STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. BUILDING ______ B. WING ______	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	**1818 NEWTON ST. NW WASHINGTON, DC 20010**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted November 2, 2022, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 494.62. The survey found that the facility was not in substantial compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 494.62. The census was 101.	E 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.	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: ADMINISTRATOR
(X6) DATE: 1-3-23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, facility staff failed to maintain an updated emergency preparedness plan. The findings included: On November 2, 2022, review of the facility's emergency preparedness plan, showed the facility failed to update its plan within the required timeframe of a minimum of one (1) year. The most recent update was January 2020. During a face-to-face interview on November 3, 2022, at approximately 11:00 AM, Employee #1 and Employee #7 acknowledged the findings.	E 004	E004: 1. The emergency preparedness plan was reviewed and updated as needed and dated to reflect review and/or revision date. 2. All other emergency preparedness plans were reviewed and updated as needed. 3. The Emergency Preparedness Team was provided an in service on the need to review the emergency preparedness plan on an annual basis. 4. The emergency preparedness plan will be reviewed monthly, revised and updated as appropriate, and current status reported to QAPI 5. Completion date: January 9, 2023 6. Maintenance Director	
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3)	E 007		

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E 007	Continued From page 2 §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to identify its resident	E 007	1. The resident population was immediately assessed for unique resident vulnerabilities and documented in the emergency preparedness plan. 2. There were no other emergency preparedness plans to be reviewed and updated. 3. The Emergency Preparedness team was provided with an in-service on the need to have an updated assessment of resident specific vulnerabilities on 11/11/22. 4. The emergency preparedness plan will be reviewed for specific resident population assessment and reported to QAPI monthly. 5. Completion date: January 9, 2023 6. MDS Director	

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E 007	Continued From page 3 population to address their specific needs in an emergency. The findings included: On November 2, 2022, review of the facility's emergency preparedness plan, showed the facility did not have documentation available to identify its specific resident population, and their unique vulnerability in the event of an emergency or disaster. Documentation that was submitted during the survey did not reflect the facility's total resident population nor was it dated. During a face-to-face interview on November 3, 2022, at approximately 11:00 AM, Employee #1 and Employee #7 acknowledged the findings.	E 007		
F 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,	F 000		

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F 000	Continued From page 4 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 level deficiencies were identified at: F 684 for Resident #26. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid 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	F 000		

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F 000	Continued From page 5 DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program LPN - Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury 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	F 000		

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F 000	Continued From page 6 Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		

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F 550 Continued From page 7

severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT 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 bag uncovered, visible to visitors and other residents from hallway.

F 550

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

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F 550	Continued From page 8 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]...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. Cross reference DCMR 3269.1d	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		

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F 578	Continued From page 9	F 578		

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept orrefuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, for four (4) of 41 sampled residents, facility staff failed to determine whether residents had Advanced Directives (AD) and failed to provide residents or their representatives the right to formulate or refuse an AD. Residents' #55, #67, #69 and #248.

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F 578

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The findings included:

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 facility staff offered the resident or their representative the opportunity to formulate or refuse Advanced Directives.

2. Facility staff failed to provide documented

F 578

F578: Advance Directive – 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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F 578	Continued From page 11 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. 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.	F 578	Advance Directive – Residents #55, 67, 69 and 248 - 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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F 578	Continued From page 12	F 578		

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.

Cross reference DCMR 3231.12

4. Facility staff failed to determine whether Resident #248 had an Advanced Directives (AD)

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	095020	A. BUILDING ______ B. WING ______	C 11/09/2022

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F 578	Continued From page 13	F 578		

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 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."

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F 578	Continued From page 14	F 578		
	Cross reference DCMR 3231.12			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii)	F 607		
	§483.12(b) The facility must develop and implement written policies and procedures that:			
	§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,			
	§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and			
	§483.12(b)(3) Include training as required at paragraph §483.95,			
	§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.			
	§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.			
	§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.			
	§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 41 sampled residents, facility staff			

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F 607

Continued From page 15

failed to implement its policies for conducting investigations of facility reported incidents as evidenced by failure to conduct a thorough investigation of: 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 mentalillness ...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 implement its policy as evidenced by failure 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

F 607

F 607: Develop/implement abuse/Neglect Policies – Residents #4 and 82)

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.

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F 607	Continued From page 16 and Pain. 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 staff who might have knowledge	F 607	F 607 - Resident #4 Continued 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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F 607 Continued From page 17
on the alleged abuse were obtained as part of the investigation for Resident #4.

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.

F 607

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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F 607	Continued From page 18 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 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	F 607	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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F 607	Continued From page 19 activated ...Resident found and returned to facility at 3:10 pm on December 17th, 2021..." On 12/27/21 at 4:29 PM, a FRI, DC00010470, 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]."	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		

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F 610	Continued From page 20 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT 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 a thorough investigation of one resident's allegation of abuse and one resident's unwitnessed fall, allegation of abuse, and elopement. Residents' #82 and #4. 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 thoroughly investigate	F 610	F 610 – residents #4 and 82 1. Resident #4 was reassessed by the Director of Nursing (DON) on November 7. DON discussed allegation with resident who does not recall being handled roughly. The DON interviewed staff who attended resident on 8/23/21. Complaint was reported to the Resident Care Coordinator (RCC) on 8/23/21. The RCC assessed Resident #4 documentation, resident had no complaints of pain or any bruising noted a the time of the complaint investigation 2. All complaint allegations were reviewed and have not identified any allegations that would rise to level of abuse or neglect.	

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F 610	Continued From page 21 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 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..."	F 610	Resident #4 continued 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 12/14/22. 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 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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F 610

Continued From page 22

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, 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;

F 610

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 there were no other allegations identified that would rise to level of abuse or neglect. All residents' 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 12/14/22

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F 610	Continued From page 23 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]." DCMR 3232.2 2. 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. 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.	F 610	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. Nurse Educator	

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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 who might have knowledge on the alleged abuse were obtained as part of the investigation for Resident #4.

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.

Cross reference DCMR 3232.2

F 635 SS=D | Admission Physician Orders for Immediate Care CFR(s): 483.20(a) | F 635

§483.20(a) Admission orders
At the time each resident is admitted, the facility must have physician orders for the resident's

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immediate care.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to ensure that one resident had a physician's order for an indwelling catheter. 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 bag uncovered, visible to visitors and other residents from 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]...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

F 635

F 635 – 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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F 635	Continued From page 26 urethral trauma..." From the date of admission, 10/31/22 to 11/08/22 (nine days later), 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."	F 635	F 641 – Resident 348, 69, 68 Res. #348 1. Resident #348 was reassessed for pressure ulcer risk on 12/12/22 by MDS coordinator. No pressure ulcer was noted during identified timeframe. MDS was modified to reflect assessment re: pressure ulcer risk on 12/12/22. There were no negative outcome as a result of this deficient practice. 2. All charts were reviewed to identify residents at risk for pressure ulcers. All residents at risk for pressure ulcers based on the Braden scale were assessed for accuracy of MDS coding. Any correction to MDS will be updated. No additional residents were found to be affected by is deficient practice. 3. The Director of Nursing provided all MDS coordinators an in-service on accurate coding of pressure ulcers/Section M on 12/8/22. 4. The DON will review MDS of residents with pressure ulcer risks for accurate MDS coding quarterly and findings reported to QAPI. 5. Completion date: January 9, 2023 6. Director of Nursing	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for three (3) of 41 sampled residents, facility staff failed to ensure that residents Minimum Data Set (MDS) assessments were coded to reflect of their status at the time of the assessments. Residents' #348, #69, and #68. The findings included: 1. Facility staff failed to code Resident #348 as being at risk for developing pressure ulcers on an Admission MDS. Resident #348 was admitted to the facility on 08/12/22 with diagnoses including Cerebral Vascular Accident, Hemiplegia and Hemiparesis, Generalized Muscle Weakness, and Mixed Receptive-expressive Language Disorder.	F 641		

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F 641

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A review of Resident #348's medical record revealed:

Physician's orders:

08/12/22 "Apply Barrier Cream To Sacral Buttocks and Peri-area Every shift."

08/12/22 "Monitor for Bruising/Bleeding every shift."

08/12/22 "Turn and Repositioning Q (every) 2 hours."

08/12/22 at 8:36 PM [Braden Scale for Prediction of Pressure Sore Risk] "..Calculate Points and Record Totals [Blank]...Interpretation of Score: 15-18 -At Risk..."

Care plan initiated on 08/13/22 "Category Skin Impairment ...[Resident #348] has impaired skin integrity...Raised area on mid-chest, abrasion to right inner thigh, and bilateral lower extremity edema..."

The Admission MDS dated 08/17/22 showed facility staff coded: severe cognitive impairment; always incontinent for bowel and bladder; had no pressure ulcers; and not at risk for developing pressure ulcers/injuries.

During a face-to-face interview on 11/08/22 at 1:15 PM, Employee #9 (MDS Coordinator), acknowledged that facility staff should have coded the Resident as at risk for developing pressure ulcers.

F 641

Resident #69

1. Resident #69 was reassessed by the MDS Coordinator and medical record reviewed on 12/9/22. The MDS coordinator completed the modification as it pertains to falls. There was no negative outcome as a result of this deficient practice.
2. All residents who experienced falls will be reassessed for accurate coding of falls/Section J and will be modified as required.
3. The Director of Nursing provided all MDS coordinators an in-service on accurate coding of falls on 12/8/22.
4. The DON will review the MDS of all residents with falls for accurate MDS coding quarterly and findings reported to QAPI.
5. Completion date: 1/9/23
6. Director of Nursing

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F 641

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2. Facility staff failed to accurately record the number of falls that Resident #69 had in the facility on the Quarterly MDS dated09/15/22.

Resident #69 was admitted to the facility on 06/14/22 with diagnoses including Repeated Falls, Parkinson's Disease and Hereditary and Idiopathic Neuropathy.

A review of Resident #69's medical record revealed:

07/27/22 at 9:13 PM [Nursing Progress Note]: "During med pass in the evening around 5:45 PM, writer found Resident laying on her side, on the floor in her room, writer asked her what happened, and she said she [slid] to the floor from her bed. she denied hitting her head on the floor..."

07/28/22 [Care Plan]: "Category: Falls...[Resident #69] had a fall on 7/27/22 due to impaired mobility/disease process..."

A Quarterly MDS dated 09/15/22 showed facility staff coded: moderately impaired cognition; and had 2 (two) falls since admission or prior assessment.

It should be noted that other than on 07/27/22, Resident #69 had no other documented falls.

During a face-to-face interview on 11/08/22 at 1:15 PM, Employee #9 (MDS Coordinator) acknowledged that facility staff inaccurately coded Resident #69 as having 2 falls instead of 1 for the Quarterly MDS dated 09/15/22.

3. Facility staff failed to accurately code Resident

F 641

Resident #68

1. Resident #68 was reassessed by the MDS Coordinator and medical record reviewed on 11/7/22. The MDS Coordinator completed the modification as it pertains to falls. There was no negative outcome as a result of this deficient practice.
2. All residents who experienced falls will be reassessed for accurate coding of falls/Section J and will be modified as required.
3. The Director of Nursing provided all MDS coordinators an in-service on accurate coding of falls on 12/8/22.
4. The DON will review MDS of all residents with falls for accurate MDS coding quarterly and findings reported to QAPI.
5. Completion Date: 1/9/23
6. Director of Nursing

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F 641	Continued From page 29 #68's Minimum Data Set (MDS) to capture that he had a 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. A MDS dated 09/01/22 showed facility staff coded, "no falls since admission/reentry or prior assessment". During a face-to-face interview conducted on 11/07/22 at 1:31 PM, Employee #9 (MDS Coordinator) reviewed the MDS and stated, "The fall is supposed to be coded. I'll make the correction now."	F 641		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		

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F 656	Continued From page 30 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive	F 656	F 656 – 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	

F 656 Continued From page 31 F 656

care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews for four (4) of 41 sampled residents, facility staff failed to develop and implement comprehensive patient-centered care plans that included goals and approaches to meet resident's medical, physical, mental and psychosocial needs. Residents' #350, #32, #299, and #26.

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:

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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."

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:

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F 656	Continued From page 33 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 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	F 656		

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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.

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 asses Resident #32's skin every shift per the care plan. Subsequently, the resident was observed with cellulitis of left lower limb with edema.

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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 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

F 656

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 an in-service 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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STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 36 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 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	F 656		

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F 656	Continued From page 37 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." DCMR 3210.4 3. 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. When he first came to the facility, he was	F 656		

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F 656	Continued From page 38 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 ..."	F 656	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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F 656	Continued From page 39	F 656		

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 11/03/22 at 3:42 PM Employee #15 (Licensed

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F 656 Continued From page 40

Practical Nurse) stated " ...Resident would refuse care initially he could do most of the things for himself." Employee #15 acknowledged the findings.

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.

Cross reference DCMR 3210.4

4. Facility staff failed to develop a care plan to address the care of Resident #26's ischemic right foot and cellulitis.

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:

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."

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

F 656 Resident # 26

1. Resident #26 was re-assessed and care plan re: skin impairment was reviewed and updated to address current assessment and treatment for right foot on 11/14/22.
2. All residents with foot related conditions were addressed and all necessary care plans were reviewed to reflect the assessment, goals, care plans and treatment.
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.
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.
5. Completion date: Jan 9, 2023
6. Director of nursing

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F 656	Continued From page 41 swelling) 0.6mg (milligrams) tablet, give 2 tablet x 1, then 1 tablet 1 hour later for Gouty exacerbation." 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)..." 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. 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. During a face-to-face interview on 11/04/22 at 12:21 PM, Employee #10 (1st Floor Charge Nurse) reviewed the care plan, acknowledged the finding and made no further comments.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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F 657	Continued From page 42 includes but is not limited to-- (A) The attending physician. (B) Aregistered nurse with responsibility for the resident. (C) Anurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident'srepresentative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for five (5) of 41 sampled residents, facility staff failed to revise the comprehensive care plans with new goals and approaches for: one resident who had a urinary tract infection (UTI); two residents who sustained falls; one resident's right foot cellulitis and gangrene; and one resident's new dialysis access site. Residents' #25, #80, #26, #68 and #79. The findings included: 1. Facility staff failed to revise Resident #25's care plan for a diagnosis of Urinary Tract Infection (UTI) on 08/11/22.	F 657	F 657 – Resident # 25, 80, 26, 68, and 79 : 1. Resident #25 was assessed by the DON on 11/7/22. The Care plan for UTI was reviewed and revised to address goals and approaches for UTI. The care plan was subsequently resolved on 11/8/22. There was no negative outcome. 2. All residents with diagnosis of UTI were assessed and all necessary care plans were revised to reflect goals that address UTIs. 3. The Nurse Educator provided all RNs an in-service on comprehensive care plans with emphasis on timely assessment and interventions to prevent and care for UTI, and goals and approaches updated on 11/4/22 (on-going). 4. The DON (or designee) will review all care plans written for newly reported UTI weekly, update as needed, and reported to QAPI monthly. 5. Completion date: Jan. 9, 2023 6. Director of Nursing	

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Resident #25 was admitted to the facility on 10/25/18 with the following diagnoses: Chronic Kidney Disease, Non-Alzheimer's Dementia, Ventricular Tachycardia, Depression, and Generalized Muscle Weakness.

Review of Resident #25 medical record showed the following:

Care plan focus area initiated on 01/27/22 "[Resident #25] has likelihood for altered urine pattern related to disease process manifested by: Dx (diagnosis) UTI... goal no complication within 90 days. Approach Provide privacy, encourage fluids, record incontinent each shift, Resident wear incontinence pads, provide perineal care... updated 08/08/22 Urine for UA (urinalysis) C/S (culture and sensitivity) was obtained and picked up by lab technician awaiting result..."

"08/05/22 [physician's order] " ...Urine for C&S to rule out UTI. Urine C&s to be done tomorrow 8/6/22..."

"08/08/22 at 2:35 PM [Nursing Progress Note] "Urine specimen for C&S lab to r/o UTI as ordered Specimen in the refrigerator awaiting pick up by the lab"

"08/11/22 at 9:34 PM [Nursing Progress Note] "Call placed to MD (medical doctor) regarding urinalysis, culture and sensitivity result Lab Urinalysis, culture and sensitivity results received bacteria few ... and organism 1>1000000 Escherichia Coli order given to start Ampicillin 500 mg (milligram) 1 tab po (by mouth) twice daily x7 days for UTI..."

There was no documented evidence that facility

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staff revised Resident #25's care plan with new goals and approach after it was confirmed that he had a UTI on 08/11/22.

During a face-to-face interview conducted on 11/8/22 at 2:30 PM, Employee #2 (DON) acknowledged the findings and made no further comments.

2. Facility staff failed to revise Resident #80's care plan with new goals and approaches after he sustained multiple falls.

Resident #80 was admitted to the facility on 07/07/20 with multiple diagnoses that included: Cerebrovascular Accident, Diabetes Mellitus, Hypertension, and Respiratory Distress.

Review of Resident #80's medical record revealed the following:

Care plan focus area initiated on 04/22/22 "Category Falls ... [Resident #80] has likelihood for falls ..."

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 ...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...Nursing will continue plan of care..."

There was no documented evidence that facility staff revised Resident #80's falls care plan with any new goals and approaches after she

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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F 657	Continued From page 45 sustained a fall on 05/11/22. During a face-to-face interview conducted on 11/08/22 at 2:30 PM, Employee #2 (Director of Nursing/DON) acknowledged findings and made no further comments. 3. Facility staff failed to revise Resident #26's comprehensive care plan with new approaches, actions, treatments and procedures to address care of the resident's right foot. 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: Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility..." 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." 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." 07/23/22 at 8:58 PM [Physician's Note] "...Patient	F 657	1. Resident #26 was assessed by the DON on 11/4/22. Care plan to address current right foot treatment was revised on 11/4. 2. All charts were reviewed to identify residents with skin breakdown. All other residents with potential for skin break down were assessed and care plan revised to reflect weekly skin assessment on 12/23/22. 3. The Nurse Educator provided all interdisciplinary care plan team members an in-service on facility's comprehensive care plan policy on 11/14/22 (ongoing). 4. The Nursing Supervisor will review care plans developed for residents with skin condition monthly and report to QAPI monthly. 5. Completion date: January 9, 2023 6. Director of nursing	

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seen at the request of nursing for ischemic [necrotic] foot and toe with surrounding cellulitis...Dark big toe dry and cellulitis...Begin Keflex (antibiotic)..."

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.

Care plan focus area, "[Resident #26] is at risk for skin impairment r/t (related to) decreased mobility..." 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 care goals and approaches that addressed actions, treatments, procedures, or activities for the care of Resident #26's right foot.

The evidence showed that facility staff failed to revise Resident #26's skin impairment care plan with new actions, treatments and procedures to address care of the resident's right foot.

During a face-to-face interview on 11/04/22 at 12:21 PM, Employee #10 (1st Floor Charge Nurse) reviewed the care plan and acknowledged the finding and made no further comments.

4. Facility staff failed to revise Resident #68's falls care plan with new interventions after he had a fall on 10/27/22.

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F 657

Continued From page 47

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 Progress 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; no behavior issues; 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 walking.

10/27/22 at 1:45 PM [Physician's Assistant Note] "Pt's nurse reported that pt had a fall and general

F 657

Resident #68

1. Residents #68 were assessed by the DON on 11/17/22. 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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STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48 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 (physical therapy)/OT (occupational therapy) consult PRN (as needed). 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..." Although Resident #68's fall care plan showed it was revised on 10/28/22, the evidence showed that facility staff failed to include any new goals , approaches, actions, treatments or procedures to address the fall. Subsequently, Resident #68 sustained another fall on 11/04/22.	F 657		

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F 657	Continued From page 49 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. 5. Facility staff failed to revise Resident #79's care plan to reflect his new dialysis access site. 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 a last revised date of 09/30/22. 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	F 657	Resident #79 1. Resident #79 was assessed by the DON on 11/4/2022. Resident did not have any negative outcome as a result of this deficient practice. Care plan was updated on 11/4/22 to address Dialysis access site. There were no negative outcome. 2. All charts were reviewed to identify residents on dialysis. One additional resident on dialysis was assessed and care plan updated on 11/4/22 to reflect new dialysis access site and the associated care of the site. 3. The nurse educator provided all clinical care staff an in-service on comprehensive care planning re: care of resident on dialysis on 11/14/22. 4. The Resident Care Coordinator (or designee) will review care plans of resident on dialysis monthly and conduct weekly rounds to verify compliance with plan of care. Findings will be reported to QAPI monthly. 5. Completion date: Jan 9, 2023 6. Nurse Educator	

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F 657	Continued From page 50 surgical site [new AV graft site] observed with transparent pressure dressing. No signs of bleeding noted..." There was no documented evidence to show that facility staff revised Resident #79's care plan to include the new dialysis access site [left arm AV graft] and the associated care of the site. During a face-to-face interview conducted on 11/04/22 at 2:56 PM, Employee #10 (1st Floor Charge Nurse) stated, "It [care plan] needs to be updated to reflect both dialysis sites and care."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, for one (1) of 41 sampled residents, facility staff failed to administer medications within the professional standards of practice. Resident #99. The findings included: According to the "Long-Term Care Nursing: Medication Pass", "...pre-pouring medications is unacceptable because the medications: cannot accurately be compared to the Medications Administration Record (MAR) and violates at least two of the seven rights of medication administration (right patient & right medication), dramatically increasing the probability of	F 658		

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F 658

Continued From page 51
medication errors ..."

https://ceufast.com/course/long-term-care-nursing-medication-pass

During an observation on 11/09/22 starting at 8:42 AM, Employee #13 (Licensed Practical Nurse) was observed retrieving a white paper cup that was located in the medication cart and contained unwrapped loose tablets to administer to Resident #99. Employee #13 was stopped by the surveyor before she could administer the unidentified, loose tablets. The employee stated "I was keeping the pills in the medication cart to give to the resident later. Employee #13 was observed not performing hand hygiene and then directly touched the tablets that were intended to be given to the resident. Employee #13 then entered Resident #99's room without identifying herself, verifying the resident's identity, or addressing the resident by name. Employee #13 did not inform Resident #99 of what medications she was being administered. Resident #99 stated she did not want the "big pills" and can only take the "flat pills". Employee #13 did not acknowledge or assess the resident's concern with possible swallowing difficulties.

In a face-to-face interview conducted at the time of observation, Employee #13 further stated, "Since I entered the room earlier, I did not know I needed to say anything else."

Resident #99 was admitted to the facility on 10/21/22, with multiple diagnoses that included: Dysphagia, Hypertension, and Gastro-Esophageal Reflux Disease.

A review of the medical record revealed the

F 658

F658 –Resident # 99

1. The Director of Nursing immediately provided Employee#13 a re-education on medication administration principles, residents rights, and infection control procedures. There were no negative outcomes as a result of this deficient practice. Employee #13 attended 1:1 education with the Nurse Educator on 11/09/22.
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. All nursing staff were provided an in-service education on residents rights and infection control principles (hand hygiene and hand washing). All licensed staff members who pass medications were provided an in-service on medication administration, resident's right, and infection control principles on 11/14/22 by the nurse educator/designee. (on-going).

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F 658	Continued From page 52 following: 10/21/22 [physician's Order] "...Diet: Pureed ..." 10/25/22 [Admission Minimum Data Set (MDS)] facility staff coded: the resident as having a Brief Interview for Mental Status summary score of "15" which indicated intact cognition; no rejection of care behavior exhibited; holding food in mouth /cheeks or residual food in mouth after meals; was I a mechanically altered diet. 11/01/22 [physician's order] "...May crush medication and give in apple [sauce]..." The evidence showed that Employee #13 failed to administer Resident #99's medications according to the accepted standards of clinical practice. During a face-to-face interview conducted on 11/08/22 at 9:23 AM, Employee #2 (Director of Nursing) stated, "She (Employee #13) is on orientation and her preceptor called out. We have challenges with staffing, and I don't have a manager for this unit."	F 658	Resident #99 continued 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: Jan. 9, 2023 6. Nurse Educator	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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F 684

Continued From page 53

by:
Based on observation, record review and staff interview, for two (2) of 41 sampled residents, 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; and facility staff failed to assess Resident #32's skin every shift per the care plan. Subsequently, the resident was observed with cellulitis of left lower limb with edema.

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) further declined and resulted in amputation on 10/26/22.

The findings included:

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

F 684

F 684 – Resident # 26, 32

A-

1. Resident #26 is no longer in the facility. No corrective action can be done for this resident during this time frame.
2. All residents with foot related conditions will be assessed and care plan developed. All resident records were reviewed to identify residents with foot related conditions. Care plan of 100% of residents with foot condition were revised to address foot condition. No additional resident had any negative outcome as a result of this deficient practice.
3. The Nurse Educator provided all interdisciplinary care plan team members an in-service on facility's comprehensive care plan policy on 11/14/2022 (on-going).
4. The Nursing Supervisor will review care plans developed for residents with foot related conditions monthly and report to QAPI monthly.
5. Completion date: January 9, 2023
6. Director of Nursing

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F 684	Continued From page 54 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. 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 #26's 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;	F 684	B- 1. Resident # 26 is no longer in the facility and no corrective action can be done during this timeframe. 2. All resident chart were reviewed for skin monitoring shower reports to identify residents in need of skin assessment. Care plans of all residents in need of assessment were revised to reflect skin assessment policy. 3. The Nurse Educator provided an in-service to all nursing staff regarding skin assessment and skin monitoring during showers on 11/14/22 (ongoing). 4. Care plans will be monitored for implementation of interventions monthly by the DON/designee and findings will be reported to QAPI monthly. Individual care plans will be revised if needed, as determined by audit findings. Staff will be provided re-education and progressive discipline. 5. Completion date: Jan.9, 2023 6. Director of Nursing	

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F 684	Continued From page 55 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. 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.	F 684		

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F 684 Continued From page 56

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 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]."

F 684

C-1.

1. Resident # 26 is no longer in the facility and no corrective action can be done during this timeframe.
2. All other residents with skin breakdown were assessed as per facility policy and care plan revised to reflect weekly skin assessment policy.
3. 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.
4. 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 implementation of interventions monthly by the DON/designee and findings will be reported to QAPI monthly.
5. Completion date: Jan.9, 2023
6. Director of Nursing

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F 684	Continued From page 57 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 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	F 684	D-1. 1. Resident # 26 is no longer in the facility and no corrective action can be done during this timeframe. 2. 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. Inservice was provided to all licensed nursing staff regarding timely implementation of physician's orders by the nurse educator. Uncompleted orders will be referred to the physician. Inservice was provided by the DON on 11/11/22. 4. Resident care coordinators will monitor timely completion of consult orders weekly and report to QAPI monthly. 5. Completion date: Jan.9, 2023 6. Director of Nursing	

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F 684

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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 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."

F 684

Resident # 32

1. Resident # 32 was assessed by the DON on 11/4/2022. Treatment order for Res. #32's left leg was obtained on 11/4/2022. Care plan was updated on 11/4/2022.
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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F 684	Continued From page 59 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 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".	F 684		

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F 684	Continued From page 60 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 ..." 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 Assistant Note] "Pt's nurse reported that pt had Doppler Scan results that need to be reviewed and addressed ... 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	F 684		

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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 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.

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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) 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 her would be below-knee amputation ... The patient and family do not wish to have major amputation ..."

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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 midway of the foot, extending to all five of her toes.

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:

A. Failure to develop a patient-centered care plan to address care of Resident #26's right foot

B. Failure to conduct ongoing skin assessments as directed by the facility's policies and "Skin Monitoring Shower Report"

C. 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)

D. Failure to obtain ordered duplex and vascular consult in a timely manner. Duplex and Vascular consult were ordered on 08/24/22. A venous

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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 [for] 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, 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

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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 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,

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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 #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 had not mentioned 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

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for Bruising/Bleeding every shift."

06/17/21 at 8:46 PM: [physician's order]: "Emollient topical lotion, apply 2x/day as needed 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 (BIMS)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

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F 684	Continued From page 68 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 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 Resident #32 and stated that when the licensed nurses do the skin assessments, they should document the any new skin areas and the condition of the other existing areas." 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 facility staff failed to	F 684		

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F 684	Continued From page 69 assess Resident #32's left leg daily per the resident's comprehensive care plan and they all acknowledged the findings. Cross reference: DCMR 3211.1	F 684	F 686 – Resident #350 1. Resident #350 is no longer in the facility to actively correct the deficiency. 2. All other residents received skin assessments. No additional residents had any negative outcome as a result of this deficient practice. 3. The nurse educator provided all licensed staff an in-service on skin assessment documentation and care planning from 11/14/2022 (on-going). 4. The DON/designee will conduct weekly audits of skin assessments and plan of care. Discrepancies between plan of care and assessment documentation will be corrected and reported to QAPI monthly. 5. Completion date: Jan 9, 2023 6. Director of nursing	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to ensure that residents received care to promote the healing of existing pressure ulcers for Resident #350. The findings included: Resident #350 was admitted to the facility admitted 10/23/19 with diagnoses including Cerebral Vascular Accident, Peripheral Vascular	F 686		

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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."

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

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F 686	Continued From page 71 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 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	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 72 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. 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	F 686		

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F 686	Continued From page 73 (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] ..." There was no evidence 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. During a face-to-face interview on 11/07/22 at 3:30 PM, Employee #11 (Clinical Educator) reviewed the findings for Resident #350 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." Cross reference DCMR 3211.1	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689

Continued From page 74

Based on record review and staff interview, for two (2) of 41 sampled resident, facility staff failed to identify and implement measures or approaches to reduce the risk of accidents (falls). Residents' #80 and #68.

The findings included:

1. 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 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..."

F 689

F 689 – Resident #80 and #68

1. Residents #80 and 68 were assessed by the DON on 11/18/22022. Both residents had repeat falls. Both residents' care plans were updated, Resident #68 was updated on 11/18 and Res#80 was updated on 12/27 to reflect additional approaches to address prevention/minimize recurrence.
2. All other residents were assessed for potential for falls. Care plans of residents with repeat falls were updated for additional approaches to prevent/minimize repeat 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 until 100% compliance is achieved and sustained for 3 months. This will be reported to QAPI monthly.
5. Completion date: Jan 9, 2023
6. Director of nursing

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F 689	Continued From page 75	F 689		

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."

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.

A Significant Change Minimum Data Set (MDS) 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.

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F 689	Continued From page 76	F 689		

Neuro check in progress. POC made aware. Nursing will continue plan of care..."

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 called..."

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.

Cross reference DCMR 3211.1

2. 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,

F 689 Continued From page 77 F 689

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 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

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F 689	Continued From page 78 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, 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. Cross reference DCMR 3211.1	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		

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F 698	Continued From page 79 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT 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: develop and implement interventions for care and monitoring of his dialysis access site; and have an emergency kit (pressure bandage) at the bedside of 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	F 698	F 698 – Dialysis - 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 done on 11/10/22. 4. The nursing 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.	

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F 698	Continued From page 80 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 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..."	F 698	Dialysis – Resident #79 continued 5. Completion date January 9, 2023 6. Director of Nursing	

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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 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 ..."

There was no documented evidence that facility staff revised Resident #79's dialysis care plan to include his new dialysis access site [left arm AV graft] and the associated care of the site; and failed to have an emergency dialysis kit at his bedside.

During a face-to-face interview conducted on 11/07/22 at 9:33 AM, Employee #15 (1st Floor Assistant Unit Manager) acknowledged the findings and stated, "LPNs are not allowed to start or revise the care plans" and that "none of the residents in the facility (2 in total) have emergency [dialysis] kits at their bedside."

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."

Cross reference DCMR 3206.1(j)

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F 711 SS=D

Physician Visits - Review Care/Notes/Order
CFR(s): 483.30(b)(1)-(3)

§483.30(b) Physician Visits
The physician must-

§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

§483.30(b)(2) Write, sign, and date progress notes at each visit; and

§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview for two (2) of 41 sampled residents, the physician failed to adequately evaluate resident's condition and total program of care 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:

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

F 711

F 711 – 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. The therapeutic recreations 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 by the author 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. The Director of Therapeutic Recreations provided the TR staff in service on documentation of quarterly notes for residents away from the facility 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 weekly and reported to QAPI monthly.
5. Completion date: Jan. 9, 2023
6. Health Information Manager

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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: Overactive Bladder and Change in Bowel Habit.

A review of the medical record revealed the following:

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10/28/22 [Nursing Progress Note] "... [Resident #298]...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."

Cross reference DCMR 3207.10

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 Kidney Failure, Pleural Effusion, Chronic Obstructive Pulmonary Disease and Combined

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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 ... 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.

During a face-to-face interview conducted on

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11/07/22 at 9:50 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comments.

Cross reference DCMR 3207.10

F 726 SS=D Competent Nursing Staff
CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

F 711

F 726

F726 – 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

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This REQUIREMENT 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 that licensed nurses had the specific competencies and skill sets necessary to care for a resident's needs and assure resident safety when administering medications. Resident #99.

The findings included:

Review of the policy titled "General Guidelinesfor Medications Administration" with a revision date of October 2018, instructed, "...Cleanse hands as appropriate ...Read the label three times before pouring the medication ...Never touch any of the medication with fingers ...Identify the resident before administering any medication. Check the arm band or photograph, call resident by name, or check with other staff members if necessary . Explain to the resident the type of medication to be administered. The resident has the right to be informed of all medications that are administered ...Administer medication and remain with resident while medication is swallowed ...Once removed from the package or container, unused doses should be destroyed by flushing in toilet or washing down drain and documenting the destruction according to policy..."

During an observation on 11/09/22 starting at 8:42 AM, Employee #13 (Licensed Practical Nurse) was observed retrieving a white paper cup that was located in the medication cart and contained unwrapped loose tablets to administer to Resident #99. Employee #13 was stopped by the surveyor before she could administer the unidentified, loose tablets. The employee stated "I

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was keeping the pills in the medication cart to give to the resident later. Employee #13 was observed not performing hand hygiene and then directly touched the tablets that were intended to be given to the resident. Employee #13 then entered Resident #99's room without identifying herself, verifying the resident's identity, or addressing the resident by name. Employee #13 did not inform Resident #99 of what medications she was being administered. Resident #99 stated she did not want the "big pills" and can only take the "flat pills". Employee #13 did not acknowledge or assess the resident's concern with possible swallowing difficulties.

In a face-to-face interview conducted at the time of observation, Employee #13 further stated, "Since I entered the room earlier, I did not know I needed to say anything else."

Resident #99 was admitted to the facility on 10/21/22, with multiple diagnoses that included: Dysphagia, Hypertension, and Gastro-Esophageal Reflux Disease.

A review of the medical record revealed the following:

10/21/22 [physician's Order] "...Diet: Pureed ..."

10/25/22 [Admission Minimum Data Set (MDS)] facility staff coded: the resident as having a Brief Interview for Mental Status summary score of "15" which indicated intact cognition; no rejection of care behavior exhibited; holding food in mouth /cheeks or residual food in mouth after meals; was I a mechanically altered diet.

11/01/22 [physician's order] "...May crush

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F 726	Continued From page 89 medication and give in apple [sauce]..." The evidence showed that Employee #13 did not have the appropriate competencies and skills sets to provide nursing and related services to assure Resident #99's safety. During a face-to-face interview conducted on 11/08/22 at 9:23 AM, Employee #2 (Director of Nursing) stated, "She (Employee #13) is on orientation and her preceptor called out. We have challenges with staffing, and I don't have a manager for this unit."	F 726	F 755 – 1. Resident # 24's controlled medications were reviewed and reconciled on 11/8/22. Discontinued narcotics were disposed of on 11/09/22. 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. Medication discontinuation orders for all residents were reviewed 11/9/22 and 100% of all other discontinued medications were returned. 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	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

F 755 Continued From page 90 F 755

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT 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: properly waste a discontinued narcotic and reconcile narcotics. Resident #24.

The findings included:

Review of the facility's policy titled "Administration of Schedule II Medications" with a revision date of October 2018, instructed "...The nurse will then count or measure the remaining drug quantity in stock and enter the amount remaining onto the narcotics inventory sheet.

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..."

1. Facility staff failed to properly discard 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

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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, onepill 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.

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.

DCMR 3227.13

2. Facility staff failed to reconcile the narcotics on multiple days.

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.

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The evidence showed that facility staff failed to perform the reconciliation of narcotics on the above-mentioned dates.

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.

Cross reference DCMR 3224.3 (d)

F 756 SS=D — Drug Regimen Review, Report Irregular, Act On
CFR(s): 483.45(c)(1)(2)(4)(5)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified

Provider's Plan of Correction (F 755 / F 756)

F756 – Resident #60

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

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irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, for one (1) of 41 residents, facility staff failed to take the action of notifying the psychiatrist as ordered, in response to a monthly MRR (medication regimen review) and to have an established, consistent location for the MRR forms to facilitate communication with the State Surveyors. Resident #60.

The findings included:

A. Facility staff failed to take the action of notifying the psychiatrist as ordered, in response to the monthly MRR (medication regimen review) for a gradual dose reduction for Resident #60.

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 Disorder,

Review of Resident #60's medical record revealed the following:

F 756

B-1.

1. The DON and nursing staff were provided information on where to locate MRRs. MRR for Resident # 60 was found and provided to psychiatrist on11/11/22. Psychiatrist reviewed the MRR on 11/11/22.
2. All residents' charts were audited for proper placement of MMR in the residents' medical record on 11/11/22. There were no negative outcome to other residents as a result of this deficient practice.
3. All licensed nursing staff were provided an in-service on MRR policy and where to locate MRRs on11/14/22 by Nurse Educator.
4. The consultant pharmacist will audit MRRs for MD response monthly and report to QAPI quarterly.
5. Completion date: January 9, 2023
6. Director of QAPI

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F 756	Continued From page 94 10/14/21 [Physician's order] "Trazadone (antidepressant) 25mg (milligram) tab (tablet) po (by mouth) qhs (every night) for insomnia..." 10/13/22 at 12:41 PM [Pharmacist Note] "MRR 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. Care plan focus area "[Resident #60] is on 9 or more medications" last reviewed/revised on 10/18/22 had the following approach, "...Follow up with pharmacy recommendations ..." Care plan focus area "[Resident #60] has likelihood for altered sleep pattern..." last reviewed/revised on 10/18/22 had the following approaches, "Administer Trazadone as ordered. Monitor effectiveness and side-effects....." 10/20/22 at 6:58 AM [Physician's Assistant Note] " ...Pt's (patient's) nurse reported that pt has a pharmacy recommendation that needs to be reviewed and addressed. Pharmacy Recommendation: Gradual reduction of Trazadone for Insomnia Order Psychiatrist consult for psych (psychiatric) medication reconciliation." 10/21/22 [physician's order] "Psychiatrist consult for psych medication reconciliation" 10/21/22 12:51 PM [Nursing Note] ". Psychiatrist consult for psych medication reconciliation	F 756		

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F 756	Continued From page 95 ordered by PA (Physician's Assistant)..." Review of the Resident #60's medical record on 11/08/22 showed that since the ordered date of 10/21/22 (totaling 18 days), there is no documented evidence that the resident was seen by the psychiatrist nor was there any evidence that the psychiatrist was notified of the resident's consult in order alter his treatment (gradual dose reduction of Trazadone). During a face-to-face interview conducted on 11/08/22 at 10:53 AM, Employee #18 (Licensed Practical Nurse/LPN) stated, "When there's an order for a psych consult, the nurse receiving the order calls and lets the psych doctor know." When asked if the psych doctor has been made aware of Resident #60's ordered psych consult, Employee #18 stated, "I can't tell if it was done. I will find out." It should be noted that facility staff was not able to provide any documented evidence that the psychiatrist was notified of the consult or that the consult had been completed. Resident #60 did not suffer any harm from this deficient practice. B. Facility staff failed to have an established, consistent location for Resident #60's MRR forms to facilitate communication with the State Surveyors. 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.	F 756		

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F 756	Continued From page 96 Recommendation made to prescriber." 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. Cross Reference DCMR 3231.9	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

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package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, in two (2) observations, facility staff failed to: store medications in accordance with professional standards of practice; and to date and initial Insulin vials.

The findings included:

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..."

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 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,

F 761

F761 –

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.
3. Licensed Nursing staff were provided in-service on the process for discarding discontinued, expired or discharged residents medications by the Nurse Educator on 11/14/22 (on-going).
4. The nursing supervisor will check medication carts 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STODDARD BAPTIST NURSING HOME	1818 NEWTON ST. NW WASHINGTON, DC 20010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 98	F 761		

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 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.

Cross reference DCMR 3227.13

2. Facility staff failed to date and initial 2 vials of Insulin that were opened.

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F 761	Continued From page 99 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. Cross reference DCMR 3227.19	F 761	761 B. 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	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to promptly notify the ordering physician of Resident #248's laboratory results that were outside of the clinical reference ranges. Resident #248. The findings included:	F 773		

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F 773 Continued From page 100

Review of the policy titled "Microbiology Culturing of Residents and Staff" dated 09/14/11 directed, "... Culture reports- attending physicians is notified when culture and sensitivity results are obtained..."

Review of the policy titled, "Lab Results" revised on 03/15/22 documented, "All lab results should be reported to the physician and recorded in a timely manner...the night charge nurse is responsible for ensuring that all requested labs were drawn and results returned..."

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:

10/19/22 at 9:56 PM [Nursing Note] " ... newly admitted ...prior to this admission resident was admitted at [Hospital Name] after a fall on 9/23/22 ...had supra pubic catheter inserted ...was found to have urosepsis ...Resident has a 16Fr (French) supra pubic catheter in place... 100cc (milliliters) output of bloody colored urine on admission..."

An Admission Minimum Data Set (MDS) dated 10/23/22 showed facility staff coded: moderately impaired cognition and had an indwelling catheter.

10/28/22 at 3:14 PM [Nursing Note] "...Supra-pubic catheter intact and patent drained 700ml of urine with blood... [Doctor's name] made aware of urine still with blood and new order for urinalysis, and urine culture and sensitivity..."

F 773

F773 – Resident 248

1. Physician was notified of the out of the clinical reference range on 11/3/22 and new medication order obtained. Resident was assessed and there was no negative outcome.
2. All urinalysis and culture and sensitivity reports were reviewed for out of clinical reference range. There were no other lab reports that were out of clinical range
3. All licensed nurses were provided an in service on timely referral of lab reports to attending physicians by the nurse educator on 11/11/22.
4. The DON or designee will review all urinalysis and culture and sensitivity lab reports weekly and review medical records for documentation of physician notification. Findings will be reported to QAPI committee quarterly.
5. Completion date: Jan.9, 2023
6. Director of Nursing

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10/29/22 [physician's order] "Urinalysis; Other test: Urine Culture and sensitivity once - one time"

10/29/22 at 7:07 AM [Nursing Note] "...Specimen collected for UA/C&S (urinalysis/urine culture and sensitivity)."

10/31/22 at 9:07 PM [Nursing Note] "...awaiting UA/C&S result..."

11/02/22 [American Health Associates] "...Urinalysis ...blood- 3+ reference range negative; ...protein 2+ reference range negative... RBC (red blood cells) - TNCT (too many to count) reference range- 0-2; WBC (white blood cells) - TNTC reference range- 0-2... Urine culture ... organism 1 > (more than) 100,000 CFU/ML (colony-forming units per milliliter) Pseudomonas aeruginosa (bacteria). Organism 2 > 100,000 CFU/ML enterococcus faecalis (bacteria). Sensitivity..."

Review of the nursing progress notes and the 24-hour report book from 11/02/22 to 11/03/22, showed no documented evidence that facility staff notified the ordering physician of Resident #248's urinalysis and culture and sensitivity results.

During a face-to-face interview conducted on 11/03/22 at 10:38 AM, Employee #15 (1st Floor Assistant Unit Manager) stated, "Critical labs are called in as well as the sent to our system where all lab results can be found. Regardless, the nurses are supposed to check that results are back from the lab and reviewed. I will make the doctor aware right now."

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F 776 SS=D Radiology/Other Diagnostic Services
CFR(s): 483.50(b)(1)(i)(ii)

§483.50(b) Radiology and other diagnostic services.
§483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
(i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter.
(ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to provide a resident with the necessary diagnostic services in a timely manner, resulting in the worsening of a right foot non-pressure related ulcer/wound that extended from the right big toe to midfoot. Resident #26.

The findings included:

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:

F 776
F 776

F 776 – Resident #26

1. Venous Duplex was done on 9/24/22 which showed no evidence of venous clots. Arterial duplex was ordered on 10/1/22 and done on 10/1 and result on 10/2/22 showed moderate stenosis of the right lower extremity. Resident was diagnosed with "gangrene of the right foot." Resident #26 is no longer in the facility. No corrective action can be done for this resident during this time frame.
2. All other charts were reviewed for doppler studies on 11/11/22. There were no other doppler study ordered.
3. The Director of Nursing provided all licensed nurses an in-service on following up on orders pending completion on 11/11/22.
4. The unit charge nurse will check doctor's orders for radiology weekly for completion and report to QAPI monthly.
5. Completion date Jan.9, 2023
6. Director of Nursing

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An Annual Minimum Data Set (MDS) dated 05/10/22 showed facility staff coded: severe cognitive impairment; no behavior issues or refusal of care; no functional limitations in range of motion; at risk for pressure ulcers; and no unhealed pressure ulcers or any other skin conditions.

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]... Order Colchicine (decreases swelling) 0.6mg (milligrams) tablet, give 2 tablet x 1, then 1 tablet 1 hour later for Gouty exacerbation."

07/31/22 [Monthly Summary] "... Resident recently completed antibiotic...for right foot cellulitis ..."

08/01/22 at 10:06 PM [Nursing Note] "...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..."

08/24/22 at 9:56 PM [Nursing Note] " ... Duplex (test that 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 ..."

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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 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 ..."

09/23/22 [physician's order] "Duplex Doppler arterial\venous right leg and left leg ..."

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 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 Assistant Note] "Pt's nurse reported that pt had Doppler Scan results that need to be reviewed and addressed ... 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] "... Bilateral

F 776 Continued From page 105 F 776

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 ..."

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 her would be below-knee amputation ... The patient and family do not wish to have major amputation..."

The evidence showed that facility staff failed to obtain the ordered duplex for Resident #26 in a timely manner. The duplex was 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 (38 days later) that showed PVD with moderate stenosis of the right lower extremity. Subsequently, a vascular consult completed on 10/26/22 documented, "gangrene of the right foot ... extending to the midfoot ... no realistic chance of healing ... The only choice for her would be below-knee amputation ..."

During a face-to-face interview conducted on 11/09/22 at 11:08 AM, Employee #2 (Director of

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F 776	Continued From page 106 Nursing/DON), #11 (Clinical Educator), 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.	F 776	F 812 – food procurement, storage and preparation	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by thefacility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT 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	F 812	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 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	

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F 812	Continued From page 107 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, one (1) of one (1) flat top grill that was stained on both sides, and food temperatures that tested below 135 degrees Fahrenheit (F) on five (5) of six (6) observations. 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. 5. During a food test tray assessment on	F 812	2. 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	

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F 812	Continued From page 108 November 3, 2022, at approximately 1:30 PM, hot foods such as puree rice (133 degrees Fahrenheit), puree peas (132 degrees Fahrenheit), brussels sprouts (98 degrees Fahrenheit), collard greens (101 degrees Fahrenheit), and sweet potatoes (105 degrees Fahrenheit) tested below recommended hot foods minimum temperatures of 135 degrees Fahrenheit. These observations were acknowledged by Employee #6 during a face-to-face interview on October 31, 2022, at approximately 10:00 AM and on November 3, 2022, at approximately 2:00 PM.	F 812	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	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

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F 842	Continued From page 109 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842	B-1 I. Resident #79's record was updated on 11/4/22 to indicate which arm should be used for blood pressure readings. There were no negative outcome for Resident #79. 2. One other resident on dialysis had his blood pressure taken on the correct arm. 3. The Nurse Educator provided all nursing staff an in-service on care for residents on dialysis to include where to safely obtain blood pressure readings on residents with AV graft sites for dialysis. 4. The Nurse manager will conduct blood pressure observations at one random day/week until 100% compliance is sustained for 3 months. Findings will be reported to QAPI. Staff who are observed to be out of compliance will be re-educated and subject to progressive discipline. 5. Completion date: January 9, 2023 6. Director of Nursing	

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F 842	Continued From page 110	F 842		

and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and otherlicensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to accurately document in Resident #79's medical record.

The findings included:

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 ..."

Resident #79 was admitted to the facility on 05/02/19 with diagnoses that included: Acute Kidney Failure, Pleural Effusion, Chronic Obstructive Pulmonary Disease andCombined Systolic (congestive) and Diastolic(congestive) Heart Failure.

Review of Resident #79's medical record showed the following:

A. The physician and the Therapeutic Recreation Director documented assessments in Resident #79's medical record at a time when he was not

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F 842	Continued From page 111 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. 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	F 842	A. 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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F 842	Continued From page 112 #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. Cross reference DCMR 3231.12 B. Facility staff failed to accurately document the location where Resident #79's blood pressure was being taken. 09/22/22 at 10:04 PM [Nursing Note] "[Resident #79] ... re-admitted from [Hospital Name] ... at 1:35 pm..." 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. 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 transparent pressure dressing. No signs of	F 842		

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bleeding noted..."

Review of Resident #79's vital signs showed that on the following dates and time, facility staff documented to taking the resident's blood pressure on the left arm:

10/28/22 at 06:10 AM
10/28/22 at 10:26 AM
10/28/22 at 10:59 AM
10/28/22 at 9:59 PM
10/29/22 at 1:43 AM
10/29/22 at 10:14 AM
10/29/22 at 1:47 PM
10/30/22 at 12:05 PM
10/31/22 at 10:57 AM
11/03/22 at 6:19 AM
11/04/22 at 6:26 AM
11/05/22 at 4:39 AM
11/05/22 at 10:43 AM
11/06/22 at 12:55 PM
11/06/22 at 10:04 PM

A total of eight (8) days, facility staff recorded obtaining Resident #79's blood pressure on the left arm.

During a face-to-face interview conducted on 11/07/22 at 9:50 AM, Employee #2 (Director of Nursing/DON) stated, "The nurses know not to take the blood pressure in the arm with the dialysis site. It's not supposed to be documented that they are taking any blood pressure on his left [arm]."

F 867 SS=F — QAPI/QAA Improvement Activities — F 867
CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)

§483.75(c) Program feedback, data systems and

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F 867	Continued From page 114 monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and	F 867	F 867 – QAPI Improvement Activities 1. The QAPI plan was reviewed by the Quality Council, comprised of the Administrator, DON, Department Directors, Nursing staff representatives, under the guidance of the Executive Clinical Director on 12/22/22. 2. The QAPI plan affects all residents, staff and facility. 3. The QAPI Committee members were provided an in-service on the Quality Assurance and Performance improvement process by the Executive Clinical Director on 12/22/22. Training on QAPI will be provided to all staff across all departments. 4. The identified areas in the statement of deficiency will be reviewed at each QA meeting. The Quality Council will evaluate findings to determine effectiveness of actions for each aspect of care and services to determine how long to monitor each aspect of care. 5. Completion date: 1/9/23 6. Administrator	

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F 867	Continued From page 115	F 867		

systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approachto determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor theeffectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

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F 867	Continued From page 116 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failing to identify areas for improvement and to develop and implement corrective and preventive actions.	F 867		

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F 867	Continued From page 117 The resident census during the survey was 101. The findings included: Facility staff failed to develop and implement appropriate plans of action to correct identified quality deficiencies as follows: Under §483.12(b)(2), F 607 Develop/Implement Abuse/Neglect Policies Under §483.12(c)(2), F 610 Investigate/Prevent/Correct Alleged Violations Under §483.21(b)(1), F 656 Develop/Implement Plan of Care Under §483.21(b)(3)(i), F 657 Plan of Care Timing and Revision Under §483.24, F 684 Quality of Care Under §483.25(b)(1) (i)(ii), F 686 Treatment/Services to Prevent/Heal Pressure Ulcers On 11/08/22 at 2:16 PM, a face-to-face interview was conducted with Employees #1 (Administrator) and #12 (Director of Quality Improvement) regarding the Quality Assurance and Performance Improvement (QAPI). Employee #12 stated, "The committee meets every month except August and December. All department heads and some direct care staff participate." - Documentation: Employee #12 explained, "Documentation is something we have reviewed as part of QAPI. We have not found problems."	F 867		

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When asked what is used to track the performance measures, Employee #2 stated, "We look at late entries, discrepancies, holes like staff not putting in any information for tasks performed [CNA (Certified Nurse Aide) documentation, TAR (Treatment Administration Record)]. Managers audit their units and report back to QAPI. There have been no problems reported."

- Skin Assessments: Employee #12 stated, "Skin assessments are reviewed in QAPI. We discuss the CNA documentation; nursing notes, to make sure wounds aren't deteriorating. Skin assessments are done at least once a week on all residents and documented on the "Skin Sheet" [an electronic form to document the condition of resident's skin]. For the shower sheet assessments, the nurse goes with the CNA performing the shower, they both do a visual inspection of the resident's skin and then nurse does a more comprehensive skin assessment. If the resident refuses the shower and gets a bed bath, the shower sheet form should reflect that [the refusal] but the skin assessment process is the same and should be completed." When asked if the QAPI committee has found any issues with the facility's documentation of skin assessments, Employee #12 stated that she was not aware that facility staff is not performing resident skin assessments weekly or on scheduled shower days.

- Care plans: Employee #12 stated that care plans are reviewed as part of QAPI and that the committee has not noted any issues with care plan development, implementation or revision.

- Investigations: Employee #12 stated, "All

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F 867	Continued From page 119 incidents and allegations of abuse and neglect are reported and an investigation must be done. Allegations and incidents reports are part of QAPI. We look for any trends and patterns." When asked if there is a performance tracking to ensure investigations are thorough and complete, Employee #12 stated, "No." Through interview with Employees #1 and #12 at the time of the QAPI review, it was determined that the Quality Assurance committee/facility staff failed to identify areas for improvement, develop and implement corrective and preventive actions related to: investigations of allegations of abuse, injuries of unknown origin, resident care plans, and resident care/treatment for pressure and non-pressure related ulcers/wounds.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880	1. Employee #13 was counseled and sent back to the Nurse educator to review medication administration principles, resident's right and infection control procedures on November 9, 2022. 2. The Infection Control Nurse and Nurse Educator conducted random observations of all medication nurses for compliance with medication administration principles, residents' rights and infection control principles (handwashing/hand-hygiene). 3. All licensed nursing staff were provided an in-service on medication administration principles, residents rights and infection control principles (handwashing/hand-hygiene). 4. Medication administration principle will be monitored monthly and reported quarterly in QAPI. 5. Completion Date: January 9, 2023 6. Infection Control Nurse	

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F 880	Continued From page 120 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT 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 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.

Cross reference DCMR 3217.6