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	HFD02-0019	A. BUILDING: _____ B. WING _____	C 11/09/2022

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L 000	Initial Comments An unannounced Recertification Survey was conducted at Stoddard Baptist Nursing Home from October 31, 2022 - November 9, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 101 and the survey sample included 41 residents. The following complaints were investigated during this survey: DC00010130, DC00010482, DC00010861 and DC00011017. The following Facility Reported Incidents (FRI) were investigated during this survey: DC00010213, DC00010305, DC00010323, DC00010331, DC00010341, DC00010434, DC00010467, DC00010470, DC00010657, DC00010700, DC00010726, DC00010763, DC00010795, DC00010971, DC00011157, DC00011161 and DC00011139. Federal and Local deficiencies were cited related to the investigation of: DC00010482, DC00011017, DC00010213, DC00010305, DC00010331, DC00010341, DC00010434, DC00010470, DC00010726, DC00010763, DC00010795, and DC00011161. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities During the survey, actual harm deficiencies were identified at 3211.1 for Resident #26. The following is a directory of abbreviations and/or acronyms that may be utilized in the report:	L 000	Stoddard Baptist Nursing Home makes its best effort to operate in substantial compliance with both Federal and State Laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This Plan of Correction (POC) is prepared and/or executed solely because it is required by Federal and State Law.	

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L 000	Continued From page 1 AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass)	L 000		

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L 000	Continued From page 2 MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's ordersheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsibleparty SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 022	3206.1 Nursing Facilities	L 022		

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L 022	Continued From page 3 There shall be written policies to govern nursing care and related medical and other services provided. This Statute is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to have in their written dialysis policy, the need for an emergency dialysis kit (pressure bandage) to be at resident's bedside. Resident #79. The findings included: Review of the policy "Care of Residents Receiving Dialysis" last reviewed on 03/22/22 directed, "...residents who are dialysis dependent will receive nursing care appropriate to their individualized needs: the existence type (i.e., shunt, fistula, or graft) and location of the residents access will be noted and referenced in subsequent nursing notes ... care provided to the dialysis resident will be documented in the care plan..." During an observation of Resident #79 on 11/07/22 at 9:22 AM, he was noted with a right chest permacath and a dressing to his left lower arm. In a face-to-face interview conducted at the resident's bedside with Employee #18 (Licensed Practical Nurse/ LPN) at the time of the observation, the employee stated that the left lower is the site for Resident #79's new dialysis access site. Employee #18 was then asked to show the surveyor where Resident #79's emergency dialysis kit (pressure bandages) is located. The employee looked through all the drawers and was not able to locate an emergency dialysis kit. When asked why Resident doesn't #79 have an emergency dialysis kit as his bedside, Employee #18 stated, "I don't know. I	L 022	Resident #79 1. Resident was assessed by the DON on 11/4/22. The care plan was updated to include new dialysis access site. A dialysis emergency kit was also placed at the bedside on 11/4/22. There were no negative outcomes for this resident. 2. Care plan for one other resident was reviewed and updated to address availability of dialysis emergency kit on 11/4/2022. There are no negative outcomes for this resident. There are no other residents on dialysis. 3. The policy on care of residents with dialysis was revised on 11/10/2022 to address the need for a dialysis emergency kit at bedside. The nurse educator provided an in-service to all nursing staff on where to obtain BP measurements on residents with dialysis access sites and the need for an emergency dialysis kit at the dialysis resident's bedside. In-service was don on 11/10/22. 4. The nurse manager will inspect all dialysis residents' bedside for dialysis emergency kit and will conduct blood pressure observation at one random day/week to ensure staff are obtaining blood pressure measurements on the correct arm. Bedside rounds and BP observation will continue weekly until there is sustained 100$ compliance for 3 months. 5. Completion date: January 9, 2023 6. Director of Nursing	

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L 022	Continued From page 4 will have to refer you to my Assistant Nurse Manager." Resident #79 was readmitted to the facility on 09/22/22 with diagnoses that included: Acute Kidney Failure, Pleural Effusion and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #79's medical record revealed the following: 09/22/22 at 10:05 PM [Nursing Note] "Double lumen line was noted on resident's right chest..." 09/22/22 [physician's order] "Resident is for dialysis every Monday, Wednesday, Friday" A Significant Change MDS dated 09/27/22 showed facility staff coded: severe cognitive impairment and received dialysis while a resident. Care plan focus area "[Resident #79] has ESRD (End Stage Renal Disease) and is Hemodialysis Dependent" showed, "Last reviewed/revised 09/30/2022. Approach: Teaching to avoid trauma to dialysis access site, monitor for fluid excess (weight gain, increased BP (blood pressure); full/bounding pulse, jugular vein distention, SOB (shortness of breath), moist cough, rales, rhonchi, wheezing, edema, worsening of edema, increased urinary output, nausea/vomiting; liquid stools, confusion, seizures). Hemodialysis at ..." 10/27/22 at 7:10 AM [Nursing Note] "...Left for surgery appointment ... AV (arteriovenous) graft placement..." 10/27/22 at 11:34 PM [Nursing Note] "Resident wheeled back on to the unit at 7:10 pm...Left arm surgical site [new AV graft site] observed with	L 022		

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L 022	Continued From page 5 transparent pressure dressing. No signs of bleeding noted..." 10/29/22 at 12:11 AM [Nursing Post Dialysis Note] "... dialysis access site; [left] arm AV graft (AVG) dressing is intact and dry, no active bleeding noted. [Left] arm AVG is positive to bruits and thrills upon auscultation and palpation ..." During a face-to-face interview conducted on 11/07/22 at 9:50 AM, Employee #2 (Director of Nursing/DON) stated, "We have an emergency cart on each unit where we keep supplies such as pressure dressings and other items to stop or slow bleeding that can be used, if needed, for dialysis residents in case of an emergency."	L 022		
L 035	3207.10 Nursing Facilities Dated orders and dated progress notes in the resident's medical record shall be used to document medical supervision at the time of each visit and shall be signed and dated by the resident's physician or the resident's nurse practitioner or physician assistant, with countersignature by the resident's physician. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 41 sampled residents, the physician failed to provide adequate medical supervision as evidenced by: no physician's order for an indwelling catheter for one resident and a physician progress note that inaccurately documented the physician's involvement in the assessment and care of one resident. Residents' #298 and #79. The findings included:	L 035		

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L 035	Continued From page 6 Review of the policy "Health Record Documentation" last revised on 02/10/20 showed, "... Each resident who is assessed by the medical, clinical and other staff at [Facility Name]] and/or who receives clinical care must have a complete and accurate medical documentation record kept at all times ...Health care services should be documented while they are being provided or as soon as possible after they are completed ..." Review of the policy "Documentation Criteria" last reviewed on 07/22/22 directed, "Clinical notes are written by a licensed nurse in the medical record. Clinical notes are randomly audited by registered nurse quarterly. Finding of audit are reported to QI (Quality Improvement) team with scheduled meeting... Clinical notes for decubitus/open wound include: description of the area, size, drainage, presence of necrotic tissue, and condition of skin around the area ... treatment was done as ordered ... skin: note condition of feet even if no open areas exist ...note for evidence of infection..." 1. Facility staff failed to adequately evaluate Resident #298's condition and total program of care as evidenced by no physician's order for an indwelling catheter that was present on admission to the facility. During a facility tour conducted on 10/31/22 at approximately 3:15 PM, Resident #298 was observed in her room with her urine collection bag uncovered, visible from hallway. Resident #298 was admitted to the facility on 10/28/22 with multiple diagnoses that included:	L 035	Resident #298 1. The Director of Nursing re-assessed Resident #298 on 11/8/22 and reviewed documentation on 11/8/22. An order for an indwelling catheter was obtained for Resident #298 on 11/8/22. There were no negative outcomes as a result of this deficient practice. 2. All other residents were reviewed for admission orders, specifically for foley catheter orders. There were no other residents affected by similar deficient practice in other 4/4 residents with Foley catheters. 3. An in-service on Admission Orders was provided by the Director of Nursing to the Licensed Nurses on 11/8/22. 4. The Director of Nursing (or designee) will audit all new resident's physician admission orders to ensure residents receives necessary care and services on admission. Audit findings will be monitored and findings shared with QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 035	Continued From page 7 Overactive Bladder and Change in Bowel Habit. A review of the medical record revealed the following: 10/28/22 [Nursing Progress Note] "... [Resident #298] is an 81-year-old African American female newly admitted from [Hospital name] ...Catheter was placed with improvement. Resident however failed void trial and catheter was replaced and is to be on until next follow up with urology..." 10/29/22 [History and Physical] "... Patient has an indwelling Foley inserted in the hospital due to urinary retention ..." Care plan focus area "Indwelling catheter ..." initiated on10/31/22 had the goal of, "Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma..." From the date of admission, 10/31/22) to 11/08/22 (totaling nine days), there was no documented evidence of a physician's order for Resident #298's indwelling urinary catheter. During a face-to-face interview conducted on 11/08/22 at 3:35 PM, Employee #2 (Director of Nursing/DON) stated, "There is no order for the catheter; she [Resident #298] came in the evening." 2. Facility failed to ensure that a physician's progress note, that documented the physician's involvement in the assessment and care of Resident #79, was accurate. Resident #79 was admitted to the facility on 05/02/19 with diagnoses that included: Acute	L 035	Resident #79 1. Physician inadvertently wrote a note on the wrong resident. The physician assessed resident and note was invalidated by the author (MD) on 12/16/22. There were no negative outcomes for this resident as a result of this deficient practice. 2. A review of all residents transferred to the hospital was conducted on 12/22/22 by the Health Information Manager to identify any similar error. There were no other residents affected by this deficient practice. 3. The Administrator provided physician re-education on accuracy of documentation on 12/14/22. 4. Physician entries on residents who are away from the facility will be monitored by the Health Information Manager weekly and reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Health Information Manager	

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L 035	Continued From page 8 Kidney Failure, Pleural Effusion, Chronic Obstructive Pulmonary Disease and Combined Systolic (congestive) and Diastolic (congestive) Heart Failure. Review of Resident #79's medical record showed the following: 07/23/22 at 10:57 PM [Nursing Note] "Resident transfer to ... ER (emergency room) via 911. MD (medical doctor) made aware of transfer ..." 07/24/22 at 2:51 AM [Nursing Note] "Call placed to [Hospital Name] in ref (reference) to resident status, Writer was told by charge that resident was admitted. No further information given..." 08/16/22 at 12:31 PM [Physician's Note] "...Attending Physician Note. Date: 8/16/2022 ... 68-year-old Caucasian male, resident of this facility since May of 2019 ...Clinically he has continued to do well and has remained stable ...There have been no new issues regarding his care. Chest Wall: Unremarkable. Lungs: Clear to auscultation and percussion. Cardiovascular ...S1 and S2 (heart sounds) within normal limits ... There has been no new issue regarding his care. We will continue his current management. Plan: Remains clinically stable. Continue current management. [Name of Physician], MD Attending Physician." 09/22/22 at 10:04 PM [Nursing Note] "[Resident #79]... re-admitted from [Hospital Name]... at 1:35 pm..." The evidence showed that the physician documented to doing an assessment on Resident #79 even though he was hospitalized from 07/23/22 to 09/22/22.	L 035		

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L 035	Continued From page 9 During a face-to-face interview conducted on 11/07/22 at 9:50 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comments.	L 035		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interviews for two (2) of 41 sampled residents, facility staff failed to ensure that the charge nurses implemented daily skin assessment for one (1) resident and failed to document evidence of	L 051		

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L 051	Continued From page 10 implementation of one (1) resident's non-compliance/refusal care plan interventions. Residents' #350, and #299. The findings included: 1. Facility staff failed to implement daily skin assessments per Resident #350's care plan. Resident #350 was admitted to the facility admitted 10/23/19 with diagnoses including Cerebral Vascular Accident, Peripheral Vascular Disease, Dysphagia, Gastrostomy Status, Lower Extremity Contracture, and Generalized Muscle Weakness. A complaint, DC00010482, received by the State Agency on 12/30/21 documented, "[Hospital Social Worker] explained that the physician asked her to file a report due to the condition of the pressure wounds ...a call was placed to the niece who also wanted to file a complaint (attach). Since, both [Local Hospital] and the niece wanted to file a complaint about the condition of and care that the member was receiving, our office is submitting the complaints together to your office for review and investigation as appropriate." A review of Resident #350's medical record revealed: 10/23/19 at 11:59 AM [physician's order]: "Apply barrier cream to sacrum, buttocks, and peri-area after each incontinent care for skin protection." 10/24/19 at 12:16 PM [physician's order]: "Monitor for Bruising/Bleeding every shift."	L 051	Resident #350 1. Resident is no longer in the facility; therefore, no corrective action can be made at this time. 2. All other residents with care plans requiring skin assessment were reviewed for implementation of intervention; skin assessment and findings were documented as needed. 3. The Nurse Educator provided all clinical staff an in-service on care planning, appropriateness of interventions, implementation of intervention as directed, and documentation of interventions performed. In-service is on-going, started 11/14/22. 4. The DON or designee will review residents care plan on skin care for resident centered and comprehensive care plan monthly. Findings will be reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 051	Continued From page 11 10/24/19 at 12:16 PM [physician's order]: "Turn and Repositioning Q (every) 2 hours." 09/08/21 [Care Plan]: "Category: Skin Integrity... [Resident #350] has potential for impairment of skin integrity, r/t (related to) peripheral vascular disease...Approach: "Assess skin condition daily and note any changes..." Quarterly Minimum Data Set dated 09/30/21 showed facility staff coded: extensive assistance for bed mobility and eating and as "totally dependent" for transfers, locomotion, toileting, dressing, bathing, and personal hygiene. In addition, facility staff coded the Resident as having no pressure ulcers, having two venous and arterial ulcers; and at risk for developing pressure ulcers/injuries. 12/06/21 at 3:00 PM [Nursing Progress Note]: "... observed with [an] intact blister in the sacrum measuring 3 cm (centimeter) x 3.5 cm x 0 cm this shift. PMD (Primary Medical Doctor) made aware [and] ordered to cleanse the area with normal saline, apply bacitracin ointment and leave open air until seen by wound doctor..." 12/06/21 at 3:20 PM [Skin Sheet]: "Description initial skin sheet: intact sacral blister, Type of Skin Assessment: Weekly Skin ...Location: Sacrum, Stage: Pressure ulcer Stage 2, Type of Wound: Blister, Appearance: Clean, Drainage: None ...Length: 3.0 cm, Width: 3.5 cm, Depth: 0 cm." Care plan initiated on 12/06/21: "Category Ulcer/Wound (skin)...Assess skin condition daily and note any changes, treatment as indicated..." From 12/07/21 to 12/09/21 (three days), there was no documented evidence that facility staff	L 051		

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L 051	Continued From page 12 assessed Resident #350's sacral area or skin condition. December 2021 Treatment Administration Record (TAR) showed that from 12/07/21 to 12/09/21, facility staff initialed to attest that they were: applying barrier cream to the resident's sacrum, buttocks, and peri-area after each incontinent care for skin protection; monitoring the resident's skin for bruising and bleeding every shift and were turning and repositioning the resident every two hours. 12/10/21 at 10: 56 AM [Nursing Progress Nurse]: "Resident seen today by [Wound Care Physician]/wound team during wound rounds for assessment and evaluation of bilateral leg dry scabs and sacral intact blister. Upon assessment, bilateral leg scabs, dry and stable..." 12/11/21 - there was no documented evidence that facility staff assessed Resident #350's sacral area. 12/11/21 Treatment Administrated Record (TAR) showed facility staff initialed to attest that they were: applying barrier cream to the resident's sacrum, buttocks, and peri-area after each incontinent care for skin protection; monitoring the resident's skin for bruising and bleeding every shift and were turning and repositioning the resident every two hours. December 2021 Medication Administration Record (MAR) showed that from 12/06/21 to 12/11/21, facility staff initialed to attest that they were cleansing Resident #350's sacral blister with normal saline, applying Bacitracin ointment, and leaving it open to air.	L 051		

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L 051	Continued From page 13 12/12/21 at 2:36 PM [Skin Sheet]: "Description initial skin sheet: intact sacral blister, Type of Skin Assessment: New Wound ...Location: Left buttocks...Length: 5.5 cm, Width: 5.5 cm, Depth: 0 cm." 12/12/21 at 3:19 PM [Nursing Progress Note]: "Resident was noted with intact blister measuring 5.5 x 5.5 ... Nursing supervisor made aware, and she came to assess Resident. Call placed to NP (Nurse Practitioner) ...and he was made aware of blister. New order to clean area with normal saline, apply bacitracin daily and leave open to air until seen by [Wound Care Physician] ..." For Resident #350, the evidence showed that facility staff implemented the daily skin assessments on the resident's sacrum from 12/07/21 to 12/09/21 (three days) and on 12/11/21. Subsequently, on 12/12/21, the resident developed a new blister on the left buttock that was first observed measuring 5.5 cm x 5.5 cm. 2. Facility staff failed to show documented evidence of implementation of Resident #299's non-compliance/refusal of care plan interventions. Resident #299 was admitted to the facility on 12/06/18 with multiple diagnoses that included: Heart Failure, Unilateral Inguinal Hernia, and Pressure Ulcer of Sacral Region. On 10/06/22 at 10:21 AM, a Complaint (DC00011017) was submitted to the State Agency that revealed the following: "... [Resident #299]'s health has declined rapidly in the past month.	L 051	1. Resident # 299 was discharged on 10/5/22. No corrective action could be done during this timeframe. 2. All other residents records were reviewed and residents identified with refusal to care were assessed and care plan updated to address advantages of treatment and consequences of refusal. 3. The interdisciplinary care plan team was provided an in-service education on addressing resident noncompliance by the Nurse Educator on 12/14/22. 4. Medical records of residents with refusal to care/noncompliance with therapeutic interventions will be reviewed monthly for documented refusal and care plan addressing noncompliance and consequences of noncompliance. 5. Completion date: Jan. 9, 2023 6. MDS Coordinator	

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L 051	Continued From page 14 When he first came to the facility, he was ambulatory with an assistive device until about one month ago. He has lost weight, is weak, unable to walk, unable to feed himself, and lies in bed, often in a fetal position. He has had an enlarged scrotum that continues to grow in size that she feels no one has addressed..." A review of the medical record revealed the following: 07/05/22 [Quarterly Minimum Data Set (MDS)]: Facility staff coded: the resident as having a Brief Interview for Mental Status (BIMS) summary score of 11, indicating moderately impaired cognition and that rejection of care occurred four (4) to (6) days but not daily. 08/08/22 at 5:03 PM [Physician Progress Note] "...Patient refused to allow me to see his scrotum ..." 08/10/22 at 2:39 PM [Nursing Progress Note] "...Resident continues refusing all AM medications..." 08/16/22 at 3:19 PM [Nursing Progress Note] "...Shower offered by staff members refused stated to writer I am clean ...also refused afternoon BP (Blood pressure)/meds (Medications)..." 09/05/22 at 3:23 PM [Nursing Progress Note] "...Resident alert and verbally responsive and oriented times 3 observed this shift lying on his bed with clothes and linens full of urine. Shower offered several times: stated "I do not need shower". Clean gowns offered, refused brief. Also refused vital signs, BP (blood pressure) meds (medications) on hold at this time ..."	L 051		

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L 051	Continued From page 15 09/25/22 at 11:39 PM [Nursing Progress Note] "...Resident was very uncooperative during evening care. He refused the assigned CNA (Certified Nurse Aide) to provide incontinent care to him. He lay in his urine and all attempt to make him comply was met with staff opposition from Resident ..." A review of a care plan with a revision date of 09/27/22, documented, "...Problem: Non -Compliance [Resident #299] is non-compliance with plan of care; refused annual flu vaccine, Non-compliance with assessment and treatment, refused covid -19 vaccine ...Approach Reiterate the purpose and advantages of treatment for the resident. Explain the disease process and consequences of refusal of therapy. Report refusal to physician. Respect resident's rights to refuse treatment (s). Involve family as needed..." 09/28/22 at 10:45 PM [Nursing Progress Note] "...Resident refused dinner..." 10/05/22 at 1:11 AM [Nursing Progress Note] "...Refused medications and meal this shift ...Refused incontinent care, refused to be reposition (sp)..." The medical record lacked documented evidence that facility staff implemented the approaches of reiterating the purpose and advantages of treatment, explaining the disease process and consequences of refusal, reporting refusal to the physician and involving family for Resident #299's non-compliance/refusal of care. During a face-to-face interview conducted on 11/07/22 at 10:53 AM, Employee #2 (Director of Nursing) acknowledged the findings and made no further comment.	L 051		

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L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating	L 052		

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L 052	Continued From page 17 independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interviews, for six (6) of 41 sampled residents, facility staff failed to ensure that sufficient nursing time was given to each resident to ensure that the residents received proper care to: ensure that one received timely treatment and care in accordance with professional standards of practice and the physician's orders for her right foot; minimize pressure ulcers and to promote the healing of ulcers for three residents; and identify and implement measures or approaches to reduce the risk of accidents (falls) for two residents. Residents' #26, #350, #349, #80, #68 and #32. These failures resulted in actual harm to Resident #26 when it was determined that the resident's reddened right big toe (first observed on 07/14/22) advanced to "gangrene of the right foot... extending to the midfoot... no realistic chance of healing...The only choice [for] her would be below-knee amputation..." on 10/26/22. The findings included: Review of the policy "Pressure Ulcers, Prevention and Care" last reviewed on 10/14/19 directed, "Full body inspection daily during skin care. Routine skin checks will be done on all residents on a basis. The attending physician, family and interdisciplinary team will be notified of ... deterioration and change ... Assess areas most at	L 052		

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L 052	Continued From page 18 risk for ulcer formation ... hip and buttocks ... heels and toes ... The licensed nurse documents on all pressure ulcers every seven days on the Pressure Ulcer Weekly Skin Assessment Sheet ..." Review of the policy "Documentation Criteria" last reviewed on 07/22/22 directed, "Clinical notes are written by a licensed nurse in the medical record. Clinical notes are randomly audited by registered nurse quarterly. Finding of audit are reported to QI (Quality Improvement) team with scheduled meeting... Clinical notes for decubitus/open wound include: description of the area, size, drainage, presence of necrotic tissue, and condition of skin around the area ... treatment was done as ordered ... skin: note condition of feet even if no open areas exist ...note for evidence of infection..." Review of the 1st floor shower book showed a document titled, "Skin Monitoring: CNA (Certified Nurse Aide) Shower Report" that directed, "perform a visual assessment or a resident's skin when giving the resident a shower. Report any abnormal looking skin to the charge nurse immediately..." The form also had an area that directed, "Charge nurse assessment" followed by a designated space for the CNA's signature as well as the charge nurse's signature. 1. Facility staff failed to ensure that Resident #26 received timely treatment and care in accordance with professional standards of practice and the physician's orders for her right foot. During a tour of the 1st floor on 10/31/22 at 12:15 PM, Resident #26 was observed in bed, covered with a sheet, with both her feet exposed. The right foot was observed to be necrotic from	L 052	Resident # 26 1. Resident # 26 is no longer in the facility and unable to retrospectively correct. 2. All residents with foot related conditions were addressed and all necessary care plans were reviewed to reflect the assessment, goals, care plans and the assessment. All other residents with skin breakdown were assessed as per facility policy and care plan revised to reflect weekly skin assessment policy. All other residents records were reviewed for incomplete duplex/vascular studies and followed through as needed. There were no other vascular/duplex studies at this time. 3. All nursing staff and the interdisciplinary team were re-educated on resident centered care planning on 11/14/22(on-going) by the Nurse Educator. The nurse Educator provided an in service to all licensed nursing staff regarding skin assessment and timely physician update on resident's condition from Nov. 14, 2022. In-service was provided to all licensed nursing staff regarding timely implementation of physician's orders by the nurse educator. Incomplete orders will be referred to the physician. In-service was provided by the Director of Nursing on 11/11/22.	

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L 052	Continued From page 19 midway of the foot, extending to all five of her toes. Resident #26 was admitted to the facility on 05/10/19 with diagnoses that included: Idiopathic Peripheral Autonomic Neuropathy, Type 2 Diabetes Mellitus and Muscle Weakness. Review of Resident #26s medical record revealed the following: 05/10/19 [physician's order] "Monitor for bruising/bleeding every shift" 05/10/19 [physician's order] "Turn and repositioning Q (every) 2 hrs (hours) every shift" Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility, incontinence, underweight" initiated on 09/10/19 had the following approaches, "Report any signs of skin breakdown (sore, tender, red, or broken areas). Provide diet and supplement as ordered. Dietary consult PRN (as needed)...Keep clean and dry as possible. Minimize skin exposure to moisture." The Annual Minimum Data Set (MDS) dated 05/10/22 showed facility staff coded the resident as: usually makes self understood; usually understands others; severe cognitive impairment; no behavior issues or refusal of care; required extensive assistance with two persons physical assist for bed mobility; required extensive assistance with one person physical assist for transfers, toilet use and personal hygiene; no functional limitations in range of motion; at risk for pressure ulcers; and no unhealed pressure ulcers or any other skin conditions.	L 052	Resident #26 continued 4. The charge nurses will review the care plans of residents with foot conditions monthly for resident centered and comprehensive care plan. Findings will be reported to QAPI monthly. The wound care team will assess residents with skin breakdown and review documentation of skin/wound assessment and notification of resident's physician weekly. Care plans will be monitored for implantation of interventions monthly be the DON/designee and findings will be reported to QAPI monthly. Resident Care Coordinators will monitor completion of consult orders weekly and reported to QAPI monthly. 5. Completion date: Jan 9, 2023 6. Director of nursing	

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L 052	Continued From page 20 06/27/22 "Monthly Summary...No skin breakdown ... no new skin issues noted..." 07/14/22 at 11:48 AM [Physician's Assistant Note] "...Pt's (patient's) nurse reported that pt complained of big toe pain and redness [right toe]...Pt admits to doing well and admits to pain to the foot ...Plan: ...Order Colchicine (decreases swelling) 0.6mg (milligrams) tablet, give 2 tablet x 1, then 1 tablet 1 hour later for Gouty exacerbation." 07/14/22 at 10:55 PM [Nursing Note] " ...MD (medical doctor) in house, made aware of RT (right) great toe swollen, new order given for Colchicine 0.6mg tab (tablet), give 2 tabs x1, then 1 tab 1 hour later for Gouty exacerbation. Order faxed, awaiting delivery ...Will continue with POC (plan of care)." 07/15/22 [physician's order] "Colchicine tablet; 0.6 mg; amt (amount): 2 tabs x1; oral Special Instructions: give 2 tablet x 1, then 1 tablet 1 hour later for Gouty exacerbation once - one time" It should be noted the order for Resident #26 to receive Colchicine was written one day after she was assessed for the pain and redness of her right foot. A review of the "1st Floor Assignment" sheet was conducted and showed that Resident #26 was scheduled to receive a shower every Monday and Thursday evening shift (3:00 PM - 11:00 PM). CNA documentation showed that on 07/17/22, evening shift, Resident #26 received a shower. However, there was no evidence that a skin report sheet was completed to show that a skin assessment was performed. Furthermore, as of	L 052		

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L 052	Continued From page 21 11/09/22, facility staff was unable to provide documented evidence that a shower report sheet had been completed on Resident #26 for any of her scheduled shower days from January 2022 to present. Treatment Administration Record (TAR) showed that from 07/15/22 to 07/22/22, facility staff documented: "0" or "none noted" in the area that directed, "Monitor for bruising/bleeding every shift"; and that Resident #26 was "turned and repositioned q (every) 2 hours". From 07/15/22 to 07/22/22 (8 days), there was no documented evidence that facility staff performed an assessment (skin color, temperature, pain and swelling) of Resident #26's right foot. 07/23/22 at 8:58 PM [Physician's Note] "...Patient seen at the request of nursing for ischemic [necrotic] foot and toe with surrounding cellulitis...Dark big toe dry and cellulitis...Begin Keflex (antibiotic)..." 07/23/22 at 11:05 PM [Nursing Note] "...New order given (1) Keflex 500mg po (by mouth) TID (three times a day) X 7 days for cellulitis of foot ...and Gangrene [Dead tissue caused by an infection or lack of blood flow]." 07/26/22 [physician's order] "Uric Acid"[laboratory test that measures waste product found in blood] 07/26/22 at 5:57 PM [American Health Associates] "...Uric Acid ... 3.9 ... Reference range 2.3 - 6.6 mg/dL (deciliter) ..." 07/28/22 at 8:11 AM [Physician's Assistant Note] "...MSc (musculoskeletal): Normal ROM (range of motion) to lower extremities, hyper pigmented	L 052		

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L 052	Continued From page 22 discoloration of the foot, and no pedal edema...Plan 1. Continue with current treatment plan and level of care...Continue with Cellulitis medication regimen and treatment." 07/31/22 [Monthly Summary] "... Resident recently completed antibiotic ...for right foot cellulitis ..." 08/01/22 at 10:06 PM [Nursing Note] "... [resident's] RT foot remains swollen, denies pain." 08/06/22 at 7:34 PM [Physician's Note] "Follow up done regarding PVD (Peripheral Vascular Disease) with dry gangrene. Hyperpigmentation persists with skin warm to touch and dry... Continue current treatment ..." A Quarterly MDS dated 08/09/22 showed facility staff coded: required extensive assistance with two persons physical assist for bed mobility; required extensive assistance with one person physical assist for personal hygiene; at risk for pressure ulcers; and 1 venous/arterial ulcer present. It should be noted that the MDS is coded as the Resident having 1 venous/arterial ulcer present. However, there are no documented skin assessments/clinical notes for any open wound/ulcer for this time period. Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility ....underweight" showed it was revised on 08/16/22. However, there was no evidence that when facility staff first noted the change in the condition to the resident's right foot, that the care plan was updated to include person-centered	L 052		

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L 052	Continued From page 23 care goals and approaches that addressed actions, treatments, procedures, or activities for the care of Resident #26's right foot. From 08/09/22 [date the MDS was coded for Resident #26 having one venous/arterial ulcer] to 08/23/22 (15 days), there was no documented evidence that facility staff performed an assessment (skin color, temperature, pain and swelling) of Resident #26's right foot. The August 2022 TAR showed that from 08/09/22 to 08/23/22 (15 days), facility staff documented: "0" or "none noted" in the area that directed, "Monitor for bruising/bleeding every shift"; and that Resident #26 was "turned and repositioned q (every) 2 hours". 08/24/22 at 9:56 PM [Nursing Note] "...Vascular Consult for RT lower extremity. [Duplex (test examines the blood flow in the major arteries and veins in the arms and legs)] for diagnosis follow up. DX (diagnosis) (1) Toe pain great toe (2) Wound great toe RT nacrotic (sp). (2) Wound care cleansing RT great toe and light dressing pending vascular consult." 08/24/22 [physician's order] "Vascular consult for rt lower extremity [Duplex] for diagnosis and follow up ..." 08/24/22 [physician's order] "Wound care cleansing RT great toe and light dressing pending vascular consult - once a day" 09/03/22 at 1:00 PM [Nursing Note] "...Seen today by wound doctor ..." 09/03/22 [physician's order] "Bacitracin (topical antibacterial) ointment; 500 unit/gram; ribbon	L 052		

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L 052	Continued From page 24 size; apply ointment to right toe once daily. Leave open to air dry ..." 09/08/22 at 11:02 AM [Physician's Assistant Note] "Pt seen at bedside on routine visit appears alert and stable.... Pt appears to be doing well and denies to pain to the foot .... MSc: Normal ROM to lower extremities, hyperpigmented discoloration of the foot, and no pedal edema. continue with current treatment and level of care ... " From 09/09/22 to 09/21/22 (13 days), there was no documented evidence that facility staff performed an assessment (skin color, temperature, pain and swelling) of Resident #26's right foot. September 2022 TAR showed that from 09/09/22 to 09/21/22, facility staff initialed in the area that directed, "Bacitracin ... apply ointment to right toe once daily. Leave open to air dry.... " indicating that the task was completed and documented: "0" or "none noted" in the area that directed, "Monitor for bruising/bleeding every shift"; and that Resident #26 was "turned and repositioned q (every) 2 hours". 09/22/22 at 7:34 PM [Physician's Assistant Note] "Pt's nurse reported that pt's right foot toes are changing color with gangrene.....Pt was communicated through phone translator.....Order bilateral duplex arterial/venous US (ultrasound) to rule out occlusion." 09/23/22 [physician's order] "Duplex Doppler arterial\venous right leg and left leg ... " 09/23/22 at 11:24 PM [Nursing Note] "Dynamic mobile called that Doppler will be done tomorrow and not today, to be done on 09/24/22 ...."	L 052		

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L 052	Continued From page 25 09/24/22 at 9:20 PM "Dynamic Mobile Imaging ... procedure: venous Doppler bilateral ... findings: the venous ultrasound is normal ...no evidence of venous clot ..." 09/26/22 at 2:54 PM [Nursing Note] "[Resident #26] was seen today by ...wound specialist and the wound team in house for dry gangrene perfusing (sp) right toes ischemic 1st, 4th and 5th toe continue Bacitracin ointment and leave open to air... No new order at this time." 09/29/22 at 6:35 PM [Physician's AssistantNote] "Pt's nurse reported that pt had Doppler Scan results that need to be reviewed andaddressed ... Imaging: Venous Doppler bilateral LE (lower extremities) shows no evidence of venous clots ...Plan Continue with current treatment plan and level of care..." 10/01/22 [physician's order] "Bilateral lower extremities arterial Doppler..." 10/01/22 at 10:00 PM [Nursing Note] "...Total care provided, turned and repositioned [every] 2 hours ... Bilateral lower extremities arterial Doppler done this shift, result pending..." 10/02/22 at 1:06 AM [Dynamic Mobile Imaging] "... procedure: arterial legs bilateral venous ... findings: right: moderate plaque is noted within visualized arteries ... Findings consistent with moderate PVD without occlusion, right lower extremity ...Moderate stenosis between right proximal femoral artery and mid SFA (superficial femoral artery). Moderate stenosis of the right distal SFA ..." It should be noted that the duplex test was first	L 052		

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L 052	Continued From page 26	L 052		

ordered on 08/24/22. A venous duplex test was not completed until 09/24/22 (31 days later), that showed no evidence of venous clots. Within this timeframe), Resident #26 had additional toes that became ischemic (4th and 5th toes). An arterial duplex was then done on 10/01/22 that showed PVD with moderate stenosis of the right lower extremity.

The October 2022 TAR showed that from 10/02/22 to 10/16/22, facility staff initialed in the area that directed, "Bacitracin ...apply ointment to right toe once daily. Leave open to air dry ..." indicating that the task was completed and documented: "0" or "none noted" in the area that directed, "Monitor for bruising/bleeding every shift"; and that Resident #26 was "turned and repositioned q (every) 2 hours".

From 10/02/22 to 10/16/22, (15 days), there was no documented evidence that facility staff performed an assessment (skin color, temperature, pain and swelling) of Resident #26's right foot.

10/17/22 at 1:47 PM [Nursing Note] "[Resident #26] was seen today by ...wound specialist and the wound team in house for dry gangrene perfusing right toes ischemic 1st, 4th and 5th to continue Bacitracin ointment and leave open to air."

10/22/22 at 5:37 PM [Nursing Note] "Resident ...seen by PCP (primary care physician) ...on shift. Orders given to send resident to the hospital for progressive gangrene, needs revascularization vs (versus) amputation ..."

10/23/22 [Hospital Discharge Summary] " ...presenting to the ED (emergency department)

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L 052	Continued From page 27 with dry gangrene of [right] foot ... Per vascular surgery, no urgent surgical intervention is warranted at this time ... recommended Betadine and dry dressing for patient's wounds ..." 10/23/22 at 10:27 PM [Nursing Note] "Resident back on the unit from ER (emergency room) visit at 3:45pm ... Resident discharged from ER with recommendation for right foot gangrene treatment with Betadine daily and to follow up with ... wound center and scheduled vascular surgery appointment on 10/26/22 ..." 10/23/22 [physician's order] "Cleanse right foot gangrene with Betadine and leave open to air daily once a day" 10/26/22 at 1:15 PM [Vascular Consult Note] " ... presents with gangrene of the right foot ... extending to the midfoot ... no realistic chance of healing ... The only choice [for] her would be below-knee amputation ... The patient and family do not wish to have major amputation ..." Review of Resident #26's comprehensive care plan showed that from 07/14/22 to 11/03/22there was no evidence that facility staff developed a patient-centered care plan with goals, approaches to address care of Resident #26's right foot. There was no evidence that facility staff provided Resident #26 with the necessary care and required services to meet the resident's needs as evidenced by: 1. Failure to develop a patient-centered care plan to address care of Resident #26's right foot 2. Failure to conduct ongoing skin assessments	L 052		

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L 052	Continued From page 28 as directed by the facility's policies and "Skin Monitoring Shower Report" 3. Failure to assess and document skin color, temperature, pain and swelling of Resident #26's right foot in order report any changes and deterioration in the residents condition to the physician from 07/15/22 to 07/22/22 (8 days), 08/09/22 to 08/23/22 (15 days), 09/09/22 to 09/21/22 (13 days) and 10/02/22 to 10/16/22 (15 days) 4. Failure to obtain ordered duplex and vascular consult in a timely manner. Duplex and Vascular consult were ordered on 08/24/22. A venous duplex test was not completed until 09/24/22 (totaling 31 days later), that showed no evidence of venous clots. Within this timeframe (31 days), Resident #26 had additional toes that became ischemic (1st, 4th and 5th toes). An arterial duplex was then done on 10/01/22 that showed PVD with moderate stenosis of the right lower extremity. The vascular consult was completed on 10/26/22 (totaling 63 days later) where it was documented, "gangrene of the right foot... extending to the midfoot... no realistic chance of healing...The only choice her would be below-knee amputation..." During a face-to-face interview on 11/04/22 at 12:21 PM, Employee #10 (1st Floor Charge Nurse) reviewed Resident #26's comprehensive care plan, acknowledged the findings, and made no further comments. During a face-to-face interview conducted on 11/07/22 at 12:09 PM, Employee #10 stated, "When the doctor's order a consult, the nurse reviews it and lets the unit secretary know so it can be scheduled. Once it is scheduled,	L 052		

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L 052	Continued From page 29 arrangements are made for transportation and the consult date is documented." When asked why Resident #26's vascular consult was never scheduled as ordered, the employee stated, "I don't know." A face-to-face interview was conducted on 11/07/22 at 3:30 PM with Employees #2 (Director of Nursing/DON) and #11 (Clinical Educator). Employee #11 stated, "Nurses are supposed to do a weekly skin assessment on all residents whether they have wounds or not. When the CNA's give a shower, they look for any new areas and report that to the nurse. The nurse then documents it in Matrix Care (facility's electronic health record system) and makes the doctor aware. There's a shower sheet that both the CNA and nurse have to sign off on. The shower sheets are kept in a binder. There's one for every unit." When asked who audits the shower sheets or Matrix Care to ensure compliance with resident skin assessments, Employee #11 stated, "I can't answer that question." Employee #2 stated, "Unit Managers are supposed to check that the shower sheets and weekly skin assessments are being done and report back to me. There have not been any audits done lately on whether the skin assessments are being completed and I have not audited or reviewed to make sure that the forms [shower report] are getting completed." When asked about the care plans either not getting developed or not being patient-centered, Employee #2 stated, "Only the RNs (registered nurses) can start or revise care plans. That's the charge nurses, evening and night supervisors and myself." Employee #2 acknowledged that licensed staff have not been developing or revising the care plans with patient-centered	L 052		

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L 052	Continued From page 30 goals and approaches. When asked about the facility's process is for when the physician orders laboratory (lab) or any other test. Employee #2 stated, "If the doctor orders a test, we call the lab or the x-ray and tell them. Once the results are in, we call the doctor and make him aware of the results. The nurse then signs and dates the form and puts it in the doctor's binder for them to sign when they come in. The night shift is supposed to check to see if tests that were ordered were obtained, if the results are back and if they were reported to the physician." When asked about the delay of Resident #26's ordered duplex test, Employee #2 stated that he doesn't know how it was missed the first time [08/24/22]. During a face-to-face interview conducted on 11/09/22 at 11:08 AM, Employee #2, #11, and #12 (Director of Quality Improvement) were made aware of the findings that Resident #26 did not receive the necessary care and required services for her right foot, causing a negative outcome. They all acknowledged the findings. 2. Facility staff failed to assess Resident #350's skin daily to prevent the development of potentially avoidable pressure ulcers or skin injuries. Resident #350 was admitted to the facility admitted 10/23/19 with diagnoses including Cerebral Vascular Accident, Peripheral Vascular Disease, Dysphagia, Gastrostomy Status, Lower Extremity Contracture, and Generalized Muscle Weakness. A complaint, DC00010482, received by the State Agency on 12/30/21 documented, "... [Hospital Social Worker] explained that the physician asked her to file a report due to the condition of	L 052	Resident #350 1. Resident is no longer in the facility; therefore, no corrective action can be made at this time. 2. All other residents with care plans requiring skin assessment were reviewed for implementation of intervention; skin assessment and findings were documented as needed. 3. The Nurse Educator provided all clinical staff an in-service on care planning, appropriateness of interventions, implementation of intervention as directed, and documentation of interventions performed. In-service is on-going, started 11/14/22. 4. The DON or designee will review residents care plan on skin care for resident centered and comprehensive care plan monthly. Findings will be reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 052	Continued From page 31 the pressure wounds ... about the condition of and care that the member was receiving ..." A review of Resident #350's medical record revealed: 10/23/19 at 11:59 AM [physician's order]: "Apply barrier cream to sacrum, buttocks, and peri-area after each incontinent care for skin protection." 10/24/19 at 12:16 PM [physician's order]:"Turn and Repositioning Q (every) 2 hours." Care Plan initiated on 09/08/21: "Category: Skin Integrity... [Resident #350] has potential for impairment of skin integrity, r/t (related to) peripheral vascular disease...Approach: "Assess skin condition daily and note any changes..." Quarterly Minimum Data Set (MDS) dated 09/30/21 facility staff coded the resident as requiring extensive assistance for bed mobility and eating and as "totally dependent" for transfers, locomotion, toileting, dressing, bathing, and personal hygiene. In addition, facility staff coded the resident as having no pressure ulcers, having two venous and arterial ulcers, and being at risk for developing pressure ulcers/injuries. 10/24/19 at 2:13 AM [physician's order]: "Monitor for bruising /bleeding every shift." 12/04/21 at 9:06 PM [Nursing Progress Note]: "...ADL (assisted daily living) care provided....." 12/05/21 at 2:19 AM [Nursing Progress Note]: ". Total adl care provided, Turned and repositioned q (every) 2 hrs (hours). " 12/05/21 at 8:47 PM [Nursing Progress Note]:	L 052		

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L 052	Continued From page 32 "...Turned and repositioned q 2 hrs no sign of pain/discomfort noted ....ADL care provided ..." 12/06/21 at 2:34 AM [Nursing Progress Note]: "Total adl care provided, Turned and repositioned q 2 hrs ..." 12/06/21 at 1:47 PM [Nursing Progress Note]: "...Turned and repositioned done every 2 hours ..." 12/06/21 at 2:29 PM [physician's order]: "Cleanse sacral intact blister with normal saline, apply Bacitracin ointment daily, leave open to air until resolved." 12/06/21 at 3:00 PM [Nursing Progress Note]: "... observed with intact blister in the sacrum measuring 3 cm (centimeter) x 3.5 cm x 0 cm this shift. PMD (Primary Medical Doctor) made aware ordered to cleanse area with normal saline, apply bacitracin ointment and leave open air until seem by wound doctor..." Care plan initiated on 12/06/21, "Ulcer/Wound (skin) ..." had the following approach, "Assess skin condition daily and note any changes, treatment as indicated..." December 2021 Medication Administration Record (MAR) revealed that from 12/06/21 to 12/10/21, facility staff documented cleaning the intact sacral blister with normal saline, applying Bacitracin ointment, and leaving it open to air daily. From 12/07/21 to 12/09/21 (three days), there was no documented evidence that facility staff assessed Resident #350's sacral area or skin condition daily.	L 052		

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L 052	Continued From page 33 12/10/21 at 10:56 AM [Nursing Progress Nurse] "Resident seen today ...during wound rounds for assessment and evaluation of bilateral leg dry scabs and sacral intact blister ..." 12/11/21: There was no documented evidence that facility staff assessed Resident #350's sacral area or skin condition. 12/12/21 at 6:37 AM [Nursing Progress Note] "...Turned and repositioned q 2 hrs..." 12/12/21 at 2:36 PM [Skin Sheet]: "Description initial skin sheet: intact sacral blister, Type of Skin Assessment: New Wound ...Location: Left buttocks, Stage: 2 ... Type of Wound: Blister, Appearance: black. Drainage: None ...Length: 5.5 cm, Width: 5.5 cm, Depth: 0 cm." 12/12/21 at 3:19 PM [Nursing Progress Note]: "Resident was noted with intact blister measuring 5.5 x 5.5. during care. Nursing supervisor made aware, and she came to assess Resident. Call placed to NP (Nurse Practitioner) ...and he was made aware of blister. New order to clean area with normal saline, apply bacitracin daily and leave open to air until seen by [Name of Wound Care Physician]. Treatment done as ordered. Call place to [Resident's representative] with no response. Message left on voice mail to call unit..." Care plan initiated on 12/12/21: "...Assess skin condition daily and note any changes, treatment as indicated ...Of note this intervention is the same intervention that was documented in the care plan for the sacral wound blister." 12/13//21, facility staff documented cleaning the	L 052		

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L 052	Continued From page 34 left buttock with normal saline, patting it dry, applying Bacitracin ointment, and leaving it open to air daily. 12/13/21: There was no documented evidence that facility staff assessed Resident #350's sacral area, the left buttocks or skin condition. It should be noted that the December 2021 Treatment Administration Record (TAR) revealed that from 12/01/21 to 12/14/21, facility staff documented that they were monitoring the resident's skin for bruising and bleeding and documented: "0" or "none noted" in the area that directed, "Monitor for bruising/bleeding every shift"; and that they were turning and repositioning Resident #350. 12/14/21 at 3:00 PM [Nursing Progress Note]: "...unspecified multiple skin impairment to bilateral lower extremities, sacrum, buttock, Resident is non-verbal on baseline; Upon assessment, Resident noted with alteration in level of consciousness ... order given to transfer to nearest ER (emergency room) for further evaluation..." Facility staff failed to assess and document daily: ulcer size; location; wound bed; shape; and condition of the surrounding tissue (edges, color, temperature, pain and swelling) in order to identify and report changes and deterioration from 12/07/21 to 12/11/21 and on 12/13/21 as directed by the care plan for Resident #350's sacral and left buttocks wound. During a face-to-face interview on 11/09/22 at 11:09 AM, Employee#12 (Director of Quality Assurance and Performance Improvement) stated that all residents should have a standing	L 052		

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L 052	Continued From page 35 physician order to monitor residents for bruising and bleeding. The nurses should perform skin assessments while monitoring the residents for bruising and bleeding. The nurses should document the skin assessments in progress notes or the weekly skin sheets. 3. Facility staff failed to document Resident #349's sacral ulcer size from 03/18/21 to 09/23/21 (6 months). Subsequently on 09/24/21, facility staff documented, that the resident's sacral ulcer "increased in size." Resident #349 was admitted to the facility on 02/03/18 with diagnoses including Pressure Ulcer of the Sacral Region Cerebral Vascular Accident, Hemiplegia and Hemiparesis, and Contracture of Muscle. A facility reported incident (FRI), DC00010341, received by the State Agency on 10/21/21 documented: "... Resident who is total care, incontinent of bowel and bladder with multiple diagnoses ...and with ongoing healing stage 4 sacral ulcer treated with Hydrogel daily. Upon assessment today, wound was noted with increase in size during am care measuring 4.5cm x 2 cm x 0.2cm ... Nursing will continue to treat as ordered." Areview of Resident #349's medical record revealed: Quarterly Minimum Data Set dated 07/29/21 facility staff coded: severe cognitive impairment; always incontinent for bowel and bladder; had multiple pressure ulcers, including two Stage 2 pressure ulcers, one Stage 3 pressure ulcer, and one Stage 4 pressure ulcer; no arterial or venous ulcers, and totally dependent for bed mobility and	L 052	#3 Resident #349 1. Resident is no longer in the facility and no correction action can be made during this timeframe. 2. All other residents' skin assessment was done, and care plans revised to reflect facility's policy on skin assessment. 3. The Nurse Educator provided an in service on the importance of a thorough skin assessment and developing care plans from 11/14/2022. The nurse educator reviewed the skin assessment policy with the nursing staff. 4. Skin assessment documentation and care plan will be reviewed by the DON/designee. Findings will be reported to QAPI quarterly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 052	Continued From page 36 all activities of daily living. 09/17/18 at 11:59 AM [physician's order]: "Apply barrier cream to sacrum, buttocks, and peri-area after each incontinent care for skin protection." 09/17/18 at 12:16 PM [physician's order]: "Monitor for Bruising/Bleeding every shift." 09/17/18 at 12:16 PM [physician's order]: "Turn and Repositioning Q (every) 2 hours." 04/15/19 at 12:20 PM [physician's order]: "Weekly Skin Sheet: Sacrum Ulcer." Care plan last revised on 11/16/19 showed, "Category: Pressure Ulcer [Resident #349's Name] has likelihood for impairment of skin integrity...Approach: Assess skin condition daily and note any changes ...Wound treatment as ordered ...treatment as indicated ..." 11/16/19 at 11:59 AM: [physician's order]: "...Air mattress to bed to promote wound healing ... Pressure ulcer of sacral region, unspecified stage..." 02/12/21 at 3:15 PM [physician's order]: "No back lying. Change sacral pressure wound dressing in 48 hours. Resume previous wound dressing 02/25/21 at 3:09 PM [physician's order]: "Resume cleanse[ing] sacrum ulcer with normal saline, pat dry, apply Hydrogel daily; cover with 4 x 4 gauze and secure with tape." 03/18/21 at 12:10 PM [Nursing Progress Note]: Resident was seen today by wound team during wound rounds for assessment and evaluation of sacrum ulcer, upon assessment, sacral ulcer pink	L 052		

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	HFD02-0019	A. BUILDING: _____ B. WING _____	C 11/09/2022

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L 052	Continued From page 37 and clean, responding well to treatment and reducing in size, measuring 3 cm x 2.5 cm x 0.1 cm , continue cleansing with normal saline, pat dry and apply Hydrogel daily and cover with dry dressing..." 09/24/21 at 9:23 AM [Skin Sheet]: "Type of Skin Assessment: Weekly skin ...Location: Sacrum, Stage: Pressure ulcer Stage 4, Type of Wound: Pressure ulcer, Appearance: Clean, Pink, Drainage: Scant ...Length: 4 cm, Width: 2 cm, Depth: 0 cm ...Treatment: Continue with Hydrogel daily after cleansing with normal saline and cover with dry dressing and apply tape ..." Review of all progress notes, shower report sheets, focused observation sheets, Braden Scales, and CNA (Certified Nurse Aide) documentation from 03/18/21 to 09/23/21 (6 months) revealed that facility staff failed to document on Resident #349's sacral ulcer size. On 09/24/21, facility staff documented, sacral ulcer "increased in size" (4 cm x 2 cm). During a face-to-face interview on 11/07/22 at 3:30 PM, Employee #11 (Clinical Educator) stated that when the licensed nurse does the skin assessments, they should document any skin areas and the condition of the other existing areas. When asked if measurements of the ulcers are part of that, Employee #11 stated, "Yes. Skin assessment and staging is part of the yearly competency." 4. Facility staff failed to identify and implement measures or approaches to reduce the risk of Resident #80 who had multiple falls having an injury of unknown origin to the left forehead. Resident #80 was admitted to the facility on	L 052	1. Resident #80 was assessed by the DON on 12/27/22. Care plan was reviewed and care plan updated/revised with new goals to prevent/minimize any future falls on 12/27/22. 2. All charts were reviewed to identify residents with prior falls. All other residents with prior falls were reviewed for care plan goal that addresses minimizing or preventing falls on 12/27/22. Additional interventions were provided in the care plan as needed. 3. The Nurse Educator provided all licensed nurses an in-service on comprehensive care plans and to revise care plan with new goals and approaches to falls prevention on 11/14/22 (on-going). 4. The Falls Committee will review all new falls weekly, update care plan for fall if needed, and reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Rehab	

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L 052	Continued From page 38 07/07/20 with multiple diagnoses that included: Cerebrovascular Accident (CVA), Seizures, Diabetes Mellitus, Hypertension, and Respiratory Distress. Review of Resident #80's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 02/14/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating intact cognition and used a wheelchair for mobility. 03/21/22 at 4:30 PM [Nurses Progress Note] "resident was seen by charge nurse and other residents suddenly slipped from her wheelchair and sat on the floor, when asked what happened she stated nothing, I just wanted to shift myself to the other side and I slipped.. head to toe assessment... MD (medical doctor) and POC (point of contact) made aware..." There was no evidence that facility staff initiated a patient-centered care plan with goals and approaches to address Resident #80's fall or any measures to prevent further falls. Care plan with a start date of 04/22/22 showed, "Category Falls" [Resident #80] has a likelihood for falls R/T [related to] seizures, CVA with left extremity weakness ...Approach: Give verbal reminders not to ambulate/transfer without assistance, keep call light within reach at all times. Encourage residents to use call lights when needed. Provide toileting assistance as needed during all shifts. Keep personal items and frequently used items within reach ...bed in the lowest position." A Significant Change Minimum Data Set (MDS)	L 052		

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L 052	Continued From page 39 dated 05/02/22, showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "3", indicating severe cognitive impairment; required extensive assistance with two person physical assist for bed mobility, transfer, dressing, and toilet use; one person physical assist for personal hygiene; no functional impairments in range of motion; no falls since admission /entry or re-entry or prior assessment. 05/15/22 at 8:45 AM [Nursing Progress Note] "writer's attention was drawn by the charge nurse to resident who was said I have had a fall in her room. When asked what happened resident stated "I wanted to go to the bathroom and I fell from my bed When asked why she didn't call for assistance, she kept mute. On Assessment, resident was found lying beside her bed with head upright, alert and oriented x2 ... MD notified who advised that resident be monitored closely and to report to him if there is any changes. Neuro check in progress. POC made aware. Nursing will continue plan of care..." The evidence showed that facility staff failed to identify and implement new goals and approaches for Resident #80 to prevent further accidents (falls) after she had a fall on 05/15/22. A Facility Reported Incident (FRI), DC00010763, received on 05/21/22 documented, "At 6:50 PM writer was called by charge nurse to see resident with a swollen area on her left side of forehead of unknown origin. On assessment, the area was soft to touch and nontender, no bruises or open area observed no pain on touching the area, Resident is alert and responsive with intermittent confusion. When asked what happened. Resident was unable to explain. POC was on the unit to visit and was notified... MD (medical doctor) was	L 052		

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L 052	Continued From page 40 called..." 5. Facility staff failed to identify and implement measures or approaches to reduce the risk of Resident #68 having an accident (fall). Resident #68 was admitted to the facility on 06/17/22 with multiple diagnoses that included: Difficulty in Walking, Muscle Weakness and Other Abnormalities of Gait and Mobility. Review of Resident #68's medical record revealed the following: 07/28/22 at 11:15 PM [Nursing Note] "... At 10:37 pm, attention drawn by the charge nurse to [Resident #68] who was said to have fallen by the roommate. When asked how it happened, resident could not explain but roommate said he was walking round the room and tripped." Care plan focus area "[Resident #68] had a fall on 7/28/22 due to poor judgment/disease process" initiated on 07/28/22 had the approaches of, " PT (physical therapy)/OT (occupational therapy) consult PRN (as needed). Encourage resident to ask for assistance and call light within reach." A Quarterly Minimum Data Set (MDS) dated 09/15/22 showed facility staff documented: vision adequate, no corrective lenses; moderately impaired cognition; required extensive assistance with one person physical assist for bed mobility, transfers; balance during moving from seated to standing was not steady, only able to stabilize with staff assistance; functional impairment in range of motion on one side for lower extremities; used a walker and wheelchair for mobility; no falls since admission/reentry or prior assessment; and received restorative nursing in transfer and	L 052	Resident #68 1. Resident #68 was assessed by the DON on 11/17/11. Care plan was reviewed and updated with additional approaches to address prevention/minimize recurrence of future falls on 11/17/2022. There was no physical injury as a result of the fall. 2. All resident charts were reviewed to identify residents with prior falls. All residents with prior falls were assessed and all necessary care plans were revised to reflect goals to prevent/minimize future falls. 3. The Nurse Educator provided an in-service to the interdisciplinary team regarding care plan development and update for residents with repeat falls. 4. Unit charge nurses will review care plans of residents with repeat falls for additional approaches and interventions weekly. This will be reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 052	Continued From page 41 walking. 10/27/22 at 1:45 PM [Physician's Assistant Note] "[Recorded as Late Entry on 10/28/2022 02:12 PM] Pt's nurse reported that pt had a fall and general assessment revealed no physical injury... Continue with current treatment plan and level of care..." 10/27/22 at 6:43 PM [Fall Risk Assessment (Post Fall)] "... Fall Risk Score - Score of 10 or higher represents a high risk for falls. Total Fall Risk Score: 17... Indicate care plan action taken. Continue current plan of care." Care plan focus area, "[Resident #68] had a fall on 10/27/22 due to poor judgment" initiated on 10/28/22 had the approaches of, "PT/OT consult PRN. Encourage resident to ask for assistance and call light within reach." 11/02/22 at 3:21 PM [physician's order] "...PT eval (evaluation) & (and) treat ...to address difficulty in walking" 11/04/22 at 4:32 PM [Fall Risk Assessment (Post Fall)] "...Total Fall Risk Score: 17 ...No Referrals Necessary ... Indicate care plan action taken. Continue current plan of care." 11/04/22 at 5:41 PM [Nursing Note] "...At 3:20 pm, resident was noted with a fall at the TV (television) area ...On assessment: alert and verbally responsive, oriented x 1(self), no bruises, bleeding, swelling or skin tear noted..." The evidence showed that facility staff failed to identify and implement approaches for Resident #68 after he had a fall on 10/27/22. Subsequently,	L 052		

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L 052	Continued From page 42 the resident sustained another fall on 11/04/22. During a face-to-face interview conducted on 11/07/22 at 1:10 PM, Employee #2 (Director of Nursing/DON) was made aware of the findings for Residents' #80 and #68. He acknowledged the findings and made no further comments. 6. Facility staff failed to asses Resident #32's skin every shift per the care plan. Subsequently, the resident was observed with cellulitis of left lower limb with edema. During an observation and interview on 11/01/22 at 3:41 PM, Resident #32 stated that her left leg had started to swell and would sometimes leak. She said she had compression stockings at one time but believed they were taken with her laundry to be cleaned and never replaced. The surveyor noted that the resident's left leg was edematous from the knee to the ankle. The skin on the resident's leg appeared dark with light pink areas at the outer knee. The resident also stated that no facility staff had looked at her leg because she did not mention her concern to them. Resident #32 was admitted to the facility on 06/17/21 with diagnoses including Peripheral Vascular Disease, Cellulitis of the Left Lower Limb, Diabetes Mellitus, and Absence of Right Leg below the Knee. Review of Resident #32's medical record revealed: 06/17/21 at 5:42 PM [physician's order]: "Monitor for Bruising/Bleeding every shift." 06/17/21 at 8:46 PM: [physician's order]: "Emollient topical lotion, apply 2x/day as needed	L 052	Resident # 32 1. Resident #32 was re-assessed by the Director of Nursing on 11/4/22. Resident was observed to have cellulitis on left leg. MD notified and new treatment order received. Care plan revised Resident's every shift skin assessment was reviewed and revised on 11/4/22. 2. All charts were reviewed to identify residents with breakdown. All residents with skin breakdown were assessed and all necessary care plans were revised to reflect weekly skin checks. 3. The DON re-educated the clinical staff on the importance of developing care plans and implementing interventions as directed in the care plan on 11/4/22 (on-going). 4. Care plans developed for residents with skin abrasion will be reviewed for appropriate interventions monthly and reported to QAPI monthly. 5. Completion date: January 9, 2023 6. Director of Nursing	

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L 052	Continued From page 43 for dry skin." Care plan initiated on 01/10/22: "Category: Skin integrity ...[Resident #32] is at risk for skin breakdown r/t (related to) lower extremity cellulitis...Approach: Assess Resident for the presence of risk factors ...Keep clean and dry as possible ...Report any signs of skin breakdown (sore, tender, red or broken areas), skin every shift..." 05/14/22 at 2:55 PM [physician's order]: "Leg wrap with non-stretch leg wrap daily to left leg for venous insufficiency." A Quarterly MDS dated 08/11/22 showed that facility staff coded: a Brief Interview for Mental Status Summary Score of "15," indicating intact cognition; required extensive assistance for bed mobility, transfers, locomotion on the unit, dressing, toilet use, personal hygiene, bathing; functional impairment on one side for lower extremity; and was at risk for developing pressure ulcers. 09/19/22 at 1:45 PM [Nursing Progress Note]: "...Complaint of dryness and scaling of the left leg...ordered Furosemide 40 mg (milligrams) and Spironolactone 25 mg once a day (to reduce edema caused by fluid accumulation). Also advised to continue the use of Cetaphil (emollient topical lotion) for dryness of the leg..." Care plan initiated on 09/19/22 "Category: Skin integrity...[Resident #32] has dryness/scaling/discoloration to left leg...Approach: Assess skin every shift ..." From 09/20/22 to 11/03/22, Resident #32's Treatment Administration Record (TAR) showed	L 052		

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L 052	Continued From page 44 that facility staff initialed to attest that they "Monitor[ed] for bruising/bleeding every shift" and applied "leg wrap with non-stretch leg wrap daily to left leg for venous insufficiency". From 09/20/22 to 11/03/22, Resident #32's Medication Administration Record (MAR) showed that facility staff initialed to attest that they applied "emollient topical lotion 2x/day for dry skin". From 09/20/22 to 11/03/22 (45 days), there was no evidence that facility staff implemented a daily assessment and the condition of Resident #32's left lower extremity to include color, temperature, pain and swelling in order to identify and report changes and deterioration. During a face-to-face interview conducted on 11/07/22 at 1:10 PM, Employee #2 (Director of Nursing/DON) acknowledged the finding and made no further comments. During a face-to-face interview on 11/07/22 at 3:30 PM, Employee #11 (Clinical Educator) reviewed the findings for Residents' #350 and #32 and stated that when the licensed nurse do the skin assessments, they should document the any new skin areas and the condition of the other existing areas. When asked if measurements of the ulcers are part of that, Employee #11 stated, "Yes. Skin assessment and staging is part of the yearly competency."	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6)	L 056		

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L 056	Continued From page 45 hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for 21 of 22 days, and sixth tenths (0.6) Advanced Practice Registered Nurse or Registered Nurse per Resident per day for 5 of 21 days in accordance with Title 22 District of Columbia Municipal Regulations (DCMR) Section 3211.5, Nursing Personnel and Required Staffing Levels. The findings included: According to the "District of Columbia Municipal Regulations for Nursing Facilities", "... beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per Resident per day of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5" A review of the nurse staffing was conducted on 11/09/22, at approximately 3:00 PM. For 21 of the 22 days reviewed, the facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per Resident per day; for five (5) of 22 days, the facility failed to provide a minimum daily average of six tenths (0.6) hours	L 056	1. Facility staffing ratio for dates identified cannot be retroactively corrected. 2. A review of staffing was conducted, however, unable to retrospectively correct areas not met. 3. The facility continues to make efforts to provide staffing according to guidelines through hiring agencies, partnering with schools of nursing, and offering recruitment bonus. Staff retention efforts such as staff recognition events, monetary incentives and pay increases. Contract with staffing agency has been initiated. 4. Staffing ratio will be monitored for adherence to required staffing ratio and reported to QAPI monthly. 5. Correction Date: January 9, 2023 6. Director of Nursing	

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L 056	Continued From page 46 of Advanced Practice Registered Nurse or Registered Nurse. The evidence revealed the following: Hours of direct nursing care per resident: 07/01/22, showed that the facility provided direct nursing care per Resident at a rate of (3.7). 07/02/22, showed that the facility provided direct nursing care per Resident at a rate of (3.6). 07/03/22, showed that the facility provided direct nursing care per Resident at a rate of (3.5). 07/04/22, showed that the facility provided direct nursing care per Resident at a rate of (3.6). 07/05/22, showed that the facility provided direct nursing care per Resident at a rate of (3.4). 07/27/22, showed that the facility provided direct nursing care per Resident at a rate of (2.9). 09/01/22, showed that the facility provided direct nursing care per Resident at rate of (3.6). 09/02/22, showed that the facility provided direct nursing care per Resident at rate of (3.5). 09/03/22, showed that the facility provided direct nursing care per Resident at rate of (3.7). 09/04/22, showed that the facility provided direct nursing care per Resident at rate of (3.9). 09/05/22, showed that the facility provided direct nursing care per Resident at rate of (3.8).	L 056		

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L 056	Continued From page 47 09/06/22, showed that the facility provided direct nursing care per Resident at rate of (3.8). 10/07/22, showed that the facility provided direct nursing care per Resident at rate of (3.9). 10/08/22, showed that the facility provided direct nursing care per Resident at rate of (3.4). 10/09/22, showed that the facility provided direct nursing care per Resident at rate of (3.4). 10/10/22, showed that the facility provided direct nursing care per Resident at rate of (3.6). 10/11/22, showed that the facility provided direct nursing care per Resident at rate of (3.5). 10/28/22, showed that the facility provided direct nursing care per Resident at rate of (3.6). 10/29/22, showed that the facility provided direct nursing care per Resident at rate of (3.5). 10/30/22, showed that the facility provided direct nursing care per Resident at rate of (3.4). 11/01/22, showed that the facility provided direct nursing care per Resident at rate of (3.6). Hours of Advanced Practice Registered Nurse or Registered Nurse nursing care per resident: 07/03/22, showed that the facility provided advanced practiced or registered nurse care per Resident at a rate of (0.55). 07/27/22, showed that the facility provided advanced practiced or registered nurse care per Resident at a rate of (0.47).	L 056		

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L 056	Continued From page 48 09/06/22, showed that the facility provided advanced practiced or registered nurse care per Resident at a rate of (0.58). 10/28/22, showed that the facility provided advanced practiced or registered nurse care per Resident at a rate of (0.56). 10/29/22, showed that the facility provided advanced practiced or registered nurse care per Resident at a rate of (0.47). During a face-to-face interview on 11/09/22 at approximately 4:00 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comment.	L 056	L-091 Resident #99 1. The Director of Nursing provided Employee#13 verbal re-education on medication administration principles (5 rights), residents rights, and infection control procedures on 11/9/22. There were no negative outcomes as a result of this deficient practice. 2. The nurse educator conducted random med pass observations for compliance with medication administration principles, residents rights and infection control (handwashing/hand hygiene). 10 staff members who pass meds were observed and demonstrated compliance. 3. The nurse educator provided all licensed nursing staff an in-service on medication administration, resident rights and infection control principles (hand washing/hand hygiene) on 11/14/22 (on-going). 4. Adherence to medication administration principles, hand hygiene will be monitored monthly by the nurse educator through weekly random observations. Staff found violating these principles will be provided re-education and progressive discipline. Finding will be reported to QAPI monthly. 5. Completion date: 1-9-2023 6. Nurse Educator	
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation and staff interview, in one (1) of five (5) medication administration observations, facility staff failed to maintain infection control practices when administering medications. Resident #99. The findings included: During a medication administration observation on 11/09/22 starting at 8:42 AM, Employee #13 (Licensed Practical Nurse) with an ungloved hand picked up the medicine cup with her finger inside	L 091		

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L 091	Continued From page 49 the cup. While picking up the cup, the Employee's finger made contact with the loose unwrapped pills. The Employee then entered the resident's room and proceeded to administer the medications to the resident without first sanitizing her hands. Employee #13 was stopped by the State Surveyor before she could give the Resident #99 the medication. In a face-to-face interview at the time of observation, Employee #13 acknowledged that she did not wash or sanitized maintain infection control and prevention practices and made no further comments.	L 091	L099 1. All items that were not labelled or dated were immediately discarded. 2. Refrigerator was checked for any food items that were not labelled or dated. There were no other food items found without label or date. 3. All dietary staff were provided an in-service on Food storage practices to address proper labelling of stored food items by the Dietary Director. 4. Weekly random check on food storage will be conducted by dietician and reported to QAPI monthly. 5. Completion date: January 9, 2023 6. Registered Dietician	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to store and prepare foods under sanitary conditions as evidenced by food items including one (1) of one (1) container of potato salad, five (5) of five (5) containers of mashed potatoes, one (1) of one (1) pan of vegetable mix noodles, one (1) of one (1) pack of turkey bologna, one (1) of one (1) box of American cheese, and one (1) of one (1) pack of roast beef, that were not labeled or dated in one (1) of one (1) walk-in refrigerator, two (2) of two (2) soiled convection ovens, one (1) of one (1) Alto-Shaam oven that was soiled on the interior and exterior, and one (1) of one (1) flat top grill that was stained on both sides.	L 099		

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L 099	Continued From page 50 The findings included: During a walkthrough of dietary services on October 31, 2022, at approximately 9:30 AM, the following were observed: 1. Food items such as one (1) of one (1) container of potato salad, five (5) of five (5) containers of mashed potatoes, one (1) of one (1) pan of vegetable mix noodles, one (1) of one (1) pack of turkey bologna, one (1) of one (1) box of American cheese, and one (1) of one (1) pack of roast beef, all stored on shelves in one (1) of one (1) walk-in refrigerator, were not labeled or dated. 2. Two (2) of two (2) convection ovens were soiled on the inside with burnt food residue. 3. One (1) of one (1) Alto-Shaam oven was soiled on the interior and exterior with cooked food residue and splashes. 4. The flat top grill was stained on the sides with grease and splashes. These observations were acknowledged by Employee #6 during a face-to-face interview on October 31, 2022, at approximately 10:00.	L 099	#2, 3, 4 1. The 2 convection ovens, Alto-Shaam oven and flat top grills were immediately cleaned. 2. All other kitchen appliances were checked for cleaning needs. There were no other kitchen appliances in need of cleaning. 3. All dietary staff were provided an in-service on cleaning procedures and cleaning schedules. 4. Weekly inspection of kitchen appliances will be done by the dietician and reported to QAPI monthly. 5. Completion date: January 9, 2023 6. Registered Dietician	
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident.	L 108		

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L 108	Continued From page 51 This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 140 degrees Fahrenheit on six (6) of six (6) observations. The findings included: During a food test tray assessment on November 3, 2022, at approximately 1:30 PM, hot foods such as puree sweet potatoes (136 degrees Fahrenheit), puree rice (133 degrees Fahrenheit), puree peas (132 degrees Fahrenheit), brussels sprouts (98 degrees Fahrenheit), collard greens (101 degrees Fahrenheit), sweet potatoes (105 degrees Fahrenheit) tested below recommended hot foods minimum temperatures of 140 degrees Fahrenheit. These observations were acknowledged by Employee #6 during a face-to-face interview on November 3, 2022, at approximately 2:00 PM.	L 108	L108. 1. Hot foods were below required serving temperatures. Hot foods were heated in microwave as needed. 2. All subsequent meals tested were within required temperature. 3. Dietary staff were provided an in-service to ensure food/trays are delivered to the residents with required temperatures. 4. Review of test trays log will be done weekly by QAPI Director and reported at monthly QA meetings. 5. Completion date: 1-9-2023 6. Director of QAPI	
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;	L 128		

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L 128	Continued From page 52 (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, in one (1) observation, facility staff failed to reconcile narcotics. The findings included: During an observation conducted on 11/08/22 at 9:20 AM on the first-floor, medication cart A, the form titled "Narcotic Sign-In Sheet" revealed that on the following dates: 10/02/22, 10/28/22, 10/30/22, and 11/07/22, only one nurse signed in on the form attesting to performing the shift count for reconciling narcotics. During a face-to-face interview at the time of the observation, Employee #15 (Licensed Practical Nurse) acknowledged the finding and made no further comment.	L 128	1. The Director of Nursing audited the narcotic signature sheet for the 1st floor Medication Cart A and reconciled the remaining controlled medications in the narcotic box on 11/10/11. There were no discrepancy in the narcotic count. 2. The Director of Nursing audited all other Medication Carts for all nursing units and reconciled the remaining controlled medications within the narcotic box. There were no discrepancy found in the narcotic count. 3. All licensed nursing staff were provided an in-service on maintenance of drug records to account for all controlled substances to include 2 licensed nursing staff for the narcotic count at the beginning and ending of each shift. 4. Narcotic logs will be checked by nursing supervisor weekly and reported to QAPI monthly. Staff who are found non-compliant will be subject to progressive discipline. 5. Completion date: January 9, 2023 6. Nurse Educator	
L 162	3227.13 Nursing Facilities Each medication that is no longer in use shall be destroyed or returned to the in-house pharmacy. This Statute is not met as evidenced by:	L 162		

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L 162	Continued From page 53 Based on observation, record review, and staff interview, for one (3) of 41 sampled residents, facility staff failed to: properly waste or return medications no longer in use to the pharmacy. Residents' #24, #62 and #35. The findings included: Review of the policy titled "Disposal of Controlled Substances" with a revision date of October 2018, instructed "...For all residents' schedule II-V medications, it is the responsibility of the facility to destroy all discontinued controlled drugs at the facility and complete the same documentation..." A review of the facility's policy titled "Returning Medications to the Pharmacy" revised in October 2018, instructed, "...Unused medications that are not a controlled substance nor require refrigeration may be returned to [Pharmacy name] if they are in a manufacturer's sealed container..." 1. Facility staff failed to properly waste Resident #24's controlled medication after it was discontinued by the prescriber. During an observation on 11/08/22 at 9:20 AM, on the first-floor unit of medication cart A, two blister packs of Clonazepam (antianxiety) were observed for Resident #24, one pack blister pack of Clonazepam 1 mg (milligram), containing 49 pills. According to the reconciliation sheet, one pill had been wasted on 11/07/22. Employee #14 (Licensed Practical Nurse) explained that Resident #24's Clonazepam 1 mg was discontinued over a week ago and that someone accidentally took a pill from the discontinued package and then had to waste it.	L 162	1. Resident # 24's controlled medications were reviewed and reconciled on 11/8/22. Discontinued narcotics were disposed of on 11/09/22 and DEA form was completed and faxed to DEA. There were no negative outcomes to Resident #24 as a result of this deficient practice. 2. Controlled medications for all residents were reviewed and reconciled on 11/9/22. There were no negative outcomes to other residents as a result of this deficient practice. 3. The Nurse Educator provided all licensed nursing staff an in-service on disposal of discontinued narcotics and medications, proper reconciliation process of controlled medications and documentation on 11/14/22. 4. Reconciliation and disposal of discontinued narcotics and medication will be audited weekly by the director of nursing or designee for 3 months of sustained 100% compliance. Findings will be reported to QAPI monthly. Non-compliant staff will be re-educated and placed on progressive discipline. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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L 162	Continued From page 54 Resident #24 was admitted to the facility on 03/29/22, with multiple diagnoses that included: Bipolar Disorder, Anxiety, and Chronic Hepatitis. Review of the medical record revealed the following: 10/29/22 [physician's order] "DC (Discontinue)...Clonazepam 1 MG ...Twice a day..." The evidence showed that for 10 days after it was discontinued by the physician, facility staff failed to properly to destroy Resident #24's Clonazepam 1mg tablets. During a face-to-face interview at the time of the observation, Employee #15 (Licensed Practical Nurse) acknowledged the finding and made no further comment. 2. Facility staff failed to properly discard Resident #62's and #35's medications from the "isolation medication cart". During an observation on 11/08/22 at 9:25 AM on the first-floor, Employee #15 (Licensed Practical Nurse) stated that the "isolation medication cart", designated for the COVID-19 positive residents, was not in use since they didn't have any COVID-19 residents in the facility. However, during an inspection of the medication cart, the following medication blister packets were observed: For Resident #62, who was admitted to the second floor, room 221 bed B on 09/07/22: Levothyroxine (thyroid hormone supplement) 88	L 162	Residents # 62 and 35 1. Residents #62 and 35's discontinued medications were discarded on 11/9/22. There were no negative outcomes to either residents. 2. All other medication carts were checked for any discontinued medications on 11/9/22. There were no discontinued medications in any of the other carts checked. There were no other isolation medication carts. 3. Licensed Nursing staff were provided in-service on the process for discarding discontinued, expired or discharged residents. medications and medication isolation carts by the Nurse Educator on 11/14/22 (on-going). 4. The nursing supervisor will check medication carts including the isolation medication cart weekly for any discontinued medications or medications that were prescribed for residents who have been discharged or expired. Findings will be provided to QAPI monthly. 5. Completion date: Jan.9, 2023 6. Nurse Educator	

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L 162	Continued From page 55 Mg (milligrams) Nifedipine (lowers blood pressure) ER (extended release) 600 mg Atorvastatin (cholesterol lowering drug) 40 mg Acetaminophen (Analgesic) 325mg For Resident #35, who was transferred to the second floor in August 2022: Acetaminophen 500mg Senna (laxative) 8.6-5.0 mg Clopidogrel (anticlotting medication) 75 mg Aspirin (analgesic) Chewable 81mg Vitamin B 12 1000mg Amlodipine (lowers blood pressure) 10 mg Donepezil (cognition enhancing medication) 10 mg Lisinopril (lowers blood pressure) 5 mg Acetaminophen 325 mg Omeprazole (for gastric reflux) 40 mg Gabapentin (anti-seizure) 400 mg During a face-to-face interview conducted at the time of the observations, Employee #15 acknowledged the findings.	L 162	L168. 1. Unlabeled and opened insulin or multidose vials on medication cart A were immediately discarded on 11/8/22. 2. All other medication storage were searched for unlabeled open vials. There were no other insulin vials found. 3. All licensed nurses were provided an in-service on proper storage and handling of insulin and other multidose vials in the facility the Nurse Educator on 11/14/22 (on-going). 4. The Nursing Supervisor will check all medication storage weekly for proper labelling of insulin and other multi dose vials. Findings will be reported to QAPI monthly. Monthly monitoring will continue until goal of 100% compliance is sustained for 3 months. 5. Completion Date: January 9, 2023 6. Nurse Educator	
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, in one (1) observation, facility staff failed to date and initial Insulin vials. The findings included:	L 168		

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L 168	Continued From page 56 A review of the facility's policy titled "Medication Labels" revised in October 2018, instructed, "... To decrease the potential of medication errors ...properly labeling medications, all medications dispensed ... will be labeled according to Federal, State, and Local laws ...Containers having no label should be destroyed..." During an observation on 11/08/22 at approximately 9:55 AM, medication cart A, on the first floor, 2 vials of Insulin were observed opened that did not have the date opened, expiration date, or staff initials written on the vials. During an interview conducted at the time of the observation, Employee #15 acknowledged the findings and made no further comment.	L 168	L198 1. Medication Regimen Review for resident #60 was referred to the psychiatrist on 10/13/22. Consultation with the psychiatrist was completed on 11/11/22. 2. MRR's of residents with referral to the psychiatrist were reviewed on11/11/22 for timely referral to the psychiatrist. There were no MRRs with outstanding referrals to the psychiatrist. 3. Inservice for all licensed nursing staff regarding timely notification of physicians on MRR consults was provided by the Nurse Educator on 11/14/2022. 4. The DON or designee will audit all MRRs for physician notification and response to pharmacists' recommendations monthly and reported to QAPI quarterly. 5. Completion date: Jan 9 2023 6. Director of QAPI	
L 198	3231.9 Nursing Facilities Each medical records shall serve as a basis for planning resident care and shall provide a means of communication between the physician and other employees involved in the residents' care. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 41 residents, facility staff failed to have an established, consistent location for the Medication Regimen Review (MRR) MRR forms to facilitate communication with the State Surveyors. Resident #60. The findings included: Resident #60 was admitted to the facility on 10/08/21 with multiple diagnoses that included: Insomnia, Thyroid Disorder, Tobacco Use, Anemia, Orthopedic Conditions and Thyroid	L 198		

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L 198	Continued From page 57 Disorder, Review of Resident #60's medical record revealed the following: 06/12/22 at 1:01 PM Pharmacist Note "MRR completed. Recommendation made to prescriber." 10/13/22 at 12:41 PM [Pharmacist Note] "MRR (medication regimen review) completed. Recommendation made to prescriber." A Quarterly Minimum Data Set (MDS) dated 10/13/22 showed facility staff coded: moderately impaired cognitive response and received Antidepressants. On 11/08/22 at approximately 9:00 AM, the facility was asked for Resident #60's monthly MRR forms from the pharmacist's for the dates 06/12/22 and 10/13/22. During a face-to-face interview conducted on 11/08/22 at 3:48 PM, Employee #2 (Director of Nursing/DON) stated that he was not able to locate any of Resident #60's MRR forms.	L 198		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a) The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b) Full name, addresses and telephone numbers of the personal physician, dentist and interested	L 201		

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L 201	Continued From page 58 family member or sponsor; (c) Medicaid, Medicare and health insurance numbers; (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge, and condition on discharge; (g) Hospital discharge summaries or a transfer form from the attending physician; (h) Medical history and allergies; (i) Descriptions of physical examination, diagnosis and prognosis; (j) Rehabilitation potential; (k) Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l) Current status of resident's condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n) The resident's medical experience upon discharge, which shall be summarized by the	L 201	L 201 Residents 55, 67, 69 and 248 1. Copies of the Advance Directive Status forms were placed in the resident #55, 67, and 69 medical records. Residents #55,67, and 69 were provided information on advance directive upon admission. Resident #248 has been discharged. 2. The Admissions Director conducted a chart audit of all residents for information on Advance Directives from 12/13/22. Residents in need of information on Advance Directive were provided information and Advance Directive Status form placed on the resident's medical records (chart). No residents were adversely affected by this deficient practice. 3. The Nurse Educator provided in-service education to the social services staff, licensed nurses, and admissions staff regarding the documentation procedures for Advance Directives and where to locate them in the resident's chart and electronic medical record on 12/14/22.	

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L 201	Continued From page 59 attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A current inventory of the resident'spersonal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interviews, for five (5) of 41 sampled residents, facility staff failed to: determine whether four residents had Advanced Directives (AD) and provide them or their representatives the right to formulate or refuse an AD; and to accurately document an assessment in one residents medical record. Residents' #55, #67, #69, #248, and #79. The finding included: Review of the policy "Health Record Documentation" last revised on 02/10/20 showed,	L 201	L 201 Continued 4. Social Service Director/ designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for documentation of the resident's Advance Directive/code status. Results of the audits will be reported to QAPI monthly and will be monitored until 100% compliance is maintained for 3 months. 5. Completion date: 1-9-23 6. Social Service Director	

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L 201	Continued From page 60 "... Each resident who is assessed by the medical, clinical and other staff at [Facility Name] and/or who receives clinical care must have a complete and accurate medical documentation record kept at all times ...Health care services should be documented while they are begun provided or as soon as possible after they are completed ..." 1. Facility staff failed to provide documented evidence that Resident #55 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #55 was admitted to the facility on 06/02/22 with diagnoses that included: Presence of Right Hip Artificial Joint, Pressure Ulcer of Right Heel, Hypothyroidism, and Tachycardia. A review of Resident #55's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 09/01/22 documented that the resident had moderately impaired cognition. Review of Resident #55's physical record revealed: A green colored piece of paper read: "Full Code" Face sheet that listed a family member as Resident #55's emergency contact. Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #55 had an Advanced Directive or that	L 201		

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L 201	Continued From page 61 facility staff offered the resident or their representative the opportunity to formulate or refuse Advanced Directives. 2. Facility staff failed to provide documented evidence that Resident #67 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #67 was admitted to the facility on 11/08/21 with diagnoses including Dementia, Psychotic Disturbance, Anxiety, Cerebral Vascular Accident, and Generalized Muscle Weakness. A review of Resident #67's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 09/15/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #68's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #68 had an Advanced Directive or that facility staff offered the resident or their representative the opportunity to formulate or refuse Advanced Directives.	L 201		

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L 201	Continued From page 62 3. Facility staff failed to provide documented evidence that Resident #69 had advanced directives or were given the opportunity to formulate or refuse an advanced directive. Resident #69 was admitted to the facility on 06/14/22 with diagnoses including Parkinson's Disease, Hereditary and Idiopathic Neuropathy. Review of Resident #69's electronic record revealed: A Quarterly Minimum Data set (MDS) dated 06/20/22 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "10," indicating moderately impaired cognition. Review of Resident #69's physical record revealed: A green colored piece of paper read: "Full Code". Under the "Legal Documents" tab, a clear, empty, plastic cover labeled "Advanced Directive" was observed. There was no documented evidence that Resident #69 had an Advanced Directive or that facility staff offered the resident or their representative the opportunity to formulate or refuse Advanced Directives. During a face-to-face interview on 11/03/22 at 3:27 PM, Employee #8 (Acting Director of Social Work) stated that if the residents have an advanced directive, it should be in the resident's medical chart behind the code sheet.	L 201		

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L 201	Continued From page 63 4. Facility staff failed to determine whether Resident #248 had an Advanced Directives (AD) and failed to offer the resident the right to formulate or refuse Advanced Directives. Resident #248 was admitted to the facility on 10/19/22 with multiple diagnoses that included: Sepsis, Urinary Tract Infection (UTI) and Benign Prostatic Hyperplasia (BPH). Review of Resident #248's medical record revealed the following: 10/20/22 at 12:12 PM [Social Services Note] "...Initial Note [Resident #248]... admitted to [Facility Name] ... is alert, oriented x 3 and verbally responsive...admitted for short-term skill nursing and rehab (rehabilitation) services and discharge to home." Care plan focus area "[Resident #248] has Advance Directive (AD), full code r/t (related to) resident/family wishes" last revised on 10/22/22 showed the approach, "Advance Directive will be reviewed with resident/family q (every) 3 months and PRN (as needed)." An Admission MDS dated 10/23/22 showed facility staff coded: moderately impaired cognition. Review of Resident #248's medical record lacked documented evidence that facility staff determined whether the resident had AD and failed to offer the resident the right to formulate or refuse an AD. During a face-to-face interview conducted on	L 201		

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L 201	Continued From page 64 11/03/22 at 9:23 AM, Employee #8 stated, "I have no idea where his (Resident #248) Advanced Directives are or even if he has one." 5. The physician and the Therapeutic Recreation Director documented assessments in Resident #79's medical record at a time when he was not actively in the facility. 07/23/22 at 10:57 PM [Nursing Note] "Resident transfer to ... ER (emergency room) via 911. MD (medical doctor) made aware of transfer ..." 07/24/22 at 2:51 AM [Nursing Note] "Call placed to [Hospital Name] in ref (reference) to resident status, Writer was told by charge that resident was admitted. No further information given ..." 08/05/22 at 12:34 PM [Quarterly Therapeutic Recreation Note] "[Resident #79] is in the knowledge of his self-identity and is able to verbally express his needs and desires. Resident continues his consistent activity participation ... empowered to make his own activity decisions.1:1 visits are also provided to buttress his constant activity engagement. Resident is reticent in speech; yet, is friendly with an easy-going personality. It is a pleasure to interact with [Resident #79]..." 08/16/22 at 12:31 PM [Physician's Note] "...Attending Physician Note. Date: 8/16/2022 ... 68-year-old Caucasian male, resident of this facility since May of 2019 ...Clinically he has continued to do well and has remained stable ...There have been no new issues regarding his care. Chest Wall: Unremarkable. Lungs: Clear to auscultation and percussion. Cardiovascular ...S1 and S2 (heart sounds) within normal limits ... There has been no new issue regarding his care.	L 201	Resident #79 1. Physician inadvertently wrote a note on the wrong resident. The physician documented the note was written in error on 12/16/22. The therapeutic recreation aide's quarterly note was written for the prior 3 months but was written while the resident was out of the facility. The TR aide note was invalidated on 12/16/22. There were no negative outcomes for this resident as a result of this deficient practice. 2. A review of all residents transferred to the hospital was conducted. On 12/22/22 by the Health Information Manager to identify similar error. There were no other residents affected by this deficient practice. 3. The Administrator provided an re-education on accuracy of documentation. The Director of Therapeutic Recreations provided the TR staff in-service on documentation of quarterly notes on residents who are not in the facility at the time the quarterly note is due on 12/14/22. 4. Physician entries and therapeutic recreations notes on residents who are away from the facility will be monitored by the Health Information Manager and reported to QAPI monthly. 5. Completion date: 1-9-2023 6. Health Information Manager	

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L 201	Continued From page 65 We will continue his current management. Plan: Remains clinically stable. Continue current management. [Name of Physician], MDAttending Physician." 09/22/22 at 10:04 PM [Nursing Note] "[Resident #79] ... re-admitted from [Hospital Name]... at 1:35 pm..." The evidence showed that facility staff documented to doing a therapeutic assessment and a physician's assessment on Resident #79 even though he was hospitalized from 07/23/22 to 09/22/22. During a face-to-face interview conducted on 11/07/22 at 9:50 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comments.	L 201		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and (e) A description of the corrective action taken.	L 204		

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L 204	Continued From page 66 This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 41 sampled residents, facility staff failed to conduct an analysis of Facility Reported Incidents (FRI) that included statement from of all potential witnesses and the corrective actions taken for one resident's allegation of abuse and one resident's unwitnessed fall, allegation of abuse, and elopement. Residents #4 and #82. The findings included: Review of the policy entitled, "Social Service Resident Abuse, Grievance and Complaints" revised 09/20/21 documented, "... All suspected abuse will be investigated, with a report of such investigation give in writing to the Administrator..." Areview of the facility's policy titled "Prohibition of Resident Abuse/Abuse Prevention" with s revision date of 09/24/22, revealed the following, "...Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness...Investigate different types of incidents, and Identify the staff member responsible for the initial reporting of results to the proper authorities...Human Resources will complete a copy of the investigation..." 1. Facility staff failed to conduct a thorough investigation of Resident #4's allegation of abuse (being handled roughly by staff). Resident #4 was admitted to the facility on 07/08/21 with diagnoses that included: Dementia and Pain.	L 204	L204 1. Resident #4 was reassessed by the Director of Nursing on November 7. DON discussed allegation with resident who does not recall being handled roughly. The DON interviewed staff who attended to resident on 8/23/21. Complaint was reported to the Resident Care Coordinator on 8/23/21. The Resident Care Coordinator assessed Res #4 on 8/23/21 and documented findings on resident's medical record. Per RCC documentation, resident had no complaints of pain or any bruising noted at the time of the complaint investigation. 2. All complaint allegations were reviewed and there were no other allegations identified that would rise to the level of abuse or neglect. 3. The Administrator provided the Social Services Staff, DON, Nursing Supervisors, and charge nurses an in-service on the process for conducting an investigation of facility reported incidents, including abuse and elopement on 12/17/21 4. Any resident complaint or reported incidents of abuse will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of the event. Any finding from the audit conducted will be discussed monthly at QAPI meeting. 5. Completion date: January 9, 2023 6. Director of Social Services	

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L 204	Continued From page 67 Review of a Facility Reported Incident (FRI), DC00010213, received by the State Agency on 08/24/21 documented, "...Charge nurse was notified by family member that [Resident #4] said she has issues with the care provided to her... she complained that her left side has been handled roughly..." Review of Resident #4's medical record showed the following: An Admission Minimum Data Set (MDS) dated 07/15/21 showed facility staff coded: severe cognitive impairment; rejection of care occurred 1-3 days; extensive assistance with two persons physical assist for bed mobility, transfers, toilet use; extensive assistance with one person physical assist for personal hygiene and dressing; and no functional impairment in range of motion for upper or lower extremities. 08/23/21 at 12:35 PM [Nursing Note] "[Resident #4] is alert, oriented and verbally responsive with intermittent confusion...Per family member, she (Resident #4) complained that her left side has been handled roughly ...head to toe assessment was done. No bruises or any open injuries were noted. Writer visited resident in her room with Social Worker, and charge nurses. She was lying in bed. She had just finished her breakfast. Writer asked resident how she is doing. She said she is doing fine. Resident did not make any further complaint..." Review of the facility's investigation packet revealed no documented evidence that statements from all staff that might have knowledge on the alleged abuse were obtained as part of the investigation for Resident #4.	L 204		

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L 204	Continued From page 68 During a face-to-face interview conducted on 11/07/22 at 11:25 AM, Employee #2 (Director of Nursing/DON) stated, "The process is for any allegations of abuse, to investigate. I will look to see if the rest of it [investigation documents] is downstairs." It should be noted that no other investigation documents were provided to the State Surveyor by the exit date of the survey. 2. Facility staff failed to implement its policy evidenced by the failure to thoroughly investigate Resident #82's unwitnessed fall, allegation of abuse, and elopement. Resident #82 was admitted to the facility on 03/19/21 with multiple diagnoses that included: Dementia, Difficulty Walking, Altered Mental Status, and Unspecified Fall. A review of Resident #82's medical record revealed the following: Quarterly Minimum Data Set (MDS) dated 07/21/21 showed facility staff coded: Brief Interview for Mental Status (BIMS) summary score of "08", indicating moderately impaired cognition; needing limited assistance with one person physical assist to walk in the room and locomotion on the unit; supervision requiring one person physical assist to walk in the corridor; no wandering behavior not exhibited; and no falls since admission/entry or reentry or the prior assessment. 09/29/21 at 9:08 AM [Nursing Progress note] "...Resident called that she was on the floor and needed help to get up at 6:30 am. On arrival in	L 204	Resident #82 1. The Incidents for Resident #82 was reported to the state agency at the time of the incidents. The Director of Nursing visited Resident #82 on 11/7/22. Resident did not recollect the events presented on the reported incidents (unwitnessed fall, allegation of abuse, elopement). The DON conducted staff interviews. Only one staff member remains at facility as it pertains to the unwitnessed fall, and that individual does not recall the incident. As it pertains to the abuse and elopement the staff were interviewed. 2. All complaint allegations were reviewed and have not identified any allegations that would rise to level of abuse or neglect. All resident charts will be reviewed for unwitnessed falls and investigated thoroughly. There were no other incidents of elopement. 3. The Administrator/designee provided the Social Services Staff, DON, Nursing Supervisors, and charge nurses an in-service on the process for conducting an investigation of facility reported incidents, including abuse and elopement on 12/12/22.	

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L 204	Continued From page 69 the room, she was observed laying on her left side on the floor beside her bed ..." 09/30/21 at 9:04 AM [Progress note] "Follow up on Pt's (patients) return from the Hospital: Pt was diagnosed of lumbar vertebra fracture..." On 09/30/21 at 10:17 PM, a FRI, DC00010305, documented, "...Resident called that she was on the floor and needed help to get up at 6:30 am. On arrival in the room, she was observed laying on the floor beside her bed..." 10/19/21 at 1:43 PM [Nursing Progress Note] "...Allege incident reported by another resident who indicated that [Resident #82] reported to him "Staff hit her with tray on her head yesterday around lunch time" Interviews with involved resident who diagnoses includes dementia, anxiety disorder, Cognitive communication deficit, Vascular dementia with behavioral disturbance , Altered mental status, and hypertension. She declined incident happened ..." On 10/20/21 at 2:23 PM, a FRI, DC0001033, submitted to the State Agency documented, "...Allege incident reported by another resident who indicated that [Resident #82] reported to him "Staff hit her with tray on her head yesterday around lunch time..." 12/17/21 at 4:26 PM [Nursing Progress note] "...Family friends visited and when the (sp) walked out, she walked behind them unnoticed. Staff went to check on the resident and visitors and could not fine (sp) either of them. Code pink activated ...Resident found and returned tofacility at 3:10 pm on December 17th, 2021..." On 12/27/21 at 4:29 PM, a FRI, DC00010470,	L 204	Resident #82 – Continued 4. All reported facility incidents including unwitnessed falls/injury, allegations of abuse, and elopement will be monitored to ensure a thorough investigation and documentation to prevent recurrence. Any finding from the audit conducted will be discussed monthly at QAPI meeting. 5. Completion date: Jan 9, 2023 6. Director of Social Services	

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L 204	Continued From page 70 documented, "...Family friends visited and when the (sp) walked out, she walked behind them unnoticed. Staff went to check on resident and visitors and could not fine (sp) either of them. Code pink activated immediately..." A review of the facility's investigation documents for Resident #82's fall on 09/29/21, allegation of abuse on 10/19/21 and elopement on 12/17/21 lacked documented evidence that: everyone with possible knowledge of the incidents were interviewed or that statements were obtained; and there was no documented measures taken to prevent further occurrences. During a face-to-face interview conducted on 11/07/22 at 1:15 PM, Employee #2 (Director of Nursing/DON) stated "I don't have those records [investigation documents]."	L 204	Resident #298 1. The CNA assigned to Resident #298 covered the resident's foley catheter collection bag as soon as CNA was made aware that bag was not covered. Resident has since been discharged and no other corrective action can be done during this time. 2. There were 4 other residents with foley catheter collection bags. All 4 residents have a Foley catheter collection bag cover and were not affected by this deficient practice. 3. The Nurse Educator provided the CNAs and other facility personnel involved in covering foley catheter collection bags on in-service education on the proper procedures to ensure dignity on 10/31/22. 4. The Director of Nursing/or designee will conduct random weekly observation of residents with foley catheters to ensure foley catheter collection bags are covered. Observation reports will be reviewed by QAPI Committee monthly and will continue to be monitored until 3 months of consistent100% compliance has been achieved. 5. Corrective action completion date: January 9, 2023 6. Nurse Educator	
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on observation, record review, and staff interview, for one (1) of 41 sampled residents, facility staff failed to ensure a resident's dignity and privacy as evidenced by failing to place a privacy cover over the resident's urine collection bag. Resident #298. The findings included: During a facility tour conducted on 10/31/22 at approximately 3:15 PM, Resident #298 was observed in her room with her urine collection	L 521		

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STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

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L 521	Continued From page 71 bag uncovered, visible to visitors and other residents from the hallway. Resident #298 was admitted to the facility on 10/28/22 with multiple diagnoses that included: Overactive Bladder and Change in Bowel Habit. A review of the medical record revealed the following: 10/28/22 [Nursing Progress Note] "...[Resident #298] is an 81-year-old African American female newly admitted from [Hospital name] ...Catheter was placed with improvement. Resident however failed void trial and catheter was replaced and is to be on until next follow up with urology..." 10/29/22 [History and Physical] "... Patient has an indwelling Foley inserted in the hospital due to urinary retention..." During a face-to-face interview conducted on 10/31/22 at approximately 3:20 PM, Employee #17 (Licensed Practical Nurse/LPN) acknowledged the finding and made no further comment.	L 521		