Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0019	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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L 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 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report:	L 000		

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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
Dl - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)

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L 000	Continued From page 2 MAR - Medication Administration Record MD - Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's ordersheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsibleparty SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 017	3203.7 Nursing Facilities	L 017		

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L 017	Continued From page 3 Each administrative record shall be retained for at least five (5) years from the date of creation. This Statute is not met as evidenced by: Based on observations, record reviews, and staff interviews, for one (1) of two (2) Units, the facility staff failed to ensure that the daily nurse staffing information was retained. The findings included: During an observation conducted on 03/07/24 at 10:41 AM on the first-floor Unit 1, the staffing information was not visibly posted anywhere on the Unit. At the time of this observation Employee #2 (Director of Nursing) was asked to show the State Surveyor where the facilityposted Unit 1's required nurse staffing information. Employee #2 pointed to a board on the right side of the day room and stated that the nursing staffing is supposed to be there, but it was not. The surveyor then asked for nursing staffing for 03/05/24 and 03/06/24, however, they were not able to provide the requested documents.	L 017	L017 Staff Posting 1. Staff Coordinator posted daily staffing on bulletin board **3/5/24**. 2. No residents were affected by this deficient practice. 3. Staffing Coordinator to develop and maintain notebook containing daily staffing sheets. Availability of daily posting to be included in Director of Nursing's (or designees) daily rounds checklist. **4/15/24**. 4. Results of rounding data to be reported monthly to QAPI Committee x 3 months. **5/14/24**. 5. Completion date: **5/17/24**. 6. Title of person(s) responsible noted in POC	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for	L 051		

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L 051	Continued From page 4 appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specificresidents; (e) Supervising and evaluating eachnursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 41 sampled residents, facility staff failed to review a residents' plan of care for appropriate goals and approaches to address the use of a central intravenous (IV) line and a cholecystectomy tube, and for a resident with 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:	L 051	L051 – 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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L 051	Continued From page 5 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: - 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)."	L 051		

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L 051	Continued From page 6 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, 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	L 051		

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L 051	Continued From page 7 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. 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.	L 051		

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L 052	Continued From page 8	L 052		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist	L 052		

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L 052	Continued From page 9 him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, for three (3) of 41 sampled residents, facility staff failed to ensure that sufficient time was given to ensure that Resident #52 received care to prevent pressure ulcer development that was first observed at a stage III; Resident #243 received effective pain assessments/evaluation for a known left hip fracture; and Resident #66's central line dressing was changed as ordered by the physician. The findings included: 1) Facility staff failed to ensure that sufficient time was given to ensure that Resident #52 received care to prevent pressure ulcer development that was first observed at a stage III. 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.	L 052	L052 – Sufficient Staff Time – (A) Resident #52 1. Resident #52's care plan was updated on **3/6/24**. 2. Weekly skin Sweeps were initiated by the Director of Nursing for on all residents. No new skin issues were noted. **(3/22/24).** 3. The DON updated Resident Assessment-Pressure Injuries policy **(5/25/24)** to include additional routine assessments (i.e., skin sweeps), risk management processes and general interventions to prevent pressure ulcers. Staff Development Nurse educated licensed nurses on the following: New/updated policies, Use of Braden scale, skin Assessments, and Pressure Ulcer Documentation. Performance Improvement Director will review at risk residents at weekly RM meetings. Update care plans during meetings as needed. (5/2/24). Use weekly line listing to review newly developed Pressure Ulcers during RM meetings to monitor progress or deterioration. **(5/20/24).** 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. Responsible party noted in POC	

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L 052	Continued From page 10 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 II: 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 III; 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 care team. 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. - 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 a listed a legal guardian who is her Responsible	L 052	L052 – Sufficient Staff Time – (B) Resident #243 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 pain medication. Documented assessments accurately reflect pain management needs are being met. No other resident is affected by this practice. **(4/22/24).** 3. DON updated Documentation Criteria policy to include requirements for accuracy and consistency in pain documentation. **(5/13/24).** Administrator developed Notification Policy. (5/1/24). Staff Development in-serviced licensed nurses were in-serviced on New/ updated policies, Pain Assessments, Notification. **(5/20/24).** Risk Management Audit resident documentation for residents on routine analgesics at weekly RM meetings on **522/24**. Update care plans during meeting as needed. 4. Assistant Director of Nursing will report audit findings via audit of resident documentation noted at RM weekly meetings to QAPI Committee monthly x 12 months. **(5/14/24)** 5. Completion date: 5/17/24 6. Responsible party noted in POC	

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L 052	Continued From page 11 Party (RP), substitute decision maker and emergency contact #1. Physician's orders dated 01/19/24 that 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 in room 106A from (Hospital name). - Warm to touch skin, mass around the mid-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 indicateshigh risk. - Continue current plan of care. A care plan focus area: [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.	L 052	L 052 – (C) Resident #66 – Sufficient Time 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 resident was affected by this practice (**3/3/24).** 3. The DON updated Dressing Change policy to address inaccurate/incomplete entries and requirements to follow physician orders and educated licensed nurses on policy change. **(4/28/24).** Advanced Practices Nurse(s) to make weekly rounds on residents with IVs, ostomies, wound and other conditions and validate orders are implemented as prescribed. Report findings to DON. **5/13/24** 4. Director of Nursing or designee will use data compiled by Advance Practice Nurses to monitor dressing change policy compliance and report outcomes to QAPI monthly x 6 months. **(5/14/24)** 5. Completion Date 5/17/24 6. Responsible party noted in POC	

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L 052	Continued From page 12 A Focused Observation Note dated 01/30/24 at 11:21 PM documented, "complete bed bath given, no new skin issue noted." A Braden Scale for Prediction of Pressure Sore Risk Quarterly Evaluation 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 Skin Observation Tool Assessment on Tuesday, 02/06/24, at 8:20 PM documented, "complete bed bath given, no new skin issue noted." A 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 bed bath given, no new skin issue noted."	L 052		

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L 052	Continued From page 13 A 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 #22 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 every2 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 of her time in bed because she has become frailer. There have been no new issues regarding her care. - Objective: remains a well-developed thin black female, in no acute distress when seen.	L 052		

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L 052	Continued From page 14 There are no new labs available for analysis. - Assessment: continues to do well and remains clinically stable. We will continue withthe current management. A 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 ointment (debridement ointment used on dead tissue) and dry dressing daily." Although the Wound Care Physician documented the treatment plan for Resident #52's stage 3 sacral ulcer, there is no evidence that this was communicated to the resident's primary care physician. A Skin Only Evaluation Note dated 02/29/24 at 4:45 PM documented, "Skin warm & dry, skin color WNL and turgor is normal; no skin issues; complete bed bath given." Review of the February 2024 Treatment Administration Record (TAR) showed that facility staff documented a check mark and their initials to indicate that Resident #52: 1. Received a shower every day shift on Mondays and Fridays and that a licensed nurse validated and ensured that the skin assessment	L 052		

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L 052	Continued From page 15 was completed; 2. Received weekly skin assessments every Friday on the evening shift; and 3. Barrier cream was applied to theresident'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 verbally responsive with intermittent confusionand generalized weakness. - Upon assessment skin is dry and warm to touch. - Resident turned and repositioned every2 hours for comfort and pressure relief. A 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". 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". 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.	L 052		

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L 052	Continued From page 16 - 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 - Notes: Cleanse with Darkins solution, apply Santyl. Cover with dry gauze. A care plan focus area: [Resident #52] has sacral ulcer Stage 2, was initiated on 03/05/24. 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 shortnessof breath. - 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. - A call was placed and spoke with the resident'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. The evidence showed that: 1. Prior to 02/28/24, there was no evidence that facility staff documented that they observed a pressure ulcer/wound or any other skin issues on	L 052		

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L 052	Continued From page 17 Resident #52's sacrum. Subsequently, on 02/28/24, the wound care physician documented an initial observation of the resident's sacrum at a stage III pressure ulcer with moderate drainage, necrotic tissue, and slough. 2. Facility staff failed to have documented evidence that Resident #52's primary care physician was notified on 02/28/24 about the resident's stage III sacral pressure ulcer/wound. As a result, no new orders or interventions were put in place until 03/01/24, over 48 hours later. 3. Facility staff failed to develop a resident centered care plan that addressed Resident #72's stage 3 sacral ulcer. 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	L 052		

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L 052	Continued From page 18 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 (Administrator) and Employee #2 acknowledged the findings. 2) Facility staff failed to ensure that sufficient time was given to ensure that Resident #243 received effective pain assessments/evaluation for a known left hip fracture. According to National Institute of Health (NIH): - Assessment of pain is a critical stepto 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, assessment, and monitoring for all identified residents with pain.	L 052		

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L 052	Continued From page 19 - 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 that directed, "Turn and reposition every 2 hours, every shift." A care plan focus area: [Resident #243] has complaints of acute pain to right hip related to post fall, that was initiated on 07/07/21, had interventions of: administer medication routine	L 052		

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L 052	Continued From page 20 and as needed, as ordered. Evaluate/record/report effectiveness. Monitor and record any complaints of pain: locationfrequency, intensity. Monitor and record any non-verbal signs of pain (guarding, restlessness). Handle gently and try to eliminate any environmentalstimuli. A physician's order dated 08/16/21 that directed, "Tramadol (narcotic pain reliever), 100 mg (milligrams), 1 tablet, twice a day PRN (as needed)" A physician's order dated 08/19/21 that directed "Monitor pain every shift." A physician's order dated 03/23/23 that 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". - Resident pain interview: verbal descriptor scale "severe". A Facility Reported Incident (FRI), DC~11996,	L 052		

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L 052	Continued From page 21 received by the State Agency on 05/29/23 at 6:30 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. - Resident refused to be assessed by the nurse supervisor, she said she will be finebut 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 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" 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 andvascular calcification. Left hip x-ray result 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.	L 052		

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L 052	Continued From page 22 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). The Treatment Administration Record (TAR) showed that on 05/30/23, day 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", 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. 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.	L 052		

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L 052	Continued From page 23 The TAR 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. 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	L 052		

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L 052	Continued From page 24 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 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 proximalfemur	L 052		

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L 052	Continued From page 25 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). The evidence showed that: 1. Facility staff received Resident #243's lefthip and left knee x-ray results on 05/30/23, 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 primary care physician or representative aware of the left hip x-ray result that showed "fracture of the neck of the proximal [left] femur". 2. Facility staff documented in Resident #243's progress notes that she was having pain in her left hip area on 05/30/23, evening shift and night shift, however there was no evidence of an assessment/evaluation of her pain based on the professional standards of practice for a known left hip fracture. 3. 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 primary care physician.	L 052		

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L 052	Continued From page 26 4. Facility staff did not notify the physician of the resident's left hip fracture until 05/31/23, at approximately 10:30 AM, 21 hours later. 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 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, stated, "We don't 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.	L 052		

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L 052	Continued From page 27 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 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 conductedon 03/13/24 at 12:25 PM, Employee #2 acknowledged the findings. 3) Facility staff failed to ensure that sufficient time was given to follow the physician's order to change the central line dressing for Resident #66. 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. - 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:	L 052		

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L 052	Continued From page 28 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 [Hospitalname] 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	L 052		

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L 052	Continued From page 29 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."	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practice registered nurse per Resident per day hours], it was determined that the facility failed to provide a minimum daily average of four	L 056		

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L 056	Continued From page 30 and one-tenth (4.1) hours of direct care per day for 10 of 10 days, and sixth tenths (0.6) Advance practiced registered nurse per Resident per day for 10 of 10 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of the Nurse Staffing was conducted on March 20, 2024, at approximately 10:33 AM. Of the 10 days reviewed, 10 days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day, and 10 days failed to provide a minimum daily average of six-tenths (0.6) hours of an advanced practiced registered nurse asfollows: Hours of Direct Care per resident per day Sunday, March 3, 2024, showed that the facility provided direct nursing care per resident at a rate of 2.75 hours. Monday, March 4, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.11 hours.	L 056	L 056 Staffing 1. Management level nurses assisted with direct care **3/3/24** 2. Care was provided without negative impact on residents. **3/4/24** 3. Recruitment plan under development by corporate Human Resources, Administrator and Director of Nursing to include contractual agreements with CNA training programs and hiring incentives **(4/25/24).** Administrator securing supplemental agency support using 2 agencies licensed in DC to increase RN coverage. **(4/15/24)** 4. Daily HPPD reviews during Clinical meeting by DON with Staffing Coordinator **(3/13/24).** Weekly meetings with DON/HR by Administrator to review progress of recruitment initiatives **(5/2/24).** **5.** Quarterly reporting to QAPI committee to track new hires and turnover rates (**5/14/24 and ongoing).** 6. Title of person(s) responsible noted in POC	

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L 056	Continued From page 31 Tuesday, March 5, 2024, showed that the facility provided direct nursing care per resident at a rate of 2.96 hours. Wednesday, March 6, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.12 hours. Thursday, March 7, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.67 hours. Friday, March 8, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.18 hours. Saturday, March 9, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.12 hours. Sunday, March 10, 2024, showed that the facility provided direct nursing care per resident at a rate of 2.89 hours. Monday, March 11, 2024, showed that the facility provided direct nursing care per resident at a rate of 2.91 hours. Tuesday, March 12, 2024, showed that the facility provided direct nursing care per resident at a rate of 2.72 hours. Hours of Advanced Practice Registered Nurse per resident per day Sunday, March 3, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.17 hours.	L 056		

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L 056	Continued From page 32 Monday, March 4, 2024, showed that thefacility provided advanced practiced registered nurses per resident at a rate of 0.35 hours. Tuesday, March 5, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.26 hours. Wednesday, March 6, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.36 hours. Thursday, March 7, 2024, showed that thefacility provided advanced practiced registered nurses per resident at a rate of 0.47 hours. Friday, March 8, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.57 hours. Saturday, March 9, 2024, showed that thefacility provided advanced practiced registered nurses per resident at a rate of 0.58 hours. Sunday, March 10, 2024, showed that thefacility provided advanced practiced registered nurses per resident at a rate of 0.38 hours. Monday, March 11, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.18 hours. Tuesday, March 12, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.37 hours. A face-to-face interview was conducted with the Staffing Coordinator at the time of the staff review, and she acknowledged the findings.	L 056		

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L 063	Continued From page 33 3212.4 Nursing Facilities A written agreement shall be executed between the facility and any contract agency employed to provide nursing personnel to the facility in compliance with the requirements of this chapter. This Statute is not met as evidenced by: Based on record review and staff interviews, facility staff failed to employ a contract agency to provide nursing personnel in compliance with the requirements of this chapter, as evidenced by the contract agency providing services on an expired District of Columbia business license. 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.	L 063	L063 – Professional Services 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 as 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 month and on-going. **(5/14/24).** 5. Completion date **5/17/24**. 6. Responsible Party noted in POC	

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L 063	Continued From page 34 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." 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.	L 063		
L 076	3215.4 Nursing Facilities As appropriate, ventilator care personnel shall be competent in the following: (a) The fundamentals ofcardiopulmonary physiology and of fluids and electrolytes; (b) The recognition, interpretation and recording of signs and symptoms of respiratory dysfunction and medication side effects, particularly those that require notification of a physician; (c) The initiation and maintenance of cardiopulmonary resuscitation and otherrelated life-support procedures; (d) The mechanics of ventilation and ventilator	L 076		

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L 076	Continued From page 35 function; (e) The principles of airway maintenance, including endotracheal and tracheotomy care; (f) The effective and safe use of equipment for administrative oxygen and other therapeutic gases and providing humidification, nebulization, and medication; (g) Pulmonary function testing and blood gas analysis when these procedures are performed within the ventilator care unit; (h) Methods that assist in the removal of secretions from the bronchial tree, such as hydration, breathing and coughing exercises, postural drainage,therapeutic percussion and vibration, and mechanical clearing of theairway through proper suctioning technique; (i) Procedures and observations to befollowed during and after extubation; and (j) Recognition of and attention to the psychosocial needs of residents andtheir families. This Statute is not met as evidenced by: Based on observations and staff interviews , for two (2) of two (2), oxygen storage rooms, facility staff failed to ensure the effective and safe storage of equipment for administering oxygen. The findings included: According to the Joint Commission: - Storing oxygen cylinders, as per the National	L 076	L076 – Essential Equipment in Safe Operating Condition 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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L 076	Continued From page 36 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 issupposed 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 the 1st floor oxygen storage room withEmployee #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."	L 076		

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L 076	Continued From page 37 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."	L 076		
L 090	3217.5 Nursing Facilities The Infection Control Control Committee shall review infection control policies and procedures annually and revise them as needed. This Statute 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 review their infection control policies and procedures annually and revise them as needed. 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 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)	L 090	L090 – 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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L 090	Continued From page 38 (#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.	L 090		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to 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	L 099		

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L 099	Continued From page 39 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 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	L 099	L099 – 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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L 099	Continued From page 40 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.	L 099	L 099 – Food Procurement, Storage & Preparation (Continued) 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.	
L 199	3231.10 Nursing Facilities Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 41 sampled residents, facility staff failed to accurately document the course of treatment in Resident #72's monthly summary report for December 2023. The findings included: Resident #72 was admitted to the facility on 10/03/22 with diagnoses that included: Pressure	L 199		

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L 199	Continued From page 41 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." 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-tubereplacement. - A call was placed call to non-emergency ambulance and the resident was transferredto [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident returned to unit at 5:10 PMfrom [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.	L 199	L 199 Course of Treatment Documentation 1. Practice involving resident #72 occurred in December 2023. Unable to make correction retroactively. 2. The Director of Nursing audited medical records of residents sent to ER for past quarter (January – March 2024) to determine if documentation accurately reflected visit. All documentation was completed correctly. No other resident was affected by this practice. **4/26/24** 3. Staff Development re-educated nurses on Documentation policy to include accurate documentation of hospitalization and/or ER transfers **5/2/24**. Audit tool was developed by Performance Improvement Director and used to review documentation for accuracy including hospital/ER transfers **(5/13/24).** 4. Audit findings presented to QAPI committee quarterly **5/14/24**. 5. Completion Date **5/17/24** 6. Title of person(s) responsible noted in POC	

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L 199	Continued From page 42 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."	L 199	L201 – Pressure Ulcer Documentation	
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a) The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b) Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c) Medicaid, Medicare and healthinsurance numbers; (d) Social security and other entitlement numbers; (e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f) Date of discharge, and condition on discharge; (g) Hospital discharge summaries or atransfer form from the attending physician; (h) Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j) Rehabilitation potential; (k) Vaccine history, if applicable, and other	L 201	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 will update Resident Assessment-Pressure Injuries policy **by 5/17/24** to include additional routine assessments (i.e., skin sweeps), risk management processes and general interventions to prevent pressure ulcers. Staff Development Nurse 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. **(5/19/24)** 5. Completion Date 5/17/24. 6. Title of person(s) responsible noted in POC.	

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L 201	Continued From page 43 pertinent information about immune status in relation to vaccine preventable disease; (l) Current status of resident's condition; (m) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a statusquo condition; (n) The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p) A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q) The plan of care; (r) Consent forms and advance directives; and (s) A current inventory of the resident'spersonal clothing, belongings and valuables.	L 201		

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L 201	Continued From page 44 This Statute is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 41 sampled residents, facility staff failed to accurately document the stage of Resident #52's sacral pressure ulcer on the comprehensive care plan. The findings included: 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; 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 Wound Care Physician Note dated 03/04/24 at 8:18 AM documented: - Stage 3 sacral decubitus ulcer. Decreased	L 201		

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L 201	Continued From page45 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.	L 201	L204 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.	
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; 7. The statement of the victim; 8. A statement indicating whether there is a pattern of occurrence; and 9. A description of the corrective actiontaken. This Statute is not met as evidenced by: Based on record reviews and staff interviews, for four (4) of 41 sampled residents, facility staff failed to ensure a thorough summary and analysis of each incident was completed immediately, reviewed within 48 hours, and	L 204		

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L 204	Continued From page 46 included interviews and witness statements. Resident 's # 192, 294, 244 and 63. The findings included: 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." 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	L 204		

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L 204	Continued From page 47 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 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	L 204		

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L 204	Continued From page 48 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, 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	L 204		

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L 204	Continued From page 49 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 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. 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	L 204		

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L 204	Continued From page 50 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 "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 amale." 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 stated that the facility leadership has changed, and she was not able to locate any additional	L 204		

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L 204	Continued From page 51 documentation concerning Resident #294's allegation of abuse. 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. 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	L 204		

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L 204	Continued From page 52 staff called 911. - Police officers came at 6:30 PM and searched Resident #63 and her belongings. No guns or any related injurious objects found. - 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 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.	L 204		

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L 204	Continued From page 53 - 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 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."	L 204		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview,facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1)	L 442		

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L 442	Continued From page 54 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 March 11, 2024, at approximately 3:30 PM.	L 442	L442 – Essential Equipment in Safe Operating Condition 1. Dining Director notified Maintenance of equipment repairs needed immediately. Repairs to pellet warmer and 2 burners were completed 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 pellets weekly to ensure that they are in working order and heat temperatures of at least 175°. 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. (5/1/24). Any problems identified will be reported to Maintenance immediately. 4. Safe operating conditions of kitchen equipment will be reported to QAPI Committee quarterly by Dining Director x3 quarters. 5/14/24. 5. Completion Date 5/17/24. 6. Title of person(s) responsible noted in POC.	
L 517	3269.1 Nursing Facilities Each resident in a nursing facility shall have the right to the following: This Statute is not met as evidenced by: Based on observation, record reviews andstaff interviews for two (2) of 41 sampledresidents, facility staff failed to ensure one (1) Resident was free from abuse. Resident #40 and Resident #25 The findings included:	L 517		

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L 517	Continued From page 55 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." 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." 1. The facility staff failed to ensure that Resident #40 was free from physical abuse by Resident #25. 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 nursing station	L 517	L517 Resident Rights 1. 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.** 2. The DON and Director of Performance Improvement reviewed resident documentation for the previous quarter (January-March) and found no indications of resident-to- resident abuse for these or other residents **(4/30/24).** 3. Administrator to develop Investigation Policy to include reporting any allegations of abuse and documentation of incident in resident's record (5/1/24). Staff Development educate all staff including security team on new policy. (5/10/24). Ombudsman to reeducate staff on resident rights **(5/13/24)** IDT team review instances of abuse/ elopement during daily clinical meetings or other indications of violation of residents' rights **(5/10/24)** 4. Report validation results to QAPI monthly. (5/14/24). 5. Completion Date 5/17/24 6. Responsible Party noted in POC	

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L 517	Continued From page 56 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. 1A. Resident #40 was admitted to the facility on 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. A care plan with a focus area of "(Resident #40) has limited physical mobility r/t (related to) seizure disorder" was initiated on 03/04/24, and had the following intervention "The resident is totally dependent on 1-2 staff for locomotion." A care plan with a focus area of "(Resident #40) has a communication problem r/t (related to) Language barrier (Russian)" was initiated on 03/04/24, and had the following interventions "Be conscious of resident position when in groups, activities, dining room to promote proper communication with others, Resident prefers to	L 517		

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L 517	Continued From page 57 communicate in Russian, Ensure/provide a safe environment." 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. 1B. 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: 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 physician's order dated 02/01/24 directed, "Target Behavior: (Wandering). At the end of each shift mark frequency -how often behavior occurred & intensity- how resident responded to redirection, every shift." A care plan with a focus area of "(Resident #25) is at risk for elopement r/t Dementia" initiated on 02/27/24, had the following interventions: "Monitor	L 517		

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L 517	Continued From page 58	L 517		

resident very closely and redirect as needed. Engage resident in activities during the day. Divert resident's attention with preferred activities during the day. Offer diversional activities such as walking with him around the unit, offer food/drink when residents behaviors begin to escalate."

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, "(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.

During a face-to-face interview conducted on 03/05/24 at 3:30 PM, Employee #23 (Registered Nurse) stated that he separated the residents, and he will write a note. In a follow-up telephone interview with Employee #23 he stated, "I saw them (Resident #40 and Resident #25) exchange blows (punches) and I took him (Resident #25) away. I did not call the medical doctor or the representative."

During a face-to-face interview conducted on

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L 517	Continued From page 59 03/07/24 at 2:59 PM, Employee #2 (Director of Nursing) 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)." During a face-to-face interview conducted on 03/07/24 at approximately 3:10 PM, Employee #1 (Administrator) stated that she did not agree with what the surveyors observed (Resident to Resident physical altercation) and presented two (2) staff members who had entered the day room after the incident occurred. During a face-to-face interview conducted on 03/07/24 at approximately 3:23 PM, Employee #28 (Director of Volunteers) stated that she witnessed Resident #25 being redirected but did not see any physical altercation. During a face-to-face interview conducted on 03/07/24 at approximately 3:30 PM, Employee #29 (Hairdresser) stated that she had just brought Resident #40 to the dayroom on 03/05/24 after cutting the residents hair and she did not witness any physical altercation.	L 517		
L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by:	L 534		

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L 534	Continued From page 60 Based on record review and staff interviews,for one (1) of 41 sampled residents, 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). 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 thefacility. - 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. 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	L 534	L534 Bed Hold 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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L 534	Continued From page 61 (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 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	L 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0019	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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L 534	Continued From page 62 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."	L 534		