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 03/20/2024

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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F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility from March 4, 2024 to March 20, 2024. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 90 and the survey sample included 41 residents. The following Complaints were investigated: DC~12523, DC~12218, DC~11951, DC~11872, DC~11474 The following Facility Reported Incidents were investigated: DC~12553, DC~12529, DC~12322, DC~12262, DC~12177, DC~12144, DC~12133, DC~ 12113, DC~12018, DC~12019, DC~11996, DC~11837, DC~11829, DC~11636, DC~11637, DC~11598, DC~11601, DC~11574, DC~11539, DC~11504, DC~11403, DC~11417, DC~11383, DC~11377, DC~11329 DC~11222, DC~11512 Citations are being cited for: DC~12523, DC~12177, DC~12018, DC~12019, DC~11996, DC~11872, DC~11829, DC~11574, DC~11512 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Savoy | TITLE: ADMINISTRATOR | (X6) DATE: 5/2/24

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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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 ColumbiaMunicipal Regulations
D/C - Discontinue
DI - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reportedincident
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

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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 Gastrostomy
PO - by mouth
POA - Power of Attorney
POS - physician's ordersheet
Prn - As needed
Pt - Patient
Q - Every
RD - Registered Dietitian
RN - Registered Nurse
ROM - Range of Motion
RP R/P - Responsibleparty
SBAR - Situation, Background, Assessment, Recommendation
SCC - Special Care Center
Sol - Solution
SW - Social Worker
TAR - Treatment Administration Record

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F 000	Continued From page 3 Ug - Microgram	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580	**F580: Notification of Changes** **1.** Residents #52 and # 243 no longer reside in the facility. However, on 4/12/2023, Security Guard was re-educated from his supervisor regarding resident monitoring and elopement prevention protocols. **2.** The Director of Nursing and nursing staff completed a skin sweep on current residents with no new skin issues identified on **3/22/2024**.The Director of Performance Improvement reviewed x-ray reports for all residents from the last 30 days. 2 of 5 resident records did not indicate physician had been notified. Nursing Staff notified physician of x-ray results on both residents on **3/22/24.** No new orders given. **3.**The administrator to develop Notification Policy by **5/1/24.** Staff Development nurse to educate licensed staff on new policy by **5/6/24.** The Director of Nursing and Interdisciplinary Team will review Electronic Health Records clinical dashboard daily to monitor changes in residents condition that require physician notification, and validate that notification occurred beginning **5/10/24**. **4.** Validation results will be reported via QA tool to QAPI committee monthly. (**5/14/24).** **5.** Completion date **5/17/2024.** **6.** Title of the person responsible noted throughout POC	

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update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, for two (2) of 41 sampled residents, facility staff failed to immediately notify the resident's primary physician or their representative when there was a change in the resident's condition that required physician intervention. Resident #52 and Resident #243.

The findingsincluded:

1. Facility staff failed to immediately notify Resident #52's primary physician and their representative of a facility acquired sacral pressure ulcer/wound.

Resident #52 was admitted to the facility on 11/26/19 with diagnoses that included: Adult Failure to Thrive, History of Falling, and Weakness.

Review of the resident's medical record revealed the following:

A face sheet that showed the resident had a legal

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guardian as her Responsible Party (RP), substitute decision maker and emergency contact #1.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 02/02/24 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "07", indicating severe cognitive impairment; at risk for pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries, wounds, or other skin problems.

A Wound Care Physician's Note dated 02/28/24 at 8:16 AM documented: "Wound rounds; Stage3 sacral decubitus ulcer; moderate drainage with necrotic tissue and slough. Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl ointment (debridement ointment used on dead tissue) and dry dressing daily."

A physician's order dated 03/01/24 at 3:32 PM directed, "Dakin's 1/2 strength External Solution 0.25 %, cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl and cover with border gauze daily."

A physician's order dated 03/01/24 at 3:38 PM directed, "Santyl External Ointment 250 Unit/GM (gram), apply to sacral ulcer topically every day shift for wound care."

Review of the medical record from 02/28/24 to 03/01/24, approximately 48 hours, showed that facility staff failed to immediately notify Resident #52's primary care physician of a change in condition (stage 3 pressure ulcer). Additionally, as of 03/06/24 there was no documented evidence that facility staff notified the resident 's

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representative.

During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, "Once a new wound area is observed, the process is to immediately call the resident's [primary] medical doctor and get new orders. The nurse will write a progress note with a description of the wound that includes size, location, drainage, what the surrounding area looks like and then also indicate that the family was notified."

2. Facility staff failed to immediately notify Resident #243's primary physician or their representative of an x-ray result that showed a left hip fracture.

Resident #243 was admitted to the facility on 05/15/19 with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility.

Review of Resident #243's medical record revealed the following:

A face sheet that showed the resident had a legal guardian as her RP and emergency contact #1.

An Annual MDS assessment dated 05/15/23 showed that facility staff coded: a BIMS summary score of "12", indicating mild cognitive impairment and had no falls since the prior assessment.

A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented:

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F 580	Continued From page7 - At 4:40 PM, the resident got up on her seatto give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RPwas called and was made aware of the fall accident. A Nursing Progress Note dated 05/29/23 at 7:36 PM documented: - At 4:40 PM, the resident got up on her seatto give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RPwas called and was made aware of the fall accident. A physician's order dated 05/29/23 directed, Left hip/left knee x-ray. Left knee x-ray results dated 05/30/23 at 1:21 PM documented: - No acute fracture, dislocation or degenerative disease. Left hip x-ray results dated 05/30/23 at 1:21 PM documented: - There is a fracture of the neck of the proximal femur without significant displacement. - Clinical Correlation and follow-up imaging recommended as indicated. A Nursing Progress Note dated 05/30/23 at 2:01 PM written by Employee #7 (Licensed Practical Nurse/LPN) documented: - X-Ray for left hip/knee done this shift,results received: No acute fracture, dislocation, or degenerative disease.	F 580		

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F 580	Continued From page 8 - Physician's Assistant (PA) made aware;no new order given. It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture. A Night Shift Nursing Progress Note dated 05/31/23 at 6:56 AM documented: - Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift (day shift, 7:00 AM - 3:30 PM) to follow-up with primary physician. A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM written by Employee #8 (Night Shift Nursing Supervisor)documented: - Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlationand follow-up imaging indicated. Please follow-up with primary medical doctor. A Day Shift Nursing Progress Note dated 05/31/23 at 12:22 PM documented: - Status post fall, order given on 05/29/23 as follows: left hip/left knee x-ray to rule out fracture. X-ray result received and indicated a fracture of the neck of the left proximal femur without significant displacement. - [Physician's Name] made aware, neworder given to transfer resident to the nearest emergency room for further evaluation. - 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware before and after transfer.	F 580		

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F 580	Continued From page 9 The evidence showed that facility staff received Resident #243's left hip and left knee x-ray results on 05/30/23 at 1:20 PM, during the day shift (7:00 AM - 3:30 PM). There is no documented evidence that the assigned day shift nurse, Employee #7, made the resident's physician or representative aware of the left hip x-ray result that showed "fracture of the neck of the proximal [left] femur". The evidence also showed that on 05/30/23, the assigned night shift nurse and nursing supervisor both documented that Resident #243's left hip x-ray showed a fracture but neither notified the resident's physician or her representative. It was not until 05/31/23, at approximately 10:30 AM, 21 hours later, that facility staff notified Resident #243's primary care physician and their RP of the left hip x-ray results. During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN) stated, "The process for when x-ray results are received is to call the medical doctor with the results. When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, "I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time." During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Nursing Supervisor) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated, "We don't have an	F 580		

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F 580	Continued From page 10 on-call list. Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00/7:30 AM because most of the doctors get angry when we call them in the middle of the night." During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated, "There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts." During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		

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F 600	Continued From page 11 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for one (1) of 41 sampled residents, facility staff failed to ensure Resident #192 was free from neglect as evidenced by the resident leaving the facility without staff knowledge. The findings included: Review of the policy titled, Missing Resident #99M-010, documented, "A resident is considered missing from the facility whenever their whereabouts cannot be ascertained. This situation is an elopement." Resident #192 was admitted to the facility on 11/10/22 with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A care plan dated 01/01/23 that documented, "Problem: [Resident #192] has risk for Elopement related to wandering evidenced by trying to enter the elevator. Goal: Resident will not elope. Approach: Monitor resident's movements closely while out of bed. Encourage resident to verbalize	F 600	F600 – Resident left facility without staff knowledge 1. Resident #192 no longer resides in facility. Was unable to implement corrective action. 2. The Director of Nursing (DON) completed elopement assessments on all current residents. Four residents were identified at risk of elopement. Pictures and face sheets were placed in Wanderers Book maintained at concierge desk on **4/26/24**. 3. The Administrator initiated meetings with Security Supervisor to review resident behaviors to include wandering, exit seeking, and other behaviors requiring monitoring and intervention by security team on **4/22/24.** Staff development nurse will re–educate security team on missing resident policy by **4/30/24**. DON and Interdisciplinary Team (IDT) will review clinical dashboard in EHR daily to monitor for any elopement activity and to validate that staff response occurred per policy. **5/3/24.** 4. Validation results will be reported to QAPI committee via QA tool and presented to QAPI committee monthly x 6 and on-going as necessary. **5/14/24** 5. Completion date 5/17/24. 6. Title of person responsible noted in POC.	On-going

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feelings of boredom/loneliness at all times. Encourage resident to participate in group activities of choice."

A Quarterly Minimum Data Set (MDS) assessment dated 02/12/23 documented the following: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living .

A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: "At 6:55 am, resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process."

Please note, According to World Weather, the temperature in the District of Columbia on 04/04/23 during the daytime ranged from 55 to 75 degrees (Fahrenheit). https://world-weather.info/forecast/usa/washington_1/april-2023/

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	095020	A. BUILDING _____ B. WING _____	C 03/20/2024

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 600	Continued From page 13 A nursing progress note dated 04/04/23 at 11:22 AM documented, "Resident was received in bed at 11:00 pm, alert, oriented and verbally responsive. During routine round, Resident was in bed through the night. Breathing even and unlabored. No sign of respiratory distress or shortness of breath noted. No complain of pain or discomfort voiced. Around 5:30 am when I pushed my medication cart down the hall to start from room 218 where I normal start. Resident was in his room. When I got to his room at 6:40 am to give him his medication, I could not see him, I checked the bathroom, he was not there, then I alert other staffs and the supervisor , then called the security officer to found out if Resident left the facility. The staffs(sp) begin to search for him all rooms and bathrooms. I left the facility with other staffs in search of him tonearby bus-stops and metro stations." A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call fromthe facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, residentrefused	F 600		

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F 600	Continued From page 14	F 600		

coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatricteam. Close monitoring in progress and maintained."

According to the investigation packet, the following employees wrote statements dated 04/04/23:?

Employee #14 (CNA) documented, "I[employee's name] worked last night April 3, 2023, and [resident's name] was assigned to me. The last time I saw [resident's name] was at 5:30 AM in his room. We the nurses on the night shift on unit (Unit2) left the floor and went to the street and metro station looking [for him] after he left the facility. We did not find him."

Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1. I asked where he was going, and he stated that his brother was picking him up front up front. He continued to the

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F 600	Continued From page 15 front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "Incident Report" dated 04/04/23 that documented, "[Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] was at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident stated] 'I have been here for too long; I was told at the other facility that I could leave.' Remains on 1:1 monitoring. Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days. Encourage participation in different activities on unit." A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented: - It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where. - I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number.	F 600		

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F 600	Continued From page 16 - I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility). - The officer agreed to hold him. Mydaughter went and picked him up from Metro Center and took him back to the nursing home. - I feel that this is a neglect on the staffthat's on the 2nd floor where he's on and security for allowing him to get out. Review of Employee #16's (Security Guard) personnel record showed the employee was hired on 05/16/22. The employee signed his initials on the Training Checklist dated 05/17/22 indicating he received training on "Never leaving the front desk unattended." Moreover, the employee signed an "Employee Warning Notice" dated 04/12/23 that documented that, "Date of incident 04/03/23 between 5AM to 5:30 AM. [Employee's name] you [were] supposed (sp) to been (sp) posted at the front desk during this time [resident's name] from room 227 walked thru the lobby past the front desk and out of the front door which caused an elopement." On 03/08/24 at approximately 11:00 AM, an observation of the lobby area revealed a security desk located adjacent to the facility's front door. At the time of the observation, a security guard and receptionist were seated at the desk. Behind the security desk, was a closet that's used by security staff. Additionally, there was a three-ring binder labeled "Wanders" and a security logbook (where security staff write notes about rounds and concerns in the facility) was noted on the desk. The security logbook lacked documented evidence of Resident #192's elopement incident	F 600		

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F 600	Continued From page 17 on 04/04/23. During a telephone interview on 03/13/24 at 8:30 AM, Employee #17 (Nursing Supervisor) stated that Resident #192's assigned nurse called and informed her that staff could not locate the resident (on 04/04/23). After Employee #16 (Security Guard), who was posted at the front desk of the lobby, informed her that he did not see the resident leave out the front door, she called a Code Pink and continued looking for the resident with other staff. During a telephone interview on 03/13/24 at 9:30 AM, Employee #16 (Security Guard) stated that he believed when he walked into the closet behind the security desk, the resident exited the facility through the front door. The employee stated that he was wrong for leaving the front desk unattended. He should have called the other security guard to cover the front desk. The employee also stated that he wrote an incident report related to Resident #192's elopement, and he thought he wrote the information in the security logbook. During a face-to-face interview on 03/13/24 at approximately 10:00 AM, Employee #18 (Security Supervisor) stated that Employee #16 (Security Guard) did not follow the company's policy when he left his post at front desk unattended on 04/04/23. He was to call the other security guard in the building to cover his post. Employee #18 reviewed that logbook and stated that she did not see documented evidence that Employee #16 documented Resident #192's elopement incident. When asked if that incident should have been documented in the logbook, Employee #18 replied "Yes".	F 600		

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F 600	Continued From page 18 Cross reference 483.25 Quality of Care F689	F 600	F607 Develop/Implement Abuse Policy 1. Residents #192 and #294 are no longer in the facility. Unable to retrospectively correct deficient practice.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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 observations, record reviews and resident and staff interviews, for four (4) of 41	F 607	2. The Assistant DON completed head-to-toe assessments for residents #25 and #40 who were alleged to have engaged in resident-to-resident abuse. No injuries or other indication of abuse were identified on either resident on **3/22/24.** The DON completed elopement assessments on all residents. Four residents were identified at risk of elopement. Pictures and face sheets were placed in Wanderers book maintained at concierge desk on **4/1/24.** Any resident who is dependent for ADLs as well as resident with history/behavioral of resident-to-resident abuse has potential for this deficient practice. The DON and Director of Performance Improvement reviewed resident documentation on **4/15/24** for the previous quarter (January- March) and found no indications of abuse for these or other residents. 3. Staff Development nurse will educate all staff including security team on resident abuse policy **4/22/24**.DON and IDT will review clinical dashboard in EHR daily to monitor for any elopement activity and to validate that staff responses occurred per policy **4/22/24.** 4. Validation results will be reported to QAPI Committee quarterly via QA tool and presented to QAPI committee monthly x6 and as necessary beginning **5/14/24**. 5. Completion date **5/17/24.** 6. Title of person responsible noted in POC.	

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sampled residents, facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect. Resident #192, Resident #40, Resident #25 and Resident #294.

The findings included:

A policy titled Prohibition of Resident Abuse/Abuse Prevention (#99-12) documented the following but not limited to: "Each resident has the right to be free from neglect. Neglect- means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

A review of the facility's policy titled "Resident Abuse" reviewed on 08/23/23, documented the following: "each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents" and "Abuse means the willful infliction of injury" and "resulting in physical harm, pain or mental anguish" and "Physical abuse includes hitting, slapping, pinching and kicking" and "Each resident has the right to be free from mistreatment, neglect" and "This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents.

Identification
Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation.

Investigation

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Investigate different types of incidents; and identify the staff member responsible for initial reporting, investigation of alleged violations and reporting of results to the proper authorities.

Protection
Protect residents from harm during an investigation.

Reporting/Response
Anyone who suspects or witnesses an alleged incident of resident abuse is required to report the incident to the Nursing Supervisor or department head immediately. The Nursing Supervisor/department head will immediately initiate and investigation and give an oral report to the Administrator."

1. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #192.

Resident #192 was admitted to the facility on 11/10/22 with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver.

Review of the medical record revealed the following:

A Quarterly Minimum Data Set (MDS) assessment dated 02/12/23 documented the following: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living .

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F 607	Continued From page 21 A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: "At 6:55 am, resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20 am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process." A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually, we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot	F 607		

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accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained."

A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented:

- It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where.
- I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number.
- I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility).
- The officer agreed to hold him. Mydaughter went and picked him up from Metro Center and took him back to the nursing home.

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F 607	Continued From page 23 - I feel that this is a neglect on the staffthat's on the 2nd floor where he's on and security for allowing him to get out. During a face-to-face interview on 03/08/24 at approximately 1:00 PM, Employee #2 (DON) stated that the facility staff failed to implement their prohibition of resident abuse/abuse prevention policy when Resident #192 eloped from the facility without staff knowledge. Cross reference 483.25 Quality of Care F689 2. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #40 and Resident #25's physical altercation. During an observation on first floor resident day room on 03/05/24 at 3:14 PM, the following was noted by two (2) State Agency Surveyors: Resident #25 was walking into the dayroom toward Resident #40, who was seated in a wheelchair and watching television. Resident #25 was then observed grabbing the push handles of Resident #40's wheelchair and pushing the wheelchair forward. Resident #25 then started hitting Resident #40 on the left side of his body. Resident #40 responded by attempting to raise his arms to block the hits. At this time, three (3) facility staff came running from the nursingstation to the day room to separate the 2 residents. The surveyors observed Employee #23 (Registered Nurse) walk away with Resident #25 and another employee rolled Resident #40 to the opposite side of the dayroom. 2A. Resident #40 was admitted to the facility on	F 607		

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05/05/22 with multiple diagnoses that included: Other Seizures, Anemia, Hypotension, and Personal History of Other Venous Thrombosis and Embolism.

Review of Resident #40's medical record revealed the following:

A Quarterly MDS assessment dated 12/12/23, revealed that the facility staff coded that the resident's preferred language is "Russia" and that the resident needs an interpreter to communicate with a doctor or health care staff; had unclear speech, sometimes makes self-understood, sometimes is able to understand others, impaired vision; Moderately impaired cognitive skills for decision making; dependent on staff forself-care; used a manual wheelchair and had no impairment in the upper extremities.

Review of the medical record showed there was no documented evidence of the physical altercation involving Resident #40 and Resident #25 that was observed by the facility's staff on 03/05/24.

2B. Resident #25 was admitted to the facility on 11/10/22 with multiple diagnoses that included the following: Unspecified Dementia, Altered Mental Status, Blindness Right Eye Category 5, Normal Vision in Left Eye, and Cognitive Communication Deficit.

Review of Resident #25's medical record revealed the following:

A Quarterly Minimum Data Set assessment dated 01/30/24 showed that the facility staff coded:

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

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F 607	Continued From page 25	F 607		

adequate hearing, clear speech, usually make self-understood, understands others, and had highly impaired vision; severely impaired cognitive skills for daily decision making; behavior symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing rummaging), rejection of care, and wandering, occurred 1 to 3 days; and no impairment on the upper or lowerextremities.

A nursing progress note dated 03/05/24 at 5:56 PM documented, "Resident is alert and verbally responsive with intermittent confusion. Resident kept pacing and wandering around the unit and wandering to other resident's rooms. Resident attempted to leave the unit 2 times during the AM (morning) shift; via the exit door behind and also via the exit door at the dining area."

A nursing progress note dated 03/06/24 at 10:28 AM documented, "Late entry 3/5/25 [3/5/24] at 18:36 [6:36 PM] [Resident #25] noted with escalating behaviors, redirected by staff to include diversional activities. Resident noted pushing a chair and this writer redirected resident by ambulating with resident around unit for redirection."

Review of Resident #25's medical record lacked any documented evidence that the facility staff noted or investigated the observed resident to resident altercation on 03/05/24.

On 3/6/2024 at 10:15 AM during an attempt to interview Resident #25; He was observed laying in bed and was non-responsive verbally to the writer's question, "Good morning how are you?"

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F 607	Continued From page 26 On 3/6/2024 at 10:30 AM during an attempt to interview Resident #40; He was observed sitting up in bed and unable to verbally respond to the writer's baseline questions such as, "Good morning how are you?" During a face-to-face interview conducted on 03/07/24 at 10:54 AM, Employee #30 (Certified Nurse Aide) stated, "Resident #25 is erratic he goes into other resident's rooms and he has hit people and he has hit me." Employee #30 went on to say that Resident #25 is redirectable. During a face-to-face interview conducted on 03/07/24 at 2:59 PM, Employee #2 stated, "I don't know of any incidents that occurred with (Resident #25) and he (Employee #23) should have followed the necessary protocols (report the incident to Administration, notify physician and resident representative, and start an investigation)." 3. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #294's allegation of staff abuse. Resident #294 was admitted to the facility on 06/16/23 with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2. Review of Resident #294's medical record revealed the following:	F 607		

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F 607	Continued From page 27 An Admission MDS assessment dated 06/21/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of "15" which indicates intact cognition; required extensive assistance of two (2) person physical assist for bed mobility, transfer, dressing, eating, and toilet use; required extensive assistance of one (1) person physical assist for personal hygiene; was dependent on staff for bathing and the resident; and had impairment on both sides in the upper and lower extremities. A care plan focus area of "Post-traumatic stress disorder/panic attack" initiated on 07/20/23 had the following interventions, "Approach resident with caution, explain all procedures to resident, and encourage activity. Report behavior." A Nursing progress note dated 08/06/23 at 10:38 PM, documented "Resident remain alert and verbally responsive." And "ADL (activities of daily living) cares provided, due medications administered and tolerated well. PO (by mouth) fluids offered. Resident c/o (complained of) pain this shift." A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/07/23 that documented: - Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023. - "Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, "I hit my head on the bed rail 3 times when I was being changed." When asked if he told the nurse about it, he stated, "she cameand	F 607		

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gave me my medications." Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said " yes she cleaned my eyes and gave me medications" When asked if he told charge nurse at that time about his head, he stated "no". Resident went on to say that his aide for that Sunday was a male."

A follow-up submission from the facility to the State Agency on 08/17/23 documented the following: "Report of investigation into the incident on August 6th (2023). After thorough clinical review with statements from staff, there was no evidence of abuse or neglect related to the resident's complaint. (Resident #294) continues to remain stable, and all due care provided to the resident before discharge to the hospital."

It should be noted that the resident's medical record lacked documented of Resident #294's allegation of physical abuse by staff member .

A review of the facility's investigation packet related to this incident/allegation, lacked documented evidence that the facility assessed Resident #294, notified the physician of the resident's allegation of abuse, interviewed all the staff that worked the shift on the day of the allegation, and obtained interviews from other residents.

During a face-to-face interview conducted on 03/18/24 at approximately 3:00 PM, Employee #2, (Director of Nursing) stated that the facility leadership has changed, and she was not able to

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F 607	Continued From page 29 locate any additional documentation concerning Resident #294's allegation of abuse.	F 607	F 609 Reporting Alleged Violations 1. Residents #192 and #294 no longer reside in the facility. Was unable to retrospectively correct this deficient practice	
F 609 SS=D	Cross Reference 22B DCMR sec. 3269.1 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all 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:	F 609	2. The DON and Director of Performance Improvement reviewed resident investigations for previous quarter (January – March) on 4/26/24. Investigations were reported within 5 days and outcomes of investigations were documented. 3. The Administrator will develop an investigation policy and reporting format to include reporting results by **5/1/24** to include timely reporting of investigations (within 5 days) and reporting outcomes of investigations. Staff Development Nurse will re-educate all staff including security team regarding Prohibition of Resident Abuse/ Abuse investigation. This includes reporting results of their investigation to the staff within 5 working days of incident **5/10/24**. Performance Improvement Director will audit investigations documentation in all instances of alleged abuse and elopement to validate policy compliance beginning **5/11/24.** 4. Audit results to be reported to QAPI committee monthly by Performance Improvement Director beginning **5/14/24.** 5. Completion date 5/17/24. 6. Title of person responsible noted in POC.	On-going

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Based on record reviews and staff interviews, for two (2) of 41 sampled residents, facility staff failed to report the results of their investigations to the State Agency within 5 (five) working days of the incident. Resident #192 and Resident #294.

The findings included:

A review of a facility policy titled "Prohibition of Resident Abuse/Abuse Prevention" revised on 12/16/22 documented the following: "The facility will designate an Abuse prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect or exploitation to the state survey agency and other officials in accordance with state law" and "An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include : Identifying staff responsible for the investigation , exercising caution in handling evidence that could be used in a criminal investigation (e.g. (for example) not tampering or destroying evidence); Investigating different types of alleged violations ; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations."

1.The facility staff failed to report the results of Resident #192's elopement incident to the State Agency within 5 working days.

Resident #192 was admitted to the facility on 11/10/22 with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver.

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Review of the medical record revealed the following:

A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: "At 6:55 am, resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process."

A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call fromthe facility security that the police found resident at a

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bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatricteam. Close monitoring in progress and maintained."

A State Survey Agency 5-day Follow-up Intake Form dated 04/04/23 at 12:11 PM documented, "[Resident's name] returned to the unit at around 8:50 am after much encouragement. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained."

A review of the facility's investigation packet lacked documented evidence describing the results of the investigation for Resident #192's elopement incident on 04/04/23.

During a face-to-face interview on 03/12/24 at approximately 3:00 PM, Employee #2 (Director of Nursing/DON) reviewed the investigation packet and stated that she did not see the results of the investigation that was conducted by the facility.

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F 609	Continued From page 33 Cross reference 483.25 Quality of Care F689 2. The facility staff failed to report the results of their investigation into Resident #294's allegation of staff abuse. Resident #294 was admitted to the facility on 06/16/23 with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2. Review of Resident #294's medical record revealed the following: An Admission MDS assessment dated 06/21/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of "15" which indicates intact cognition. A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/08/23 that documented: - Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023. - "Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, "I hit my head on the bed rail 3 times when I was being changed." When asked if he told the nurse about it, he stated, "she came and gave me my medications." Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said " yesshe	F 609		

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F 609	Continued From page 34 cleaned my eyes and gave me medications" When asked if he told charge nurse at that time about his head, he stated "no". Resident went on to say that his aide for that Sunday was a male." A follow-up submission from the facility to the State Agency on 08/17/23 10 days after the initial intake documented the following: "Report of investigation into the incident on August 6th (2023). After thorough clinical review with statements from staff, there was no evidence of abuse or neglect related to the resident's complaint. (Resident #294) continues to remain stable, and all due care provided to the resident before discharge to the hospital." During a face-to-face interview conducted on 03/18/24 at approximately 3:00 PM, Employee #2, (Director of Nursing) stated that the facility leadership has changed, and she was not able to locate any additional documentation concerning Resident #294's allegation of abuse.	F 609		
F 610 SS=E	Cross Reference 22B DCMR sec. 3269.1 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	F 610		

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F 610	Continued From page 35 investigation is in progress. §483.12(c)(4) Report the results of all 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 reviews and staff interviews,for four (4) of 41 sampled residents, facility staff failed to have documented evidence that they conducted thorough investigations. Resident #'s 192, 294, 244 and 63. The findingsincluded: Review of the facility's policy "Prohibition of Resident Abuse/Abuse Prevention" revised 09/24/22 documented: - Investigation: Identifying and interviewing all involved persons including the alleged victim, alleged perpetrator and others who might have knowledge of the allegations Review of a facility policy titled, "Prohibition of Resident Abuse/Abuse Prevention (#99-12)" documented the following but not limited to: "Neglect-means failure to the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Investigation of alleged Abuse and Neglect - Focusing the investigation on determining if neglect has occurred, the extent, and the cause. Providing complete and thorough documentation of the investigation."	F 610	F610 Investigation 1. Residents # 192, # 294 and #244 no longer reside in facility. DON reviewed investigation for resident #63 for incident that occurred on 6/9/23. Unable to retrospectively implement corrective action for any resident involved. 2. The Administrator reviewed all available incidents reported to DC Health on elopement, verbal threats of harm or allegation of staff abuse for the quarter (January – March 2024) on **3/30/24** to determine if thorough investigations were conducted. Review validated that investigations were completed. 3. Administrator will develop investigation policy to include completion of thorough investigations by **4/30/24.** Staff development will educate all staff including Security team on new policy **by 5/10/24.** Interdisciplinary Team will review investigations, if any during daily clinical meeting to validate policy compliance beginning **5/10/24.** 4. Validation results will be reported via investigation tool to QAPI committee monthly 5/14/24. 5. Completion Date 5/17/24. 6. Title of person responsible noted in POC.	On-going

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F 610	Continued From page36 A policy entitled, Missing Residents (#99M-010) documented in part, "The Search Director is to assign personnel to search the boiler, storage, and equipment rooms, laundry and kitchen areas, the roof and basement, if any, beneath beds and other furniture, beneath stairways, parked vehicles and shrubbery." 1. Facility staff failed to have documented evidence that they conducted thorough investigations of Resident #192's elopement from the facility. Resident #192 was admitted to the facility on 11/10/22 with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A Quarterly Minimum Data Set (MDS) assessment dated 02/12/23 documented the following: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living . A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: "At 6:55 am, resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team	F 610		

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F 610	Continued From page 37	F 610		

comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process."

A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call fromthe facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62,

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Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatricteam. Close monitoring in progress and maintained."

A review of the facility's investigation packet dated 04/04/23 lacked documented evidence of the following:

-The staff findings when they searched the boiler, storage, and equipment rooms, laundry and kitchen areas, the basement, beneath beds and other furniture, beneath stairways, parked vehicles, shrubbery, parking lot, bus stops, and the neighborhood, as outlined in the Missing Resident policy.
- If neglect occurred, the extent and cause of the neglect, as outlined in their Prohibition of Resident Abuse/Abuse Prevention policy.
- Interviews of Unit #1's night shift staff (person who might have knowledge of the incident) and Interview of ex-wife and daughter. As outlined in their Prohibition of Resident Abuse/Abuse Prevention policy.

It should be noted that the resident got off the elevator on Unit 1 to exit the front door. This showed that facility staff failed to have documented evidence that a thorough investigation was conducted for Resident #192's elopement incident on 04/04/23.

During a face-to-face interview on 03/12/24 at approximately 3:00 PM, Employee #2 (DON) reviewed the investigation packet and stated that she did not see that a thorough investigation was

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conducted by the facility. The employee also stated that she looked through other facility investigative documents and could not find any additional documents related to the investigation for Resident #192's elopement on 04/04/23.

Cross reference 483.25 Quality of Care F689

2. The facility staff failed to conduct a thorough investigation into Resident #294's allegation of staff abuse.

Resident #294 was admitted to the facility on 06/16/23 with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2.

Review of Resident #294's medical record revealed the following:

An Admission MDS assessment dated 06/21/23 showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of "15" which indicates intact cognition.

A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/08/23 that documented:
- Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023.
- "Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, "I hit my head on the bed rail 3 times when I was being changed." When asked if he told the nurse about it, he stated, "she cameand

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F 610	Continued From page 40 gave me my medications." Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said "yes she cleaned my eyes and gave me medications." When asked if he told charge nurse at that time about his head, he stated "no". Resident went on to say that his aide for that Sunday was a male." A review of the facility's investigation packet, showed no documented evidence that the facility assessed the resident, notified the physician, interviewed all the staff present at the time of the alleged incident, or that they interviewed other residents. During a face-to-face interview conducted on 03/18/24 at approximately 3:30 PM, Employee #2 (Director of Nursing) stated that the facility leadership has changed, and she was not able to locate any additional documentation concerning Resident #294's allegation of abuse. Cross Reference 22B DCMR sec. 3269.1 3. Facility staff failed to thoroughly investigate Resident #244's allegation of a verbal threat of harm by Resident #63. 3A. Resident #63 was admitted to the facility on 11/08/21 with diagnoses that included: Vascular Dementia, Cognitive Communication Deficit, and Symptoms and Signs Involving Cognitive Functions and Awareness.	F 610		

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F 610	Continued From page 41 Review of Resident #63's medical record revealed: A census tracking form showed that Resident #63 resided on unit 1, room 124, A bed, since 03/14/2023. A Quarterly Minimum Data Set (MDS) assessment dated 04/11/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "09", indicating moderate cognitive impairment; no potential indicators of psychosis; no behavioral symptoms directed at others; limited assistance for locomotion on the unit; no functional limitations in range of motion in upper/lower extremities; used a walker for mobility; received antianxiety and antidepressant mediations 7 times during the last 7 days. A Facility Reported Incident (FRI), DC~12019, received by the State Agency on 06/09/23 at 8:10 PM documented: - At the dinner area at around 6:15 PM, Resident [#63] made a verbal threat to shoot another resident in Room 102A [Resident #244] with a gun, making an attempt to reach for something under her clothing. Immediately, the staff called 911. - Police officers came at 6:30 PM and searched Resident #63 and her belongings. No guns or any related injurious objectsfound. - The physician was notified and referred to the psychiatrist for review. - Representative aware. - Police officers advise nursing staff to separate the residents and departed at 7:00 PM. 3B. Resident #244 was admitted to the facility on	F 610		

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06/17/21 with diagnoses that included: Cognitive Communication Deficit, Mild Cognitive Impairment and Muscle Weakness.

Review of the resident's medical record revealed the following:

A census tracking form showed that Resident #244 resided on unit 1 room 102, A bed, since 04/11/23.

An Annual MDS assessment dated 04/12/23 showed facility staff coded: a BIMS summary score of "15", indicating intact cognition; no indicators of psychosis; no behavioral symptoms directed towards others; no functional limitations in range of motion for upper extremities; independent with walking and picking up objects.

A FRI, DC~12018, received by the State Agency on 06/09/23 at 7:58 PM documented:
- This event occurred at the dinner area at around 6:15 PM.
- Resident #244 reported to the charge nurse that another resident in room 124 A (Resident #63) told her that she will shoot her with a gun, making attempt to reach for something under her clothing.
- Immediately, the staff called 911.
- Police officers came at 6:30 PM and searched Resident #63's room and her belongings. No guns or any related injurious objects found.
- The physician and representative weremade aware.
- Police officers advise nursing staff to separate the residents and departed at 7:00 PM.

Review of the investigation documents provided

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F 610	Continued From page 43 to the surveyor on 03/11/24 showed that Resident #244 reported the incident to Employee #3 (Assistant Director of Nursing/ADON). Further review of the investigation documents showed facility staff failed to conduct a thorough investigation as evidenced by no documented interviews or statements from the involved persons (alleged victim and alleged perpetrator) and no interviews from the staff present at the time of the alleged incident. During a face-to-face interview on 03/12/24 at 10:35 AM, Employee #3 acknowledged the finding and stated, "When there's an incident on my shift, I do the incident report to Department of Health (DOH), collect statements from the residents and staff. All that gets forwarded to the DON. I can't remember if I got statements from anyone when this incident happened." Cross Reference 22B DCMR Sec. 3232.2	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, ifany;	F 625		

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F 625	Continued From page 44 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to provide Resident #66's representative with written information that specified the duration of the state bed-hold policy before transfer to the hospital. The findings included: Review of the facility's "Bed Hold" policy, last reviewed on 04/26/23, documented that: - The admissions office will mail out the "Bed Hold notification form" to each resident/point of contact each time they are out of the facility. - The form will be mailed out the next business day. - The notification shall provide the number of [bed-hold] days remaining. Resident #66 was admitted to the facility on 12/27/21 with diagnoses that included: Dementia, Hypertension and Hyperlipidemia.	F 625	F625 Notice of Bed Hold Policy 1. The Admissions Director verbally notified spouse of resident #66 bed hold days. Resident returned to his previous room after hospitalization **(3/5/24).** 2. Social Services Coordinator audited medical records of residents sent to hospital over past quarter (January-March 2024) on **3/7/24** and found twelve 6-108s were not done. All were completed by **4/1/24.** 3. Social Services Director will update Bed Hold Policy by 5/1/24. The Admission, and Social Worker staff were re-educated by the Staff Development on Bed Hold Policy. Staff development will educate staff on changes by 5/14/24. The IDT will review all hospital transfers that occurred within previous 24-48 hours during daily clinical meeting for timely monitoring of policy compliance beginning 4/25/24. 4. The Performance Improvement Director will report results of daily compliance reviews to QAPI Committee monthly x 3 months beginning 5/14/24. 5. Completion Date: 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 625	Continued From page 45 Review of the Resident #66's medical record revealed the following: It was noted that the face sheet documented Resident #66's wife as his responsible party and emergency contact. A Significant Change Minimum Data Set (MDS) assessment dated 12/19/23 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "03" indicating severely impaired cognitive status. An eInteract Situation Background Assessment Request (SBAR) note dated Sunday, 02/04/24 at 1:48 AM documented: - Situation: fever nausea/vomiting; blood pressure (BP): 87/53, pulse 122. - At about 9:30 PM, writer was notified by charge nurse that resident did vomit after dinner, and supra pubic catheter drainage bag observed with mild blood, bloody discharge from urethratoo. - Order given to send resident tonearest emergency room for furtherevaluation. - Wife notified at 1:30 AM. A Health Status Note dated 02/04/24 at 2:38 PM documented, "Telephone call was place by the writer to [Hospital name] and it was confirmed that resident has been admitted." On 03/06/24, the State Surveyor asked facility staff to provide documented evidence of written information given to Resident #66's representative specifying the state bed-hold policy and number of bed-holds available however, they did not have any documentation. During a face-to-face interview on 03/07/24 at	F 625		

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F 625	Continued From page 46 9:29 AM, Employee #4 (Social Services Director) stated that the written notice of bed-hold policy and number of bed-hold days was done by Admissions Department. "I am not sure who does that (provide bed-hold policy/days) on the off hours or weekends." A face-to-face interview was conducted on 03/07/24 at 11:05 AM with Employee #12 (Admissions Director) and Employee #13 (Director Sales and Marketing). Employee #12 stated, "The process is to review and check the nurse's notes and physician's orders to see what residents were transferred out. The residentswho were transferred out are then discussed during stand down meeting (conducted on weekdays), at which time, a 6-108 [Notice of discharge, transfer, relocation] form is generated. I can't answer as to why Resident #66 does not have one for February [2024]. I was told that it was completed, but the ball was dropped on that one." Cross Reference 22B DCMR Sec. 3270.1 (Facility staff failed to discharge Resident #66 in accordance with the Nursing Home and Community Resident's Protection Act of 1985 (District of Columbia Law 6-108)).	F 625		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for	F 638		

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F 638	Continued From page 47 one (1) of 41 sampled residents, facility staff failed to complete a quarterly (every 3 months) assessment for Resident #72. The findings included: Review of the facility's contracts showed that [Company name], effective on 02/12/24, was responsible for completing the facility's Minimum Data Set (MDS) assessments. The contract documented: - [Company Name] shall provide the facility with ongoing MDS department support, specifically, to organize, review, encode and confirm timely completion of all admission, quarterly, annual and significant change in status MDS assessments. Resident #72 was admitted to the facility on 10/03/22 with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 3, Dysphagia, Aphasia, Pain, and Cerebral Infarction. Review of Resident #72's MDS transmittal sheet provided to this surveyor on 03/08/24 documented: - Annual MDS assessment - dated 10/03/23 showed "Accepted", indicating that it was accepted by Center for Medicare and Medicaid Services (CMS). - Quarterly MDS assessment - with an assessment reference date (ARD) of 02/16/24 showed "In progress", indicating that it had not been completed by facility staff. It should be noted that this Quarterly assessment should have been completed within 14 calendar days of the ARD (03/01/24). However, review of Section Z (Assessment	F 638	F 638 – Quarterly Assessments Every three months. 1. Sections of quarterly assessment were completed by social worker for Resident #72, which included language, ethnicity and race and modification submitted. **(3/4/24).** 2. The DON reviewed MDS transmittal sheet for January – March 2024 to identify other residents potentially affected. All were completed. No other residents were impacted by this practice. **(4/18/24).** 3. The Performance Improvement Director educated all members of Interdisciplinary team on timely completion of MDS assessments (4/17/24). The Performance Improvement Director developed tracking tool to monitor timely completion of assessments. The Interdisciplinary team will review findings in clinical meetings daily. (4/25/24). 4. Results of tracking tool will be reported to the QAPI committee monthly x3 months and on-going as necessary by the Director of Performance Improvement. (5/14/24). 5. Completion date 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 638	Continued From page 48 Administration) of the Quarterly MDS with an ARD of 02/16/24 documented: Sections A1005 (Ethnicity), A1010 (Race), and A1110 (Language) were not completed until 03/04/24 (3 days late). During a telephone interview on 03/14/24 at 12:36 PM, Employee #21 (Director of MDS Support Systems) stated, "There is a 14-day window from the ARD to complete all the information in all sections of the assessment. Anything after that time frame is considered late. If the ARD end date is February 16th, [2024] and the section is signed on March 4th, [2024], per the regulation, yes, that is considered late." The evidence showed that facility staff failed to complete a quarterly MDS assessment every 3 months for Resident #72.	F 638	F 640 - Encoding/Transmitting Resident Assessments 1. Section C of the MDS was completed for resident #89 on **3/4/24** by Social Worker and transmitted. 2. The Director of Nursing reviewed MOS transmittal sheets for past quarter (January - March 2024). All MDS were completed and accepted. No other residents were affected by this practice. **(4/18/24).** 3. Staff development educated all the Interdisciplinary Team on timely completion of all MDS sections **(4/17/24)**. Performance Improvement Director developed tracking tool to monitor timely completion of assessments and review findings in clinical meeting daily. **(4/25/24).** 4. The results of tracking tool for completion of assessment will be reported to QAPI committee monthly x 3 months by Performance Improvement data. **5/14/24.** 5. Completion date 5/17/24. 6. Title of person(s) responsible noted in POC.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident'stransfer, reentry, discharge, and death. (vi) Background (face-sheet) information, ifthere is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640		

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F 640	Continued From page 49 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conformsto standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior fullassessment. (v) Significant correction of priorquarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admissionassessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. 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 have documented evidence a resident's Admission Minimum Data Set (MDS) Assessment was completed as evidenced by not coding the resident's cognitive patterns in Section C. Resident #89.	F 640		

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F 640	Continued From page 50 The findings included: Resident #89 was admitted to the facility on 01/29/24 with multiple diagnoses that included: Cerebral Infarction and Multiple Sclerosis. Review of Resident #89's medical record revealed: An Annual MDS Assessment dated 02/05/24 documented: "Section C - Cognitive Patterns, Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be conducted? 1. Yes. However, there was no documented evidence that facility staff conducted the BIMS, as evidenced by Sections C0200, C0400 and C0500 were "blank". Additionally, there was no documented evidence of the resident's BIMS summary score that indicated the resident's cognitive status. During a face-to-face interview conducted on 03/07/24 at 2:07 PM, Employee #4 (Director of Social Services) reviewed the Admission MDS and stated that it was her role to complete section C (Cognitive Patterns) which she completes on the day residents are admitted or the next day. As of the date of this interview (38 days after Resident #89's admission), facility staff had not completed the previously mentioned section of the Admission MDS.	F 640		
F 656 SS=D	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 51 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	F656 – Comprehensive Care Plan 1. The care plan of resident #66 was updated to include use of IVs and are of cholecystostomy tube by Director of Nursing. Resident #71's care plan was updated to include falls. **(3/7/24).** 2. The DON reviewed care plans for the period January - March 2024 to ensure goals and approaches needed to meet residents' physical needs are addressed. No other residents were affected by this deficient practice. **4/18/24.** 3. DON and Performance Improvement (PI) Directors reeducated IDT on use of the comprehensive assessment when developing care plans. IDT Team will review and update care plans during weekly Risk Management meetings beginning **5/2/24.** 4. The DON or designee will report audit findings to QAPI committee monthly x 6 months. **5/14/24.** 5. Completion date: 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 656	Continued From page 52 care plan, must- (iii) Be culturally-competent and trauma-informed. 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 develop a care plan with goals and approaches to address a resident's use of a central intravenous (IV) line and a cholecystectomy tube and failed to implement a resident's care plan intervention for falls. Resident #66 and Resident #71. The findings included: Review of the facility's "Interdisciplinary Care Plans" policy, last reviewed on 11/10/22, it documented: - An individualized interdisciplinary care plan will be maintained for each resident. - Information recorded on the care plan includes date problems and/or needs first addressed, active problems and current needs of the resident. 1. Facility staff failed to develop care plans with goals and approaches for Resident #66's use of a central intravenous (IV) line and a cholecystectomy tube. Resident #66 was admitted to the facility on 12/27/21 with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia. Review of the resident's medical record revealed the following: A Health Status Note dated 02/14/24 at 4:21 PM that documented:	F 656		

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F 656	Continued From page 53 - Resident was readmitted from [Hospitalname] to the facility. - Central line placed on 02/09/24 on the right upper arm. - Resident underwent Cholecystostomy tube placement on 02/04/24. - Right gallbladder drainage bag. Physician's orders dated 02/14/24 directed: -Cholecystectomy tube care (abdomen, right upper), flush with 10 ml (milliliters) of 0.9 Sodium Chloride two times a day; irrigate with 60 CC's (milliliters) of saline every shift. -Peripherally inserted central catheter (PICC), 1 lumen brachial right, for antibiotic treatment; monitor PICC line dressing daily for redness, swelling and drainage every shift; change PICC line dressing every week, every evening shift every on Friday. Review of Resident #66's medical record on 03/07/24, (22 days after readmission) showed no documented evidence that facility staff developed a comprehensive resident-centered care plan with goals and approaches to address the Resident's use of a PICC or the cholecystectomy tube with a drainage bag. During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, "Those care plans should've been started on readmission (02/14/24)." 2. Facility staff failed to implement Resident #71's care plan interventions for falls. A Facility Reported Incident (FRI), DC~11512, submitted to the State Agency on 01/17/23,	F 656		

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F 656	Continued From page 54	F 656		

documented the following: "Charge Nurse called writer to room 321b to see Resident lying on the floor on her back with a pillow under her head at 5.10 am. When asked what happened Resident stated that two men carried her on the wheelchair to upstairs. Resident is alert and responsive with intermittent confusion. Head to toe assessment was done. A small cut noted on left side of the head with minimal bleeding. Area measured 0.1 cm (centimeters) and no depth. Area was cleansed. Ice pack applied."

Resident #71 was admitted to the facility on 06/14/22, with multiple diagnoses that included: Parkinson's Disease, Cognitive Communication Deficit, and Personal History of Non-Hodgkins Lymphomas.

During an observation on 03/04/24 at approximately 10:15 AM with Employee #7 (Licensed Practical Nurse/LN), Resident #71 was noted in her room lying in bed with the head of bed raised and bed in lowest position. The following was observed:
-The call light device was hanging in a loop, on the wall behind the bed, not within the resident's reach.
-The bedside table was noted at the foot of the bed with a thermos cup on top of it not within the resident's reach.
-A floor mat was noted on the left side of the bed, however, there was not one on the right side of the bed. Instead, a floor mat was noted rolled up, placed against the wall and covered by a white sheet. At the time of the observation, the State Surveyor asked Resident #71 if she was able to press the call light for assistance and the resident stated she does not know where the call light is.

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F 656	Continued From page 55 A review of Resident #71's medical record revealed the following: A physician's order dated 01/17/23 directed, "Floor mats (left and right) to bedside when resident is in bed every shift for safety." A Quarterly MDS assessment dated 12/19/23 showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "10" indicating moderate cognitive impairment; was totally dependent on staff for toileting, bathing and dressing; and had 2 falls since the last MDS assessment. A care plan dated 01/09/24 documented, "Focus Area: Falls- [Resident #71] had an alleged fall on 1/8/2024. Interventions included: Continue to monitor resident. Continue to educate resident on the use of call light. Encourage resident to call for help when needed, Call light within reach and Floor Mats at bedside when resident is in bed for safety q (every) shift." The evidence showed that facility staff failed to implement the following interventions of Resident #71's care plan: call light within reach and floor mat at the bedside. During a face-to-face interview at the time of the observation, Employee #7 acknowledged the findings, placed the call light and bedside table within the resident's reach, and placed the floor mat bedside the resident's bed.	F 656		
F 686 SS=G	Cross Reference 22B DCMR Sec. 3210.4 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 56 §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 Resident #52 received care to prevent pressure ulcer development that was first observed at a Stage 3. This deficiency resulted in actual harm to Resident #52 on 02/28/2024. The findings included: Review of the facility's Wound Care Consultant Contract dated 09/14/22 documented,"The Wound Care Consultant agrees to serve as the Wound Care Consultant to coordinate medical care in the facility and provide clinical guidance and oversight regarding wound care; provide diagnosis and treatment recommendations for wounds; and sign and date all orders, such as medications."	F 686	F686 – Treatment/Prevention/Services of Pressure Ulcers. 1. Resident #52's skin was assessed and her care plan reviewed to ensure all appropriate interventions were in place on 3/6/24. 2. Weekly skin Sweeps were initiated on 3/22/24 by the Director of Nursing for all residents. No new skin issues were noted for any resident. No additional residents were impacted by this deficient practice. 3. The DON and Staff Development educated the nursing staff on Pressure ulcers. DON to include additional routine assessments (i.e., skin sweeps), risk management processes and general interventions to prevent pressure ulcers. Staff Development Nurse to educate nursing staff on: Use of Braden scale, skin Assessments, and Pressure Ulcer Documentation. DON and IDT will review pressure ulcer line listing weekly during RM meetings to monitor for any new pressure ulcers, the progress or deterioration of existing PUs beginning 5/10/24. 4. DON or designee will report pressure ulcer outcomes noted in weekly RM meetings to QAPI monthly x 12 months. **(5/14/24)** 5. Completion Date 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 686	Continued From page 57 Review of the facility's "Pressure Ulcers, Prevention and Care" policy revised on 11/10/22 documented: - Skin integrity alteration will be reported to the physician for treatment orders. - Classification of pressure ulcers: Stage 2: a partial thickness of skin is lost (epidermal layer has been lost, but dermis is at least partially intact); may present as blistering surrounded by an area of redness and/or indurations. Stage 3; a full thickness of skin is lost, exposing the subcutaneous tissues; present as a shallow crater (unless covered by eschar - thick brown, black or yellow crust); may be draining. There is also depth at this stage. - A specific plan of care must be developed by nursing and the interdisciplinary careteam. Review of the "Resident Assessment - Pressure Injuries" policy revised on 11/10/22 documented, "Accurate assessments addressing each resident's skin status will be conducted by qualified staff and correctly documented in the medical record; and a qualified health professional will document the presence, number, stage and pertinent characteristics of any pressure injury on the wound documentation form in the medical record." Resident #52 was admitted to the facility on 11/26/19 with diagnoses that included: Adult Failure to Thrive, History of Falling, and Muscle Weakness. Review of the resident's medical record revealed the following: A face sheet that showed Resident #52 had listed a legal guardian, substitute decision maker and	F 686		

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F 686	Continued From page 58 emergency contact #1. Physician's orders dated 01/19/24 directed: "Apply barrier cream to sacrum, buttocks and peri-area every shift for skin protection; weekly skin assessment, every evening shift every Friday; resident to have shower every day shift, every Monday and Thursday, Licensed nurse will validate and ensure skin assessment is completed." A Hospital Discharge Summary dated 01/27/24 documented: - Admission on 01/20/24 at 1:57 PM. - Chief complaint - altered mental status,low oxygen and blood pressure. - Physical exam at discharge - skin: warm and dry. A Readmission Note dated 01/27/24 at 9:01 PM documented: - Resident readmitted into the facility. - Warm to touch skin, mass around themid-arm and in the inguinal area was noted, IV (intravenous) related bruises on bilateral upper arm were noted. A Readmission Braden Scale Evaluation dated 01/27/24 documented: - Resident's score 11. - Interpretation of score: 10-12 indicates high risk. - Continue current plan of care. A care plan documented: [Resident #52] has impaired skin integrity related to bilateral upper arm bruises/mass in the mid arm/inguinal area that was initiated on 01/27/24. A Focused Observation Note dated 01/30/24 at	F 686		

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11:21 PM documented, "complete bed bath given, no new skin issue noted."

A quarterly Braden Scale (a tool used to foster early identification of residents at risk for developing pressure ulcers) dated 02/01/24 at 5:42 PM documented:
- Resident's score 11 (interpretation of score: 10-12 indicates high risk).
- No referrals necessary.
- Continue current plan of care

A physician's order dated 02/02/24 directed, "Turning and repositioning every 2 hours as tolerated and PRN (as needed) everyshift".

A Significant Change in Status Minimum Data Set (MDS) assessment dated 02/02/24 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "07" indicating severe cognitive impairment; no rejection of care behaviors; required substantial/maximal assistance for toileting hygiene, shower/bathing; frequently incontinent of bowel and bladder; at risk for pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries, wounds or other skin problems.

A [nursing] Skin Observation Tool Assessment on Tuesday, 02/06/24, at 8:20 PM documented, "complete bed bath given, no new skin issue noted."

A [nursing] Skin Observation Tool Assessment on Tuesday, 02/13/24, at 10:53 PM documented, "Complete bed bath given."

A Skin Observation Tool Assessment on Friday, 02/16/24, at 11:55 PM documented, "complete

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F 686	Continued From page 60 bed bath given, no new skin issue noted." A [nursing] Skin Observation Tool Assessment on Friday, 02/23/24, at 10:37 PM documented, "complete bed bath given, no new skin issue noted." A care plan focus area: The resident has limited physical mobility r/t (related to) weakness, that was initiated on 02/23/24 had approaches/interventions that included, "monitor/document/report any s/sx (signs and symptoms) of immobility: contractures forming or worsening, skin-breakdown." The Treatment Administration Record (TAR) for February 2024 showed that on Monday, 02/26/24, facility staff documented a check mark and their initials to indicate that Resident #52 had a shower and that the nurse validated and ensured that a skin assessment was completed. A Nursing Progress Note dated 02/26/24 at 2:24 PM documented: - Upon assessment, skin is dry and warm to touch. - Resident turned and repositioned every 2 hours for comfort and pressure relief. A care plan focus area: [Resident #52] is at risk for bladder incontinence related to deconditioning that was initiated on 02/26/24, that had approaches/interventions that included, "weekly skin assessment." An Attending Physician's note on Tuesday, 02/27/24, at 10:58 AM documented: - Subjective: [Resident #52] spends most ofher time in bed because she has becomefrailer.	F 686		

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There have been no new issues regarding her care.
- Objective: remains a well-developed thin black female, in no acute distress when seen. There are no new labs available for analysis.
- Assessment: continues to do well and remains clinically stable. We will continue with the current management.

A [nursing] Skin Only Evaluation Note on Tuesday, 02/27/24, at 10:50 PM documented:
- Skin warm & dry, skin color within normal limits (WNL) and turgor is normal; complete bed bath given, no new skin issue noted.

A Wound Care Physician's Note on Wednesday, 02/28/24, at 8:16 AM documented: "Wound rounds: Stage 3 sacral decubitus ulcer, moderate drainage with necrotic tissue and slough; Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl (debridement agent used on dead tissue) ointment and dry dressing daily."

Although the Wound Care Physician documented a treatment order for Resident #52's new Stage 3 sacral ulcer, the medical record lacked documented evidence that the resident's primary care physician was notified about Resident #52's new Stage 3 sacral pressure ulcer/wound on 02/28/24. As a result, no new orders or interventions were implemented until 03/01/24 (over 48 hours later).

A Skin Only Evaluation Note dated 02/29/24 at 4:45 PM documented, "Skin warm & dry, skin color WNL (within normal limits) and turgor is normal; no skin issues; complete bed bath given."

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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 62 Review of the February 2024 Treatment Administration Record (TAR) dated from 02/01/24 to 02/29/24 showed that facility staff documented a check mark and their initials to indicate that Resident #52: 1. Received a shower everyday shift on Mondays and Fridays and that a licensed nurse validated and ensured that the skin assessment was completed. 2. Received weekly skin assessments every Friday on the evening shift; and 3. Barrier cream was applied to the resident's sacrum, buttocks, and peri-area every shift for skin protection. A Health Status Note dated 03/01/24 at 2:25 PM documented: - Resident remains alert and verballyresponsive with intermittent confusion and generalized weakness. - Upon assessment skin is dry and warm to touch. - Resident turned and repositioned every 2 hours for comfort and pressure relief. A [nursing] Skin Only Evaluation Note dated 03/01/24 at 3:06 PM documented, "Skin warm & dry, skin color WNL and turgor is normal; no skin issues; complete bed bath given." A physician's order dated 03/01/24 at 3:32 PM directed, "Dakin's 1/2 strength External Solution 0.25 % (Sodium Hypochlorite) cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl and cover with border gauze daily".	F 686		

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	095020	A. BUILDING _____ B. WING _____	C 03/20/2024

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F 686	Continued From page 63 A physician's order dated 03/01/24 at 3:38 PM directed, "Santyl External Ointment 250 Unit/GM (gram), apply to sacral ulcer topically everyday shift for wound care". A Wound Care Physician Note dated 03/04/24 at 8:18 AM documented: - Late Entry: created on 03/07/24 at 8:21 AM. - 100-year-old female with cachexia - Stage 3 sacral decubitus ulcer. Decreased slough and drainage. 8 cm (centimeters) long by 6 cm wide by 2 cm deep. - Plan: Continue Santyl dressings daily. A Skin Observation Tool Assessment dated 03/04/24 at 1:08 PM documented: - Site: Sacrum - Type: Pressure - Length: 8 cm - Width: 6 cm - Stage II (Stage 2) [It should be noted that wound care physician staged the resident's sacral wound as a Stage 3 on 02/28/24.] - Notes: Cleanse with Darkins solution, apply Santyl. Cover with dry gauze. A Health Status Note dated 03/06/24 at 7:56 AM documented: - Fluids offered but poorly tolerated encouraged to take more fluids but refused after several attempts. - Resident on oxygen at 2 liters via nasal cannula for shortness of breath for shortness ofbreath. - A call was placed to medical doctor in reference to resident with poor intake with order to transfer resident to the nearest emergency room for evaluation and treatment.	F 686		

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F 686	Continued From page 64 - A call was placed and spoke with theresident's representative. A Health Status Note dated 03/06/24 at 10:52 PM documented: - Call placed to [Hospital name] at 10:30 PM to check on resident status, resident has been admitted. During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) stated, "Skin assessments are done weekly in PCC (Point Click Care, the facility's electronic health record system). That form is used to assess the wound for any changes. Once a new wound area is observed, the process is to immediately call the medical doctor and get new orders. The nurse will write a progress note with a description of the wound that includes size, location, drainage, what the surrounding area looks like and then also indicate that the family was notified. A new care plan is either initiated or revised." During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director/Resident #52's primary physician) stated, "The wound doctor is allowed to put in orders. Any provider that provides services at this facility is credentialed and can put in orders. I can't answer as to why [Wound Doctor] did not directly put in the wound care orders. I did see the resident (on 02/27/24). The nursing staff did not communicate any skin issues to me, and I did not turn her over to do any assessment of her skin during my time with her." During a face-to-face interview on 03/20/24 at approximately 12:30 PM, Employee #1	F 686		

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F 686	Continued From page 65 (Administrator) and Employee #2 acknowledged the findings. Cross reference 22B DCMR Sec. 3211.1(Facility staff failed to ensure that Resident #52 received sufficient nursing care and services to prevent pressure ulcer development that was first observed at a Stage 3.)	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: Based on observation, record reviews, staff interviews, and a family interview, for one (1) of 41 sampled residents, the facility's staff failed to provide adequate supervision for a resident. As a result, the resident left the facility without staff knowledge (Resident #192). The findings included: Review of the policy titled, Missing Resident #99M-010, documented, "A resident is considered missing from the facility whenever their whereabouts cannot be ascertained. This situation is an elopement." Resident #192 was admitted to the facility on 11/10/22 with multiple diagnoses including:	F 689		

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F 689	Continued From page 66 Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A care plan dated 01/01/23 that documented, "Problem: [Resident #192] has risk forElopement related to wandering evidenced by trying to enter the elevator. Goal: Resident will not elope. Approach: Monitor resident's movements closely while out of bed. Encourage resident to verbalize feelings of boredom/loneliness at all times. Encourage resident to participate in group activities of choice." A Quarterly Minimum Data Set (MDS) assessment dated 02/12/23 documented the following: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living . A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: "At 6:55 am, resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at	F 689	F689 – Free from Accident/Supervison 1. Resident #192 is no longer in facility. Unable to retrospectively correct. 2. DON completed Elopement Assessments on all residents. Four residents were identified at risk of elopement. Pictures and face sheets were placed in Wanderer's Book maintained at concierge's desk, **(4/17/24).** 3. Staff Development Nurse re-educated all staff including security team on elopement with emphasis on supervision 4/18/24. The administrator initiated monthly meetings with security supervisor to review resident behaviors to include wandering, exit seeking, and other behaviors requiring monitoring and interventions by security team 4/22/24. DON and IDT review EHR clinical dashboard daily to monitor elopements and to validate supervision was provided per policy and document 5/5/24. 4. PI Director will report validation data from clinical dashboard to QAPI committee monthly x6 beginning 5/14/24. 5. Completion Date 5/17/24. 6. Title of person(s) responsible noted in POC.	

4.

3. The administrator initiated monthly

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7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process."

Please note, According to World Weather, the temperature in the District of Columbia on 04/04/23 during the daytime ranged from 55 to 75 degrees (Fahrenheit). https://world-weather.info/forecast/usa/washington_1/april-2023/

A nursing progress note dated 04/04/23 at 11:22 AM documented, "Resident was received in bed at 11:00 pm, alert, oriented and verbally responsive. During routine round, Resident was in bed through the night. Breathing even and unlabored. No sign of respiratory distress or shortness of breath noted. No complain of pain or discomfort voiced. Around 5:30 am when I pushed my medication cart down the hall to start from room 218 where I normal start. Resident was in his room. When I got to his room at 6:40 am to give him his medication, I could not see him, I checked the bathroom, he was not there, then I alert other staffs and the supervisor , then called the security officer to found out if Resident left the facility. The staffs(sp) begin to search for him all rooms and bathrooms. I left the facility with other staffs in search of him tonearby bus-stops and metro stations."

A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, "At 6.55 am, I was informed that the resident in room 227B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about

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resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call fromthe facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatricteam. Close monitoring in progress and maintained."

According to the investigation packet, the following employees wrote statements dated 04/04/23:?

Employee #14 (CNA) documented, "I[employee's name] worked last night April 3, 2023, and [resident's name] was assigned to me. The last time I saw [resident's name] was at 5:30 AM in his room. We the nurses on the night shift on unit (Unit2) left the floor and went to the street and

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F 689	Continued From page 69 metro station looking [for him] after he left the facility. We did not find him." Employee #15 (Housekeeping Director) documented, "I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1. I asked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting." Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an "Incident Report" dated 04/04/23 that documented, "[Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] was at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM." A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, "Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident stated] 'I have been here for too long; I was told at the other facility that I could leave.' Remains on 1:1 monitoring. Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days. Encourage participation in different activities on unit."	F 689		

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F 689	Continued From page 70 A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented: - It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where. - I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number. - I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility). - The officer agreed to hold him. Mydaughter went and picked him up from Metro Center and took him back to the nursing home. - I feel that this is a neglect on the staffthat's on the 2nd floor where he's on and security for allowing him to get out. Review of Employee #16's (Security Guard) personnel record showed the employee was hired on 05/16/22. The employee signed his initials on the Training Checklist dated 05/17/22 indicating he received training on "Never leaving the front desk unattended." Moreover, the employee signed an "Employee Warning Notice" dated 04/12/23 that documented that, "Date of incident 04/03/23 between 5AM to 5:30 AM. [Employee's name] you [were] supposed (sp) to been (sp) posted at the front desk during this time [resident's name] from room 227 walked thru the lobby past the front desk and out of the front door which caused an elopement."	F 689		

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F 689	Continued From page 71 On 03/08/24 at approximately 11:00 AM, an observation of the lobby area revealed a security desk located adjacent to the facility's front door. At the time of the observation, a security guard and receptionist were seated at the desk. Behind the security desk, was a closet that's used by security staff. Additionally, there was a three-ring binder labeled "Wanders" and a security logbook (where security staff write notes about rounds and concerns in the facility) was noted on the desk. The security logbook lacked documented evidence of Resident #192's elopement incident on 04/04/23. During a telephone interview on 03/13/24 at 8:30 AM, Employee #17 (Nursing Supervisor) stated that Resident #192's assigned nurse called and informed her that staff could not locate the resident (on 04/04/23). After Employee #16 (Security Guard), who was posted at the front desk of the lobby, informed her that he did not see the resident leave out the front door, she called a Code Pink and continued looking for the resident with other staff. During a telephone interview on 03/13/24 at 9:30 AM, Employee #16 (Security Guard) stated that he believed when he walked into the closet behind the security desk, the resident exited the facility through the front door. The employee stated that he was wrong for leaving the front desk unattended. He should have called the other security guard to cover the front desk. The employee also stated that he wrote an incident report related to Resident #192's elopement, and he thought he wrote the information in the security logbook. During a face-to-face interview on 03/13/24 at	F 689		

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F 689	Continued From page 72 approximately 10:00 AM, Employee #18 (Security Supervisor) stated that Employee #16 (Security Guard) did not follow the company's policy when he left his post at front desk unattended on 04/04/23. He was to call the other security guard in the building to cover his post. Employee #18 reviewed that logbook and stated that she did not see documented evidence that Employee #16 documented Resident #192's elopement incident. When asked if that incident should have been documented in the logbook, Employee #18 replied "Yes".	F 689	F 694 – Parenteral/IV Fluids 1. The dressing was changed immediately by ADON for resident #66 on **3/4/24.** 2. There were no additional residents with PICC lines. No other residents were affected by this practice**. (3/3/24)** 3. DON will update Dressing Change policy by **5/13/24** to address inaccurate/incomplete entries and requirement to follow physician orders. Advanced Practice Nurse(s) will make weekly rounds on residents with IVs, ostomies, wounds beginning 5/6/24, validate orders are implemented as prescribed and report findings to DON. 4. Director of Nursing or designee will use data compiled by Advanced Practice Nurses to monitor policy compliance. Report outcomes to QAPI monthly x 6 months. **(5/14/24)** 5. Completion date: 5/17/24. 6. Title of person(s) responsible noted in POC.	On-going
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to follow the physician's orderto change Resident #66's peripherally inserted central catheter (PICC) line dressing every Friday. The findings included: Review of the facility's "PICC/Midline/CVAD (central venous access device) Dressing Change" policy dated 10/05/22, it documented: - It is the policy of this facility to change PICC, midline or CVAD dressing weekly or if soiled, in a manner to decrease potential for infection.	F 694		

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- Physician's orders will specify type of dressing and frequency of change.

Resident #66 was admitted to the facility on 12/27/21 with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia.

Review of Resident #66's medical record revealed:

A Significant Change Minimum Data Set (MDS) assessment dated 12/19/23 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "03", indicating severely impaired cognitive status.

A Health Status Note dated 02/14/24 at 4:21 PM that documented:
- Resident was readmitted from [Hospital name] to the facility.
- Central line placed on 02/09/24 on the right upper arm.

Physician's order dated 02/14/24 directed,
- PICC, 1 Lumen brachial right, for antibiotic treatment, monitor PICC line dressing daily for redness, swelling and drainage every shift.
- Change PICC line dressing every week, every evening shift, on Friday.

Review of the Treatment Administration Record (TAR) for February 2024 showed facility staff documented a check mark and their initials to indicate that the central line dressing change was completed on Friday, 02/16/24, Friday, 02/23/24 and on Friday, 03/01/24 and that they were monitoring the dressing site every shift.

During an observation on 03/04/24 at 10:30 AM

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F 694	Continued From page 74 with Employee #5 (Licensed Practical Nurse/LPN), Resident #66 was observed with a single lumen PICC to his right upper arm with a dressing that was dated, "2/9/24". When asked why the resident's central line dressing had not been changed since 02/09/24, the employee stated, "The dressing does not get changed on my shift (day shift, 7:00 AM - 3:30 PM) and only a Registered Nurse (RN) is allowed to change the dressing. I will get an RN to come and change the dressing now." The evidence showed that from 02/14/24 to 03/04/24, facility staff failed to follow the physician's order to change Resident #66's central line dressing. It should be noted that the last documented central line dressing change was performed by hospital staff on 02/09/24. The first-time facility staff changed Resident #66's central line dressing was on 03/04/24 (24 days after the resident's readmission). During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, "The physician's order was not followed and the nurses documented that they did something they in fact did not complete." Cross Reference 22B DCMR Sec. 3211.1 (Facility staff failed to ensure that sufficient time was given ensure that Resident #66's central line dressing was changed as ordered by the physician.)	F 694		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		

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F 697	Continued From page 75 The facility must ensure that pain management is provided to residents who require such services, consistent 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 record review and staff interview, for one (1) of 1 residents sampled for pain management, facility staff failed to ensure that Resident #243 received effective pain assessments/evaluation for a known left hip fracture. The findings included: According to National Institute of Health (NIH): - Assessment of pain is a critical step to providing good pain management. - Nurses working with patients with acute pain must select the appropriate elements of assessment for the current clinical situation. - The most critical aspect of pain assessment is that it is done on a regular basis (e.g., once a shift, every 2 hours) using a standard format. The assessment parameters should be explicitly directed. - To meet the patients' needs, pain should be reassessed after each intervention to evaluate the effect and determine whether modification is needed. The time frame for reassessment also should be directed. - Pain assessment should include intensity, location, and quality. https://www.ncbi.nlm.nih.gov/books/NBK2658/ Review of the facility's "Pain Management" policy (not dated) showed: - The facility will provide optimal pain control,	F 697	F697 - Pain Management 1. Resident #243 no longer resides in the facility. Unable to retrospectively correct practice. 2. The DON reviewed pain assessments for all residents receiving routine and PRN pain medication **4/22/24.** Documentation reflected pain management needs are being met. No other resident is affected by this practice. **(4/22/4).** 3. DON and Staff Development to re-educate licensed staff on accuracy, consistency in pain documentation, pain characteristics, reconciling diagnostic test results with physician orders, documentation, and order transcription. This will include physician notification of diagnostic test results. Staff Development will also ensure licensed staff are trained on pain assessment documentation including assessments pre- and post- pain medication. **(5/13/24)**. ADON to review resident documentation for compliance for residents on analgesics in weekly RM meetings. 4. ADON will report audit findings via RM audit of resident to QAPI Committee monthly x 12 months beginning **5/14/24.** 5. Completion date: **5/15/24**. 6. Title of person(s) responsible noted in POC.	

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assessment, and monitoring for all identified residents with pain.
- Pain will be measured on a 0-10 scale. Cognitively impaired residents will be assessed utilizing behavioral or visual indicators.
- Pain assessment will occur with the onset of new pain.

Review of the facility's "Documentation Criteria" policy revised on 07/22/22 showed:
- Clinical notes for pain control include location, severity, quality, duration, and cause.
- Note when pain medication is given (very important) and note if/when pain relief is obtained and length of relief.

Resident #243 was admitted to the facility on 05/15/19 with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility.

Review of the resident's medical record revealed the following:

A care plan focus area: [Resident #243] has chronic pain to back and knees related to Osteoporosis, that was initiated on 05/16/19, had interventions that included: administer medications as ordered. Monitor and record effectiveness; monitor and record any complaints of pain: location frequency, intensity, effect on function, alleviating factors, aggravating factors; monitor and record any non-verbal signs of pain (guarding, withdrawal, crying, restlessness, etc.).

A physician's order dated 05/24/19 directed: "Turn and reposition every 2 hours, every shift."

A care plan focus area: [Resident #243] has

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complaints of acute pain to right hip related to post fall, that was initiated on 07/07/21, had interventions of: administer medication routine and as needed, as ordered.
Evaluate/record/report effectiveness. Monitor and record any complaints of pain: location frequency, intensity. Monitor and record any non-verbal signs of pain (guarding, restlessness). Handle gently and try to eliminate any environmental stimuli.

A physician's order dated 08/16/21 directed: "Tramadol (narcotic pain reliever), 100 mg (milligrams), 1 tablet, twice a day PRN (as needed)"

A physician's order dated 08/19/21 directed: "Monitor pain every shift."

A physician's order dated 03/23/23 directed: "Tramadol 50 mg, twice a day."

A physician's order dated 04/07/23 that directed, "Acetaminophen (pain reliever) 500 mg, 2 tablets three times a day, as needed for pain."

An Annual Minimum Data Set (MDS) assessment dated 05/15/23 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 12, indicating mild cognitive impairment; received scheduled pain medication regimen; no falls since the prior assessment and did not receive any opioid medications.

A Pain Assessment Note dated 05/29/2023 at 5:51 PM documented:
- Pain site - left lower extremity. Received scheduled pain medication regimen.
- Resident pain interview intensity rating on the Numeric Rating Scale (0-10) "3".

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- Resident pain interview: verbal descriptor scale "severe".

A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented:
- At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side.
- Resident refused to be assessed by the nurse supervisor, she said she will be fine but verbalized feeling pain to the left thigh, 4/10.
- The physician was called and gave an order for an x-ray of the affected leg.
- Resident RP was called and was made aware of the fall accident.

A physician's order dated 05/29/23 directed "Left hip/left knee x-ray"

A Nursing Progress Note dated 05/30/23 at 6:50 AM documented:
- Range of motion within normal limits bilateral upper and right lower extremities with limited mobility left lower extremity.
- Denies any pain at rest but complained of moderate pain with guarding to left hip upon assessment. Given PRN Tylenol (Acetaminophen) 1000 mg with good effect.
- X-ray to left hip to be done in the morning.

Left knee x-ray result dated 05/30/23 at 1:21 PM documented:
- No acute fracture, dislocation or degenerative disease.
-There is soft tissue swelling and vascular calcification.

Left hip x-ray result dated 05/30/23 at 1:21 PM

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documented:
- There is a fracture of the neck of the proximal femur without significant displacement.
- Clinical Correlation and follow-up imaging recommended as indicated.

A Nursing Progress Note dated 05/30/23 at 2:01 PM documented:
- X-ray for left hip/knee done this shift, results received: No acute fracture, dislocation or degenerative disease, there is a swelling tissue and vascular calcification.
- Physician's Assistant (PA) made aware; no new order given.
- Resident was able to get transferred from the bed to wheelchair with assistance.

It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture.

The Restorative Point of Care documentation dated 05/30/23 showed that Resident #243 received 15 nursing minutes of walking on the day shift (7:00 AM - 3:30 PM).

A Nursing Progress Note dated 05/30/23 at 11:37 PM documented:
- Day 1 post fall, pain to left hip/knee. Routine pain medication administered as ordered.

The Treatment Administration Record (TAR) showed that on 05/30/23, day shift (7:00 AM - 3;30 PM), facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the

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same date and shift also showed that in the section that directed, "monitor for pain every shift", Employee #7 documented her initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture.

The TAR also showed that on 05/30/23, evening shift (3:00 PM - 11:30 PM), facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the same date and shift also showed that in the section that directed, "monitor for pain every shift", facility staff documented their initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture.

A Night Shift (11:00 PM - 7:30 AM) Nursing Progress Note dated 05/31/23 at 6:56 AM documented:
- Range of motion within normal limits bilateral upper and right lower extremities with limited mobility left lower extremity.
- Complaints of pain upon assessment. Given Tramadol 50 mg with good effect. No visible injuries noted.
- Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift to follow-up with primary physician.

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It should be noted that although the employee documented that Resident #243's left hip x-ray results showed a fracture, he failed to notify the resident's primary care physician.

The TAR showed that on 05/30/23, night shift, facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the same date and shift also showed that in the section that directed, "monitor for pain every shift", facility staff documented their initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture.

A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM, written by Employee #8 documented:
- Status post fall, no bruise, no redness noted.
- Resident guarding her left leg/hip. Medicated for complaints of pain to left upper leg with Tramadol 50 mg and effective.
- Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Please follow-up with primary medical doctor.

It should be noted that although Employee #8 documented that Resident #243's left hip x-ray results showed a fracture, she failed to notify the resident's primary care physician.

The Restorative Point of Care documentation dated 05/31/23 showed that Resident #243 received 15 nursing minutes of walking on the

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day shift.

The TAR showed that on 05/31/23, day shift, facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours.

A Nursing Progress Note dated 05/31/23 at 12:22 PM documented:
- Status post fall, order given on 5/29/23 as follows: left hip/ Left knee x-ray to rule out fracture. X-ray result received and indicated "a fracture of the neck of the left proximal femur without significant displacement."
- [Physician's Name] made aware, new order given to transfer resident to the nearest emergency room for further evaluation of fracture of the neck of the left proximal femur.
- 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware of before and after transfer.

A Hospital Discharge Summary dated 06/12/23 at 6:00 AM documented:
- 05/31/23 - Computed Tomography (CT) Scan of pelvis without contrast: acute appearing mildly impacted subcapital left femoral neck fracture.
- Percutaneous fixation of left femoral neck fracture completed (the insertion of pins or wires through the skin to hold the bones in a proper position while they heal).

During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN who worked on 05/30/23, day shift) stated, "The process for when x-ray results are received is to call the medical doctor with the results. I don't think I received both

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results for [Resident #243] at the same time, or else I would have documented the results in my note." When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, "I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time."

During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Supervisor who worked on 05/30/23) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated that the facility did not have a physicians on-call list [list of physicians to call on specific days and time frames]. The employe also said "Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00-7:30 AM because most of the doctors get angry when we call them in the middle of the night."

During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated, "There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. If there's an abnormal result that is not critical, it makes sense to call in the morning and not at 3:00 AM. If there is an abnormal lab, x-ray, or incident, that should be reported to the provider during that shift when it happens. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported

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F 697	Continued From page 84 immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts." During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (DON) acknowledged the findings.	F 697		
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 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	F 761	F761 Label/Storage of Drugs and Biologicals 1. Procurement Officer immediately separated oxygen tanks and relocated empty tanks to basement. **3/4/24** 2. Procurement Officer reviewed the location of oxygen tanks on both units to ensure all were stored appropriately. **3/3/24.** 3. Staff Development will re-educate nursing staff on Oxygen Safety and Storage policy. **5/2/24.** Nursing will notify Procurement Officer when tanks are empty and need to be removed from unit. Procurement Officer will also make daily rounds to identify empty tanks, remove them from the unit, and store them in the basement storage area until pickup by the oxygen company. **5/3/24.** 4. Procurement Officer will monitor storage locations weekly. Report compliance to QAPI Committee monthly x 3 months. **(5/14/24).** 5. Correction Date **5/15/24.** 6. Title of person(s) responsible noted in POC.	

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by:
Based on observations and staff interviews, for two (2) of two (2) oxygen storage rooms, facility staff failed to ensure that empty oxygen tanks were not stored in the same area as full oxygen tanks intended for patient use.

The findings included:

According to the Joint Commission:
- Storing oxygen cylinders, as per the National Fire Protection Association (NFPA) 99-2012, 11.6. 5.2, is about ensuring full and empty cylinders are not comingled.
- Those cylinders defined as 'empty' by the organization shall be segregated from all other cylinders that are intended for patient care use.

https://www.jointcommission.org/standards/standard-faqs/home-care/environment-of-care-ec/000001261/#:~:text=Storing%20oxygen%20cylinders%2C%20as%20per,intended%20for%20patient%20care%20use.

1. An observation on 03/05/24 at 10:09 AM of the 2nd floor oxygen storage room, with Employee #22 (Licensed Practical Nurse/LPN) showed, one (1) empty oxygen tank was stored in the same area with four (4) full oxygen tanks that were stored for resident use.
At the time of the observation, Employee #22 stated, "I'm not sure who checks the oxygen tanks in the supply room, but a nurse is supposed to look and check the tank before taking it out to use for a patient (resident), which means they shouldn't grab one if it's empty. Empty tanks are kept in the basement for pickup."

2. An observation on 03/05/24 at 10:47 AM of

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F 761	Continued From page 86 the 1st floor oxygen storage room with Employee #7 (LPN) showed two (2) empty oxygen tanks were stored in the same area with three (3) full oxygen tanks. At the time of the observation, Employee #7 stated, "Empty [oxygen] tanks are stored downstairs. I would have to refer you to my DON (Director of Nursing) about whether empty and full oxygen tanks can be stored together. I will remove the empty oxygen tanks and bring them downstairs." During a face-to-face interview conducted on 03/05/24 at 10:56 AM, Employee #2 (DON) acknowledged the findings and stated, "The facility did not have a policy or procedure for storage of oxygen tanks. Best practice is for whoever checks the code carts to also ensure that there are only full tanks in the oxygen storage room." Cross Reference 22B DCMR Sec. 3215.4(f) (Facility staff failed to ensure the effective and safe storage of equipment for administering oxygen.)	F 761		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic 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 results that fall outside of	F 777		

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	095020	A. BUILDING _____ B. WING _____	C 03/20/2024

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F 777	Continued From page 87 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 radiology results that fell outside of clinical reference range. Resident #243. The findings included: Resident #243 was admitted to the facility on 05/15/19 with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility. Review of Resident #243's medical record revealed the following: An Annual MDS assessment dated 05/15/23 showed that facility staff coded: a BIMS summary score of "12", indicating mild cognitive impairment and had no falls since the prior assessment. A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A Nursing Progress Note dated 05/29/23 at 7:36 PM documented:	F 777	F777 Radiology/Diagnosis/Notify Results 1. Resident #243 no longer resides in facility. Retrospective correction not implemented for this resident. 2. DON reviewed x-ray reports for all residents on 3/25/24. Chart for 2 of 5 residents did not indicate physician had been notified. The physician was notified on 3/25/24 of x-ray results with no new orders given. 3. DON to review clinical dashboard daily to monitor changes in resident condition that require physician notification such as radiology reports and lab results beginning 3/27/24. Staff Development to educate licensed staff on notification of physician for changes in condition, or radiology/lab results outside of clinical reference range. (5/3/24) Performance Improvement Director will monitor resident documentation daily during clinical interdisciplinary meeting to validate notifications occur per policy beginning 5/5/24. 4. Performance Improvement Director to report validation data as noted in clinical meeting to QAPI committee monthly x 6. (5/15/24) 5. Completion date: 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 777	Continued From page 88	F 777		

- At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side.
- The physician was called and gave an order for an x-ray of the affected leg.
- Resident RP was called and was made aware of the fall accident.

A physician's order dated 05/29/23 directed, Left hip/left knee x-ray.

Left knee x-ray results dated 05/30/23 at 1:21 PM documented:
- No acute fracture, dislocation or degenerative disease.

Left hip x-ray results dated 05/30/23 at 1:21 PM documented:
- There is a fracture of the neck of the proximal femur without significant displacement.
- Clinical Correlation and follow-up imaging recommended as indicated.

A Nursing Progress Note dated 05/30/23 at 2:01 PM written by Employee #7 (Licensed Practical Nurse/LPN) documented:
- X-Ray for left hip/knee done this shift, results received: No acute fracture, dislocation, or degenerative disease.
- Physician's Assistant (PA) made aware; no new order given.

It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture.

A Night Shift Nursing Progress Note dated 05/31/23 at 6:56 AM documented:

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F 777	Continued From page 89	F 777		

- Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift (day shift, 7:00 AM - 3:30 PM) to follow-up with primary physician.

A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM written by Employee #8 (Night Shift Nursing Supervisor) documented:
- Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Please follow-up with primary medical doctor.

A Day Shift Nursing Progress Note dated 05/31/23 at 12:22 PM documented:
- Status post fall, order given on 05/29/23 as follows: left hip/left knee x-ray to rule out fracture. X-ray result received and indicated a fracture of the neck of the left proximal femur without significant displacement.
- [Physician's Name] made aware, new order given to transfer resident to the nearest emergency room for further evaluation.
- 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware before and after transfer.

The evidence showed that facility staff received Resident #243's left hip and left knee x-ray results on 05/30/23 at 1:20 PM, during the day shift (7:00 AM - 3:30 PM). There is no documented evidence that the assigned day shift nurse, Employee #7, made the resident's physician aware of the left hip x-ray result that showed "fracture of the neck of the proximal [left] femur".

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F 777	Continued From page 90	F 777		

The evidence also showed that on 05/30/23, the assigned night shift nurse and nursing supervisor both documented that Resident #243's left hip x-ray showed a fracture but neither notified the resident's physician or her representative.

It was not until 05/31/23, at approximately 10:30 AM, 21 hours later, that facility staff notified Resident #243's primary care physician and their RP of the left hip x-ray results.

During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN) stated, "The process for when x-ray results are received is to call the medical doctor with the results. When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, "I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time."

During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Nursing Supervisor) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated, "We don't have an on-call list. Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00/7:30 AM because most of the doctors get angry when we call them in the middle of the night."

During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated,

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F 777	Continued From page 91 "There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts." During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.	F 777		
F 812 SS=F	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 the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		

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F 812	Continued From page 92 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 serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 135 degrees Fahrenheit (F) on six (6) of six (6) observations, two (2) of two (2) convection ovens, and two (2) of two (2) grease fryers that were soiled throughout, ready-to-eat (RTE), open bags of foods such as two (2) of two (2) packs of cold cuts, one (1) of two (2) bags of shredded yellow cheese, three (3) of five (5) packs of sliced yellow cheese, one (1) of one (1) bag of feta cheese, one (1) of one (1) jar of applesauce stored in the walk-in refrigerator, that were not labeled to indicate a "use-by ' date, pieces of frozen chicken that were being thawed improperly, and a sanitize water solution in the 3 compartment sink that tested below the recommended 200 parts per million (PPM). The findings include: Test tray food temperatures were inadequate as puree hot foods such as chicken (106.5), spinach (104.1), potatoes (105.8), and regular hot foods such as fried chicken (134.4), spinach (114.4), and potatoes (106.6) tested at less than 135 degrees. Cooking equipment such as two (2) of two (2) convection ovens, and two (2) of two (2) grease	F 812	F 812 Food Procurement/Storage/ Preparation 1. During the survey, areas that could be addressed immediately are reflected in actions below: a. Test trays were used for purposes of staff education as pertains to hot food temperatures. Staff were also re-educated on ensuring food could be re-heated on the unit for residents if requested. b. 2 of 2 convection ovens were cleaned immediately c. 2 of 2 grease fryers were cleaned immediately d. Open bags of RTE food items not labeled to indicate “use by” date or being thawed improperly including cold cuts, shredded cheese, sliced cheese, feta cheese, apple sauce, and frozen chicken were discarded immediately 3/4/24. 2. Manager checked all food items for proper labeling dates and packaging. Several items were discarded. 3/4/24.Director reviewed and re-educated staff on food labeling 3/7/24. 3. Production Manager conducted daily rounds to walk-in coolers, freezers, reach-in coolers, and dry storage for food labeling/dating. 4/1/24. Evening Cook to update nightly Close Out Log to check for labels/dates with new items added to Log as needed. 5/1/24. Production Manager to review/update Master Cleaning Schedule for daily, weekly, and as needed equipment cleaning by 5/5/24. Back-up supply of water sanitizer solution to be maintained in Director’s office to ensure availability 5/1/24.	

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F 812	Continued From page 93 fryers, were soiled with cooked food residue. Ready-to-eat foods such as two (2) of two (2) open packs of cold cuts, one (1) of two (2) open bag of shredded yellow cheese, three (3) of five (5) open packs of sliced yellow cheese, one (1) of one (1) open bag of feta cheese, and one (1) of one (1) open jar of applesauce stored in the walk-in refrigerator, were not labeled to indicate a "use-By ' date. Numerous pieces of chicken meat were submerged in a sink full of water for thawing, with no running water or water velocity to create constant movement. The water 'sanitize' solution from the three-compartment sink tested at less than 100 parts per million (PPM) on March 4, 2024, at approximately 10:30 am. The recommended water sanitize solution in the 3 compartment sink is 200 parts per million (PPM). These observations were acknowledged by Employee #9 during a face-to-face interview on March 11, 2024, at approximately 3:30 PM.	F 812	F 812 Food Procurement/ Storage/ Preparation. 4. Director will document audit findings from logs and report to QAPI Committee monthly x3 months 5/14/24. 5. Completion date: 5/17/24. 6. Title of person(s) responsible noted in POC.	
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c)	F 836		

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F 836	Continued From page 94 §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to provide documented evidence that the Nurse Staffing Agency used to supplement the facility's nursing staff was	F 836	F836 License Compliance 1. The Chief Human Resources Officer canceled the services of staffing agency immediately. No additional services were provided by the staffing agency. (3/4/24). 2. No other deficient practice was identified as the facility has no other agency contract. (3/4/24). 3. Human Resources will fully vet staffing agencies prior to entering into a contractual agreement to ensure requirements are met under state law (i.e., at minimum to include business license in DC and current insurance). (3/4/24). 4. Human Resources will monitor license requirements and report to QAPI committee x 1 months and on-going until compliance updated whenever staffing agency is solicited. (5/14/24). 5. Completion date 5/17/24. 6. Title of person(s) responsible noted in POC.	

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F 836	Continued From page 95	F 836		

operating in compliance with applicable Federal, State, and local laws and regulations, as evidenced by providing services in the District of Columbia (D.C.) on an expired business license. The facility's census on the first day of the survey was 90.

The findings included:

A review of a letter addressed to [Nurse Staffing Agency's Name] dated 04/26/2021 from the D.C. Department of Health documented, "Enclosed is your Certificate of Licensure that covers the period April 2, 2021, through April 11, 2022."

A review of the Staffing Agency's business license issued by the District of Columbia revealed a license number with an expiration date of 04/11/2022.

A review of the Service Contract between Nurse Staffing Agency and the facility, signed on 02/02/23 by Employee #19 (Chief Human Resources Officer) documented, "Thank you for choosing [Nurse Staffing Agency's Name] to assist with your staffing needs."

A review of the facility's invoices for the Staffing Agency revealed that the facility used 14 nursing staff (RN's, LPN's and CNA's) from 02/02/23 to 03/10/24, a combined total of approximately 150 shifts.

During a face-to-face interview conducted on 03/18/24 at 1:04 PM Employee #2 (DON) reviewed the Nurse Staffing Agency's expired business license and stated, "I didn't know their license was expired."

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F 836	Continued From page 96 During a face-to-face interview conducted on 03/18/24 at 1:21 PM Employee #19 (Chief Human Resources Officer) stated that, "I initiated the relationship between [Nurse Staffing Agency's Name] and the facility started using CNA's and RN's February 2023." The employee further stated that she didn't ask about the Nurse Staffing Agency's license until the State Surveyors entered the facility on 03/04/24. It should be noted that the nursing staff from the Nurse Staffing Agency all had current licenses to practice in D.C. Cross Reference 22B DCMR Sec. 3212.4	F 836		
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 97 §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 and resident review evaluations and	F 842	F842: Medical Records 1. Residents #66, 52, and 72 no longer reside in facility. Unable to retrospectively correct. 2. DON completed audits of current residents' TARs for PICC line dressings and current residents with pressure ulcers. No additional residents had PICC lines. Two residents had pressure ulcers with no stage noted. Assessments with corrected staging were completed 4/22/24. Audit was conducted by DON of monthly summaries completed in last 30 days. No inaccuracies were identified. 4/19/24. 3. DON re-educated nursing staff on pressure ulcers including routine assessments (e.g., skin sweeps), risk management processes, general interventions to prevent pressure ulcers, accuracy of documentation on Monthly Summaries, and accuracy of TARs. Staff Development to re-educate licensed nurses by 5/14/24 on skin assessments, pressure ulcer documentation and dressing changes. Performance Improvement Director will complete monthly nursing documentation audits for accuracy and completeness by 5/13/24. 4. Results of documentation audits will be presented by Performance Improvement Director to QAPI Committee monthly x6 months and ongoing as necessary. 5/14/24. 5. Completion date: 5/17/24. 6. Title of person(s) responsible noted in POC.	

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determinations conducted by the State;
(v) Physician's, nurse's, and other licensed 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 reviews and staff interviews, for three (3) of 41 sampled residents, facility staff failed to accurately document in the residents' medical record. Resident #66,

The findings included:

Review of the "Documentation Criteria" policy last reviewed on 07/22/22, documented:
- The objective is to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

1. Facility staff failed to accurately document n Resident #66's Treatment Administration Record (TAR).

Resident #66 was admitted to the facility on 12/27/21 with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia.

Review of Resident #66's medical record revealed:

A Significant Change Minimum Data Set (MDS) assessment dated 12/19/23 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of "03", indicating severely impaired cognitive status.

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A Health Status Note dated 02/14/24 at 4:21 PM that documented:
- Resident was readmitted from [Hospital name] to the facility.
- Central line placed on 02/09/24 on the right upper arm.

Physician's order dated 02/14/24 directed,
- PICC, 1 Lumen brachial right, for antibiotic treatment, monitor PICC line dressing daily for redness, swelling and drainage every shift.
- Change PICC line dressing every week, every evening shift, on Friday.

Review of the Treatment Administration Record (TAR) for February 2024 showed facility staff documented a check mark and their initials to indicate that the central line dressing change was completed on Friday, 02/16/24, Friday, 02/23/24 and on Friday, 03/01/24 and that they were monitoring the dressing site every shift.

During an observation on 03/04/24 at 10:30 AM with Employee #5 (Licensed Practical Nurse/LPN), Resident #66 was observed with a single lumen PICC to his right upper arm with a dressing that was dated, "2/9/24". When asked why the resident's central line dressing had not been changed since 02/09/24, the employee stated, "The dressing does not get changed on my shift (day shift, 7:00 AM - 3:30 PM) and only a Registered Nurse (RN) is allowed to change the dressing. I will get an RN to come and change the dressing now."

The evidence showed that from 02/14/24 to 03/04/24, facility staff failed to failed to accurately document on Resident #66's TAR.

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During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, "The physician's order was not followed and the nurses documented that they did something they in fact did not complete."

2. Facility staff failed to accurately document the stage of Resident #52's sacral pressure ulcer/wound on the comprehensive resident care plan.

Resident #52 was admitted to the facility on 11/26/19 with diagnoses that included: Adult Failure to Thrive, History of Falling, and Muscle Weakness.

Review of the resident's medical record revealed the following:

A Significant Change in Status Minimum Data Set (MDS) assessment dated 02/02/24 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "07" indicating severe cognitive impairment and had no unhealed pressure ulcers/injuries, wounds, or other skin problems.

A Wound Care Physician's Note dated 02/28/24 at 8:16 AM documented: "Wound rounds; Stage 3 sacral decubitus ulcer; moderate drainage with necrotic tissue and slough; Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl ointment (debridement ointment used on dead tissue) and dry dressing daily."

A Wound Care Physician Note dated 03/04/24 at

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8:18 AM documented:
- Stage 3 sacral decubitus ulcer. Decreased slough and drainage. 8 cm (centimeters) long by 6 cm wide by 2 cm deep.

A care plan focus area initiated on 03/05/24 documented, "[Resident #52] has sacral ulcer Stage 2."

During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated that the resident's care plan would be revised.

Cross Reference 22B DCMR Sec. 3231.12 (Facility staff failed to accurately document the stage of Resident #52's sacral pressure ulcer on the comprehensive care plan.)

3. Facility staff failed to accurately document in Resident #72's December 2023 monthly summary report.

Resident #72 was admitted to the facility on 10/03/22 with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 3, Dysphagia, Aphasia, Pain, and Cerebral Infarction.

Review of the resident's medical record revealed the following:

An Annual MDS assessment dated 10/03/23 showed facility staff coded: severely impaired cognitive skills for decision making and received 51% or more of nutrition via a feeding tube.
A physician's order dated 12/24/23 directed, "Transfer resident to nearest ER (emergency room) for G (gastrostomy) - tube replacement."

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F 842	Continued From page 102 A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: - Resident G tube was dislodged. - The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency room for G-tube replacement. - A call was placed call to non-emergency ambulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident returned to unit at 5:10 PM from [Hospital name]. - New G-tube noted to be intact/patent and dry, no bleeding noted. A Resident Monthly Summary Report dated 12/30/23 at 4:45 AM documented: - No ER visit/hospitalization this month. - Continue plan of care. This evidence showed that facility staff inaccurately documented that Resident #72's had no ER visits for the month of December 2023. During a face-to-face interview on 03/14/24 at 12:46 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated "OK." Cross Reference 22B DCMR Sec. 3231.10 (Facility staff failed to accurately document the course of treatment in Resident #72's monthly summary report for December 2023.)	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 103 §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 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,	F 880	F880 Infection Prevention and Control 1. Infection Preventionist Nurse initiated review of all policies immediately to identify policies that required review/ updates. (3/11/24). 2. All residents can potentially be affected by deficient practices. Audit was conducted by IP nurse to identify policies to be updated. (4/1/24). 3. IP will review/update policies on infection control. Staff will be educated by IP nurse and Staff Development on policies (4/15/24 and ongoing). 4. Report of policy updates will be submitted to QAPI by Infection Preventionist quarterly x 3. 5/14/24. 5. Completion Date: 5/17/24. 6. Title of person(s) responsible noted in POC.	

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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.
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 record review and staff interview, for 12 out of 25 Infection Control policies and procedures, facility staff failed to have documented evidence that they were reviewed at least annually.

The findings included:

A review of the facility's Infection Control Policy and Procedure binder on 03/19/24 revealed that the following policies lacked review dates:
Admission of Residents During an Outbreak

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F 880	Continued From page 105 Control of Methicillin-Resistant Staphylococcus Aureus (MRSA) Colonization (#11-015) Control of Vancomycin-Resistant Enterococcus (VRE) Infection (#06-003) Discharge Room Cleaning (Non-Isolation/Infection Precaution Room) Handling Infectious Waste Infection Outbreak Response and Investigation Infectious Waste Material Exposure Control (#99-013) Multiple Drug Resistant Organisms (MDRO) (#06-002) Reporting of In-House Infection and Communicable Disease (#99-01) Treatment of Urinary Tract Infection Visitation During a Communicable Disease Outbreak. This binder also showed a policy titled, "Antibiotic Stewardship (#19-007)" that had a review date of 07/22/22. During a face-to-face interview on 03/18/24 at approximately 2:00 PM, Employee #28 (Infection Preventionist) reviewed the policies and stated that she did not see the dates the policies were reviewed. The employee also said that she would work on reviewing the policies and ensuring they are based on national standards and the facility's assessment.	F 880		
F 883 SS=D	Cross Reference 22B DCMR Sec. 3217.5 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		

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F 883	Continued From page 106 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883	F883 Influenza and Pneumococcal Vaccine 1. Influenza education was provided to residents #4 and 49 by Assistant Director of Nursing. (3/19/24). 2. An audit was completed by Director of Nursing for current residents. Identified residents who refused the vaccine were educated and re-offered the influenza vaccine (3/25/24). 3. The Infection Preventionist nurse and Staff Development nurse provided education to staff, resident and family members regarding the benefits and potential side effects of Influenza immunization. (5/8/24). 4. Administration of influenza will be reviewed during daily Clinical meetings and results reported to QAPI committee quarterly by Infection Preventionist. (5/14/24). 5. Correction Date 5/15/24. 6. Title of person(s) responsible noted in POC.	

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(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, for two (2) of 41 sampled residents, facility staff failed to have documented evidence that the residents or their responsible party received education on Influenza vaccination. (Resident #4 and Resident #49).

The findings included:

Review of the Immunization of Residents for Flu (Influenza) and Pneumococcal (#10-00) Policy with a review date of 07/20/23 documented the following but not limited to, "The resident or the resident's legal representative is provided education regarding the benefits and potential side effect of immunizations."

1. Resident #4 was admitted to the facility on 07/02/22 with multiple diagnoses including Dementia.

A review of the face sheet showed that Resident #4's son was her responsible party.

A quarterly Minimum Data Set (MDS) assessment dated 08/02/23 documented a Brief

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Interview for Mental Status (BIMS) summary score of "3", indicating the resident had a severely impaired cognitive status.

A review of a document titled, "Preventive Health Care Report (Influenza Vaccine)" dated 09/27/23 documented the following but not limited to, "Administered Yes-In house, Administration Date/Time 09/27/23 at 10:43 AM, Route - Intramuscular, Site - Left Deltoid." Continued review of the document showed that sections: Education Provided to Resident/Family/POA (power-of-attorney) and Education Provided By- were blank indicating that education was not provided by staff.

A review of a nursing progress note dated 09/27/23 at 12:16 PM documented, "Alert and verbally responsive. Agreed to take the Flu (Influenza) shot 0.5 ml (milliliters) IM (intra-muscular) given to left deltoid, no adverse reaction. V/S (vital signs) [blood pressure] 118/58, [pulse] 64, [respiration] 18, [temperature] 97.6."

Resident #4's medical record lacked documented evidence that education regarding the benefits and potential side effect of the Influenza vaccination (immunization) was provided to the resident or her responsible party.

2. Resident #49 was admitted to the facility on 03/28/19 with multiple diagnoses including Dementia.

A review of the face sheet showed that Resident #9's daughter was her responsible party.
A Quarterly MDS assessment dated 08/02/23 documented a Brief Interview for Mental summary score of "7, indicating the resident has

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a severely impaired cognitive status.

Review of a document titled, "Preventive Health Care Report (Influenza Vaccine)" dated 09/26/23 documented the following but not limited to, "Administered Yes-In house, Administration Date/Time 09/26/23 at 12:24 PM, Route - Intramuscular, Site - Left Deltoid, and Education Provided to Resident/Family/POA (power-of-attorney) - No." Continued review of the document showed that section and Education Provided By- was blank indicating that education was not provided by staff.

A nursing progress note dated 09/26/23 at 2:17 PM documented, "VSS (vital signs). [blood pressure]123/78, [pulse] 67, [respiration] 18, [temperature] 98. Resident received 0.5 ml (milliliters) flu vaccine left deltoid IM (intra-muscular) lot#370274 exp, (expiration) 5/2024, no adv (adverse) reaction."

Resident #49's medical record lacked documented evidence that education regarding the benefits and potential side effect of the Influenza vaccination (immunization) was provided to the resident or her responsible party.

During a face-to-face interview on 03/18/24 at approximately 10:00 AM, Employee #22 (LPN/Charge Nurse) stated that the facility's protocol is residents and/or their responsible parties are provided education on the benefits and potential side effect of vaccines on admission and prior to administration of all vaccines.

During a face-to-face interview on 03/18/23 at approximately 2:00 PM, Employee #2 (DON) reviewed Resident #4's and Resident #49's

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F 883	Continued From page 110 documents and stated that she did not see that the residents or their responsible parties were provided education on the Influenza vaccine.	F 883		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) defective food pellet warmer, and two (2) of four (4) burners from one (1) of one (1) gas stove that did not function when tested. The findings include: During a walkthrough of dietary services on March 4, 2024, at approximately 9:00 am: One (1) of one (1) food pellet warmer was inoperative. Two (2) of four (4) burners from one (1) of two (2) gas stoves did not light up when the knob was activated. These observations were acknowledged by Employee #9 during a face-to-face interview on	F 908	F908 Essential Equipment in Safe Operating Condition 1. Dining Director notified Maintenance Director regarding equipment. Repairs to pellet warmer, 2 food burners and gas stove were done on 3/5/24. 2. Maintenance Director completed assessment of kitchen equipment and found all equipment in working order. No residents were impacted by this practice. 3/12/24. 3. Dining Director to check temperature of warming pallets weekly to ensure that they are in working order and heat at temperature of at least 1750. Temperature readings are documented on Safety Check Log maintained in kitchen. Gas burners are checked daily before use and condition documented on Safety Check Log (5/17/24). Any problems identified will be reported to Maintenance immediately. 4. Dining Director to report operating condition of kitchen equipment to QAPI committee quarterly x 3 quarters. (5/14/24). 5. Correction Date 5/17/24. 6. Title of person(s) responsib1e noted in POC.	

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 03/20/2024

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 908	Continued From page 111 March 11, 2024, at approximately 3:30 PM.	F 908		