, " administer the order and Review of the policy " 02/22, documented, " administration Record 03/2022 documented of medication and treat assigned to the reside validated the ten Righ includes right asset Licensed nurses will at treatment to residents orders" 1. Facility staff failed to #104's pain medication physician's order. Resident #104 was ref 05/05/22 with multiples Malignant Neoplasm	<ul> <li>who require such services, asional standards of practice, erson-centered care plan, als and preferences.</li> <li>is not met as evidenced</li> <li>an, record review and staff of 67 sampled residents, rovide pain management in obysician's order. Residents'</li> <li>Pain Management" revised The licensed nurse will as indicated"</li> <li>Medication/Treatment d and Initials" revised , " Prior to administration atment, the licensed nurse ent must check and this of Medication which ssment, right evaluation administer medication and a following the physician</li> </ul>	F 697	F697	THE	*09/23/22
	administer the order a Review of the policy " Administration Record 03/2022 documented of medication and trea assigned to the reside validated the ten Righ includes right asses Licensed nurses will a treatment to residents orders" 1. Facility staff failed t #104's pain medication physician's order. Resident #104 was re 05/05/22 with multiple Malignant Neoplasm	As indicated" Medication/Treatment d and Initials" revised , " Prior to administration atment, the licensed nurse ent must check and hts of Medication which ssment, right evaluation administer medication and a following the physician to administer Resident on in accordance with the e-admitted to the facility on a diagnoses, including,				

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		095015	B. WING				C / <b>29/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		13	380 SOUTHERN AVE SE		
OEREI	REHADIENATION AND			W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					F697		09/23/22
F 697		e 154 Ulcer of Sacral Region , essure Ulcer of Left Buttock,	F 69		MEASURE TO PREVENT RECURRENCE:		
	Unstageable. Quarterly Minimum D 05/12/22 showed in S Patterns) that facility resident as having a I Status Summary Sco that the resident had G (Functional Status) that Resident #104 re with one person phys mobility and eating, w requiring one person transfers, dressing, to hygiene. In Section N documented that resi days during the last 7 admission/entry or re A review of Resident revealed: On 06/20/22 at 6:00 F directed, "Percocet Ta (Oxycodone-Acetami mouth four times a da Medication Administra 2022 revealed that they Tablet 5-325 mg (Oxy Resident #104 from O Review of the June 2 (Numeric Scale) docu	ata Set (MDS) dated Section C (Cognitive staff documented the Brief Interview for Mental re (BIMS) of "15," indicating intact cognition. In Section of, facility staff documented equired extensive assistance ical assistance for bed vas totally dependent physical assistance for bilet use and personal I (Medications) facility dent received opioids for 3 days or since entry. #104's medical record PM the physician's order ablet 5-325 mg nophen). Give 2 tablet(s) by ay for pain 7-10." ation Record (MAR) for June e facility's licensed nursing y administered Percocet ycodone-Acetaminophen), to 06/21/22 to 06/24/22. 022 Pain Rating Report umented: 4/10; 8:08 AM-0/10; 1:16			The facility Staff Development and PharmScript Pharmacy Consultants will provide education to the facility licer nurses to ensure that medication administration meet professional standard of practice, and ensuring that licensed nurses administer medications and treatments following physician orders by 9/23/22.	nsed	

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		MEDICAID SERVICES		E CONSTRUCTION		<u>D. 0938-0391</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
						С
		095015			06	/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	06/21/22 - 12:55 AM- AM-4/10, 2:15 PM-1/ 06/22/22 - 9:36 AM-0 11:51 PM- 0/10 06/23/22 - 1:58 AM-0 AM-0/10; 12:14 PM-0 06/24/22 - 12:00 AM- A review of Resident' revealed that from 06 staff failed to administ accordance with the specified to administ resident for a pain rat During a face-to-face Employee #3, Assista (ADON), after review 2022 MAR, acknowle licensed nursing staff Resident#104 when t less than 7-10 and th further comment. 2. Facility staff failed #133's narcotic pain r physician. Resident #133 was a 07/08/21 with diagnos Right Leg and Acute I During a medication a on 06/15/22 at 8:46 A that his pain level was Employee #11 (Regis	4/10, 1:55-0/10 AM, 6:11 10, and 6:25 PM- 0/10 /10, 5:36 PM-0/10, and /10; 6:07 AM-0/10, 10:59 )/10, 5:23 PM-0/10 6/10 and 6:00 AM 6/10 s #104's medical record i/21/22 to 06/24/22, facility tered Percocet in physician's order, which er the medication to the ting of 7-10. interview on 06/20/22, ant Director of Nursing ing Resident #104's June edged that the facility's administered Percocet to the resident's pain rating was e employee offered no to administer Resident medication as ordered by the dmitted to the facility on ses that included: Pain in Kidney Failure. administration observation M, Resident #133 stated s "6" on a scale of 1 to 10.	F 697		nts that facility de pain th the 5 4, then, I be presented 7 Assurance	09/23/22

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		095015	B. WING				C 29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 380 Southern ave se VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Review of Resident # revealed the following 05/27/22 [Physician's pan reliever) Patch 72 (micrograms)/HR (ho transdermally one tim pain management an 05/28/22 [Physician's (pain reliever) Tablet mouth one time a day wound care" 05/30/22 [Physician's "Oxycodone-Acetami (Percocet) (Give 1 tal day for Pain [level of A Significant Change dated 06/06/22 show Brief Interview for Me score of 15, indicating intact cognitive respo and PRN (as needed experienced pain occ Care plan revised on on pain medication th pain Administer an ordered by physician. efficacy" Review of the June 2 Administration Record	<ul> <li>mouth to Resident #133.</li> <li>"133's medical record</li> <li>Order] "Fentanyl (narcotic</li> <li>2 Hour 25 MCG</li> <li>ur) Apply 1 patch</li> <li>be a day every 3 day(s) for</li> <li>d remove per schedule"</li> <li>Order] "Acetaminophen</li> <li>500 MG Give 2 tablet by</li> <li>of or Pain 30 minutes prior to</li> <li>Order]</li> <li>nophen Tablet 5-325 MG</li> <li>olet by mouth two times a</li> <li>] 7-10"</li> <li>Minimum Data Set (MDS)</li> <li>ed that facility staff coded: a</li> <li>ntal Status (BIMS) summary</li> <li>g that the resdeint had an</li> <li>nse, received scheduled</li> <li>) pain medication and</li> <li>asionally.</li> <li>06/14/22 "[Resident #133] is</li> <li>erapy (Percocet) r/t right leg</li> <li>algesic medications as</li> <li>Review for pain medication</li> <li>022 Medication</li> <li>d (MAR) showed that facility</li> <li>ycodone-Acetaminophen</li> </ul>	F	697	F698 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: The facility cannot retroactively correct the deficiency. Resident #21's dialysis pressure dressin fistula site was immediately removed aff being notified. Resident was reassesse head to toe on 08/17/22 by licensed nur Resident suffered no negative outcome	ng AV ter ed from rse.	09/23/22

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		MEDICAID SERVICES				O. 0938-039 <sup>2</sup>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY IPLETED
		095015	B. WING		C 06/29/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē	
SEDENITY	REHABILITATION AND			1380 SOUTHERN AVE SE		
JERENITT	REHADIEITATION AND			WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	Continued From page	e 157	F 69	7		09/23/22
	06/02/22 at 9:00 AM a 06/04/22 at 9:00 AM a at 6:00 PM Pain level 06/05/22 at 9:00 AM a 06/06/22 at 9:00 AM a 06/06/22 at 9:00 AM a 06/07/22 at 9:00 AM a 06/08/22 at 9:00 AM a 06/09/22 at 9:00 AM a 06/10/22 at 9:00 AM a 06/10/22 at 9:00 AM a 06/11/22 at 9:00 AM a 06/12/22 at 9:00 AM a 06/13/22 at 9:00 AM a 06/16/22 at 9:00 AM a The evidence showed follow the physician's Resident #133's narc evidenced by licensed Percocet when the re	and 6:00 PM Pain level =0 Pain level =2 and 06/06/22 = 0 and 6:00 PM Pain level =3 and 6:00 PM Pain level =0 Pain level =2 and 06/10/22 = 0 and 6:00 PM Pain level =0 and 6:00 PM Pain level =0 Pain level =2 and 06/14/22 = 0 Pain level =6 and 06/15/22 =0 Pain level =6 and 06/15/22 =0 Pain level =4 interview conducted on Employee #10 ding and stated, sk, he (Resident #133) says er but I know it's not possible and need is saying is not and facility staff failed to order for administering otic pain medication d staff administering sident's pain level was less		IDENTIFICATION OF OTHER WITH THE POTENTIAL TO BI AFFECTED. All the residents on dialysis in the potential to be affected.	Ē	
F 698 SS=D	than 7 on the pain sca Dialysis	uro.	F 69	8		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE	
		095015	B. WING _				C 29/2022
NAME OF P	ROVIDER OR SUPPLIER		-	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
SERENIT	Y REHABILITATION AND			13	880 SOUTHERN AVE SE		
OERENIT				W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensurequire dialysis receives with professional star comprehensive person the residents' goals a This REQUIREMENT by: Based on record revision interview, for one (1) facility staff failed to redressing from Reside Fistula site in accordator order. The findings included Resident #21 was add 05/05/21 with diagnost Renal Disease and C A Quarterly Minimum 05/09/22 showed in S Patterns) that facility resident as having a la Status Summary Sco- intact cognition. Review of the physicid directed, "Remove pri arm 6 hours post dial Friday] every evening During a face-to-face 11:55 AM, Resident as bare and the second bleeding this morning	ure that residents who ve such services, consistent adards of practice, the on-centered care plan, and nd preferences. is not met as evidenced iew, resident and staff of 67 sampled residents, emove the pressure nt #21's arteriovenous (AV) ance with the physician's : mitted to the facility on ses that included End Stage hronic Kidney Disease. Data Set (MDS) dated Section C (Cognitive staff documented the Brief Interview For Mental re (BIMS) of "13," indicating an's order dated 05/05/21 essure dressing on the left ysis, [Monday, Wednesday,	F	598	F698 MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/ in-services to the facility lice nurses on the importance of implement post dialysis care in accordance with the physician's order; which includes asset and removal of pressure dressing from arteriovenous (AV) Fistula site post dialysis by 9/23/22. MONITORING CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house wide audit of resident on dialysis to ensure that residents receivs proper care of the pressure dressing fr arteriovenous (AV) Fistula site post dia accordance with the physician's order. will be completed weekly times 4, then monthly times 3 months. The findings of these audits will be pre monthly for 3 months to Quality Assura Performance Improvement (QAPI) con	ve om Audit , sented ance	09/23/22

Facility ID: HCI

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TATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
							С	
		095015	B. WING			06/	29/2022	
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032			
0(1) 15		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE	
F 698	Continued From page	150		~~~			09/23/2	
F 090	Continued From page		F	698				
		sheet (bed linen) from her write the red spots on the						
		write the red spots on the e #33] put a dressing on it.						
		nove the dressing last night						
		hen I came from dialysis.						
	· · /	oved it this morning and						
		d bleeding. That's when I						
		my room) and she put						
	-	my arm." At the time of this						
		21 showed the writer a folded spots on it; and the resident						
	pointed to a piece of							
		ver the AV Fistula site.						
	Review of the Medica	ation Administration Record			F726 CORRECTIVE ACTION FOR			
		shift, showed the nurse			THE AFFECTED RESIDENTS:			
	-	ated location indicating that			The facility cannot retroactively correct th	nis		
	he/she removed the r	esidents pressure dressing.			deficiency.			
	Facility staff failed to	remove Resident #21's			The affected Resident #133 immediately received pain medication according to			
	pressure dressing in				professional standard of practice, parame	eters		
	physician's order.				and according to the physician orders. Resident was reassessed from head to to	be		
	During a face-to-face	interview on 06/21/22 at			on 08/17/22 by licensed nurse. Resident suffered no			
	approximately 12:15				negative outcome.			
	acknowledged the fin	-						
F 726	Competent Nursing S		F	726	Resident #257 skin assessment was immediately performed according to			
SS=D	CFR(s): 483.35(a)(3)	(4)(C)			professional standards after being notified	d		
	§483.35 Nursing Serv	vices			and as ordered by the physician. The skir	n		
		e sufficient nursing staff with			sheet observation sheet is being used			
		etencies and skills sets to			appropriately and is ongoing to ensure resident's skin is monitored. Resident was	S		
	provide nursing and r	elated services to assure			reassessed from head to toe on 08/17/22	2 by		
	-	ttain or maintain the highest			licensed nurse. No new skin issues were			
		mental, and psychosocial			found and resident did not suffer any neg outcome.	ative		
		sident, as determined by						
	resident assessments	s and individual plans of care						

Facility ID: HCI

If continuation sheet Page 160 of 184

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	accordance with the fa at §483.70(e). §483.35(a)(3) The fac licensed nurses have and skill sets necessa needs, as identified th assessments, and dea §483.35(a)(4) Providin limited to assessing, e implementing resident to resident's needs. §483.35(c) Proficience The facility must ensu to demonstrate compo- techniques necessary needs, as identified th assessments, and dea This REQUIREMENT by: Based on observation interview, for two (2) of facility staff failed to p services to assure resi by failure to: (1) provide management that met practice and (2) ensu	ty's resident population in acility assessment required sility must ensure that the specific competencies ary to care for residents' arough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and t care plans and responding y of nurse aides. Irre that nurse aides are able etency in skills and y to care for residents'	F	726	F726		09/23/22
		Pain Management" revised The licensed nurse will attending					

Facility ID: HCI

If continuation sheet Page 161 of 184

STATEMENT OF DERIGENCIES AND PLANT     (M1) PROVIDERSUPPLIERCIAN UBATTRECATION NUMBER 0 95015     (22) MLTTREC CONSTRUCTION A BUILING		-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
UNME OF PROVIDER OR SUPPLIER         SERIEST ADDRESS, CITY, STATE, ZIP CODE           SERENTY REHABILITATION AND HEALTH CENTER LLC         Integration of the series outmines of the series of the series outmines of the series of the series of the series outmines of the series of the seri	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			COMF	PLETED
IMAGE			095015	B. WING			
SERENTY REHABILITATION AND HEALTH CENTER LLC     WASHINGTON, DC 20032       (PAI)ID PREETX TAG     SUMMARY STREMENT OF DEFICIENCIES (EACH DEPICIENCIES DE YFLL) REGULATIONY ON LSC DENTIFING INFORMATION)     D D D PREETX TAG     D D D D D D D D D D D D D D D D D D D	NAME OF PF	ROVIDER OR SUPPLIER					
Preserve Trace         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US DE DETIFYING INFORMATION)         PREFIX Tag         CREATE CAPPENDER ATTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         COMELTION UNIT           F 728         Continued From page 161 physician/designee for pain management and administer the order as indicated"         F 728         F726 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.         F726 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.         09/23/22           documentation/Record' revised 02/2022 documented, " Clinical documentation is required to record pertinent racks, findings, and observations about the resident"         F 728         IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.         09/23/22           All the resident sin the facility have the potential to be affected.         Note the policy "Medication/Treatment doministration Record and Initials" revised 03/2022 documented, " Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check and validated the ten Rights of Medication which includesright assessment, right evaluation Licensed nurses will administer medication and treatment to residents following the physician orders"         1. Facility staff failed to provide Resident #133 with pain management that met professional standards of practice.         F         F         F         F         F         F         F         F         F         F         F         F         F         F         F         F         F         F         F <t< td=""><td>SERENITY</td><td>REHABILITATION AND</td><td>HEALTH CENTER LLC</td><td></td><td></td><td></td><td></td></t<>	SERENITY	REHABILITATION AND	HEALTH CENTER LLC				
<ul> <li>F 72b Continued From page 161</li> <li>P 72b Continued From page 161</li> <li>P 72b IDENTIFICATION OF OTHERS</li> <li>O9/23/22</li> <li>O0/23/22</li> <li>Occumentation/Record' revised 02/2022</li> <li>Occumentation/Record' revised 02/2022</li> <li>Occumentation/Record' revised 02/2022</li> <li>Occumentation/Record' revised 02/2022</li> <li>Occumentation Record and Initials' revised</li> <li>O3/2022 documentation is required to record and Initials' revised</li> <li>O3/2022 documented, " Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check and validated the ten Rights of Medication and treatment to resident must reduce will administer medication and treatment to resident soft explanation and treatment to resident soft to the facility on 07/09/21 with diagnoses that included: Pain in Right Leg and Acute Kidney Failure.</li> <li>During a medication administration observation on 06/15/22 at 8:46 AM, Resident #133 stated that his pain level was "6" on a scale of 1 to 10. Employee #11 (Registered Nurse) then proceeded to administer 00; explanation the sole #133.</li> <li>Review of Resident #133's medical record</li> </ul>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 726	physician/designee for administer the order a Review of the policy " Documentation/Record documented, " Clin required to record per observations about the Review of the policy " Administration Record 03/2022 documented, of medication and treat assigned to the reside validated the ten Right includes right assess Licensed nurses will a treatment to residents orders" 1. Facility staff failed the with pain management standards of practice. Resident #133 was act 07/08/21 with diagnoss Right Leg and Acute H During a medication at on 06/15/22 at 8:46 A that his pain level was Employee #11 (Regiss proceeded to adminiss pain reliever) - APAP (milligram) 1 tablet by	r pain management and is indicated" Clinical d" revised 02/2022 ical documentation is tinent facts, findings, and e resident" Medication/Treatment d and Initials" revised " Prior to administration atment, the licensed nurse ent must check and ts of Medication which ssment, right evaluation administer medication and following the physician o provide Resident #133 at that met professional dmitted to the facility on uses that included: Pain in Kidney Failure. administration observation M, Resident #133 stated s "6" on a scale of 1 to 10. tered Nurse) then ter Oxycodone (narcotic (Acetaminophen) 5-325 MG mouth to Resident #133.	F 72	<ul> <li>IDENTIFICATION OF OTHERS</li> <li>WITH THE POTENTIAL TO BE</li> <li>AFFECTED.</li> <li>All the residents in the facility have</li> </ul>		09/23/22

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		MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION		E SURVEY PLETED
						С
		095015	B. WING		06	/29/2022
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 726	05/27/22 [Physician's pan reliever) Patch 77 (micrograms)/HR (ho transdermally one tim pain management an 05/28/22 [Physician's (pain reliever) Tablet mouth one time a day wound care" 05/30/22 [Physician's "Oxycodone-Acetami (Percocet) (Give 1 tal day for Pain [level of A Significant Change dated 06/06/22 show Brief Interview for Me score of 15, indicating intact cognitive respo and PRN (as needed experienced pain occ Care plan revised on on pain medication th pain Administer an ordered by physician efficacy" Review of the June 2 Administration Recor staff administered Ox Tablet 5-325 MG 1 tal 06/01/22 at 9:00 AM 06/02/22 at 9:00 AM	<ul> <li>Gorder] "Fentanyl (narcotic 2 Hour 25 MCG ur) Apply 1 patch he a day every 3 day(s) for d remove per schedule"</li> <li>Gorder] "Acetaminophen 500 MG Give 2 tablet by y for Pain 30 minutes prior to</li> <li>Gorder] nophen Tablet 5-325 MG blet by mouth two times a ] 7-10"</li> <li>Minimum Data Set (MDS) ed that facility staff coded: a ental Status (BIMS) summary g that the resdeint had an ense, received scheduled ) pain medication and casionally.</li> <li>06/14/22 "[Resident #133] is herapy (Percocet) r/t right leg algesic medications as . Review for pain medication</li> <li>022 Medication d (MAR) showed that facility cycodone-Acetaminophen blet as followed:</li> <li>and 6:00 PM - Pain level =5 and 6:00 PM Pain level =0 Pain level =6 and 06/04/22</li> </ul>	F 72	MEASURE TO PREVENT RECURRENCE: The facility Staff Developer and Ph Pharmacy Consultants will provide to the facility licensed nurses to en medication administration meet pro standard of practice, by ensuring th licensed nurses administer medica treatments following physician orde 9/23/22. The facility Staff Developer will pro education/ in-services to the facility nurses and nursing assistants to en residents receive care consistent w professional standards of practice of prevent development of wound by ensuring skin sweep and documen done as scheduled and reporting a change in condition of the resident manner 9/23/22.	education sure that fessional hat tions and ers by vide licensed hsure tith o and tation are ny	09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		095015	B. WING				29/2022
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE	-	
JERENIT				V	VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	06/05/22 at 9:00 AM a 06/06/22 at 9:00 AM a at 6:00 PM Pain level 06/07/22 at 9:00 AM a 06/08/22 at 9:00 AM a 06/09/22 at 9:00 AM a 06/10/22 at 9:00 AM a 06/11/22 at 9:00 AM a 06/12/22 at 9:00 AM a 06/13/22 at 9:00 AM a 06/13/22 at 9:00 AM a 06/14/22 at 9:00 AM a 06/14/22 at 9:00 AM a 06/16/22 at 9:00 AM a at 6:00 PM Pain level 06/16/22 at 9:00 AM a The evidence showed follow the physician's Resident #133's narc evidenced by licensed Percocet when the re than 7 on the pain sca	and 6:00 PM Pain level =0 Pain level =2 and 06/06/22 = 0 and 6:00 PM Pain level =3 and 6:00 PM Pain level =0 Pain level =2 and 06/10/22 = 0 and 6:00 PM Pain level =0 and 6:00 PM Pain level =0 Pain level =2 and 06/14/22 = 0 Pain level =6 and 06/15/22 = 0 Pain level =6 and 06/15/22 = 0 Pain level =4 interview conducted on Employee #10 ding and stated, sk, he (Resident #133) says er but I know it's not possible og on medically. He has a lot e pain level he's saying is not d that facility staff failed to order for administering otic pain medication d staff administering isident's pain level was less ale.	F	726	MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/C will conduct house wide audit to identify residents with pain and ensure that facilicensed nurses provide pain manager meet professional standards of practice times 4, then, monthly times 3 months. Assistant Director of Nursing (ADON)/Designee will conduct house v audit of resident skin sweep and documentation to identify potential resid facility staff failed to provide care consis professional standards of practice to pr development of wound. This will be co weekly times 4, then, monthly times 3 r The findings of these audits will be prese monthly for 3 months to Quality Assura Performance Improvement (QAPI) com	vide dents that stent with event with event the nducted nonths. sented nce	

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		095015	B. WING					C 29/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 726	Osteomyelitis of Left <i>A</i> Diabetes Mellitus with Vascular Disease. Review of Resident <i>#</i> revealed the following 04/06/22 at 10:09?AM "Resident is a 86 year 04/06/22 with left foot left toe, right lateral fo 2.95cm (centimeter) <i>X</i> open area 1.80ccm X necrotic tissue 0.83cm Physician's orders: 04/06/22 "Weekly skin nurse. Document and doctor)/NP (Nurse Pra findings every day shi 04/06/22 "Apply moist lubrication every day shi Care Plan updated or has potential for press (related to) decreased incontinence Monit any changes in skin s	tage 3). dmitted to facility on ses that included: Acute Ankle and Foot, Type 2 a Foot Ulcer and Peripheral 257's medical record g: A [Skin/Wound Note] rs old male re-admitted on diabetic ulcer, absence of not necrotic tissue measured ( 1.71cm, left second toe 1.29cm, right great toe n x 1.62cm"	F 7	26	DEFICIENCY)			09/23/22
	has an ADL (activities performance deficit r/	n 04/13/22 [Resident #257] of daily living) self-care t generalized weakness staff to provide bath/shower						

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES			I	NTED: 08/12/2022 FORM APPROVED B NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>′</i>		(X3)	) DATE SURVEY COMPLETED
		095015	B. WING			C 06/29/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTION CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 726	bath when a full bath tolerated totally dep repositioning and turn Reposition q 2 hou avoid injury require for redness, open are and report changes 06/01/22 [Weekly Skin skin impairment: none A Quarterly MDS date staff coded: moderate potential indicators of care, extensive assist assist for bed mobility impairment on both si always incontinent for unstageable pressure upon admission/entry ulcers. 06/06/22 at 2:51 PM [ Assessment Request on coccyx During in writer was notified by staff assigned to resic on coccyx which mea 0.55cm. Moderate dra 06/06/22 at 2:51 PM [ "Coccyx wound 0.8"	hecessary Provide sponge or shower cannot be bendent on staff for ing in bed and as necessary rs and as necessary to s skin inspection. Observe as, scratches, cuts, bruises ." In Assessment] " Describe e" ed 06/03/22 where facility ely impaired cognition, no psychosis, no rejection of cance one person physical and personal hygiene, des for lower extremities, bowel and bladder, 2 e ulcers that were present or reentry and diabetic foot Situation Background ] "Situation: Observe wound continent care at 2:45 pm, CNA (Certified Nurse Aide) dent of an opening area sure L=0.87cm X W= ainage noted from sites" [Skin Observation Tool] 7cm 0.55cm" [Skin/Wound Note] " and wound evaluation ure ulcer"	F 72			
	06/10/22 at 1:02 PM [	Wound/Pressure Ulcer				

Facility ID: HCI

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		095015	B. WING			C /29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	Note] " Pressure ul 0.87 cm width 0.55 cr acquired" Review of the form "L List" (not dated) provi 06/23/22 showed that schedule for a bath/sl Thursday. During a face-to-face 11:05 AM, Employee stated, "Skin sweep a scheduled shower da completed by the CN sheet, then it (skin sw done." Review of Resident # documented evidence Observation Sheet" w (Thursday), which is f bath/shower day. Review of the CNA do Resident #257 receiv day from 06/02/22 to Review of the Treatm (TAR) showed that fa area that directed, "A for skin lubrication ev to 06/05/22 (4 days) i completed. The evidence showed (06/02/22 to 06/05/22 failed to document an	cer/Stage 3 sacrum length n depth 0.1 cm in house Unit 3 Resident Bath/Shower ded to the surveyor on t Resident #257 was on the nower every Monday and interview on 06/23/22 at #12 (Registered Nurse) assessments are done on ys. A skin sweep form is A and nurse. If there's no veep assessment) wasn't 257's medical record lacked that a "Skin Sweep vas completed on 06/02/22 Resident #257's scheduled bocumentation showed that ed a bed bath (BB) every	F 726	F755 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The affected Resident#256 was reasse from head to toe on 08/17/22 by licensed nurse. Resident suffered no negative outcome. Education was provided to facility nurses licensed on proper way of wasting of medications. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected.	essed	09/23/22

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-				FOR	D: 08/12/2022 MAPPROVED D. 0938-0391	
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	095015	B. WING			C 29/2022	
ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
REHABILITATION AND	HEALTH CENTER LLC					
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
Continued From page	167	F 726	F755		09/23/22	
#257 was observed w on his sacrum on 06/0 During a face-to-face 11:39 AM, Employee acknowledged the find should not be found w stages. The CNA's an and report any change have been educated of Sweep Sheet on show refuses the bath, show should be documente [nurse's] note." Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)( §483.45 Pharmacy Se The facility must provi drugs and biologicals them under an agreen §483.70(g). The facility personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical servic that assure the accura dispensing, and admin biologicals) to meet th §483.45(b) Service Co must employ or obtain pharmacist who- §483.45(b)(1) Provide	ith a Stage 3 pressure ulcer 06/22. interview on 06/23/22 at #13 (Educator) ding and stated, "Resident's with wounds at advanced d nurses know to document es to the skin. Nursing staff on documenting on the Skin ver days. If the resident wer or the skin sweep, it d on the form and in a edures/Pharmacist/Records 1)-(3) ervices de routine and emergency to its residents, or obtain nent described in ty may permit unlicensed er drugs if State law er the general supervision of es. A facility must provide tes (including procedures ate acquiring, receiving, histering of all drugs and te needs of each resident. onsultation. The facility in the services of a licensed es consultation on all		MEASURE TO PREVENT RECURRENCE: The facility Staff Developer will provide education/in-services to the facility lic nurses on the importance of ensuring controlled medications were accurate recorded as given and accurately rec wasted in the designated location; an accurately reconcile controlled medic 9/23/22.	ensed I that the Ply orded d		
	S FOR MEDICARE & M F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER REHABILITATION AND SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page #257 was observed w on his sacrum on 06/0 During a face-to-face 11:39 AM, Employee a acknowledged the find should not be found w stages. The CNA's an and report any change have been educated of Sweep Sheet on show refuses the bath, show should be documente [nurse's] note." Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)() §483.45 Pharmacy Se The facility must provid drugs and biologicals them under an agreer §483.70(g). The facility personnel to administer permits, but only under a licensed nurse. §483.45(a) Procedurer pharmaceutical service that assure the accurated dispensing, and admini- biologicals) to meet the §483.45(b) Service Com must employ or obtain pharmacist who- §483.45(b)(1) Provide	CORRECTION       IDENTIFICATION NUMBER:         095015         ROVIDER OR SUPPLIER <b>REHABILITATION AND HEALTH CENTER LLC</b> SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 167         #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22.         During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages. The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bath, shower or the skin sweep, it should be documented on the form and in a [nurse's] note."         Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)         §483.45 Pharmacy Services         The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.         §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.         §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	S FOR MEDICARE & MEDICAID SERVICES         IF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING         095015       B. WING         095016       B. WING         REHABILITATION AND HEALTH CENTER LLC       D         SUMMARY STATEMENT OF DEFICIENCIES (EAD DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 167       F 726         #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22.       F 726         During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages. The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bath, shower or the skin sweep, it should be documented on the form and in a [nurse's] not."       F 755         Pharmacy Strvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)       F 755         §483.45(a) Procedures. A facility must provide personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.       §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.         §483.45(b) Service Consultation. The facility must employ or obtain the services o	S FOR MEDICARE & MEDICAID SERVICES         # DEFICIENCIES CORRECTION       (x1) PROVIDERSUPPLIENCLIA UDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING         095015       B. WING         000/DER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 1330 SOUTHERN AVE SE WASHINGTON, DC 20032         rechabilitation and health CENTER LLC       STREET ADDRESS, CITY, STATE, ZIP CODE 1330 SOUTHERN AVE SE WASHINGTON, DC 20032         rechabilitation of DEFICIENCY MUST BE PRECEDED BY FULL RECOULTORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 167 #257 was observed with a Stage 3 pressure ulcer on his sacrum on 06/06/22.       F 726         During a face-to-face interview on 06/23/22 at 11:39 AM, Employee #13 (Educator) acknowledged the finding and stated, "Resident's should not be found with wounds at advanced stages. The CNA's and nurses know to document and report any changes to the skin. Nursing staff have been educated on documenting on the Skin Sweep Sheet on shower days. If the resident refuses the bai, shower or the skin sweeve, it should be documented on the form and in a furuses] note: "       F 755         §483.45(a)(b)(1)-(3)       \$483.45(a)(b)(1)-(3)       F 755         §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administer drugs if State law permits, but only under the general supervision of a licensed nurse.       F 755         §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, recei	MENT OF HEALTH AND HUMAN SERVICES       FORM EDICARE & MEDICALD SERVICES       OMB NC         CORRECTON       (x1) PROVIDERSUPPLIFICATION       (x2) PROVIDERSUPPLIFICATION       (x3) DOTE         OPERATION       (x3) PROVIDERSUPPLIFICATION       (x3) DOTE       (x3) DOTE         OWDER OR SUPPLER       (x4) PROVIDERSUPPLIFICATION       (x3) DOTE       (x3) DOTE         REHABILITATION AND HEALTH CENTER LLC       STREET ADDRESS, CITY, STATE, 2P CODE       130 SOUTHERN AVE SE       (x4) DOTE         RECACIDENCIES       (x4) PROVIDERS PLAN OF CORRECTION         RECACIDENCIES       (x4) PROVIDERS PLAN OF CORRECTION         RECACIDENCIENCY WIST DE PRECEDED BY YILL       RECOLLARGENCE       F755       F755         Continued From page 167       F725       F726       F755         MEASURE TO PREVENT       RECURRENCE:       The facility Staff Developer will provide aducation on the skin Statege 3 pressure ulcer on his sacrum on 06/08/22.       F755       The facility Staff Developer will provide aducation in aducation's accurately recorded as given and accurately recorded as given an	

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	): 08/12/2022 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095015	B. WING			C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	receipt and dispositio sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on record revi facility staff failed to e medications were acc and accurately record location; and accurate medications for one ( resident controlled dr Residents #256. The findings included Resident #256 was ac 06/10/22 with diagnos Osteoarthritis of Hip, of Bladder and Clostr According to the phys the resident is to rece relieve moderate to rr mg (milligram) one ta as needed for pain 6- During an observation one (1) of two (2) Mee there was one resider physician's order that	shes a system of records of n of all controlled drugs in able an accurate nines that drug records are in ount of all controlled drugs iodically reconciled. is not met as evidenced ew and staff interviews, ensure that the controlled curately recorded as given led wasted in the designated ely reconcile controlled 1) of three (3) sampled ug records reviewed.	F 755	F755 MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house w to identify residents with controlled medication accurately administer controlled medication unused controlled medication are dispo- in the designated location. This audit wi conducted weekly times 4, then, monthl 3 months. The findings of these audits will be pres monthly for 3 months to Quality Assurar Performance Improvement (QAPI) com	ication tion, and sed of I be y times ented nce	09/23/22

Facility ID: HCI

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	-	D HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	l` '				LETED
						(	c I
		095015	B. WING			06/	29/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE		
				N	ASHINGTON, DC 20032		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
							09/23/22
F 755	Continued From page	9 169	F7	755			
	for pain 6-10."						
	Deview of the country!						
		ed drug administration 250 showed the amount and					
	count received from the						
		Tramadol was observed with					
		wever, the controlled drug					
		showed, "amount remaining			F803		
	as 24" as of 06/16/22	at [no time recorded].			CORRECTIVE ACTION FOR THE		
	-	interview on 06/16/22 at			AFFECTED RESIDENTS:		
	approximately 03:54 I				The affected Resident #102 was immedia		
		ated, "I went to give the on by she refused. I wasted			provided with the menu and alternative m after being notified and is ongoing so that		
		he nurse that I worked with			resident can make food choices Resider	nt	
	during the night."				reassessed was from head to toe on 08/ by the licensed nurse. No negative outcon noted.		
	Further review of the				noted.		
		d revealed the second nurse					
		asting of the Tramadol did I space for witnessing on			The affected Resident #82 was immediat provided with the menu and alternative m		
		Also, the nurse failed to			after being notified and is ongoing so that		
		medication wasted in the			resident can make food choices Resider		
	allotted space.				reassessed was from head to toe on 08/ by the licensed nurse. No negative outcon noted.		
		that facility staff did not					
		I reconcile the number of					
		d to Resident #256 and					
	record for Resident #2	led drug administration 250.					
		internieur en 00/10/00					
	approximately 03:54 I	interview on 06/16/22 at					
		ated, "When I gave the pill					
	,	ng number. I should have					
	written '24' tablets ren						
F 803	Menus Meet Residen	t Nds/Prep in Adv/Followed	F 8	303			
SS=D							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095015	B. WING				C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 803	Menus must- §483.60(c)(1) Meet the residents in accordanguidelines.; §483.60(c)(2) Be prep §483.60(c)(3) Be follow §483.60(c)(4) Reflect, reasonable efforts, the ethnic needs of the re- input received from re- groups; §483.60(c)(5) Be upd §483.60(c)(6) Be revised dietitian or other clinic professional for nutritions §483.60(c)(7) Nothing construed to limit the personal dietary choid This REQUIREMENT by: Based on observational resident interview for residents, facility staff all the facilities reside food choices and the update menus periodit	<ul> <li>(7)</li> <li>d nutritional adequacy.</li> <li>e nutritional needs of ce with established national</li> <li>bared in advance;</li> <li>wed;</li> <li>based on a facility's</li> <li>e religious, cultural and sident population, as well as esidents and resident</li> <li>ated periodically;</li> <li>ewed by the facility's sally qualified nutrition onal adequacy; and</li> <li>g in this paragraph should be resident's right to make the the tas evidenced</li> <li>n, record review, staff and two (2) of 67 sampled failed to provide menus to ints so that they could make facility's staff failed to cally and have them</li> </ul>	F	803	F803		09/23/22
	update menus periodi	-					

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/12/2022 M APPROVED <u>O. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		СОМ	E SURVEY PLETED C
		095015	B. WING			/29/2022
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 803	1. Resident #102 was 07/30/20, with multipl the following: Adult Fi Ulcer of Sacral Regio Unspecified Joint, Co Contracture Left Knew Malnutrition and Muse Review of the Quarte (MDS) dated 06/02/21 coded the following: Section C (Cognitive Mental Status Summa intact cognition. Section E (Behavior): -Presence & Frequent exhibited Section G (Functiona "Extensive Assistance physical assist" Transfer "extensive a "Two-person physical Dressing "Extensive a "Two-person physical Eating "Supervision" Toilet use "Extensive -person physical assi Personal Hygiene "Ex requiring "One-person Section K (Swallowin Swallowing Disorder Review of the Physical following:	s admitted to the facility on e diagnoses that included ailure to Thrive, Pressure n, Stage 3, Contracture ntracture Right Knee, e, Moderate Protein Calorie cle Weakness. rly Minimum Data Set 2, revealed facility staff Patterns): Brief Interview for ary Score "15" indicating Rejection of Care ney "0" Behavior not I Status): Bed mobility e" requiring "Two-person ssistance" requiring assist" requiring "Set-up help only" assistance" requiring "One st" tensive assistance" in physical assist"	F 80	<ul> <li><sup>3</sup> F803 periodically and have the by the facilities Dietitian/ Nu by 9/29/22.</li> <li>MONITORING CORRECTIV ACTION: The Director of Food and Services/Designee will co house wide audit to to identify residents that facility staff provide menus so that th make food choices weekly time</li> </ul>	tritionist Æ Nutrition nduct potential f failed to ey could	09/23/22

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		095015	B. WING		06	/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 803	Continued From page		F 80	3		00/00/00
	"(Resident #102) is at to) Clinical DX (Diagn Protein Calories Main Sickle Cell Trait, Calo (Hypertension) Requi nutritional supplemen 07/31/20,had multiple following: "Continue p importance of adhere order/limiting food fro service staff to regula preference changes. An observation and fa conducted on 06/24/2 Resident #102 stated there is not enough mac and cheese for a water" The surveyor a menu and if he raised Resident 102 stated " A face-to-face intervie 06/24/22 at approxim #30 (Registered Dieti #102) complains he h director of food servio The surveyor asked ti menus are and how r replacement. The die survey a menu that May 2022 (The curren survey was June 202 wall by the nursing sta	an with a focus area of t nutritional risk r/t (related hosis) Adult Failure to Thrive, nutrition, Type 1 Diabetes, sulus of Kidney, GERD, HTN ring liberalized diet and oral its" initiated on the interventions including the providing education on nce to facility diet m outside facility Food rly check on resident's food " ace-to-face interview were 22 at approximately 1:00PM, "The food is terrible and .One time they gave me a meatI can't get cold ice asked the resident about the these issues with staff? 'I do not get a menu" ew was conducted on ately 2:23 PM, Employee cian) stated "He (Resident has been seen by the ses and she follows up. he dietician where the esident could get a meal tician then showed the was posted for the month of nt month at the time of 2), on a bulletin board on a ation. The menu was noted of font and in area not		F812 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No resident was affected by this defici practice. Test tray of hot food was reassessed 6/21/22. Food temperature was within standard temperature range and Test is ongoing. The ceiling light located in a common area of the kitchen was replaced on 6/14/22. The wall behind the grease fryer was so on 6/14/22. The plate warmer was connected to po source immediately on 6/21/22 and is ongoing. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All the residents in the facility have the potential to be affected .	on the tray sealed ower	09/23/2

Facility ID: HCI

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		095015	B. WING				C / <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SEDENITY	REHABILITATION AND			13	80 SOUTHERN AVE SE		
JERENIT				W	ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 803	was a form labeled "N services That had foo lunch and dinner. Em was the alternative m 2. Resident #82 was 06/13/17, with multipl the following: Age-Re Bilateral, Vitamin B12 Unspecified, Vitamin and Unspecified Dem Disturbance. Review of a complain (Department of Healt Resident #82 docume providing my brother when meals will result An observation and fa conducted on 06/22/2 #82, the surveyor obs and noticed his break untouched and cover resident if he had eat which Resident # 82 can't eat those power asked the resident if I Resident # 82 respon no good they don't se Review of the Annual dated 06/02/22, revea the following: Section B (Hearing, S "Impaired" Corrective Lenses "Y	Next level Hospitality od choices for breakfast uployee #30 stated the form ienu for residents. admitted to the facility on e diagnoses that included elated Nuclear Cataract, 2 Deficiency Anemia D Deficiency Unspecified, nentia Without Behavioral at received by DOH h) on 02/22/22 concerning ented " I have been meals I would like to know me being served" ace-to-face interview were 22 at 10:18 AM with Resident served resident in his room tfast tray appeared ed. The surveyor asked the en and how was the food to stated "It was disgusting I red eggs" The surveyor he told staff to which oded "That ain't going to do end a menu" Minimum Data Set (MDS) aled that facility staff coded Speech, and Vision) Vision	F	t r t f f t	F812 Director of Maintenance /Designed will conduct house wide round/a common areas within the facility a the residents rooms to identify potent walls that wall are damaged with holes. Any issue found during this audit w corrected by 9/29/22 Food and Nutrition Services Direct /Designee will conduct rounds/au the kitchen to ensure the plate wa is connected to electricity to help maintain	udit of and ial will be or dit in	09/23/22

						B NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		095015	B. WING			C 06/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 803		174	E 80'	3 5040		09/23/22
F 803	Mental Status Summa intact cognition. Section G (Functional "Independent" requirin help from staff" Section K (Swallowing Swallowing Disorder ' Review of the Physici following: 06/01/22 "R Thin liquids consisten residents request" Review of the care pla "(Resident #82 is at n Dementia, Heart Failu Disorder-requiring Re nutritional supplemen had interventions whie "Regular Diet, Regula Consistency, Feeding tray set up" During a face-to-face 06/22/22 at 10:55 AM Floor Unit Manager) " they have to say som them something else" is a menu where resid how would a resident tray replaced. Employ get the dietician to sp During a face-to-face 06/22/22 at 12:07 PM (Registered Dietitian) residents choose alter they do not like a food	ary Score "14" indicating I status) Eating ng "No set up or physical g/Nutritional Status) "None of the above" ans orders revealed the Regular diet Regular texture, icy, Double Portion per an with a focus area of utritional risk related to ure, Major Depressive gular diet and oral ts" date revised 06/02/22, ch included the following ar texture, Thin Liquid b Ability Independent with interview conducted on with Employee #33 (2nd If they don't like the meal, ething then we can give ' The surveyor asked if there dents can make choices and get a meal or item on the vee #33 stated she would eak with the surveyor. interview conducted on with Employee #30 The surveyor asked how rnatives or replacements if d item that is being served. she was not sure and that	F 803	Food and Nutrition Service ensure that that the kitchen serve and distribute food in with professional standards food services by 09/23/22. Dietician and Nutritionist wit that the food served to the accordance with profession practice for food services. Any issues will be corrected Food and Nutrition Service will conduct food temperatu- units to confirm that the food temperature of hot food is a per food service standards. found will be corrected by	staff members accordance of practice for Il ensure residents are in al standards of d by 9/23/22. es Director ure test on the od at 140 degrees Any issues	

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	3		C
		095015	B. WING			06/29/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE	
SERENIT	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 803	During a face-to-face 06/22/22 at approxim Employee #38 (Kitche (alternative menu) is wall right here." The form that Employ menu is labeled "Ney The form was not eas	interview conducted ately 12:15 PM with en Director) "This always available it is on the yee #38 said is an alternative xt Level Hospitality services"	F 80	provide education/in-servi maintenance staff on imp 1.maintaining and ensurin light are cracked and loos facility. 2.maintaining and ensurin facility walls are not dam by 9/23/22. MONITORING OF CORR ACTION: Food and Nutrition Service	ces to the ortance of : g no ceiling se around the g that the aged with holes. ECTIVE es Director/	09/23/2
F 812 SS=D	residents. Food Procurement,St CFR(s): 483.60(i)(1)(/ §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and food (iii) This provision doe from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio	tore/Prepare/Serve-Sanitary 2) ty requirements. re food from sources red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional rvice safety. is not met as evidenced and staff interview, facility and serve foods under	F 81	Designee will conduct rou	nds in the d is distributed sional d will conduct ensure that the thin the standard 4,then monthly Designee round/audit of facility and the e no ceiling light ekly times 4,	

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/12/2022 MAPPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095015	B. WING				C / <b>29/2022</b>	
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC	1	138	REET ADDRESS, CITY, STATE, ZIP CODE NO SOUTHERN AVE SE ASHINGTON, DC 20032	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	fahrenheit (F) during cracked and loose ce kitchen, a damaged v and staff failure to fol practice. The findings include: During a food test tra 2022, at approximate as ham (117 degrees (105.7 degrees Fahre (111.7 degrees Fahre (111.7 degrees Fahre minimum required ter Fahrenheit (F). These observations v Employee #38 and/or face-to-face interview approximately 2:15 P During a walkthrough 14, 2022, at approxin following were observa- 1. A ceiling light locat kitchen was cracked 2. The wall behind the with holes. 3. Staff failed to conn warmer to help maint on the tray line on Ju approximately 12:45 of four (4) hot food ite	a test tray assessment, a elling light in the main wall behind the grease fryer, low food quality standards of y assessment on June 21, ely 2:00 PM, hot foods such a Fahrenheit), cabbage enheit), and mechanical ham enheit), tested below the mperature of 140 degrees were acknowledged by r Employee #42 during a y on June 21, 2022, at M. of dietary services on June nately 10:00 AM, the yed: ted in a common area of the and loose. e grease fryer was damaged mect one (1) of one (1) plate rain hot food temperatures ne 21, 2022, at PM. Subsequently, three (3) ems tested below required a test tray assessment on	F	812			09/29/22	

Facility ID: HCI

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		MEDICAID SERVICES				<u>0. 0938-039</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
						С
		095015	B. WING		06	/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	(REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
						09/23/2
F 812		e 177 vere acknowledged by	F 81	2 F880 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT:		
	Employee #38 and/or face-to-face interview approximately 3:00 P	r Employee #42 during a / on June 27, 2022, at M.		Resident #38 was administered med after being notified using parameter physician orders and licensed nurse education on proper administration	s per was	
SS=D	CFR(s): 483.80(a)(1)	(2)(4)(e)(f)	F 88	medications following infection prev practices. Resident was reassessed from head to toe on 08/17/22 by	ention	
	infection prevention a	blish and maintain an and control program		licensed nurse. Resident suffered no negative outco Resident #66 was assessed and	ome	
		nent and to help prevent the nsmission of communicable		monitored closely x 3 days for signs and symptoms of Covid-19. by licensed nurses post exposure to employee who was not vaccinated v Covid-19 vaccine, and was not wea	o an vith	
	program. The facility must esta and control program	a) Infection prevention and control by must establish an infection prevention ol program (IPCP) that must include, at		recommended face shield and N95 on 06/29/22. Resident #66 remained clinically stable without any symptor Covid-19. Resident suffered no neg outcome.	d ns of	
	a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			Employee #6 was verbally educated importance of the of wearing PPE a maintaining a minimum of 6 feet wh with resident or in the care area. Em was written up and suspended pend termination. Employee #6, resigned from susper Resident #406 was discharged on 7/21/22. Other resident belonging in were removed, the closet was thoro cleaned on 06/16/2022.	and hile working hployee #6 ding hsion. the closet	
	procedures for the probut are not limited to:	llance designed to identify ble diseases or v can spread to other		Cleaned on 06/16/2022. Resident suffered no negative outco	ome.	

Facility ID: HCI

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DATE		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG			PLETED	
		095015	B. WING				C 29/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
SERENITY	Y REHABILITATION AND	HEALTH CENTER LLC		1380 SOUTHERN AVE SE WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 880	Continued From page	e 178	F 8	80			09/23/22	
	(ii) When and to who	m possible incidents of se or infections should be			IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:			
	to be followed to prev (iv)When and how iso	nsmission-based precautions /ent spread of infections; plation should be used for a			All residents residing in the facility have potential to be affected.			
	(A) The type and dura depending upon the i				MEASURE TO PREVENT RECURRENCE:	-1 -		
	involved, and (B) A requirement that least restrictive possi circumstances. (v) The circumstance must prohibit employ disease or infected si contact with residents contact will transmit t (vi)The hand hygiene			The facility Staff Development will provie education/in-services to all facility staff infection control and prevention which include: Hand hygiene, Donning and do of Personal Protective Equipment (PPE), Maintaining social distancing of least 6 feet while interacting with others Importance of minimizing or prevent the potential spread infection (COVID-19) and other infectious diseases and the importance of proper cleaning and sanitizing resident rooms a	ffing at			
					shared equipment.			
	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.							
	IPCP and update the	view. ιct an annual review of its ir program, as necessary. Γ is not met as evidenced						
	Based on observation resident interviews, for residents, failed to pr	ons, record reviews, staff and or three (3) of 67 sampled operly minimize or prevent of infection as evidenced by						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 08/12/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095015	B. WING _				C <b>29/2022</b>
	ROVIDER OR SUPPLIER	HEALTH CENTER LLC		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	[unvaccinated staff] F Equipment (PPE) why #66 less than six (6) f clean Resident #406's admission. The findings included 1. Facility staff failed the potential spread of hand hygiene prior to one (1) resident. "Wash hands before a to prevent cross infect residue from the hand https://www.nursingtin nister-eye-drops-and- Administering eyedro and put on clean glow https://journals.lww.co 000/Administering_eye During a medication a on 06/16/2022 at app Employee #46, (Licer administering Reside him using a plastic sp gave the resident a co Employee #46 then p Refresh eye drops int eyes without first perf At the time of the obs acknowledged that sh	hygiene prior to ops to Resident #38; wearing Personal Protective en interacting with Resident feet away; and thoroughly s room prior to their : properly minimize or prevent of infection by not performing administering eye drops to and after instilling eye drops tion and to remove drug ds." mes.net/archive/how-to-admi ointments-26-09-2014/ psPerform hand hygiene res." om/nursing/Citation/2007/05 vedrops.14.aspx administration observation roximately 10:25 AM, nsed Practical Nurse) was nt #38's oral medication to boon. Employee #46 then	F	880	MONITORING OF CORRECTIVE ACTION: Assistant Director of Nursing (ADON)/Designee will conduct house w visual audit to identify resident on eye of to ensure that the licensed nurse perform hand hygiene when administering eye drops. Audit will be of weekly times 4, then, monthly times 3 m Unit Managers/Designee will conduct a visual audit of empty rooms on the units to identify potential resident rooms that are not cleand still contains belonging of previous residents. Director of Admissions/Designee will conduct house wide visual audit to admission ready empty rooms to identify potential rooms and closet that not properly clean and still contain belo of previous residents. Audits will be do weekly times 4, then, monthly times 3 m The Assistant Director of Nursing (ADON)/Designee will conduct house wide visual audit to identify potential residents that employees failed to properly minimize or prevent the potential spread infection (COVID-19) by not properly wearing Personal Protective Equipment (PPE) when interacting with Resident le than six (6) feet away weekly times 4, then monthly times 3 months. The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	drops done months. ean are onging ne months. he	09/23/22

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED 10. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		095015	B. WING		C 06/29/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO		
SERENT				WASHINGTON, DC 20032		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From page the resident's eyes.	e 180	F 8	80		09/23/22
	minimize or prevent t (COVID-19) by not w	ated staff failed to properly he potential spread infection earing Personal Protective en interacting with Resident feet away.				
	Review of the facility's policy entitled, "COVID-19 Healthcare Staff Vaccination", instructed unvaccinated staff to wear a N95 mask and face shield in the facility and continue to follow infection prevention guidelines.					
	#6 (Social Worker) w sitting at his desk talk approximately less th employee was not we mask. Resident #66 v	eximately 2:00 PM, Employee as observed in his office sing to a resident who was an 2 feet away. The earing a face shield or N95 was observed wearing a nder his chin not covering				
		s COVID-19 Staff r Provider form showed Worker) was not vaccinated				
	the resident was adm with multiple diagnost Pacemaker, Hyperter Continued review of t resident received Mo vaccinations on the fo	he record showed the				

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	-	D HUMAN SERVICES					FORM	0: 08/12/2022 A APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
095015		B. WING				C 06/29/2022		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
SERENITY REHABILITATION AND HEALTH CENTER LLC					380 SOUTHERN AVE SE VASHINGTON, DC 20032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 02/08/22.	181	F	880				09/23/22
		interview on 06/29/22 at M, Employee #6 was not with the surveyor.						
	and Employee #2 (DC approximately 2:15 Pl he did not have on a f he only spoke with Re minutes. When asked policy for wearing PPl	M, Employee #6 stated that ace shield or N95 because						
	prevent the potential	to properly minimize or spread of infection by not esident #406's room prior to						
	06/10/22 with diagnos Stenosis of the Spinal Femur, Cervicalgia (n	l Canal, Fracture of the Left eck pain), Lumbago (low codes/icd10cm/M542], and						
	Review of Resident # revealed:	406's medical record						
	documented, "adm Resident is alert/orien make needs know(n)	Nurses Admission Note] itted from [Local Hospital] ted x 3, cooperative, able to [Name of Physician] nt admission to the facility						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
095015		095015	B. WING			C 06/29/2022		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
	at approximately 9:20 resting in her bed. The facility staff had not the before she was admitt person's belongings ( closet. The resident a was aware because the admitted her into the measure of the saw clothing already here During an observation approximately 9:40 Al- Employee #33, Unit M to Resident #406's roop permission, the employ closet and acknowled bundles of clothing co- hanging in the resident asked Resident #406 and the resident replies the dresser and nights During a face-to-face 9:44 AM, Employee # housekeeping and nu clean a room before a thoroughly. Housekee room; when they find nursing staff know." E three covered bundles resident's room. Essential Equipment, CFR(s): 483.90(d)(2) Maintai and patient care equip	and interview on 06/16/22 AM, Resident #406 was be resident reported that oroughly cleaned her room ted, because another clothes) were hanging in her dded that the facility staff he staff person who room opened the closet and hanging in the closet. In on 06/16/22 at M, the surveyor asked fanager, to accompany her om. With the resident's oyee opened the Resident's ged that there were three overed with white trash bags ht's closet. The employee if the clothes were hers, ed, "No, I put my clothes in stand." interview on 06/16/22 at 33 stated, " It is the rsing staff's responsibility to a resident is admitted oping cleans and checks the clothing, they usually let the Employee #33 removed the			F908 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT The dishwasher was repaired on June 22, 2022. No negative outcome observed.		09/23/22	

Event ID: FZSW11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/12/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095015		B. WING _			C 06/29/2022	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SERENITY	REHABILITATION AND	HEALTH CENTER LLC			380 SOUTHERN AVE SE /ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 908	by: Based on observation staff failed to maintain safe condition as evid conveyor dishwasher move peg racks filled silverware and/or food The findings include: During observations in 21, 2022, at approxim one (1) conveyor dish automatically move so machine. to ensure p and proper final rinse cups, dishes, silverwa Consequently, the ne and the dishwasher w 2022. These observations of	is not met as evidenced as and staff interview, facility a essential equipment in lenced by one (1) of one (1) that failed to automatically with cups, dishes, d trays through the machine. a dietary services on June hately 11:00 AM, one (1) of twasher failed to biled items through the proper wash, proper rinse, of peg racks filled with are and/or food trays. cessary parts were ordered, vas repaired on June 22, were acknowledged by a face-to-face interview on	FS		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All facility essential equipment and patient care equipment have potential to be affected. MEASURE TO PREVENT RECURRENCE The facility Staff Development will provide education/in-services to the facility mainter staff and Kitchen staff on importance of maintaining essential and patient care equi in safe condition. MONITORING OF CORRECTIVE ACTION The Director of Maintenance/Designee will complete house wide audit of all facility ess and patient care equipment to identify pote equipment that is not maintained in a safe condition weekly times 4,then monthly time months. The findings of these audits will be present monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committ	nance coment : ential ntial s 3 ed	09/23/22

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