STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING ______ B. WING ______	C 09/26/2022

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UNIQUE REHABILITATION AND HEALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001

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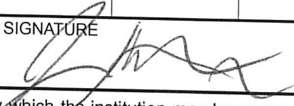
F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility on September 11 - 26, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 208 and survey sample included 63 residents. The following complaints were investigated during this survey: DC00010905, DC00010736, DC00010675, DC00010481, and DC00010174. The following facility reported incidents were investigated during this survey: DC00010969, DC00010848, DC00010824, DC00010782, DC00010732, DC00010730, DC00010702, DC00010683, DC00010641. DC00010624, DC00010380, DC00010317, DC00010299, DC00010302, DC00010242, DC00010241, DC00010228, DC00010223, DC00010212, and DC00010135. Federal and Local deficiencies were cited related to the investigation of: DC00010905, DC00010481, DC00010445, DC00010324, DC00010577, DC00010898, DC00010463, DC00010502, DC00010299, DC00010228, and DC00010223. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities During the survey actual harm level deficiencies were identified at: F600 (Resident #204), F686, and F689 (Resident #3).	F 000		12/5/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE Administrator (X6) DATE 12-01-2022

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

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F 000	Continued from page 1 The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record	F 000		12/5/2022

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F 000	Continued from page 2 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 canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram The following deficiencies are the results of this survey:	F 000	**Unique Rehabilitation and Health Center makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.**	12/5/2022
F 550 SS=D	Resident Rights/Exercise of Rights			

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F 550 — Continued from page 3

CFR(s): 483.10(a)(1)(2)(b)(1)(2)

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

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

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

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her

F 550 — Completion date: 12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

   Resident #193 was assessed by Licensed nurse on 9/20/22. Resident suffered no negative outcomes. Staff was in-serviced upon discovery to ensure that Resident #193's privacy curtain is left closed while receiving personal care including bed baths to maintain dignity and privacy.

   Staff #24 was in-serviced by Staff educator on 9/19/22 to ensure residents maintain privacy and dignity at all times.

   Resident #132 and #158 was assessed by licensed nurse on 9/13/2022 and suffered no negative findings. Resident's room was installed with a stop sign door banner to discourage residents who wander from entering her room. Staff was in-serviced on 11/21/22 by staff educator to ensure frequent checks are in place during resident rounds to prevent other residents to wander in other resident rooms.

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

   All residents have the potential to be affected by this practice. Social Work Director or designee will conduct a house wide audit to ensure that resident privacy and dignity are maintained during bed baths and entering resident rooms. Any negative findings will be corrected upon discovery.
   .

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F 550 Continued from page 4

rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident, and staff interviews, for three (3) of 63 sampled residents, the facility's staff failed to ensure that they were provided dignity and privacy. Residents' #193, #132, and #158.

The findings included:

1. The facility staff failed to ensure that Resident #193 was provided dignity and privacy as evidenced by staff exiting the room and leaving the privacy curtain open while resident was partially naked and receiving a bed bath.

Resident #193 was admitted to the facility on 05/18/22, with multiple diagnoses that included the following: Hemiplegia Affecting Left Nondominant Side, Post Traumatic Stress Disorder and Major Depressive Disorder.

A Quarterly Minimum Data Set (MDS) dated 08/19/22, showed that the facility's staff coded the following: intact cognition; totally dependent for toilet use and personal hygiene requiring 1 staff assist; totally dependent on staff and requiring the support of 2 staff.

05/18/22 [Physician Order] "Shower twice a week per patient request ..."

On 09/19/22 at approximately 10:15 AM,

F 550

3. MEASURE TO PREVENT REOCURRENCE — 12/5/2022

Staff Educator/designee will provide an in-service all Staff on Resident rights including maintaining privacy and dignity completed by 12/5/2022.

During grand rounds, staff will conduct a house wide audit to ensure that resident privacy and dignity are maintained during care and in resident room entries. All negative findings will be corrected upon discovery.

4. MONITORING CORRECTIVE ACTION

Social Work Directors or designee will conduct a house wide audit to ensure that resident privacy and dignity are maintained. This audit will be completed weekly times four (4) and monthly times three (3). Negative findings will be corrected upon discovery. All findings to be reported to the monthly QAPI for further recommendations.

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F 550	Continued from page 5 Resident #193 was observed receiving a bad bath which was performed by two staff. Employee #24 (Certified Nurse Aide) was observed leaving residents bedside and opening the privacy curtain and then exiting the room without closing the privacy curtain while Resident #193 was partially nude in the bed. During a face-to-face interview conducted on 09/19/22 at approximately 11:00 AM, Employee #24 (Certified Nurse Aide) acknowledged the findings and stated, "I was supposed to close the curtain." Cross Reference DCMR - 3269.1d 2. Facility staff failed to ensure that they were provided dignity and privacy to Residents' #132 and #158. The following was observed on unit 3 north on 09/12/22: A. During an interview on 09/12/22 at 2:30 PM with Resident #132, she complained that two men keep coming in and out of her room. When asked if she reported this to staff, she stated, "Yes, I did. They have not done anything about it." During the interview, this surveyor observed two male residents that opened Resident #132's room door, wandered into the door, and then turned around and left out without communicating with the resident. Resident #132 was admitted to the facility on	F 550		12/5/2022

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F 550	Continued from page 6 02/24/22 with multiple diagnoses including: Schizophrenia, Major Depressive Disorder, and Generalized Anxiety Disorder. A review of the Quarterly Minimum Data set [MDS] dated 08/29/22, showed that facility staff coded: cognitively intact. B. During an interview on 09/12/22 at 2:42 PM with Resident #158, she complained that "two men keep coming in and out of my room, they talk nasty to me, I report them they come whenever." When asked if she reported this to staff, she stated "yes, but they have been too busy to see or do anything about it". During the interview, this surveyor observed two male residents that opened Resident #158's room door, wandered into the door, and then turned around and left out without communicating with the resident. Resident #158 was admitted to the facility on 06/30/20 with multiple diagnoses including: Major Depressive Disorder and Generalized Anxiety Disorder. A review of the Annual Minimum Data set [MDS] dated 07/15/22, showed that facility staff coded Resident #158 as cognitively intact. The evidence showed that facility staff failed to ensure resident dignity and respect were maintained because there was no staff on the unit to monitor or keep residents that were wandering in the hallway from entering the resident's room.	F 550		12/5/2022

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F 550	Continued from page 7 During a face-to-face interview conducted on 09/12/22 at 3:15 PM with Employee #28, [CNA] she was observed sitting at the computer at the nursing station. When I asked who was monitoring the residents for privacy, she stated, "I am waiting to be relieved from duty." The employee acknowledged that Residents' #132 and #158 were not being provided with dignity and privacy and made no further comments.			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g) (17) (18) (i)-(v) §483.10(g) (17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g) (17) (i)(A) and (B) of this section. §483.10(g) (18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582	1. **CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS** This deficiency of providing NOMNC to residents affected cannot be retroactively corrected. Resident #202 and resident #253 resident suffered no negative outcomes as a result of this deficiency. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who were discharged from Medicare services have the potential to be affected. Social worker or designee will conduct an audit of all completed NOMNC issued weekly for four weeks, and monthly for 3 months beginning November 10, 2022. Any negative findings will be corrected upon discovery if applicable.	12/5/2022

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F 582 Continued from page 8

and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for two (2) of 63 sampled residents, facility staff failed to ensure that residents or their representatives were provided the Notice of Medicare Non-Coverage (NOMNC) form no later than noon of the day before the effective date listed for discontinuance of skilled services. Residents' #202 and #203.

The findings included:

F 582

3. MEASURE TO PREVENT REOCURRENCE — 12/5/2022

The Director of Social Work or designee will re-educate the Social workers on ensuring that residents or their representatives were provided the Notice of Medicare Non-Coverage (NOMNC) form no later than noon of the day before the effective date listed for discontinuance of skilled services. This will be completed by 12/5/2022.

Discharges and discontinuation of skilled services will be reviewed weekly during the UR meeting with the IDT to ensure that Notice of Medicare Non-Coverage (NOMNC) form is provided no later than noon of the day before the effective date listed for discontinuance of skilled services.

4. MONITORING CORRECTIVE ACTION

Social services director or designee will conduct audits all NOMNC issued weekly for four weeks, and monthly for 3 months beginning November 10, 2022. The results from the reviews and audits will be reviewed in QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated.

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F 582	Continued from page 9	F 582		12/5/2022

Continued from page 9

The "Notice of Medicare Non-Coverage" form stipulates that "...The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily..."

1. Resident #202 was readmitted to the facility on 04/08/22 with diagnoses that included Severe Protein-Calorie Malnutrition and Pneumoconiosis.

Review of Resident #202's NOMNC form showed an effective last day of skilled nursing services was on 06/19/22. The form also showed that facility staff provided Resident #202's legal guardian notification on 06/20/22.

The evidence showed that facility staff failed to ensure that Resident #202' legal guardian was provided the NOMNC form prior to the discontinuance of skilled services.

2. Resident #203 was admitted to the facility on 08/22/22 with diagnoses that included: Dementia, Cognitive Communication Deficit and Hypertension.

Review of Resident #203's NOMNC form showed an effective last day of skilled services was on 09/01/22. The form also showed that facility staff provided Resident #203's representative notification on 09/01/22.

The evidence showed that facility staff failed to ensure that Resident #203's representative was provided the NOMNC form prior to the effective

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F 582	Continued from page 10 date listed for discontinuance of skilled services. During a face-to-face interview conducted on 09/14/22 at 10:41 AM, Employee #5 (Social Worker) reviewed Resident #202 and #203's NOMNC forms and stated, "The protocol is to give at least two days' notice that skilled services are ending so that the resident or their representative have the option to appeal. It doesn't matter if the resident is going home or staying in the facility."			12/5/2022
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1) -(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584	**1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS** Facility Maintenance Director or Designee addressed the following to ensure that housekeeping services were provided to maintain a safe, clean, comfortable environment by cleaning: the identified six ceiling vent covers and replaced identified five stained ceiling tiles upon discovery.	

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F 584

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in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by ceiling vent covers that were soiled throughout on six (6) of eight (8) resident care units, and ceiling tiles that were stained on five (5) of eight resident care units.

The findings included:

During an environmental walkthrough of the facility on September 12, 2022, between 10:00 AM and 1:00 PM the following were observed:

1. Ceiling vent covers were soiled with dust in common areas including:

Three (3) of five (5) in the hallway on 4 South
Three (3) of three (3) in the hallway on 4 North
Four (4) of four (4) in the hallway on 3 South
Seven (7) of seven (7) in the dayroom on 3 South

F 584 — Completion date: 12/5/2022

2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED

No residents were found to have been adversely affected. Maintenance director performed a house wide audit of all ceiling tiles and ceiling vent covers on 11/21/22. No other issues were identified. Any additional issues if found will be corrected upon discovery.
.

3. MEASURE TO PREVENT REOCURRENCE

The Maintenance Director or Designee will re-educate the maintenance associates on conducting rounds to ensure that the ceiling tiles and vents covers are clean to maintain a safe, clean, comfortable environment for the residents by 12/5/2022.

Maintenance Director, will perform a House wide audit, monthly of all ceiling tiles and vents covers. All negative findings will be corrected upon discovery.

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F 584	Continued from page 12 Three (3) of three (3) in the hallway on 3 North Four (4) of five (5) in the Rehab Department on 3 North One (1) of two (1) in the dayroom on 3 North One (1) of two (2) in the hallway on 2 South One (1) of one (1) in the dayroom on 2 South One (1) of one (1) in the hallway on 1 South 2. Ceiling tiles were stained in common areas including: Two (2) in the dining room on 4 North One (1) in the hallway on 4 North Five (5) in the hallway on 4 South Two (2) in the hallway on 2 South One (1) in the hallway on 2 North One (1) in the hallway on 1 South These findings were acknowledged by Employee #15 on September 12, 2022, at approximately 4:00 PM.	F 584	**4. MONITORING CORRECTIVE ACTION** Maintenance Director, will perform a full house wide audit and then monthly of all ceiling tiles and vents covers x 3 months. The results from the observations and rounds will be reviewed during the monthly QAPI meeting and then re-evaluated to determine if further monitoring is indicated.	12/5/2022
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

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F 600	Continued from page 13 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to provide Resident #204 with the necessary care and required services to meet the resident's needs subsequently, resulting in a negative physical outcome, multiple pressure ulcers first observed at advanced stages. These failures resulted in actual harm to Resident #204 when the resident obtained facility acquired ulcers. The findings included: Review of a Complaint, DC00010905, received by the State Agency on 07/29/22 revealed allegations that the facility failed to provide the proper to Resident #204. The complaint alleged the resident was neglected and sustained significant physical injuries over an unknown period which resulted in hospitalization. Medical record review indicated Resident #204 was admitted to the facility on 04/21/16 with multiple diagnoses that included: Mild Protein-Calorie Malnutrition, Dementia, Altered Mental Status, Muscle Weakness and Osteoporosis. Review of physician orders revealed: -07/14/21, "Monitor skin for easy bruising (EB), bleeding (B), Skin Discoloration (SD), None (N) every shift and alert MD with any changes, Resident on Aspirin (blood thinner) EC (enteric coated) daily."	F 600	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #204 is discharged on 7/23/22. This deficiency cannot be retroactively corrected and resident cannot be reassessed. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. House wide skin sweep assessments were completed on 11/16/22 on all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep.	12/5/2022

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F 600	Continued from page 14 -08/26/21, "Provide incontinent care with each incontinent episode. Wash peri area with soap and water, pat dry and apply barrier cream every shift and as needed." Review of the facility's "Wound/Pressure Ulcer Management" policy, revised on 10/01/21 showed, "... Any alteration in skin integrity will be reported to the physician immediately..." Review of the facility's "Wound Prevention Program" policy (not dated) showed, "...Weekly skin checks will be conducted by the license nurse. This will be documented in the resident's Electronic Medical Record (EMR). Daily, during routine care, the Certified Nursing Assistant will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse..." Review of the facility's "Treatment/Services to Prevent/Heal Pressure" policy (not dated) showed, "... The facility will ensure that ... a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers ... a resident with pressure ulcers receive necessary treatment and services ... to promote healing, prevent infection and prevent e ulcers from developing ... the nurse will notify the physician anytime the pressure sore is showing signs of non-healing or infection ..." Per a 03/03/22 physician's order, Resident #204 was to have a "Shower twice a week on Monday and Wednesday and per patient request..." This order was discontinued on 4/20/22. An Annual Minimum Data Set (MDS) dated	F 600	**3. MEASURE TO PREVENT REOCURRENCE:** The licensed nurses will complete a skin assessment upon admission and the wound nurse/designee will complete a thorough skin assessment within 24-48 post-admission and validate all impaired areas were documented and treatments are ordered and care plan is initiated. Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place. Education will be completed by 12/5/2022. Staff Educator/Designee will conduct in-service/education to all licensed nurses on their responsibility regarding monitoring the nursing assistants to ensure showers are being given and skin assessment completed timely for residents and turning, and positioning is properly implemented per physician orders. Completed by 12/5/22. Staff Educator/Designee will conduct an in-service/education to all licensed nurse and certified nursing assistants to ensure that documentation on bath and shower sheets and skin assessments accurately reflect the resident's condition. This will be completed by 12/5/2022	12/5/2022

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04/13/22, showed that facility staff coded Resident #204 as having severe cognitive impairment; requiring total dependence with one to -two persons' physical assist for bed mobility and transfers; extensive assistance with one-person physical assist for toilet use and personal hygiene; frequently incontinent of urine and bowel; active diagnoses of Anemia; no significant weight loss; at risk for pressure ulcers; and no pressure ulcers, wounds or other skin problems.

1a. Skin area #1- right foot:

04/18/22 at 4:28 PM "Nurses Note ...Skin warm to touch and no new skin issues noted. Continued to require total care with all ADL (activities of daily living) cares. Turned and repositioned for pressure relief ..."

04/19/22 at 5:14 PM "Skin Observation Tool (Licensed Nurse) ... skin is intact, warm and well lubricated. No wound;"

04/20/22 [Treatment Administration Record (TAR)] facility staff documented, "yes", a check mark (meaning administered), and initialed to indicate that a shower was completed;

04/20/22 [physician's order] "Skin Assessment weekly on shower day by license nurse every day shift every Thu (Thursday);"

04/20/22 [physician's order] "Shower twice a week and per patient request every day shift every Thu, Sat (Saturday);"

04/21/22 (Thursday) [Shower/Bath Shower] " ...12 (skin intact/no irritation); complete bed bath;"

4. MONITORING CORRECTIVE ACTION
Unit Managers/Designee will conduct a weekly skin assessment ongoing and conduct a bath and shower sheet audit weekly x 4, then monthly x 3 to ensure that these are completed timely and accurately. All negative findings will be addressed upon discovery. Findings will be brought to QAPI monthly for recommendations and review.

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04/21/22 treatment administration record [TAR] - facility staff initialed to indicate that the weekly skin assessment was completed;

04/22/22 at 7:34 PM "Social Services Note ... IDT (interdisciplinary team) meeting was held ... No sig. (significant) changes to report resident is stable."

A care plan with a review date of 4/22/22 documented the following:

-Focus area "[Resident #204] has an ADL self-care performance deficit r/t (related to) impaired balance and other conditions" ..."Provide incontinent care with each incontinent episode. Wash peri area with soap and water,pat dry and apply barrier cream every shift and as needed. The resident requires assistance by staff with bathing/showering routinely and as necessary ...The resident requires assistance by staff for toileting."

-Focus area, "[Resident #204] has bladder and bowel incontinence r/t deconditioning" ... "Apply moisture barrier cream to skin after each incontinent care...Report any signs of skin breakdown."

-Focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" ... "Keep skin clean and dry. Use lotion on dry skin. Provide incontinent care routinely and as needed."

-Focus area, "[Resident #204] is at risk for pressure ulcer development r/t immobility" ... "...administer medications as ordered ... administer treatments as ordered ...

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assess/record/monitor wound healing every shift ... report improvements and declines to the "D."

On Resident #204's 04/23/22 treatment administration record (TAR) facility staff documented "yes", a check mark, and initialed to indicate that a shower was completed.

The 04/23/22 (Saturday) [Shower/Bath Sheet] documented "...complete bed bath," however there was no licensed nurse signature on the form.

The 04/26/22 at 11:29 AM Skin Observation Tool" from the Licensed Nurse documented "...No new skin issues noted."

Review of the April 2022 TAR from 04/01/22 to 04/28/22, showed that facility staff documented "N", meaning no or none, in the area that directed", "Monitor skin for easy bruising, bleeding, skin discoloration ...every shift and alert MD (medical doctor) with any changes. Staff also documented no refusal of care behaviors and that the resident was turned and repositioned every two hours.

A 04/28/22 at 4:56 PM Podiatry Note documented, "...Patient is seen bedside for thick, elongated toenails and wound right foot ... Skin: Distal aspect of right hallux with noted sanguineous (sp) scab and eschar (dead tissue) to distal aspect, noted purulence and deep probing sinus ... distal aspect of right 5th toe with noted dry sanguineous scab and eschar to distal aspect
... recommend vascular consult to evaluate for healing potential. Ulcer right 5th toe. Dry eschar right 5th toe ... Ulcer right Hallux. Pain right

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tolerance. Noted deep probing and purulence during exam ...Recommend starting antibiotics. Please obtain labs: CBC (complete blood count) with Diff (differential), CMP (complete metabolic panel), ESR (erythrocyte sedimentation rate). Please obtain x-rays of right foot to rule out osteomyelitis of right hallux."

04/29/22 at 9:23 AM "Tissue Analytics ... Right heel ...Length: 2.45 cm; width: 2.67 cm; Wound acquired 4/29/22; [percent] epithelialization 100.00; Stat-s - new; Acquired in house? Yes; Etiology- pressure ulcer - Suspected DTI (deep tissue injury) ...Dressing change frequency - daily, dressings- skin prep.."

04/29/22 at 1:55 PM "Tissue Analytics Right great toe ... Length: 1.40 cm, width: 1.60 cm; Wound Acquired 4/28/22, [percent] slough/eschar 100.00 ...Stat-s - New; Acquired in House? Yes; Etiology Arterial ...Dressing change frequency BID (twice a day), cleanse wound with- Normal Saline, dressing- Betadine."

A 04/29/22 at 10:20 AM Situation Background Assessment Request (SBAR) communication form documented the following: Situation: skin areas on right great toe red right heel. Date problem or symptom started: 04/29/2022 ... resident had podiatry foot care at the bed side and then was observed with a right arterial area to the right great toe. Reddened area to the right heel. Skin intact. MD and RP (representative) aware. Treatment order in placed."

A 04/29/22 at 11:10 AM late entry note indicated", "Nurses Note Late Entry ... Resident had Podiatry foot care at the bedside on 4/28/22 and a right great toe ulcer was observed after the podiatry

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care and Resident has reddened right heel, skin is intact. Responsible party... was made aware. No indication of pain. Right heel elevated on a pillow."

The medical record contained wound notes stating:

-04/29/22 at 2:18 PM "Skin/Wound Note... Comprehensive skin and wound evaluation for consult: right heel, right great toe... Dermatologic - wound(s) present...Right heel DTI. Right great toe arterial ulcer...Patient seen by podiatry 4/28/22. Per podiatry, recommend vascular consultation to evaluate healing potential, recommend x-ray of right foot to rule out osteomyelitis of right hallux".."

-04/29/22 at 2:21 PM "Skin/Wound Note Late Entry... MD, R/P... made aware of resident's right heel wound and right great toe (podiatry-caused) wound. Nursing staff aware."

The physician gave orders related to these areas on 05/2/22 to request the following:

-05/02/22, "Right great toe surgical site- Paint with Betadine (antiseptic) and secure with bordered gauze twice daily every day and evening shift for wound healing;" and,

-05/02/22, "Right heel D-I - Apply Skin prep and leave open to air daily every day shift for wound healing." This order was discontinued on 5/9/22.

Although the Tissue Analytics documented dressing orders on 4/29/22, there were no physician orders documented until '05/02/22, 4 days later. Furthermore, there was no

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documented evidence that licensed nursing staff performed dressing changes during those 4 days.

Resident #204's care plan was updated on 5/4/22 to show the following:

-focus area, "[Resident #204] has a right great [toe] wound related to arterial insufficiency" initiated on 05/04/22 showed"...Administer treatment per physician orders. Notify physician and family/responsible party of skin condition."

-focus area, "[Resident #204] has right heel [DTI]" initiated on 05/04/22 showed, "...Apply skin moisturizers to skin as needed. Apply skin prep as ordered. Offload right heel with wedge/cushion foam as ordered."

The podiatrist documented on 05/05/22 at 6:02 PM... follow-up wound right foot ... Bandage to right heel left intact, deferred to wound care. Distal aspect of right hallux with noted eschar to distal aspect, noted scant purulence however improved since last exam ...distal aspect of right 5th toe with noted dry sanguineous scab and eschar to distal aspect ... recommend vascular to evaluate for healing potential (ordered) ...Discussed with charge nurse as concern for deep infection ... Consider antibiotics pending labs. Please obtain labs ... order has been placed. Please obtain X-rays of right foot to rule out osteomyelitis of right hallux (noted order has been placed)."

Subsequent physician orders revealed:

-05/05/22 [physician's order] "CBC (complete blood count) with Diff (differential), ESR (erythrocyte sedimentation rate), CRP (c-reactive

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protein) next lab day,"

-05/05/22 [physician's order] "X rays 3 views of right foot to r/o (rule out) osteomyelitis- deep wound, pain, physical limitation one time only,"

-05/05/22 [physician's order] "Consult for vascular evaluation for healing potential..."

It should be noted that these treatments were recommended on 04/28/22, however the physician's order was not placed until 05/05/22, 8 days later.

The orders were completed, and the results were:

-05/07/22 at 10:23 PM "Radiology Results Note...Date of Test: 5/6/2022. Type of Test: Right foot, complete, 3+ views ... Findings ... No evidence of osteomyelitis..."

-05/24/22 "Report of Consultation ... Vascular consult for wound healing potential ... findings: dry stable gangrene of r (right) hallux ... Diagnosis: toe gangrene ..."

-06/08/22 at 10:04 PM "Laboratory Note Results. Date of test: 6/8/2022. Type of test ... CBC W/Diff ... Actions/New Orders: Waiting for doctor's review ..."

Although it was ordered on 05/05/22, the labs were not obtained until 06/08/22, 34 days later.

The Nurse Practitioner documented on 06/09/22 at 1:04 PM, " ...Labs and medications reviewed."

For Resident #204's right foot, the evidence mentioned above revealed that although facility

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staff documented to implementing the interventions for Resident #204 from 04/01/22 to 04/27/22, the resident was first observed with a right great toe wound at 100 percent eschar and a right 5th toe wound at 30 percent eschar on 04/28/22. Facility staff failed to have a doctor's order for dressing changes to the right foot for 4 days and failed to obtain ordered labs in a timely manner.

1b. Skin area #2- sacrum:

06/28/22 at 9:30 AM "Skin Observation Tool (Licensed Nurse) ... Site: Right heel. Type -pressure, length 3.79cm, width-4.58cm, depth, 0.0cm, stage -Suspected Deep Tissue Injury; R. (right) great toe site - type - arterial, length-1.28cm, width-0.71cm, depth -0.0cm, Stage-N/A. Resident has treatment orders for the sites and is followed by the wound team."

06/29/22 at 12:26 AM "Nurses Note ... Resident is stable and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact on right heel and right great toe. No drainage noted. Paint with Betadine prep on right great toe in this shift. Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. Extensive assist for ADL care provided ..."

06/30/22 at 3:25 PM "Nurses Note ... Resident is alert and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact, no drainage and

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F 600	Continued from page 23 redness noted, ADLS and oral hygiene provided by staff ..." 06/30/22 (Thursday) [Shower/Bath Sheet] " ...12 (skin intact/no irritation)"; "condition of skin" section was left blank; "complete bed bath given". 07/01/22 at 8:02 AM "Nurses Note ...skin remain unchanged dry and warm to touch ...Turned and repositioned every two hours... Right heel and right great toe wound dressing intact ..." 07/02/22 [Shower/Bath Sheet] "condition of skin" section showed facility staff documented a line and "12", indicating skin intact/no irritation and "bed bath" 07/02/22 at 11:40 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact on right heel and right great toe ...Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. Extensive assist for ADL care provided ..." 07/03/22 at 7:43 AM "Nurses Note... Turned and repositioned every two hours. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact..." 07/03/22 at 3:35 PM "Nurses Note...skin dry and warm to touch...Right heel and right big toe wound dressing is changed...ADL provided by staff." 07/03/22 at 11:35 PM "Nurses Note ...Skin is warm to touch, well moisturized. No skin bruising,	F 600		12/5/2022

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F 600	Continued from page 24 bleeding noted. Continue monitoring skin wound on right foot. Changed wound dressing on right heel and right great toe ...Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. The pressure ulcer is a little wider in the resident's coccyx area. Dressing done..." There was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the licensed staff on 07/03/22. 07/04/22 at 1:57 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, No skin bruising and bleeding noted ... Right heel and right great toe wound dressing intact ..." Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" showed, " ...07/04/22 IDT meeting held. Care plan reviewed and updated ...Patient has an actual wound/sacral DTI." Although it was discussed at the care plan meeting, there was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the IDT on 07/04/22. 07/05/22 at 10:44 PM "SBAR...Communication Tool... Situation Pressure ulcer on coccyx, approx. 10cm*10cm*0.2...Date problem or symptom started 7/3/2022... Identify whether the problem/symptom has gotten worse/better/stayed the same since it started- Worse... Pressure ulcer	F 600		12/5/2022

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F 600	Continued from page 25	F 600		12/5/2022

of coccyx area got wider and worse...Assessment: In my opinion, residents need active pressure ulcer treatment and care ..."

The above SBAR showed that the licensed nurse completing the form listed her own name under the section "person contacted".

07/05/22 at 11:09 PM "Nurses Note...Continue monitoring skin wound on right foot and coccyx area. Wound dressing intact on right heel and right great toe ...The pressure ulcer of coccyx area is wider and worse. Approx. 10cm*10cm*0.2, drainage noted. Dressing changed. I notified to Dr. (doctor) about resident's condition via SBAR..."

Review of the July 2022 TAR from 07/01/22 to 07/05/22, showed that facility staff documented: "N", meaning no or none, in the area that directed, "Monitor skin for easy bruising, bleeding, skin discoloration ...every shift and alert MD with any changes"; no refusal of care behaviors; a check mark, and initials to indicate that incontinent care was provided with barrier cream applied to peri area every shift; and that the resident was turned and repositioned every two hours, every shift.

From 07/03/22 to 07/05/22 (3 days), there was no documented evidence facility staff notified the physician or requested any intervention for Resident #204's sacral area.

07/06/22 at 3:30 PM "SBAR...Communication Tool... Situation suspected DTI on the sacral ... Date problem/symptom started 07/06/2022 ...Person contacted ... son [RP] ... Provider visit [medical doctor's name] ..."

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07/06/22 at 5:04 PM "Skin Observation Tool (Licensed Nurse) ... Site: sacrum. Type- pressure, length- 9.0cm, width-12.0cm, depth-0.0cm, stage- suspected deep tissue injury. Resident has a new area to the sacrum suspected DTI. Thin. Frail skin. Pressure relief mattress. Treatment order in place. Repositioning every 2 hours. Labs and Dietary consult."

07/06/22 [physician's order] "Sacral Wound: Cleanse with normal saline solution; pat dry, apply silver alginate on wound bed and secure with borded (sp) gauge daily and PRN every day shift for skin care" (discontinued 07/08/22)

Care plan focus area, "[Resident #204] has a new wound site DTI on the sacrum, fragile, thin skin" initiated on 07/06/22 showed, "Monitor/document wound... Notify physician as indicated. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of infection ..."

07/07/22 at 11:22 AM "Tissue Analytics ... Location; sacrum; length 10.80 cm; width 9.48 cm; depth 0.10 cm ... Date wound acquired 7/6/22; [percent] slough/eschar 30.00; Wound status - new; acquired in house? Yes ..."

For Resident #204's sacrum area, the above evidence revealed that facility staff failed to: accurately assess, document on the resident's skin on 07/03/22 and report signs of worsening skin breakdown. Additionally, facility staff failed to notify the physician for 3 days after the sacrum wound was first documented as "wider." Subsequently, when seen by the wound Nurse Practitioner on 07/07/22, the sacral area

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measured 10.80 cm by 9.48 cm by 0.10 cm deep with 30% eschar.

During a face-to-face interview on 09/15/22 at 3:25 PM, Employee #2 (Director of Nursing/DON) reviewed the shower/bath sheets for Resident #204 and stated, "When the CNA (Certified Nurse Aide) is giving the resident a shower or bath, the nurse is to go in to do the head-to-toe skin assessment with the CNA present. The nurse documents what she sees and they both [CNA and nurse] sign the bath sheet. The Condition of Skin section should always be completed. It documents the resident's current wounds or skin issues and anything new that is noted. If the resident refuses the shower, bath or skin assessment, it is documented on the form, the progress note and the MD and RP are notified."

During a telephone interview on 09/15/22 at 4:34 PM, Employee #6 (Podiatrist) stated, "I saw [Resident #204] in April (2022) as part of regular podiatry services at the facility done every Thursday. I noted a dry, stable, eschar wound on the right 5th toe and a dry, eschar area near the right big toe. I started to debride the area [right big toe] and pus just started coming out. The nurse was in there with me. I wrote the recommendations [labs, x-ray, and ultrasound] in my note. When I came in on May 5th (2022), I saw that none of the recommendations were followed, so I wrote them again and they were finally ordered."

During a face-to-face interview conducted on 09/16/22 at 9:32 AM, Employee #7 (Staff Educator/1 north Unit Manager) reviewed the progress notes and licensed skin assessments for Resident #204 for April 2022 and stated,

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F 600	Continued from page 28 "Looking at the resident's feet is part of the skin assessment. [Resident #204] started getting the wounds on her right foot treated after she was seen by the podiatrist. The staff [nurses and CNAs] did not mention to me that they observed any skin issues on [Resident #204's] feet." Employee #7 then reviewed the July 2022 progress notes and the 07/05/22 SBAR for Resident #204 and stated, "The staff documented to doing skin assessments but there's no mention of anything being on her sacrum area until July 3rd [2022]. Whoever first notices the change in the skin is the one who makes the doctor and family aware. The nurses know to notify the doctor immediately for any changes and to document it in the progress notes. This SBAR [dated 07/05/22] was not done properly. Another one was done on the 6th [07/06/22] where the family and doctor were notified."	F 600		12/5/2022
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1) -(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, for three (3) of 63 sampled residents,	F 607		

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Continued from page 29

facility staff failed to implement its abuse policies and procedures. Residents' #505, #148, and #191.

The findings included:

Review of the facility's policy entitled, "Prohibition of Abuse" revised 02/2022, read: "...Policy: Sexual abuse is non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault. Procedure ...E. Protection ...3. In the case of a resident abusing another resident, the facility will separate the resident (s) as appropriate during the investigation ...F. Reporting 1. All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health [State Agency] via the Event Reporting System electronically ...within two (2) hours if serious bodily injury occurred or there is an allegation of abuse..."

Review of the facility's policy entitled "Dealing with Combative Resident" revised 07/01/2022, documented, " ...In case of physical altercation, resident to resident, resident to staff and staff to resident, supervisor or the designee will call and file a complaint with Metropolitan Police Department (MPD) ...."

1. Facility staff failed to separate Resident #505 and Resident #148 during an investigation of a resident-to-resident altercation and failed to call or file a complaint with the Metropolitan Police Department.

On 09/06/22 at 7:42 PM the facility submitted a

F 607

12/5/20/22

1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS

Resident #505 was assessed head to toe by licensed nurse on 9/28/22. Resident suffered no negative outcomes. Resident #505 was moved on 9/14/22 to ensure resident safety.

Resident #148 was moved on 9/12/22 to ensure resident safety. Resident #148 was discharged on 9/27/22. The resident cannot be assessed retroactively.

Resident #191 was separated from Resident #148 to ensure resident safety. Resident #191 was assessed head to toe on 9/20/22 by licensed nurse. Resident suffered no negative outcomes.

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F 607	Continued from page 30 Department of Health (DOH) Complaint/ Incident Report Form that documented the following: “Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ... Victim ... [Resident #148] ... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...At about 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room to [Resident #148's room] ...he pushed sitter in the stomach and pushed [Resident #148] down to the floor while she was coming out of her bathroom...." 1A. Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Schizoaffective Disorder, Dementia with Behavioral Disturbance, Altered Mental Status, Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. Review of Resident #505 medical record revealed the following: An Admission Minimum Data Set (MDS) dated 09/02/22 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of others. 09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive r/t (related to) Dementia...Goal: [Resident #505] will not harm self or others...Interventions: Modify environment..." 09/03/22 [Physician Order]: "Resident on 1:1	F 607	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTE** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months (May 2022 to October 2022) to ensure the facility implemented it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. Any negative findings will be corrected upon discovery if applicable. This will be completed by 12/5/22.	12/5/2022

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F 607	Continued from page 31 Nursing Supervision for Elopement and Fall Risk every shift ..." SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..." 1B. Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling. Review of Resident #148's medical record revealed: An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing. 09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR] documented, "... [Resident #148], was pushed by another resident to the floor with no injury ...complained of lower back pain, [with a pain rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..." 09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further evaluation of rib pain."	F 607	**3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership to ensure the facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. This will be completed by 12/5/22. Incidents and accidents are discussed during the clinical meetings to ensure that facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner. Any negative findings will be corrected upon discovery if applicable.	12/5/2022

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F 607	Continued from page 32 Review of the facility's alpha census on 09/20/22 showed that Resident #505 and Resident #148 remained on the same unit after the incident. The above evidence showed that facility staff failed to implement it's "Prohibition of Abuse" by failure to separate the residents and failed to implement it's "Dealing with Combative Resident" policy by failing to call and file a complaint with Metropolitan Police Department (MPD) after the incident. During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police." He added that Resident #505 remained on 1:1 monitoring, but both residents remained on the same unit until their quarantine periods were over. Cross Reference DCMR 3232.5 2. Facility staff failed to follow its policy evidenced by failure to report Resident #191's allegation of abuse [sexual] to the state Department in a timely manner.	F 607	**4. MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months (May 2022 to October 2022) to ensure the facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and reporting of allegation of abuse [sexual] to the applicable authorities in a timely manner, weekly for four weeks and monthly for three months. Results of finding will be forward to QAPI for review and recommendations.	12/5/2022

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F 607	Continued from page 33 Resident #191 was admitted to the facility on 06/09/21 with multiple diagnoses including Depressive Disorder, Anxiety Disorder, Schizoaffective Disorder, Hyperlipidemia, Hypertension Diabetes Mellitus, Anemia, and Chronic Renal Disease. During a face-to-face interview conducted with Resident #191on 09/12/22 at 2:00 PM, when asked about being abused she stated, "My roommate came to my bed at night, take my blanket off, try to have sex with me. I reported her and call the police on her." Review of the DOH Complaint/Incident Report form showed facility submitted it to the state agency on: 08/10/22 at 10:23 AM documented, "[Resident name] ... admitted on 06/09/2021with a Brief Interview for Mental Status (BIMS) summary score of 15...Resident verbalized that during night shift of 08/09/22 that, "My roommate was making sexual request towards me. She called the police who then called the charge nurse and upon initial investigation, roommate was soundly asleep at the time of report and police therefore decided not to continue the investigation. Both resident assessments done and benign at this time Resident were separated and [Resident name] is in room alone, investigation in progress, final report to follow." Review of the Situation, Background, Assessment, Result Form signed and dated on 08/09/22 by Employee #2 [Director of Nursing] showed, "... at approximately 3 AM, received call from police department about resident reported to them that room-mate had made sexual request[s] to her. Writer put police female police on hold to find out what is going on ...writers ' findings to	F 607		12/5/2022

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F 607	Continued from page 34 police, is room-mate was fast asleep and not aware of what patient was talking about. Then the police said okay "Thanks". Writer upon assessment to resident, she denied pain, skin intact with no new skin issues noted, vital signs stable and recorded." The evidence showed the alleged sexual abuse was reported to the night charge nurse on 08/09/22 at 3:00 AM by a phone call from the police who call[ed] the facility. The DOH Complaint/Incident Report form was submitted on: 08/10/2022 at 10:23 AM, 28 hours later, instead of within 2 hours for an allegation of abuse [sexual abuse]. A face-to-face interview was conducted with Employee #2 [DON], on 9/23/22 at 3:00 PM concerning reporting alleged abuse on time to the state agency, she acknowledged the findings. Cross Reference DCMR 3232.4	F 607		12/5/2022
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the	F 608		

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F 608	Continued from page 35 State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews, for two (2) of 63 sampled residents, facility staff failed to report a reasonable suspicious crime (physical assault of one resident to another) to the appropriate law enforcement entity. Residents' #505 and #148. The findings included: Review of the facility's policy entitled "Dealing with Combative Resident revised 07/01/2022, documented, " ...In case of physical altercation, resident -to- resident, resident- to- staff and staff-to- resident, supervisor or the designee will call and file a complaint with Metropolitan Police Department (MPD) ...." Resident #505 Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included:	F 608	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #505 was assessed head to toe by licensed nurse on 9/28/22. Resident suffered no negative outcomes. Resident #505 was moved on 9/14/22 to ensure resident safety. Resident #148 was moved on 9/12/22 to ensure resident safety. Resident #148 was discharged on 9/27/22. The resident cannot be assessed retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022 to ensure the facility implemented it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and to report a reasonable suspicious crime (physical assault of one resident to another) to the appropriate law enforcement entity. Any negative findings will be corrected upon discovery if applicable. This will be completed by 12/5/22.	12/5/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING ______ B. WING ______	C 09/26/2022

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F 608

Continued from page 36

Schizoaffective Disorder, Dementia with Behavioral Disturbance, Altered Mental Status, Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation.

On 09/06/22 at 7:42 PM the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: “Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ...Victim ...[Resident [#148] ... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...At about 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room to [Resident #148's room] ...he pushed sitter in the stomach and pushed [Resident #148] down to the floor while she was coming out of her bathroom ...."

Review of Resident #505 medical record revealed the following:

An Admission Minimum Data Set (MDS) dated 09/02/22 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of others.

09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive r/t (related to) Dementia...Goal: [Resident #505] will not harm self or others...Interventions: Modify environment..."

09/03/22 [Physician Order]: "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk

F 608

3. **MEASURE TO PREVENT REOCURRENCE**

Education/ Designee will in-service all staff and leadership to ensure the facility implements it's "Prohibition of Abuse Policy”, "Dealing with Combative Resident Policy”, and report a reasonable suspicious crime (physical assault of one resident to another) to the appropriate law enforcement entity in a timely manner.
This will be completed by 12/5/22.

Incidents and accidents are discussed during the clinical meetings and risk management meeting to ensure that facility implements it's "Prohibition of Abuse Policy”, "Dealing with Combative Resident Policy”, report a reasonable suspicious crime (physical assault of one resident to another) to the appropriate law enforcement entity in a timely manner.
Any negative findings will be corrected upon discovery if applicable.

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F 608	Continued from page 37 every shift ..." SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..." Resident #148 Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling. Review of Resident #148's medical record revealed: An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing. 09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR] documented, "... [Resident #148], was pushed by another resident to the floor with no injury ...complained of lower back pain, [with a pain rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..." 09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further	F 608	**4. MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements it's "Prohibition of Abuse Policy", "Dealing with Combative Resident Policy", and report a reasonable suspicious crime (physical assault of one resident to another) to the appropriate law enforcement entity in a timely manner. weekly for four (4) weeks and monthly for three (3) months. Results of finding will be forward to QAPI for review and recommendations.	

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F 608	Continued from page 38 evaluation of rib pain." The above evidence showed that facility staff failed to call and file a complaint with Metropolitan Police Department (MPD) after the incident. During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police."	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		

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F 609	Continued from page 39 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for three (3) of 63 sampled residents the facility staff failed to: report an incident of alleged staff of resident abuse/mistreatment the State Agency; report an unusual incident in which a resident was found unresponsive after going into the facility's courtyard; and report the results of its investigation of one resident's allegation of staff verbal abuse and violation of dignity. Residents' #193, #53, and #403. The findings included: Review of the facility's policy titled "Prohibition of Abuse" revised on 02/22, stated "...Anyone who has knowledge of any kind of abuse should report immediately to their immediate Supervisor. During the Weekend Administrator or Manager on Duty ... or in his/her absence, the Nursing Supervisor or his/her designee. Staff will complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee. ...All alleged violations,	F 609	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #53 was assessed head to toe on 9/20/22 by the licensed nurse. Resident suffered no negative outcomes. Resident #193 was assessed head to toe on 9/13/22 by the licensed nurse with no negative outcomes. The incident of alleged abuse was reported on 9/13/22 to the proper authorities. Upon discovery, alleged staff member was separated from Resident #193 to ensure resident safety. Resident #403 was discharged on 11/26/21. The resident cannot be assessed retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements its policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner.	

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F 609	Continued from page 40 the administrator, Director of Nursing or designee shall notify the Department of Health, via the Event Reporting System electronically or by phone in the event the electronic system being unavailable within twenty-four (24) hours of knowledge of the alleged incident and within two (2) hours if serious bodily injury has occurred or there is an allegation of abuse..." 1. The facility's staff failed to report an incident of alleged abuse that Resident #193 made to staff to the State Agency. Resident #193 was admitted to the facility on 05/18/22, with multiple diagnoses that included the following: Diabetes Mellitus Without Complications Type 2, Hemiplegia Affecting Left Nondominant Side, Post Traumatic Stress Disorder and Major Depressive Disorder. An observation and resident interview were conducted on 09/13/22 at 3:00 PM, with Resident #193, he stated "An aide gets angry with me in the morning because I have diarrhea, she told me she is not going to change me in the morning. While in the room she talks loud on her phone and curses and uses explicit language." Resident #193 went on to explain that the aide was in the room with another staff who he said was from "speech" (Speech language pathologist) and the other staff observed what occurred. Review of the medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 08/19/22, showed that the facility's staff coded the following: intact cognition; totally dependent for toilet use and personal hygiene requiring one (1)	F 609	**3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership to ensure the facility implements its policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. This will be completed by 12/5/22. Incidents and accidents are discussed during the clinical meetings to ensure the facility implements its policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Any negative findings will be corrected upon discovery if applicable.	12/5/2022

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F 609	Continued from page 41 staff assist; bathing resident was totally dependent on staff and requiring the support of two (2) staff; impairment on both sides for both the upper and lower extremities. Review of the facility's grievance folder showed no documented evidence of the allegation of abuse/neglect that Resident #193 made concerning the incident with the aide and there was no evidence in the medical record of a report made to the State Agency as of 09/15/22. During a face-to-face interview conducted on 09/13/22 at 4:07 PM, Employee #2 (Director of Nursing) was questioned by the Surveyor and asked if the facility conducted an investigation and reported Resident #193's allegation of abuse to the State Agency. Employee #2 stated, "He never reported any of this to me." Employee #2 also stated that they had not reported this to the state agency. During a face-to-face interview conducted on 09/15/22 at 3:14 PM, Employee #25 (Speech language pathologist) stated "He (Resident #193) communicated many things about his care to me. I was there when he was refused care by a CNA (Certified Nurse Aide) due to her needing to deal with other residents. It was very unprofessional, dismissive, inconsiderate tone, harsh, critical and not respectful. I spoke to my supervisor and reported this ..." Employee #25 went on to explain that the incident happened on Monday 09/12/22, and she said that she reported this to her supervisor that day. During a face-to-face interview conducted on 09/15/22 at approximately 3:30 PM, Employee #48 (Director of Rehab) stated "(Employee #25)	F 609	**4. MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements its policy on reporting incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner, weekly for four (4) weeks and monthly for three (3) months. Results of finding will be forward to QAPI for review and recommendations.	12/5/2022

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F 609	Continued from page 42	F 609		12/5/2022

told me on that day of a conversation that resident had with staff, and he asked staff to change his diaper. Employee #48 went on to explain that Employee #25 described the CNA's behavior as rude and that he did not tell anyone about it.

2. Facility staff failed to report an unusual incident where Resident #53 was found unresponsive after going into the courtyard to smoke.

Resident #53 was admitted to the facility on 12/10/19, with multiple diagnoses that included: Tobacco Use, Hemiplegia and Hemiparesis Following Cerebral Infarction, History of Falling, Cataract, Other Psychoactive Substance Abuse and Cognitive Communication Deficit.

Review of the medical record revealed the following:

03/22/22 [Quarterly Minimum Data Set (MDS)] showed that the facility staff coded: intact cognition. Resident has no impairment in the upper or lower extremity, and uses a wheelchair and walker for mobility.

Review of the physicians' orders revealed the following:

05/31/22 [Physician Order] "Send the resident to the nearest ER (emergency room) due to change in mental status one time only ..."

05/31/22 at 5:04 PM [Nursing Progress] " ...Resident returned from courtyard with suspected ingestion of opioids around 2:40 PM with clinical characteristics of unresponsiveness, slow breathing, sleepiness and sweating.

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Resident (has a) is a history of psychoactive substance abuse ...notified DR (Doctor) ...and naloxone (opiate antagonists) 2 doses of 0.4mg/ml is administered at 2:50 pm and 3:00 pm intramuscular to reverse Opioid overdose. After the injection the resident is still unresponsive and breathing is low and shallow...911 took the resident to (hospital) for further treatment and left the facility at 3:58 pm ..."

05/31/22 at 5:50 PM [Nursing Progress] " ...Resident is a smoker and was observed around 2.45pm when he returned from smoking in the court yard to have a change in his mental and physical status, sweating profusely. Resident was assisted to his bed and a complete head to toe assessment done, pupils were fixed and dilated, sweating profusely and could not answer questions, skin was warm to touch, breathing was shallow-respiratory. Oxygen started at 2 liters a minute via nasal cannula ...Resident had vital signs but still not responding to touch and voice ..."

The medical record lacked any documented evidence that the facility reported to the State Agency, the unusual occurrence in which Resident #53 became unresponsive and was given Naloxone and sent to the hospital.

During a face-to-face interview conducted on 09/21/22 at approximately 5:00 PM, Employee #2 (Director of Nursing) she acknowledged the findings and stated “Do I need to submit to DOH (Department of Health) (State Agency) for unresponsiveness?"

Cross Reference DCMR 3232.4

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3. Facility staff failed to report the results of it's investigation of Resident #403's allegation of staff verbal abuse and violation of dignity rights to the State Agency.

Resident #403 was admitted to the facility on 08/02/21 with multiple diagnoses that included: Type 2 Diabetes Mellitus, Visual Disturbances and Cerebral Infarction.

Review of two (2) Facility Reported Incidents (FRI), DC00010223 and DC00010228, received by the State Agency on 08/27/21 documented, " ...The resident stated that he was verbally abused by the staff and his dignity violated ... 'The employee was very unprofessional ... When me and my wife tried to find out about the medication, this employee became so defensive, rude and rolling her eyes while talking ..."

Review of Resident #403's medical record revealed the following:

An Admission Minimum Data Set (MDS) dated 08/08/21 showed facility staff coded: intact cognition and required one-person physical assist for activities of daily living (ADLs).

08/23/21 at 8:28 PM "Daily Skilled Note Late Entry ... No mood indicators noted... No behaviors observed ...Resident and wife were very aggressive and abusive toward writer. Resident pushed site (side) (sp) table at writer was shouting and cursing writer, just because the 3-unit insulin given to resident was not enough. Both evening supervisors informed immediately..."

08/23/21 at 8:58 PM "Daily Behavior

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Documentation Late Entry ... Hitting others. Pushed site (side) (sp) table on writer. Screaming. Cursing at others. Cursing and screaming at writer with his wife on the phone."

08/24/21 at 6:17 PM "Physicians Progress Note ...Patient seen on telemedicine rounds with the nurse manager ... and staff. Patient complaints were listened to and have been addressed..."

08/25/21 at 9:37 PM "Progress Note Late Entry ... The resident was seen on telemedicine rounds [08/24/21] ...at 5.55 pm in his room ...During the telemedicine visit, the resident stated he had a compliant about the nurse that worked the previous day evening shift [08/23/21] to be specific, the resident stated he was verbally abused by the staff and his rights and dignity violated ...An investigation was initiated, the employee was identified and immediately suspended pending outcome of investigation ... Employee was interviewed ... The Unit manager asked the employee to go and apologized to resident but employee refused ... employee statement was received via email. Employee was notified she will be on suspension pending outcome of investigation."

Review of the facility's investigation packet lacked documented evidence that facility staff reported the results of the investigation to the State Agency.

During a face-to-face interview conducted on 09/20/22 at 11:13 AM, Employee #2 (Director of Nursing/DON) stated that she was not aware that results of the investigations had to be reported to the State Agency.

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F 610 SS=D

Investigate/Prevent/Correct Alleged Violation
CFR(s): 483.12(c)(2) -(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident, and staff interview for three (3) of 63 sampled residents, facility staff failed to: investigate an unusual incident in which a resident was found unresponsive; and to take necessary corrective actions after a resident-to-resident incident. Residents' #53, #148, and #505.

The findings included:

Review of the facility's policy entitled, "Prohibition of Abuse" revised 02/2022, read: "...Policy: Sexual abuse is non-consensual sexual contact of any type with a resident includes but is not limited to sexual harassment coercion or sexual assault. Procedure ...E. Protection ...3. In the

F 610

12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**
Resident #53 was admitted to the hospital on 5/31/22 and returned on 6/2/22 in stable condition. Head to toe assessment completed on 6/3/2022, by licensed nurse and suffered no negative outcomes.

Resident #148 was discharged 9/27/22. This deficiency cannot be corrected retroactively.

Resident #505 was assessed head to toe by licensed nurse on 9/28/22. Resident suffered no negative outcomes. Resident #505 was moved on 9/14/22 to ensure resident safety.

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	095036	A. BUILDING ______ B. WING ______	C 09/26/2022

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F 610	Continued from page 47 case of a resident abusing another resident, the facility will separate the resident (s) as appropriate during the investigation ...F. Reporting 1. All alleged violations, the Administrator, Director of Nursing, or designee shall notify the Department of Health [State Agency] via the Event Reporting System electronically ...within two (2) hours if serious bodily injury occurred or there is an allegation of abuse..." 1.The facility staff failed to investigate an unusual occurrence in which Resident #53 was found unresponsive after going to the courtyard to smoke and subsequently required Naloxone (Opiate antagonists) and transport to the hospital. Resident #53 was admitted to the facility on 12/10/19, with multiple diagnoses that included: Tobacco Use, Hemiplegia and Hemiparesis Following Cerebral Infarction, History of Falling, Cataract, Other Psychoactive Substance Abuse and Cognitive Communication Deficit. Review of the medical record revealed the following: 03/22/22 [Quarterly Minimum Data Set (MDS)] showed that the facility staff coded: intact cognition. Resident has no impairment in the upper or lower extremity, and uses a wheelchair and walker for mobility. Review of the physicians' orders revealed the following: 05/31/22 [Physician Order] "Send the resident to the nearest ER (emergency room) due to change in mental status one time only ..."	F 610	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements its policy on properly investigating any unusual incident; and to take necessary corrective actions after a resident-to-resident incident in a timely manner. Any negative findings will be addressed upon discovery.	12/5/2022

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F 610	Continued from page 48 05/31/22 at 5:04 PM [Nursing Progress] " ...Resident returned from courtyard with suspected ingestion of opioids around 2:40 PM with clinical characteristics of unresponsiveness, slow breathing, sleepiness and sweating. Resident (has a) is a history of psychoactive substance abuse ...notified DR (Doctor) ...and naloxone (opiate antagonists) 2 doses of 0.4mg/ml is administered at 2:50 pm and 3:00 pm intramuscular to reverse Opioid overdose. After the injection the resident is still unresponsive and breathing is low and shallow ...911 took the resident to (hospital) for further treatment and left the facility at 3:58 pm ..." 05/31/22 at 5:50 PM [Nursing Progress] " ...Resident is a smoker and was observed around 2.45pm when he returned from smoking in the court yard to have a change in his mental and physical status, sweating profusely. Resident was assisted to his bed and a complete head to toe assessment done, pupils were fixed and dilated, sweating profusely and could not answer questions, skin was warm to touch, breathing was shallow-respiratory. Oxygen started at 2 liters a minute via nasal cannula ...Resident had vital signs but still not responding to touch and voice ..." The medical record lacked any documented evidence that the facility investigated resident's episode of becoming unresponsive on 05/31/22. During a face-to-face interview conducted on 09/21/22 at approximately 5:00 PM, Employee #2 (Director of Nursing) when asked if the facility investigated the resident's episode of unresponsiveness that occurred on 05/31/22,	F 610	**3. MEASURE TO PREVENT REOCURRENCE** Education/ Designee will in-service all staff and leadership on the Abuse Policy and procedures to ensure the facility implements its policy on properly investigating any unusual incident; and to take necessary corrective actions after a resident-to-resident incident in a timely manner. This will be completed 12/5/2022. Incidents and accidents are discussed during the clinical meetings to ensure the facility implements its policy on investigating incident of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Any negative findings will be corrected upon discovery if applicable.	12/5/2022

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F 610	Continued from page 49 Employee #2 stated, "We do not have it." Cross Reference DCMR 3232.2 2. Facility staff failed to take the necessary corrective action of separating Residents' #505 and #148 after a resident-to-resident incident. On 09/06/22 at 7:42 PM the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: “Aggressive Behavior (Resident to Resident) [Resident #505] ...Aggressor ... Victim ... [Resident #148] ... [Resident #505] oriented to self, otherwise very confused. On 1:1 Nursing supervision...At about 3 AM today, writer received a call from Nursing Supervisor stating that [Resident #505] ran out of his room to [Resident #148's room] ...he pushed sitter in the stomach and pushed [Resident #148] down to the floor while she was coming out of her bathroom...." 1A. Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Schizoaffective Disorder, Dementia with Behavioral Disturbance, Altered Mental Status, Anxiety Disorder, Other Symptoms and Signs Involving Cognitive Awareness, and Disorientation. Review of Resident #505 medical record revealed the following: An Admission Minimum Data Set (MDS) dated 09/02/22 documented that facility staff coded: severely impaired cognition; displayed behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, wandering, and intruding on the privacy of	F 610	4. **MONITORING CORRECTIVE ACTION** LNHA/ Designee will conduct an audit of incident report forms for the past six months(May 2022 to October 2022) to ensure the facility implements its policy on investigating incident of alleged abuse, take necessary corrective actions after a resident-to-resident incident and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner, weekly for four (4) weeks and monthly for three (3) months. Results of finding will be forward to QAPI for review and recommendations.	12/5/2022

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F 610	Continued from page 50	F 610		12/5/2022

others.

09/02/22 [Care Plan]: "[Resident #505] has potential to be physically aggressive r/t (related to) Dementia...Goal: [Resident #505] will not harm self or others...Interventions: Modify environment..."

09/03/22 [Physician Order]: "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift ..."

SBAR [Situation, Background, Assessment/Appearance, and Request Communication Tool] dated 09/06/22 documented: " Situation: Pushing another resident to the floor ...pushed the resident [Resident # 148], who was coming from the bathroom to the floor...Resident [#505] was redirected and taking (taken) to his room by 5 (five) nursing staff..."

1B. Resident #148 was admitted to the facility on 07/28/22 with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Atrial Fibrillation, Seizures, and History of Falling.

Review of Resident #148's medical record revealed:

An Admission Minimum Data Set (MDS) dated 08/03/22 documented that facility staff coded: intact cognition; not steady; and only able to stabilize with staff assistance when moving on or off the toilet and from seated to standing.

09/06/22 [Situation, Background, Assessment/Appearance, and Request (SBAR] documented, "... [Resident #148], was pushed by

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F 610	Continued from page 51 another resident to the floor with no injury ...complained of lower back pain, [with a pain rating] of 3/10...order given for lumbar and vertebra X-ray to R/O (rule out) fracture due to fall ..." 09/08/22 [Physician Order]: "Transfer resident to the nearest ER (Emergency Room) for further evaluation of rib pain." Review of the facility's alpha census on 09/20/22 showed that Resident #505 and Resident #148 remained on the same unit after the incident. During a face-to-face interview on 09/20/22 at 2:06 PM, Employee #30, Night Supervisor, stated that he received a call from Employee #31, Charge Nurse on the Second Floor, that Resident #505 had pushed Resident # 148 down. Staff separated the two residents and redirected Resident #505 to his room. Resident #148 did not want to be moved at first and seemed to be in pain. The resident said she called the police, so I called 911 for an ambulance to have her evaluated and transferred to the hospital. The employee then stated, "After speaking with the Director of Nursing (DON) today, I understand that I should have also called the police." He added that Resident #505 remained on 1:1 monitoring, but both residents remained on the same unit until their quarantine periods were over. Cross Reference DCMR 3232.2	F 610		12/5/2022
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		

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F 622	Continued from page 52 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622	**1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS** Resident #254 was discharged 10/26/21 and no longer resides at the facility. This cannot be retroactively corrected. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Social work director or designee will conduct a house wide audit of all discharges home for the last three months (August 2022 to October 2022) to ensure that the information required for resident-initiated discharge is included. This will be completed by 12/5/22. Any negative findings will be corrected upon discovery.	12/5/2022

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F 622	Continued from page 53 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622	**3. MEASURE TO PREVENT REOCURRENCE** The Director of Social Work or designee will re-educate the Social workers on ensuring that all resident discharges to home include all necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care are in place. This will be completed by 12/5/2022.	12/5/2022

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F 622	Continued from page 54 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, the facility's staff failed to ensure the information required for resident-initiated discharge to occur was a part of the medical record. Resident #254. The findings included: Resident #254 was admitted to the facility on 08/20/21 with diagnoses of unspecified fracture of right Calcaneus, Fracture of Right Femur, Fracture of Facial Bone, Laceration of Other Parts of the Head, Blindness of Left Eye and Gastrostomy Status. A review of the resident's medical record showed the following: Physician's order dated 08/20/21 directed, "Admit to skilled level of care. The resident requires SNF [skilled nursing facility] covered care on a daily basis." Care plan initiated 08/25/21 with revision date 11/04/21 Focus: "[resident name] shows potential for discharge and his family member expresses wishes for discharge to home". Goal: "[resident name] will be discharged to home when rehabilitation/self-care goals are met, and he is medically cleared." Target date 11/29/21. Discharge Summary dated 10/26/2021 at 2:15	F 622	**4. MONITORING CORRECTIVE ACTION** Social worker will conduct an audit on all discharges weekly for four (4) weeks, and monthly for three (3) months to ensure that the information required for resident-initiated discharge is complete. The results from the audits will be reviewed during the monthly QAPI meeting for 3 months and then re-evaluated to determine if further monitoring is indicated. All negative findings will be corrected upon discovery.	12/5/2022

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F 622	Continued from page 55 PM showed, " ... discharged home to [home address] from the facility today 10/26/2021 at 12:30 PM. At the request of his RP [representative], pending planned discharge with PCA (personal care attendant) services. Resident was picked up from the facility by his mother with family arranged transportation ...resident has feeding tube in place pending follow up appointment ...on 11/17/21. 11:00 am at [hospital name] ...advanced to regular diet, mechanical soft texture ... water flush through the G-tube ...Fracture of right calcaneus (heel bone) is resolved, fiber glass cast ...removed ... has an orthopedic booth with weight bearing status ... Medication reconciliation and education...provided to resident and mother. ...was given to resident information of all recommended referral 6 days' supply of home medication..." There was no evidence that facility staff documented arrangements or instructions for care specific to Resident #254's gastrostomy feeding tube post discharge. During a face-to-face interview on 09/20/22 at 1:32 PM, Employee #5 (Social Services), acknowledged the findings and stated that she was not the social worker that carried out the discharge planning arrangements at that time for Resident #254.	F 622		12/5/2022
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		

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F 625	Continued from page 56 the resident goes on therapeutic leave; the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to provide Resident #253's responsible party (RP) written notice of the bed-hold policy when he was transferred to the hospital. The findings included: Resident #253 was admitted to the facility on 06/07/21 with multiple diagnoses that included: Dependence on Renal Dialysis, Chronic Atrial Fibrillation and Hypertension.	F 625	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** . Resident #253, did not suffer any negative outcomes as a result of failure to provide a bed hold policy to the resident or resident representative. Resident was discharged on 10/14/21. This cannot be corrected retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents discharged have the ability to be affected by this practice. Social worker /Designee will conduct a house wide audit for the past 3 months (Aug-October) of residents who are discharged or transferred to the hospital to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/designee will provide an in-service to the Social Services and licensed nurses on providing residents and/or resident representatives with a written Bed Hold Policy upon discharge from the facility. Medical records clerk, will attach the bedhold policy to all hospital transfer packages. Education will be completed by 12/5/2022.	12/5/2022

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F 625	Continued from page 57 Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on 10/19/21 documented, " ...Resident was scheduled to dialysis today 9/28/21 by 10am at...Dialysis Center ... At 9:10am, Resident was transported out of the facility via a wheelchair ... At 3:40pm, Dialysis Nurse ...called the unit that resident has been sent to [Hospital Name] ER (emergency room) by Dialysis Center MD (medical doctor) to be evaluated per stroke protocols..." Review of Resident #253's medical record revealed the following: The face sheet that documented that Resident #253's responsible party was his sister. An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident. 09/28/21 at 8:30 PM "Nurses Note ...Writer called [Hospital Name] ER (emergency room) at 8:10pm and spoke to RN (registered nurse) ... she said resident will be admitted to further evaluate for a stroke. MD (medical doctor) was notified of resident admission at 8:15pm. RP (representative) ... was also called and notified of resident's admission ..." There is no documented evidence that facility staff provided Resident #253's RP with the bed hold policy. During a face-to-face interview conducted on 09/22/22 at 2:36 PM, Employee #5 (Social Worker) acknowledged the finding and made no	F 625	**4. MONITORING CORRECTIVE ACTION** Social worker /Designee will conduct a house wide audit for the beginning August 2022 of residents who are transferred or discharged to the hospital and monitored ongoing to ensure that resident and responsible parties are notified and provided with a copy of the bed hold policy that was attached to the transfer package when a resident was transfer out of the facility and to ensure they were updated in writing of the number of bed hold days remaining. This audit will be completed monthly for the past three (3) months, weekly times four and monthly times three. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery.	12/5/2022

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F 625	Continued from page 58 further comments. Cross Reference DCMR 3270.1	F 625		12/5/2022
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING ______ B. WING ______	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001

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F 636	Continued from page 59 on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to complete Resident #1's Minimum Data Set (MDS) assessment within 14 days of the assessment reference date (ARD). The findings included: Resident #1 was admitted to the facility on 12/09/21 with multiple diagnoses that included: Liver Cell Carcinoma and Malignant Neoplasm of Prostate.	F 636	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident # 1 was discharged from the facility on 4/22/22. This cannot be corrected retroactively. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. MDS Nurse/Designee will conduct a house wide audit to ensure that all current residents, new admissions and readmissions have a complete Minimum Data Set (MDS) assessment completed within 14 days of the assessment reference date (ARD). Any negative findings will be corrected upon discovery as appropriate.	12/5/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 60 Review of Resident #1's medical record revealed the following: A Quarterly MDS dated 03/16/22 showed facility staff coded: intact cognition; required supervision and set-up only for activities of daily living; and no functional limitation in range of motion. 03/31/22 at 5:24 PM "...Social Service Note/Overnight stay... spoke with resident and his nephew... Resident is going to his nephew college graduation and will be celebrating with his family. Resident will be using 7 of his 18 days of calendar year overnight stay. Resident will be picked up by his family on Saturday, April 2nd and will be returning back to the nursing center on Saturday, April 9th accompanied by his nephew. Residents medications for the week has been ordered, and the nephew has received medication education. Social worker informed the resident and nephew that resident will have 11 days left of the 18 overnight stay. Social worker will continue to provide support and assistance as needed to resident and family during resident nursing home stay." 04/02/22 [physician's order] "Resident is out for LOA (leave of absence) by 4/2/2022 and will returner [return] 4/9/2022" 04/02/22 at 6:02 PM "Nurses Note...Resident was alert and oriented when he left the facility for LOA at 6:00 pm with his nephew...nephew... told me that... 'He received medication education, resident medication is ordered to the nearest pharmacy to be picked up'. Resident will be back by 4/9/2022. All due medication given before he left the facility well tolerated..."	F 636	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will provide education/in-service to the interdisciplinary team on the accurate and timely development of MDS assessments to ensure that the comprehensive Minimum Data Set (MDS) assessment were completed within 14 days of the assessment reference date (ARD). Education will be completed by 12/5/2022. During clinical meeting, the MDS nurse will notify the IDT of scheduled MDS assessments to ensure that assessments are completed within 14 days of the assessment reference date (ARD).	12/5/2022

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F 636	Continued from page 61 04/09/22 at 11:13 PM "Nurses Note...Resident who had been on LOA with the family was expected back today. Several calls had been made to the family...without any response. [Medical Doctor] had been notified. The social worker...is made aware." 04/10/22 at 8:09 AM "Nurses Note...Resident who had been on LOA was expected back yesterday. Several calls were made to his relative... without any response. The doctor and social worker were made aware of this... another call was made to [RP] and he stated that they had to transfer [Resident #1] to [Hospital Name] in Virginia for profuse rectal bleeding. Call was made the hospital and on speaking to his nurse there, the nurse confirmed that [Resident #1] was being admitted for low Hemoglobin. The social worker and [Medical Doctor] had been notified..." Review of the "Discharge - Return Anticipated" MDS with an assessment reference date (ARD) of 04/02/22 showed that in Section Z (Assessment Administration) facility staff documented, "... Sections A, B, C, D, E, G, GG, H, I, J, K, M, N, O, P, Q ...completed 9/11/2022". The form was noted to have been electronically signed on 09/11/2022. The evidence showed that facility staff documented an ARD of 04/02/22 on Resident #1's "Discharge - Return Anticipated" MDS however, it was not completed and signed until 09/11/22, five months later. During a face-to-face interview conducted on 09/22/22 at 12:20 PM, Employee #8 (MDS Coordinator) stated, "The MDS person who did	F 636	**4. MONITORING CORRECTIVE ACTION** MDS Nurse/Designee will conduct an audit to ensure that all new admissions and readmissions have a complete Minimum Data Set (MDS) assessment completed within 14 days of the assessment reference date (ARD). This audit will be done for the past 3 months(August 2022 – October 2022), weekly times four (4), then monthly times three (3). This will be reported monthly to the Quality Assurance and Performance Improvement team, for further recommendation. All negative findings will be corrected upon discovery.	12/5/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued from page 62 this one comes in to help us sometimes on the weekends. She must've seen that an MDS was missing and completed one on the 11th [09/11/22]."	F 636		12/5/2022
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for four (4) of 63 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) for one resident's functional impairment, one resident's bowel status, one resident's fall and one resident's fall and oxygen use. Residents' #20, #102, #133, and #158. The findings included: 1. Facility staff failed to accurately code Resident #20's functional impairment. Resident #20 was admitted to the facility on 04/02/18 with multiple diagnoses that included: Muscle Weakness, Hemiplegia and Hemiparesis, Hypertension and Type 2 Diabetes Mellitus. Review of the resident's medical record revealed the following: A Quarterly MDS dated 05/25/22 showed facility staff coded: functional impairment on one side for upper and lower extremities. Care plan focus area "[Resident #20] has limited	F 641		

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F 641 Continued from page 63

physical mobility r/t (related to) right sided weakness" reviewed on 06/02/22.

Care plan focus area "[Resident #20] will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis..." reviewed on 06/02/22.

07/15/22 at 3:15 PM [Physicians Progress Note] "... Rt (right) sided weakness. Right hand flexion contracture..."

A Quarterly MDS dated 08/25/22 showed facility staff coded: no functional impairment in upper extremities and functional impairment on one side for lower extremities.

The evidence showed that facility staff inaccurately coded Resident #20 as not having any impairment to her upper extremities.

During a face-to-face interview conducted on 09/20/22 at 1:23 PM, Employee #9 (MDS Coordinator) reviewed both MDS' and stated, "OK."

2. Facility staff failed to accurately code Resident #102's bowel status.

Resident #102 was admitted to the facility on 11/19/20 with diagnoses that included: Constipation and End Stage Renal Disease (ESRD).

Review of Resident #102's medical record revealed:

A Quarterly MDS dated 07/21/22 showed facility staff coded: intact cognition; independent with

F 641 — Completion date: 12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

   Resident #20 MDS assessment was corrected for accuracy on 11/17/2022 based on the documentation in the medical records. Resident suffered no negative outcomes.

   Resident #102 MDS assessment was corrected for accuracy on 11/17/2022 based on the documentation in the medical records. Resident suffered no negative outcomes.

   Resident #133 MDS assessment was corrected for accuracy 11/17/2022. based on the documentation in the medical records. Resident suffered no negative outcomes.

   Resident #158 MDS was corrected for accuracy on 11/17/2022 based on the documentation in the medical records Resident suffered no negative outcomes.

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

   All resident MDS Assessments have the potential to be affected. MDS Director/Designee will complete a house wide audit on the most recent quarterly and annual MDS assessments for the month of September 2022 to ensure accuracy of functional impairments, bowel and bladder status, history of falls, and status on the use of oxygen. Any findings will be corrected upon discovery.

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F 641 — Continued from page 64

toilet use; occasionally incontinent of urine; and frequently incontinent of bowel.

Review of the Certified Nurse Aide (CNA) documentation used for the look back period (7 days) for the aforementioned MDS showed that facility staff documented that Resident #102 was "continent" at all times. Further review showed that facility staff documented Resident #102 was "continent" at all times in July 2022.

The evidence showed that facility staff inaccurately coded Resident #102 as "frequently incontinent of bowel".

During a face-to-face interview conducted on 09/21/22 at 3:49 PM, Employee #8 (MDS Coordinator) reviewed the MDS and stated, "I am not sure why it [MDS] says "frequently incontinent" for bowel. The [CNA] documentation shows [Resident #102] was continent every day for the look back period. This is an incorrect coding."

3. Facility staff failed to ensure Resident #133's MDS was accurately coded to reflect the resident's falls.

Resident #133 was admitted to the facility on 10/01/21 with diagnoses that included anemia, Hypertension, Muscle weakness, Altered Mental Status, Other Abnormalities of Gait and Mobility, and Bradycardia.

Review of the Quarterly MDS) dated 03/02/22, and 06/02/22, revealed in section J (Health Conditions), facility staff coded:

F 641 — Completion date: 12/5/2022

3. MEASURE TO PREVENT REOCURRENCE

MDS Director/Designee will provide education/in-service to the interdisciplinary team on proper completion of the MDS assessment to ensure accuracy of functional impairments, bowel and bladder status, history of falls, and status on the use of oxygen. This will be completed by 12/5/22.

4. MONITORING CORRECTIVE ACTION

MDS Director/Designee will complete a house wide audit on the most recent quarterly and annual MDS assessments for the month of September, and two comprehensive assessments monthly for three (3) months to ensure accuracy of functional impairments, bowel and bladder status, history of falls, and status on the use of oxygen. Findings will be reported monthly to the Quality Assurance and Performance Improvement team for further recommendation. All negative findings will be corrected upon discovery.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued from page 65	F 641		12/5/2022

J1700 - Did the resident have a fall anytime in the last month prior to admission/entry or reentry, facility staff coded "0", indicating no; Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? facility staff coded "0", indicating no

J1800- Has the resident had any falls since admission/entry or reentry or the prior assessment ...whichever is most recent? facility staff coded "0", indicating no.

Review of a Facility Reported complaint/Incident form to Department of Health submitted on 08/20/22, showed, "... Resident stated he lowered himself to the floor early morning around 6 am while transferring from bed to chair..."

Review of the care plan revised on 08/22/2022 with a focus area of, "[Resident #133] is at moderate risk for falls r/t [related/to] Gait/Balance problems showed, 12/21/21, alleged he had a fall with no injury, and 08/20/22, stated he had unwitnessed fall with no injury."

Review of the Annual MDS dated 09/02/22, revealed in section J (Health Conditions) facility staff coded the following:

J1800 - "Any Falls since Admission/or Prior Assessment...wherever is more recent" was coded as "1"

The evidence showed that facility staff failed to accurately code Resident #133's MDS completed on 03/02/22, 06/02/22, and 09/02/22 for falls under section J1800.

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F 641	Continued from page 66 During a face-to-face interview conducted on 09/21/22 at 12:35 PM, Employee #9 (MDS Coordinator) acknowledged the finding and made no further comments. 4. Facility staff failed to accurately code the MDS to reflect Resident #158's fall and oxygen use. Resident #158 was admitted to the facility on,06/30/20, with multiple diagnoses that included: Asthma, Epilepsy, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Acute Respiratory Failure. Review of Resident #158's medical record revealed the following: 4A. Review of the Facility Complaint/Incident Report form submitted to Department of Health on 7/02/22 showed, "...At around 1:30 PM during rounds [Resident #158], was observed on the floor laying on her back...According to staff that found her ..." Review of the Facility Complaint/Incident Report form submitted to Department of Health on 07/06/22 showed, "...At 9:30 PM, [Resident #158] was observed on the floor laying on her left side by the assigned CNA... Resident stated, I can't remember how I got on the floor ..." Review of Annual MDS dated 07/15/22 revealed in section J (Health Conditions) facility staff coded: J1700 - Did the resident have a fall anytime in the	F 641		12/5/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued from page 67	F 641		12/5/2022

last month prior to admission/entry or reentry, facility staff coded "0", indicating no; Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? facility staff left "blank", indicating no

J1800- Has the resident had any falls since admission/entry or reentry or the prior assessment ...whichever is most recent? facility staff did code "0", indicating no.

4B. Physician's order dated 07/13/22 directed "Oxygen at 2LPM [liters per minute] via Nasal cannula every shift...

Review of Annual MDS dated 07/15/22 revealed in Section O0100 (Special treatments, Procedures, and Programs), the oxygen therapy section was left blank indicating "not on oxygen"

The evidence showed that facility staff failed to accurately code Resident #158's MDS on 06/02/22 and on 09/02/22 oxygen use.

During a face-to-face interview conducted on 09/21/22 at 12:35 PM, Employee #8 (MDS Coordinator) acknowledged both of the findings in Resident #158's MDS' and made no further comments.

F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j)	F 642		

§483.20(h) Coordination.
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

§483.20(i) Certification.

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F 642 — Continued from page 68

§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.

§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

§483.20(j) Penalty for Falsification.
§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-
(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff knowingly falsified Resident #1's Discharge - Return Anticipated Minimum Data Set (MDS) assessment.

The findings included:

Resident #1 was admitted to the facility on 12/09/21 with multiple diagnoses that included: Liver Cell Carcinoma and Malignant Neoplasm of Prostate.

Review of Resident #1's medical record revealed the following:

F 642 — Plan of correction (Completion date: 12/5/2022)

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

   Resident # 1 was discharged from the facility on 4/22/22. This cannot be corrected retroactively

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

   All residents have the potential to be affected. MDS or Designee will conduct a House wide audit on all discharge assessments for 3 months (August-October). Any negative findings will be corrected upon discovery as appropriate.

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F 642	Continued from page 69 A Quarterly MDS dated 03/16/22 showed facility staff coded: intact cognition; required supervision and set-up only for activities of daily living; and no functional limitation in range of motion. 03/31/22 at 5:24 PM "...Social Service Note/Overnight stay... spoke with resident and his nephew... Resident is going to his nephew college graduation and will be celebrating with his family. Resident will be using 7 of his 18 days of calendar year overnight stay. Resident will be picked up by his family on Saturday, April 2nd and will be returning back to the nursing center on Saturday, April 9th accompanied by his nephew. Residents medications for the week has been ordered, and the nephew has received medication education. Social worker informed the resident and nephew that resident will have 11 days left of the 18 overnight stay. Social worker will continue to provide support and assistance as needed to resident and family during resident nursing home stay." 04/02/22 [physician's order] "Resident is out for LOA (leave of absence) by 4/2/2022 and will [return] 4/9/2022" 04/02/22 at 6:02 PM "Nurses Note...Resident was alert and oriented when he left the facility for LOA at 6:00 pm with his nephew...nephew... told me that... 'He received medication education, resident medication is ordered to the nearest pharmacy to be picked up'. Resident will be back by 4/9/2022. All due medication given before he left the facility well tolerated..." 04/09/22 at 11:13 PM "Nurses Note...Resident who had been on LOA with the family was expected back today. Several calls had been	F 642	**3. MEASURE TO PREVENT REOCURRENCE** MDS Director/Designee will provide education/in-service to the interdisciplinary team on proper completion of the MDS assessment to ensure accuracy of resident's discharge status. This will be completed by 12/5/22. **4. MONITORING CORRECTIVE ACTION** MDS or Designee will conduct a House wide audit on all discharge assessments for 3 months (August-October), 2 Comprehensive MDS assessment weekly x 4 and 2 Comprehensive Assessment Monthly X 3 Months. This will be reported monthly to the Quality Assurance and Performance Improvement team for further recommendation. All negative findings will be corrected upon discovery.	12/5/2022

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F 642		F 642		12/5/2022

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made to the family...without any response. [Medical Doctor] had been notified. The social worker...is made aware."

04/10/22 at 8:09 AM "Nurses Note...Resident who had been on LOA was expected back yesterday. Several calls were made to his relative... without any response. The doctor and social worker were made aware of this... another call was made to [RP] and he stated that they had to transfer [Resident #1] to [Hospital Name] in Virginia for profuse rectal bleeding. Call was made the hospital and on speaking to his nurse there, the nurse confirmed that [Resident #1] was being admitted for low Hemoglobin. The social worker and [Medical Doctor] had been notified..."

Review of the "Discharge - Return Anticipated" MDS with an assessment reference date (ARD) of 04/02/22 showed that in Section Z (Assessment Administration) facility staff documented, "... Sections A, B, C, D, E, G, GG, H, I, J, K, M, N, O, P, Q ...completed 9/11/2022". The form was noted to have been electronically signed on 09/11/2022.

The evidence showed that Resident #1 left the facility on 04/02/22 on LOA and did not return. However, review of the "Discharge-Return Anticipated" MDS showed that facility staff documented on 09/11/22 that they assessed Resident #1 and completed Sections A through Z of the aforementioned MDS dated 04/02/22.

During a face-to-face interview conducted on 09/22/22 at 12:20 PM, Employee #8 (MDS Coordinator) stated, "The MDS person who did this one [MDS] comes in to help us sometimes on the weekends. She must've seen that an MDS

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F 642	Continued from page 71 was missing and completed one on the 11th [09/11/22]."	F 642		12/5/2022
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		

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F 656	Continued from page 72 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, for two (2) of 63 sampled residents, facility staff failed to: develop a comprehensive person-centered care plan to address one resident's use of supplemental oxygen; and implement one resident's care plan intervention of having a one to one (1:1) supervision while in the courtyard. Residents' #64, and #176. The findings included: 1. Facility staff failed to develop a comprehensive person-centered care plan to address Resident #64's use of supplemental oxygen. Resident #64 was admitted to the facility on 03/18/22 with multiple diagnoses that included: Atrioventricular Block Second Degree, Anxiety Disorder Unspecified Fall, and Anemia. During an observation and interview conducted on 09/22/22 at approximately 9:40 AM, Resident #64 was observed with his oxygen tubing and nasal cannula laying on the bed, the tubing was not marked with a date and time and the oxygen was set on 1 liter. Resident #64 stated, "I turn my oxygen on and off and take off the nasal cannula when I don't need it."	F 656	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #64 was educated on the on the risk and benefits related to the proper use of oxygen supplement and following the doctor's order. Residents oxygen tubing and nasal cannula was marked with a date and time upon discovery. Staff was educated to check on the resident's oxygen supplement use during resident rounds to ensure that it is set-up properly according to the resident's MD orders and care plan. Resident #64 comprehensive care plan was reviewed to ensure oxygen supplement us in accordance to MD orders and interventions are properly implemented on 9/20/2022. Resident suffered no negative outcomes. Resident #176 is supervised at all times while in the courtyard by the courtyard monitor staff upon discovery. Resident #176 signed a social contract on 10/27/22 to abide by the facility policies and conduct including alcohol consumption. Resident #176 comprehensive care plan was reviewed and updated to reflect the appropriate care based on the resident's needs. These interventions are properly implemented. Resident suffered no negative outcomes	12/5/2022

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Review of the medical record revealed the following:

A Quarterly Minimum Data Set (MDS) dated 06/24/22, showed that the facility staff coded the following: intact cognition; and that oxygen therapy was performed during the last 14 days of assessment.

03/18/22 [Physician's Order] "Staff to Administer Medications"

05/18/22 [Physician's Order] "Oxygen at 2 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for sob (Shortness of Breath)"

The medical record lacked documented evidence of a care plan that addressed Resident #64's use of oxygen as needed for shortness of breath.

During a face-to-face interview conducted on 09/22/22 at 1:00 PM, Employee #32 (Charge Nurse 2 south) acknowledged there was no care plan that addressed residents prescribed oxygen treatment and stated, "He (Resident #64) has shortness of breath."

Cross Reference DCMR 3210.4

2. Facility staff failed to implement Resident #176's care plan intervention of having 1:1 supervision while in the courtyard.

During an observation on 09/22/22 at approximately 4:30 PM on unit 4 South, Resident #176 was observed yelling profanities at facility staff as he wheeled himself past the nurses' station with two security officers behind him. When asked what was going on, Employee #12

F 656

2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED

All residents who require 1:1 supervision and residents who use oxygen supplementation have the potential to be affected by this deficient practice. House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery.

12/5/2022

3. MEASURE TO PREVENT REOCURRENCE

Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person-centered care plan and proper implementation of the care plans on all residents with 1:1 supervision and residents on oxygen supplements. Education will be completed by 12/5/2022.

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(Security Officer) stated, "I saw [Resident #176] coming in from the courtyard (smoking area) with a bottle of alcohol in his lap that was 75% already drunken. I said to him he's not allowed to have that and he started yelling and cussing at me and got in the elevator. I called [Employee #1/Administrator]. The other security officer came with me and we followed him up here."

Resident #176 was admitted to the facility on 08/25/15 with diagnoses that included: Alcohol Abuse with Intoxication, Anemia and Atrial Fibrillation.

Review of Resident #176's medical record revealed the following:

10/18/21 [physician's order] "Thiamine (supplement) HCl (Hydrochloride) Tablet 100 MG (milligrams) Give 1 tablet by mouth one time a day for Alcohol abuse"

Care plan focus area, "[Resident #176] has a behavior problem of drinking liquor in the facility r/t (related to) life style" revised on 08/19/22 showed, " ...can go to [Local Store] with facility staff or family member ...1:1 supervision while in courtyard (initiated 06/08/22) ..."

A Quarterly Minimum Data Set (MDS) dated 08/23/22 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, meaning intact cognition; no physical or verbal behavioral symptoms directed towards others; independent with activities of daily living (ADLs); required supervision for locomotion off the unit; and used a wheelchair for mobility.

Review of the smoke aide schedule for 09/22/22

4. MONITORING CORRECTIVE ACTION

House wide audit will be completed by the Unit managers/Designee on residents with 1:1 supervision and residents on oxygen supplements to ensure that comprehensive care plans are accurate and properly implemented. Any negative findings will be corrected upon discovery. This will be completed during the three (3) month period (August 2022- October 2022), weekly times four (4), then monthly for three (3) months. Results to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected upon discovery.

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F 656	Continued from page 75 evening shift 3:00 PM - 11:00 PM showed that two employees were scheduled for the courtyard, Employee #16 and #17, both Smoke Aides. During a face-to-face interview conducted on 09/23/22 at 11:39 AM, when asked if she was aware that Resident #176 required 1:1 supervision at all times when in the courtyard, Employee #16 stated, "No." During a telephone interview conducted on 09/23/22 at 11:45 AM, Employee #17 stated that he also was not aware that Resident #176 required 1:1 supervision while in the courtyard. The evidence showed that facility staff failed to implement the care plan intervention of providing Resident #176 with 1:1 supervision while in the courtyard. Cross Reference DCMR 3210.4	F 656		12/5/2022
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interview, for one (1) of 63 sampled residents, facility staff failed to update Resident #20's fall and skin care plan focus areas with new goals and interventions after he sustained a fall and when he was observed with a bruise on his right cheek.

The findings included:

Resident #20 was admitted to the facility on 04/02/18 with multiple diagnoses that included: Muscle Weakness, Hemiplegia and Hemiparesis, Hypertension and Type 2 Diabetes Mellitus.

Review of Resident #20's medical record revealed the following:

A Quarterly MDS dated 08/25/22 showed facility staff coded: unable to complete the Brief Interview for Mental Status (BIMS); required extensive assistance with one person physical assist for transfers; independent with locomotion on the unit; no functional impairment in upper

F 657

12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

Resident #20 comprehensive care plan on fall and skin care was reviewed and modified to ensure that it is accurate and interventions are properly implemented on 9/20/2022. Resident head to toe assessment was completed by the licensed nurse on 9/20/22 Resident suffered no negative outcomes.

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

All residents have the potential to be affected by this deficient practice. ADON/Designee will conduct an audit of five comprehensive care plans to ensure that the fall history and skin was reviewed and modified accurately and timely. Any negative findings will be corrected upon discovery.

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F 657	Continued from page 77 extremities; functional impairment on one side for lower extremities; wheelchair for mobility; no falls since admission/entry or reentry or the prior assessment. 09/12/22 at 9:20 PM "Post Fall Huddle ...Specific location of fall: Hallway ... Was a new intervention added to residents care plan ... Yes ..." 09/12/22 at 9:50 PM "Nurses Note ...Resident at 9pm during the staff regular round saw the Resident sitting on the floor beside his wheel chair ..." 09/13/22 at 4:54 PM "Situation Background Assessment Request (SBAR) Communication Tool ... situation- purple discoloration noted at the right chick bone of resident's face ...Resident's face was observed with a purple discoloration at the right chick (sp) bone. Resident complained of pain ...MD (medical doctor) made aware and X ray of facial bones and skull ordered ..." Care plan focus area, "[Resident #20] reported that he fell 2 days ago from the wheelchair, no injury noted" revised on 09/12/22 showed, " ...observed sitting on the floor in the hallway." There was no documented evidence that facility staff updated this care plan with new goals and interventions after the fall on 09/12/22. Care plan focus area, "[Resident #20] is at risk for alteration in skin integrity ..." reviewed on 08/30/22 showed, " ... Observe skin condition ... daily; report abnormalities ..." There was no documented evidence that facility staff updated this care plan to include goals and interventions to address the bruise on Resident #20's right cheek on 09/13/22.	F 657	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a comprehensive person centered care plan to ensure that the fall and skin areas are reviewed and modified accurately and timely. Education will be completed by 12/5/2022. During the weekly risk management meeting, the IDT will review all incidents and accidents and ensure that residents comprehensive care plan are updated accurately and timely including fall and skin incidents. All findings will be corrected upon discovery. During the clinical meeting, all incidents and accidents are reviewed by the IDT team and residents comprehensive care plan are updated accurately and timely including fall and skin incidents. All findings will be corrected upon discovery. **4. MONITORING CORRECTIVE ACTION** ADON/Designee will conduct an audit of five comprehensive care plans to ensure that the fall and skin areas are reviewed and modified accurately and timely. Any negative findings will be corrected upon discovery. This audit will be conducted weekly times four, then monthly times three to be reviewed during at Quality assessment and Assurance meetings for further recommendations.	12/5/2022

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F 657	Continued from page 78 During a face-to-face interview conducted on 09/19/22 at 3:43 PM, Employee #10 (4th Floor Unit Manager) reviewed both care plan focus areas and made no further comments. Cross Reference DCMR 3210.4	F 657		12/5/2022
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, in one (1) of four (4) medication administration observations, facility staff failed to administer medications within the professional standards of practice. The findings included: According to the "Long-Term Care Nursing: Medication Pass", " ...pre-pouring medications is unacceptable because the medications: cannot accurately be compared to the Medications Administration Record (MAR) and violates at least two of the seven rights of medication administration (right patient & right medication), dramatically increasing the probability of medication errors ..." https://ceufast.com/course/long-term-care-nursin	F 658	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Employee #11 was given a medication pass training and competency test. Employee #11 passed the competency test conducted by the staff educator on 10/22/22. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All resident in the facility have the potential to be affected. 3. **MEASURE TO PREVENT REOCURRENCE** The Staff Educator/Designee will provide education /in-service to all licensed nurses on medication administration. Education will be completed by 12/5/2022.	

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F 658	Continued from page 79 g-medication-pass During a medication administration conducted on 09/12/22 at 9:09 AM on unit 4 South, the following was observed: Employee #11 (Licensed Practical Nurse) pre-poured a resident's medications (6 in total) into a medicine cup, then entered the residents room, checked the resident's blood pressure and was about to administer the medications when the employee was stopped by the State Surveyor. At the time of the observation, Employee #11 was asked if that's the standard of practice for medication administration. Employee #11 stated, "As far as I know, that's how it is done. I know the medications I am going to give. It seems a lot to bring all these packages to the bedside. If the resident refused a medication, I can just take it out because I know what the pills looks like."	F 658	**4. MONITORING CORRECTIVE ACTION** The Staff development/Designee will observe med pass on one nurse/unit per week for four weeks, one nurse/unit per month for 3 months to ensure med pass is done accurately per standards of practice. Results of the audit will be given to Quality Assurance Performance Improvement Committee for review and recommendations. All negative findings will be corrected upon discovery and additional on the spot training if indicated.	12/5/2022
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to	F 660		

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F 660	Continued from page 80 identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized	F 660	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #402 was discharged from the facility on 8/11/22. This cannot retroactively be corrected. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who discharge home have the potential to be affected by this deficient practice. SW or designee team will conduct a house wide audit of all discharges for the past three months (August 2022 – October 2022), and all current residents to ensure discharge planning care plan and meetings are completed and the needs of the residents are met for a successful discharge back to the community. Any negative findings will the corrected upon discovery.	12/5/2022

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F 660	Continued from page 81 patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to develop a discharge care plan for Resident #402 that addressed her needs for discharge back to the community. The findings included: Resident #402 was admitted to the facility on 10/14/21 with multiple diagnoses that included: Multiple Sclerosis, Difficulty in Walking, Heart Failure and Hypertension. Review of a Complaint, DC00010481, received by the State Agency on 12/30/21 documented, " ... [Resident #402] has been trying to get discharged and service assistance since 09/24/21 ..." Review of Resident #402's medical record	F 660	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will educate the Interdisciplinary team regarding the accurate completion of a discharge care plan to ensure that it addresses resident needs for discharge back to the community. Education will be completed by 12/5/2022. During UR meeting and clinical meeting, discharge planning will be discussed by the clinical team to ensure that discharge care plan is accurate and meet the needs of the resident. Any issues found will be corrected and family members will be notified to ensure that the resident has a successful and safe discharge back to the community.	12/5/2022

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F 660	Continued from page 82 revealed the following: 10/14/21 at 5:29 PM "Social Services Assessment Admission" showed, Section E (Discharge Assessment/Planning) was left blank; Section F (Care Planning) was left blank. An Admission Minimum Data Set (MDS) dated 10/20/21 showed facility staff coded: moderately impaired cognition; required extensive assistance to total dependence with one-person physical assist for bed mobility, transfer, dressing, eating toilet use and personal hygiene; expected to be discharged to the community; discharge plan already occurring; referral to the contact agency not needed. 11/18/21 at 3:46 PM "Care Plan Meeting Note... Discharge meeting...was done today ...The IDT (interdisciplinary team) present ... [Representatives]... [Resident #402] refused to be part of the meeting ...The family friend said that [Resident #402] has been given 20hrs by [Home Agency] ...social worker said she will call...to ask them for exactly what benefit resident has been given... resident has a neurology and cardiovascular appointment coming up. The neurology appointment is coming up in January [2022], and the cardiology is in progress ...The discharge date was not agreed on yet as the social worker made the team know that resident has to stay for 90 days before the department of aging and another group can assist in the ramp building in the resident's house to facilitate easy going out and coming in of resident with stairs." 11/18/21 at 6::32 PM "Social Work Progress Note Late Entry ... [Representative] wants the resident to be discharged and they were informed that it	F 660	**4. MONITORING CORRECTIVE ACTION** SW or designee team will conduct a house wide audit of all discharges for the past three months (August 2022 – October 2022) and ongoing to ensure discharge planning care plan and meeting were completed and the needs of the residents are met for a successful discharge back to the community. Any negative findings will the corrected upon discovery. This audit will be conducted weekly times four (4), then monthly times three (3) to be reviewed during at QAPI meetings for further recommendations. All negative findings will be corrected upon discovery.	12/5/2022

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F 660	Continued from page 83 has to be a safe discharged. They have to have a doctor's order and she must have services in the home... [Representative] is asking that the resident have a ramp placed on her home so that she can get in and out the house... Social Worker will call DC (District of Columbia) Office of Aging to find out about the ramp..." 01/14/22 at 10:17 AM "Social Services Assessment Quarterly Review" showed, Section E (Discharge Assessment/Planning) was left blank; Section F (Care Planning) was left blank. 04/20/22 at 4:47 PM "Social Work Progress Note Late Entry...Social Worker was called to the floor to meet with... care manager for the resident in the community. She stated that the Home Health Agency that will provide care for the resident is [Name of Agency] ...will notify nursing when the PCA (personal care aide) services will be placed in the home. Then a discharge planning meeting will be scheduled." 06/07/22 at 12:56 PM "Social Work Progress Note... IDT Meeting was held on behalf of resident to discuss his status and discharge. IDT Team met with resident and attorney. Her son participated by phone... Resident is alert and requires max assistance. She expressed a desire to return to her home in the community. Resident has been connected to the safe at home program to do renovations to her home. Resident needs the renovations so that she can return home safely. [Community Transition Specialist] DC Office on Aging and Community Services...has been coordinating her services. There is no date to start the renovations but the assessment has been completed. The meeting has been continued to Monday, June 13, 2022 at 1PM via	F 660		12/5/2022

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F 660	Continued from page 84 conference call..." 06/13/22 at 7:47 AM "Social Work Progress Note Late Entry...Discharge Planning ... Meeting was held on behalf of resident to plan her discharge. IDT Team met with resident and her brother. Community Transition Specialist...participated by phone. The discharge planning meeting was postponed to 6/27/2022 at 1:30PM because repairs to the resident's home have not been done by the Safe at Home program. Resident has 15 hours of PCA Services; however, nursing feels she needs 24 hours' care. Nursing will meet with the Attending Physician for her opinion. The agency who has verbally accepted resident's PCA hours states they do not have the nursing staff to provide her services. RP may need to select another agency." 07/14/22 at 4:35 PM "Social Work Progress Note... [Home Care Agency Name] has accepted resident's PCA hours (15) per 7 days a week. Today, resident completed assessment..." 07/15/22 at 7:30 AM "Social Work Progress Note Late Entry... Discharge IDT meeting was held via conference call on behalf of resident to discuss the services in place and to set a discharge date ... Safe At Home has already completed the necessary modifications in the home. Hospital bed and wheelchair has already been delivered ...Resident is supposed to be discharged on 7/21/2022..." 08/11/22 at 11:33 AM "Social Work Progress Note Discharge Summary: Resident was discharged to home. She was escorted by her mother and sister. Resident will received 15 hours of PCA Services for 7 days a week...	F 660		12/5/2022

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F 660	Continued from page 85 Nursing Services will be provided...for PT (physical therapy) and OT (occupational therapy) services also medication management. Resident will be monitored in the community by Community Transition Specialist, DC Office on Aging and Community Services... Case Worker... will also follow resident in the community..." Review of the comprehensive care plan lacked documented evidence that facility staff developed a discharge care plan with goals and interventions to address Resident #402's discharge needs. During a face-to-face interview conducted on 09/16/22 at 3:02 PM, Employee #5 (Social Worker) stated, "For the area "Care Planning" of the Social Services Assessment, if it was filled out, it would have automatically generated a care plan in PCC (Point Click Care). Regardless, social services are responsible to initiating the discharge care plan." Cross Reference DCMR - 3270.2b	F 660		12/5/2022
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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F 684	Continued from page 86 Based on record review and staff interview, for two (2) of 63 sampled residents, facility staff failed to ensure: Resident #194 was provided a psychiatric evaluation in a timely manner; and that Resident #253 was administered his blood pressure medications as ordered by the physician. Residents' #194 and #253. The findings included: Review of the "Medication/Treatment Administration Record and Initials" policy dated February 2022 showed, " ...Prior to administration of medication and treatment, the licensed nurse assigned to the resident must check am validate ... right medication ...dosage ... assessment, evaluation. Licensed nurses will administer medication and treatment to residents following the physician orders ..." 1. Facility staff failed to ensure that Resident #194 was provided a psychiatric evaluation in a timely manner. Resident #194 was admitted to the facility on 12/02/19 with diagnoses that included: Sequelae of Cerebral Infarction, Aphasia and Major Depressive Disorder. Review of a Facility Reported Incident (FRI), DC00010299, received by the State Agency on 10/02/21 documented, " ... [Resident #36] was in the dining room area while waiting for banking ...jumped the line ...she (Resident #194) reacted by putting her hand on [Resident #36] first..."	F 684	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #194 received her psychological evaluation. Psych evaluation and medications review was completed on 9/29/22 and 10/25/22. Resident was determined to be appropriate with the current medications. Psychiatrist stated that the resident does not require any immediate changes in her psychiatric care. Resident #253 is discharged 10/14/2021. This cannot be retroactively be corrected. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who require a psychological evaluation and residents on Midodrin Medication have the ability to be affected. Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation and all residents on Midodrin medication to ensure that residents are provided psychiatric evaluation, and provided Midrodin as prescribed by the physician by 12/5/22. Any issues found will be corrected upon discovery.	12/5/2022

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F 684	Continued from page 87 Review of Resident #194's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 08/17/21 where facility staff coded: severe cognitive impairment; no physical or verbal behaviors directed towards others; supervision for walking in the corridor; independent with locomotion off the unit; no impairment in range of motion; and used a walker for mobility. 10/01/21 at 3:45 PM "Situation Background Assessment Request (SBAR) ...Communication Tool... Situation: Resident to resident altercation...At around 10:45 AM per [Resident #194] ...while she was in the area of the main dining room for banking resident stated that a male resident known to be the resident in room 408B (Resident #36), came in front of her and she asked him to move he became aggressive to her ... Resident stated that security and staffs were present and immediately separated them. Social services director called the police...service director asked resident does she feel safe at this time, and she stated yes, she feels safe ... Resident spoke with the police and filed her report." Care plan focus area, "[Resident #194] was involved in physical altercation with another resident on 10-01- 21" initiated on 10/01/21 documented, "... Psych consult." 10/04/21 at 4:37 PM "Care Plan Note Late Entry...Post incident IDT (interdisciplinary team) meeting...meeting following resident's incident at main dining room area on 10-01-21 was held today 10-04-21 with the team members, and resident's emergency contact...Both resident will	F 684	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and on following ensuring that MD orders on Psych evaluations are implemented in a timely manner and in-service on the importance of accurate medication administration as ordered by the physician. Education will be completed by 12/5/2022. **4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all the residents who require psychological evaluation and residents on Midodrin medication weekly times four then three times monthly for three months. Results will be given to QAPI monthly for recommendations to ensure services and medications are provided timely and accurately according to the physician's orders. All negative findings will be corrected upon discovery.	12/5/2022

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F 684		F 684		12/5/2022

Continued from page 88

be followed up for medication review and psychiatrist consult ..."

10/04/21 [physician's order] "Psych consult"

02/18/22 at 12:45 AM "Physicians Progress Note... Psychiatric New Evaluation...Patient seen to evaluate mental status and adjust medications for behavioral disturbance..."

The evidence showed that the physician's order for Resident #194 to receive a psychiatric evaluation on 10/04/21 was not completed until 02/18/22, four (4) months later.

During a face-to-face interview on 09/15/22 at 12:50 PM, Employee #10 (4th floor Unit Manager) stated, "When there's a psych (psychiatric) evaluation order, the psych doctors are called and we let them know there's a new evaluation ordered for a resident. I will have to check and see what caused the delay in [Resident #194] getting seen."

Cross Reference DCMR - 3271.1d

2. Facility staff failed to ensure that Resident #253 was administered his blood pressure medications as ordered by the physician.

Resident #253 was admitted to the facility on 06/07/21 with multiple diagnoses that included: Dependence on Renal Dialysis, Chronic Atrial Fibrillation and Hypertension.

Review of a Facility Reported Incident (FRI), DC00010324, received by the State Agency on

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F 684	Continued from page 89 10/19/21 documented, " ...Resident was scheduled to dialysis today 9/28/21 by 10am at...Dialysis Center ... At 9:10am, Resident was transported out of the facility via a wheelchair ... At 3:40pm, Dialysis Nurse ...called the unit that resident has been sent to [Hospital Name] ER (emergency room) by Dialysis Center MD (medical doctor) to be evaluated per stroke protocols ... resident had elevated HR (heart rate) during dialysis ...right-sided mouth drop, and slow responds to command outside of baseline..." Review of Resident #253's medical record revealed the following: 07/25/21 [physician's order] "Dialysis on Tuesday, Thursday and Saturday...for End Stage Renal Disease" An Admission Minimum Data Set (MDS) dated 07/31/21 showed facility staff coded: severely impaired cognition and received dialysis while a resident. Care plan focus area, "[Resident #253] has medical diagnosis of Hypotension" reviewed on 08/03/21 showed "...will maintain BP (blood pressure) within acceptable range as determined by MD (medical doctor) ... Give medications as ordered..." 08/10/21 [physician's order] "Midodrine (for low blood pressure) HCl (Hydrochloride) Tablet 5 MG (milligrams), give 1 tablet by mouth three times a day every Mon (Monday), Wed (Wednesday), Fri (Friday), Sun (Sunday) for low bp (blood pressure), please hold if SBP (systolic blood pressure) > (greater than) 110 or HR (heart rate) > (greater than) 60"	F 684		12/5/2022

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F 684	Continued from page 90	F 684		12/5/2022

Medication Administration Record (MAR) for September 2021 showed that facility staff administered Midodrine 5 MG on the following dates:

09/03/21 at 1:00 PM - SBP 125/77 HR 86
09/05/21 at 9:00 AM - SBP 125/67 HR 78
09/05/21 at 1:00 PM - SBP 125/67 HR 78
09/05/21 at 5:00 PM - SBP 128/76 HR 72
09/10/21 at 9:00 AM - SBP 127/68 HR 80
09/10/21 at 1:00 PM - SBP 127/68 HR 80
09/10/21 at 5:00 PM - SBP 114/76 HR 76
09/12/21 at 5:00 PM - SBP 120/78 HR 68
09/13/21 at 9:00 AM - SBP 130/76 HR 80
09/13/21 at 1:00 PM - SBP 127/68 HR 80
09/17/21 at 9:00 AM - SBP 118/60 HR 76
09/17/21 at 1:00 PM - SBP 126/70 HR 74
09/17/21 at 5:00 PM - SBP 119/79 HR 79
09/19/21 at 1:00 PM - SBP 120/62 HR 66
09/19/21 at 5:00 PM - SBP 122/74 HR 80
09/20/21 at 9:00 AM - SBP 103/62 HR 91
09/20/21 at 1:00 PM - SBP 114/76 HR 87
09/22/21 at 9:00 AM - SBP 128/78 HR 78
09/22/21 at 1:00 PM - SBP 131/76 HR 86
09/24/21 at 9:00 AM - SBP 116/67 HR 70
09/24/21 at 1:00 PM - SBP 116/67 HR 70
09/27/21 at 9:00 AM - SBP 118/75 HR 100
09/27/21 at 1:00 PM - SBP 118/75 HR 100

The evidence showed that facility staff administered Midodrine 5 MG to Resident #253 when the physician's order directed to not do so when the systolic blood pressure was over 110 and the heart rate was over 60.

During a face-to-face interview conducted on 09/22/22 at 11:32 AM, Employee #19 (2nd Floor Unit Manager) stated that education is provided

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F 684	Continued from page 91 to nurses about medications and following the parameters for administration. Cross Reference DCMR - 3211.1	F 684		12/5/2022
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, for one (1) of 63 sampled residents, facility staff failed to ensure that one resident received the proper assistive device to maintain vision. Resident #53. The findings included: Resident #53 was admitted to the facility on 12/10/19 with multiple diagnoses that included: Unspecified Cataract, Hemiplegia and Hemiparesis Following Cerebral Infarction and History of Falling. During an observation and face-to-face interview conducted on 09/21/22 at approximately 11:30	F 685	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #53 was assessed head to toe by licensed nurse on 9/27/22. Resident suffered no negative outcomes. Resident #53 saw an ophthalmologist on 10/13/2022. Resident was prescribed with new glasses and is ordered. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents who require glasses could be affected. Unit managers will conduct a house wide audit for all residents to ensure that residents receive proper assistive device to maintain vision by 12/5/2022. Any negative findings will be corrected upon discovery.	

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F 685	Continued from page 92 AM, Resident #53 stated he lost his glasses months ago and he needs them to read. Review of the medical record revealed the following: 06/02/22 [Physician's Order] "Ophthalmology Consult Treat as needed" 06/16/22 [Ophthalmology Assessment] Documented that Resident #53 required glasses and instructs "...Encourage full-time use for distance and reading ..." A Quarterly Minimum Data Set (MDS) dated 06/22/22, showed that the facility staff coded the following: In section B (Hearing, Speech, and Vision) "Adequate" was coded for ability to see in adequate light (with glasses or other visual appliances) and facility staff coded resident as not needed corrective lenses. In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) summary score "15" indicating intact cognition. Review of the facility's grievance binder revealed 2 handwritten grievances dated 07/18/22 and 07/19/22, concerning Resident #53 not having eyeglasses to aid in his vision. A grievance dated 07/18/22, documented "...Resident stated that he reported his eyeglasses were broken months ago to nursing staff. He has waited 3 months for a new pair..." A care plan with a focus area of, "(Resident #53) has impaired visual function r/t (related to) unspecified Cataracts and other vitreous opacities of unspecified eye ..." revised on	F 685	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/designee will provide in-service or education to ensure that residents that residents receive proper assistive device to maintain their vision. This will be completed by 12/5/22. **4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct an audit of Unit managers will conduct a house wide audit for all residents to ensure that residents receive proper assistive device to maintain vision for the past 3 months, then four (4) times weekly for one month then three times monthly for three months. Results will be given to QAPI monthly for recommendations. All negative findings, with residents missing devices to maintain their vision will be referred to an ophthalmologist upon discovery.	12/5/2022

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F 685	Continued from page 93 07/21/22 had the following interventions "Arrange consultation with eye care practitioner as required ...Monitor /document /report PRN (as needed) any s/sx (signs and symptoms) of acute eye problems ...Sudden visual loss ...Tell the resident where you are placing their items..." During a face-to-face interview conducted on 09/21/22 at approximately 1:00 PM, Employee #42 (Charge Nurse) stated "He [Resident #53] lost his glasses, we will ask the social worker to help him get them replaced."	F 685		12/5/2022
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, for one (1) of 63 sampled residents, facility staff failed to ensure residents received care consistent with the professional standards of practice to prevent the development of pressure ulcers. Residents' #204	F 686		

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F 686	Continued from page 94 These failures resulted in actual harm to Resident #204 when the resident obtained facility acquired ulcers. The findings included: Review of the facility's "Wound Prevention Program" policy (not dated) showed, "...Weekly skin checks will be conducted by the license nurse. This will be documented in the resident's Electronic Medical Record (EMR). Daily, during routine care, the Certified Nursing Assistant will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse..." Review of the facility's "Treatment/Services to Prevent/Heal Pressure" policy (not dated) showed, "... The facility will ensure that ... a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers ... a resident with pressure ulcers receive necessary treatment and services ... to promote healing, prevent infection and prevent e ulcers from developing ... the nurse will notify the physician anytime the pressure sore is showing signs of non-healing or infection ..." Review of the facility's "Wound/Pressure Ulcer Management" policy, revised on 10/01/21 showed, "... Any alteration in skin integrity will be reported to the physician immediately..." Facility staff failed to ensure Resident #204 received care, consistent with professional standards of practice, to prevent pressure ulcer	F 686	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #204 is discharged on 8/9/22. This deficiency cannot be retroactively corrected and resident cannot be reassessed. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All resident has the potential to be affected. House wide skin sweep assessments were completed on 11/16/22 on all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep.	12/5/2022

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F 686	Continued from page 95 development found at advanced stages. Resident #204 was admitted to the facility on 04/21/16 with multiple diagnoses that included: Mild Protein-Calorie Malnutrition, Dementia, Altered Mental Status, Muscle Weakness and Osteoporosis. Review of a Complaint, DC00010905, received by the State Agency on 07/29/22 showed, "... [Facility Name] failed to provide the proper care and appropriate care owed to its long-term resident ... [Resident #204] was neglected and sustained significant physical injuries over an unknown period which resulted in her current hospitalization ..." Review of Resident #204's medical record revealed the following: 07/14/21 [physician's order] "Monitor skin for easy bruising (EB), bleeding (B), Skin Discoloration (SD), None (N) every shift and Alert MD with any changes, Resident on Aspirin EC (enteric coated) daily" 08/26/21 [physician's order] "Provide incontinent care with each incontinent episode. Wash peri area with soap and water, pat dry and apply barrier cream every shift and as needed" 03/03/22 [physician's order] "Shower twice a week on Monday and Wednesday and per patient request..." (Discontinued on 04/20/22) An Annual Minimum Data Set (MDS) dated 04/13/22, showed that facility staff coded: A Brief interview for Mental Status (BIMS) summary score of 7, indicating severe cognitive	F 686	**3. MEASURE TO PREVENT REOCURRENCE:** House wide skin sweep assessments were completed on 11/16/22, for all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep. The licensed nurses will complete a skin assessment upon admission and the wound nurse/designee will complete a thorough skin assessment within 24-48 post-admission and validate all impaired areas were documented and treatments are ordered and care plan is initiated. Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place. Education will be completed by 12/5/2022.	12/5/2022

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impairment; required total dependence with one to -two people's physical assist for bed mobility, transfers; extensive assistance with one-person physical assist for toilet use and personal hygiene; frequently incontinent of urine and bowel; active diagnoses of Anemia; no significant weight loss; at risk for pressure ulcers; and no pressure ulcers, wounds or other skin problems.

Skin area #1- right foot:

04/18/22 at 4:28 PM "Nurses Note ...Skin warm to touch and no new skin issues noted. Continued to require total care with all ADL (activities of daily living) cares. Turned and repositioned for pressure relief ..."

04/19/22 at 5:14 PM "Skin Observation Tool (Licensed Nurse) ... skin is intact, warm and well lubricated. No wound"

04/20/22 [Treatment Administration Record (TAR)] facility staff documented "yes", a check mark (meaning administered), and initialed to indicate that a shower was completed.

04/20/22 [physician's order] "Skin Assessment weekly on shower day by license nurse every day shift every Thu (Thursday)"

04/20/22 [physician's order] "Shower twice a week and per patient request every day shift every Thu, Sat (Saturday)"

04/21/22 (Thursday) [Shower/Bath Sheet] " ...12 (skin intact/no irritation); complete bed bath"

04/21/22 [TAR] - facility staff initialed to indicate that the weekly skin assessment was completed

F 686

Staff Educator/Designee will conduct in-service/education to all licensed nurses on their responsibility regarding monitoring the nursing assistants to ensure showers are being given and skin assessment completed timely for residents and turning, and positioning is properly implemented per physician orders. Completed by 12/5/22.

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Staff Educator/Designee will conduct an in-service/education to all licensed nurse and certified nursing assistants to ensure that documentation on bath and shower sheets and skin assessments accurately reflect the resident's condition. This will be completed by 12/5/2022

4. **MONITORING CORRECTIVE ACTION**
Unit Managers/Designee will conduct a weekly skin assessment ongoing and conduct a bath and shower sheet audit weekly x 4, then monthly x 3 to ensure that these are completed timely and accurately. All negative findings will be addressed upon discovery. Findings will be brought to QAPI monthly for recommendations and review.

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04/22/22 at 7:34 PM "Social Services Note ... IDT (interdisciplinary team) meeting was held ... No sig. (significant) changes to report resident is stable ..."

Care plan focus area, "[Resident #204] has an ADL self-care performance deficit r/t (related to) impaired balance and other conditions", reviewed on 04/22/22 showed, "Provide incontinent care with each incontinent episode. Wash peri area with soap and water, pat dry and apply barrier cream every shift and as needed. The resident requires assistance by staff with bathing/showering routinely and as necessary ...The resident requires assistance by staff for toileting..."

Care plan focus area, "[Resident #204] has bladder and bowel incontinence r/t deconditioning" reviewed on 04/22/22 showed, "Apply moisture barrier cream to skin after each incontinent care. Calazime (skin protectant paste) cream to buttocks and perineal area with incontinent changes every shift. Incontinent check every two hours and change when soiled and PRN (as needed). Report any signs of skin breakdown."

Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" reviewed on 04/22/22 showed, "Keep skin clean and dry. Use lotion on dry skin. Provide incontinent care routinely and as needed ..."

Care plan focus area, "[Resident #204] is at risk for pressure ulcer development r/t immobility" reviewed on 04/22/22 showed, "...administer

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medications as ordered ... administer treatments as ordered ... assess/record/monitor wound healing every shift ... report improvements and declines to the MD."

04/23/22 [TAR] facility staff documented "yes", a check mark, and initialed to indicate that a shower was completed

04/23/22 (Saturday) [Shower/Bath Sheet] "...complete bed bath". There was no licensed nurse signature on the form.

04/26/22 at 11:29 AM "Skin Observation Tool (Licensed Nurse) ...No new skin issues noted"

Review of the April 2022 TAR from 04/01/22 to 04/28/22, showed that facility staff documented: "N", meaning no or none, in the area that directed, "Monitor skin for easy bruising, bleeding, skin discoloration ...every shift and alert MD (medical doctor) with any changes; no refusal of care behaviors; and that the resident was turned and repositioned every two hours.

04/28/22 at 4:56 PM "Podiatry Note ... Patient is seen bedside for thick, elongated toenails and wound right foot ... Skin: Distal aspect of right hallux with noted sanguineous (sp) scab and eschar (dead tissue) to distal aspect, noted purulence and deep probing sinus ... distal aspect of right 5th toe with noted dry sanguineous scab and eschar to distal aspect ... recommend vascular consult to evaluate for healing potential. Ulcer right 5th toe. Dry eschar right 5th toe ... Ulcer right Hallux. Pain right Hallux. Partial debridement of ulcer to patient tolerance. Noted deep probing and purulence during exam ...Recommend starting antibiotics. Please obtain

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F 686	Continued from page 99 labs: CBC with Diff, CMP, ESR, CMP. Please obtain x-rays of right foot to rule out osteomyelitis of right hallux..." 04/29/22 at 9:23 AM "Tissue Analytics ... Right heel ...Length: 2.45 cm; width: 2.67 cm; Wound acquired 4/29/22; [percent] epithelialization 100.00; Status - new; Acquired in house? Yes; Etiology- pressure ulcer - Suspected DTI (deep tissue injury) ...Dressing change frequency - daily, dressings- skin prep..." 04/29/22 at 1:55 PM "Tissue Analytics Right great toe ... Length: 1.40 cm, width: 1.60 cm; Wound Acquired 4/28/22, [percent] slough/eschar 100.00 ...Status - New; Acquired in House? Yes; Etiology Arterial ...Dressing change frequency BID (twice a day), cleanse wound with- Normal Saline, dressing- Betadine..." 04/29/22 at 10:20 AM "Situation Background Assessment Request (SBAR) ...Communication Tool...Situation: skin areas on right great toe red right heel. Date problem or symptom started: 04/29/2022 ... resident had podiatry foot care at the bed side and then was observed with a right arterial area to the right great toe. Reddened area to the right heel. Skin intact. MD and RP (representative) aware. Treatment order in place." 04/29/22 at 11:10 AM "Nurses Note Late Entry ... Resident had Podiatry foot care at the bedside on 4/28/22 and a right great toe ulcer was observed after the podiatry care and Resident has reddened right heel, skin is intact. Responsible party... was made aware. No indication of pain. Right heel elevated on a pillow." 04/29/22 at 2:18 PM "Skin/Wound Note...	F 686		12/5/2022

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Comprehensive skin and wound evaluation for consult: right heel, right great toe... Dermatologic - wound(s) present...Right heel DTI. Right great toe arterial ulcer...Patient seen by podiatry 4/28/22. Per podiatry, recommend vascular consultation to evaluate healing potential, recommend x-ray of right foot to rule out osteomyelitis of right hallux..."

04/29/22 at 2:21 PM "Skin/Wound Note Late Entry... MD, R/P... made aware of resident's right heel wound and right great toe (podiatry-caused) wound. Nursing staff aware."

05/02/22 [physician's order] "Right great toe surgical site- Paint with Betadine (antiseptic) and secure with bordered gauze twice daily every day and evening shift for wound healing"

05/02/22 [physician's order] "Right heel DTI - Apply Skin prep and leave open to air daily every day shift for wound healing" (discontinued on 05/09/22)

The evidence showed that the Tissue Analytics documented dressing orders however, there was no physician's orders until 05/02/22, 4 days later. Furthermore, there was no documented evidence that licensed staff performed dressing changes during those 4 days.

05/05/22 at 6:02 PM "Podiatry Note ...follow-up wound right foot ... Bandage to right heel left intact, deferred to wound care. Distal aspect of right hallux with noted eschar to distal aspect, noted scant purulence however improved since last exam ...distal aspect of right 5th toe with noted dry sanguineous scab and eschar to distal aspect ... recommend vascular to evaluate

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healing potential (ordered) ...Discussed with charge nurse as concern for deep infection..."

05/05/22 [physician's order] "Consult for vascular evaluation for healing potential ..."

05/07/22 at 10:23 PM "Radiology Results Note...Date of Test: 5/6/2022. Type of Test: Right foot, complete, 3+ views ... Findings ... No evidence of osteomyelitis ..."

05/24/22 "Report of Consultation ... Vascular consult for wound healing potential ... findings: dry stable gangrene of r (right) hallux ... Diagnosis: toe gangrene ..."

For Resident #204's right foot, the evidence mentioned above revealed that although facility staff documented to implementing the interventions for Resident #204 from 04/01/22 to 04/27/22, the resident was first observed with a right great toe wound at 100 percent eschar and a right 5th toe wound at 30 percent eschar on 04/28/22. Facility staff failed to have a doctor's order for dressing changes to the right foot for 4 days.

Skin area #2- sacrum:

06/28/22 at 9:30 AM "Skin Observation Tool (Licensed Nurse) ... Site: Right heel. Type -pressure, length 3.79cm, width-4.58cm, depth, 0.0cm, stage -Suspected Deep Tissue Injury; R. (right) great toe site - type - arterial, length-1.28cm, width-0.71cm, depth -0.0cm, Stage-N/A. Resident has treatment orders for the sites and is followed by the wound team."

06/29/22 at 12:26 AM "Nurses Note ... Resident is

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stable and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact on right heel and right great toe. No drainage noted. Paint with Betadine prep on right great toe in this shift. Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. Extensive assist for ADL care provided ..."

06/30/22 at 3:25 PM "Nurses Note ... Resident is alert and verbally response ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact, no drainage and redness noted, ADLS and oral hygiene provided by staff ..."

06/30/22 [Shower/Bath Sheet] " ...12 (skin intact/no irritation)"; "condition of skin" section was left blank; "complete bed bath given".

07/01/22 at 8:02 AM "Nurses Note ...skin remain unchanged dry and warm to touch ...Turned and repositioned every two hours... Right heel and right great toe wound dressing intact ..."

07/02/22 [Shower/Bath Sheet] "condition of skin" section showed facility staff documented a line and "12", indicating skin intact/no irritation and "bed bath"

07/02/22 at 11:40 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Wound dressing intact on right heel and right great toe ...Provide incontinent care with

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each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. Extensive assist for ADL care provided ..."

07/03/22 at 7:43 AM "Nurses Note... Turned and repositioned every two hours. Both heels elevated with pillow to prevent pressure ulcer. Right heel and right great toe wound dressing intact..."

07/03/22 at 3:35 PM "Nurses Note...skin dry and warm to touch...Right heel and right big toe wound dressing is changed...ADL provided by staff."

07/03/22 at 11:35 PM "Nurses Note ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Changed wound dressing on right heel and right great toe ...Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. The pressure ulcer is a little wider in the resident's coccyx area. Dressing done..."

There was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the licensed staff on 07/03/22.

07/04/22 at 1:57 PM "Nurses Note ... Skin is warm to touch, well moisturized. No skin bruising, No skin bruising and bleeding noted ... Right heel and right great toe wound dressing intact ..."

Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile

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skin and Aspirin use" showed, " ...07/04/22 IDT meeting held. Care plan reviewed and updated ...Patient has an actual wound/sacral DTI."

Although it was discussed at the care plan meeting, there was no documented evidence that further actions such as further assessment of the resident, notifying the physician, or documenting a request for intervention was taken by the IDT on 07/04/22.

07/05/22 at 10:44 PM "SBAR...Communication Tool... Situation Pressure ulcer on coccyx, approx. 10cm*10cm*0.2...Date problem or symptom started 7/3/2022... Identify whether the problem/symptom has gotten worse/better/stayed the same since it started- Worse... Pressure ulcer of coccyx area got wider and worse...Assessment: In my opinion, residents need active pressure ulcer treatment and care ..."

The above SBAR showed that the licensed nurse completing the form listed her own name under the section "person contacted".

07/05/22 at 11:09 PM "Nurses Note...Continue monitoring skin wound on right foot and coccyx area. Wound dressing intact on right heel and right great toe ...The pressure ulcer of coccyx area is more wider and worse. Approx. 10cm*10cm*0.2, drainage noted. Dressing changed. I notified to Dr. (doctor) about resident's condition via SBAR..."

Review of the July 2022 TAR from 07/01/22 to 07/05/22, showed that facility staff documented: "N", meaning no or none, in the area that directed, "Monitor skin for easy bruising, bleeding, skin discoloration ...every shift and alert MD with

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F 686	Continued from page 105 any changes"; no refusal of care behaviors; a check mark, and initials to indicate that incontinent care was provided with barrier cream applied to peri area every shift; and that the resident was turned and repositioned every two hours, every shift. From 07/03/22 to 07/05/22 (3 days), there was no documented evidence facility staff notified the physician or requested any intervention for Resident #204's sacral area. 07/06/22 at 3:30 PM "SBAR...Communication Tool... Situation suspected DTI on the sacral ... Date problem/symptom started 07/06/2022 ...Person contacted ... son [RP] ... Provider visit [medical doctor's name] ..." 07/06/22 at 5:04 PM "Skin Observation Tool (Licensed Nurse) ... Site: sacrum. Type-pressure, length- 9.0cm, width-12.0cm, depth-0.0cm, stage- suspected deep tissue injury. Resident has a new area to the sacrum suspected DTI. Thin. Frail skin. Pressure relief mattress. Treatment order in place. Repositioning every 2 hours. Labs and Dietary consult." 07/06/22 [physician's order] "Sacral Wound: Cleanse with normal saline solution; pat dry, apply silver alginate on wound bed and secure with borded (sp) gauge daily and PRN every day shift for skin care" (discontinued 07/08/22) Care plan focus area, "[Resident #204] has a new wound site DTI on the sacrum, fragile, thin skin" initiated on 07/06/22 showed, "Monitor/document wound... Notify physician as indicated. Monitor/document/report PRN (as needed) any	F 686		12/5/2022

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s/sx (signs and symptoms) of infection ..."

07/07/22 at 11:22 AM "Tissue Analytics ... Location; sacrum; length 10.80 cm; width 9.48 cm; depth 0.10 cm ... Date wound acquired 7/6/22; [percent] slough/eschar 30.00; Wound status - new; acquired in house? Yes ..."

For Resident #204's sacrum area, the above evidence revealed that facility staff failed to: accurately assess, document on the resident's skin on 07/03/22 and report signs of worsening skin breakdown. Additionally, facility staff failed to notify the physician for 3 days after the sacrum wound was first documented as "more wider", subsequently, when seen by the wound Nurse Practitioner on 07/07/22, the sacral area measured 10.80 cm by 9.48 cm by 0.10 cm deep with 30% eschar.

During a face-to-face interview on 09/15/22 at 3:25 PM, Employee #2 (Director of Nursing/DON) reviewed the shower/bath sheets for Resident #204 and stated, "When the CNA (Certified Nurse Aide) is giving the resident a shower or bath, the nurse is to go in to do the head-to-toe skin assessment with the CNA present. The nurse documents what she sees and they both [CNA and nurse] sign the bath sheet. The "Condition of Skin" section should always be completed. It documents the resident's current wounds or skin issues and anything new that is noted. If the resident refuses the shower, bath or skin assessment, it is documented on the form, the progress note and the MD and RP are notified."

During a telephone interview on 09/15/22 at 4:34 PM, Employee #6 (Podiatrist) stated, "I saw [Resident #204] in April (2022) as part of regular

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F 686	Continued from page 107 podiatry services at the facility done every Thursday. I noted a dry, stable, eschar wound on the right 5th toe and a dry, eschar area near the right big toe. I started to debride the area [right big toe] and pus just started coming out. The nurse was in there with me. I wrote the recommendations [labs, x-ray, and ultrasound] in my note. When I came in on May 5th (2022), I saw that none of the recommendations were followed, so I wrote them again and they were finally ordered." During a face-to-face interview conducted on 09/16/22 at 9:32 AM, Employee #7 (Staff Educator/1 north Unit Manager) reviewed the progress notes and licensed skin assessments for Resident #204 for April 2022 and stated, "Looking at the resident's feet is part of the skin assessment. [Resident #204] started getting the wounds on her right foot treated after she was seen by the podiatrist. The staff [nurses and CNAs] did not mention to me that they observed any skin issues on [Resident #204's] feet." Employee #7 then reviewed the July 2022 progress notes and the 07/05/22 SBAR for Resident #204 and stated, "The staff documented to doing skin assessments but there's no mention of anything being on her sacrum area until July 3rd [2022]. Whoever first notices the change in the skin is the one who makes the doctor and family aware. The nurses know to notify the doctor immediately for any changes and to document it in the progress notes. This SBAR [dated 07/05/22] was not done properly. Another one was done on the 6th [07/06/22] where the family and doctor were notified." Cross Reference DCMR 3211.1	F 686		12/5/2022

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F 689 SS=G Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, for three (3) of 63 sampled residents, facility staff failed to provide adequate supervision and assistance to residents to prevent accidents and injury as evidenced by: 1. failure to secure Resident #3's wheelchair with the seatbelt in the transportation van; 2. failure to assign a 1:1 monitor to Resident #505; and 3. failure to provide Resident #176 with 1:1 supervision while in the courtyard. (Residents' #3, #505 and #176)

These failures resulted in actual harm to Resident #3, example #1.

The findings included:

1. Facility staff failed to provide adequate supervision to Resident #3, who was not secured in the transportation van with a seatbelt and subsequently sustained an injury when he flipped out of his wheelchair during transport to an appointment.

Review of the facility's policy entitled, "Resident Transportation To and From Medical Appointment" (revised 07/2022) documented,

F 689

12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

Resident #3 resident was admitted and treated at the hospital on 11/3/21. The resident was stable and was discharged on 11/11/21 Resident returned to the facility on 11/11/21. Head to toe assessment was completed on 11/11/21. No new negative findings were found.

Employee #27 was in-serviced on facility transportation policy to ensure that the resident is safe and secure in the transport van prior to leaving. Employee is also encouraged that for any reason she cannot validate the resident is secure, the transportation driver is made aware and to escalate the situation to the DON/house supervisor or administrator if unable to verify the resident's safety.

Resident #505 1:1 supervision is in place as indicated in the care plan. Head to toe assessment was completed on 9/28/2022, Resident suffered no negative outcomes. The staffing coordinator and charge nurse will ensure that 1:1 supervision is scheduled without any gaps.

Resident #176 is supervised at all times while in the courtyard by the courtyard monitor staff upon discovery. Resident #176 signed a social contract on 10/27/22 to abide by the facility policies and conduct including non-consumption of alcohol. Resident #176 comprehensive care plan was reviewed and updated to reflect the appropriate care based on the resident's needs. These interventions are properly implemented. Resident suffered no negative outcomes

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

All facility residents using transportation escorts or needing one on one supervision have the potential to be affected.

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F 689	Continued from page 109 "The assigned Certified Nursing Assistance (Certified Nursing Aide/CNA) or designee will ensure the resident is safe and well strapped and secure with the belt ...while in the transportation van." Resident #3 was re-admitted to the facility on 10/04/21 with diagnoses that included: Acute Osteomyelitis, Atherosclerosis of Native Arteries of Extremities with Intermittent Claudication Right Leg, Hemiplegia, Spinal Instabilities of the Cervical Region and Generalized Muscle Weakness. A Quarterly Minimum Data Set (MDS) dated 10/29/21 documented that facility staff coded: severely impaired cognition; upper and lower extremity impairment on one side; required extensive assistance for transfers; and using an (electrical) wheelchair for mobility. A facility reported incident (DC00010380) received by the State Agency on 11/04/21 at 5:20 PM documented, ". Resident left the facility this morning at about 10:20 AM, for a scheduled Vascular appointment ...with his electric wheelchair accompanied by the facility escort with a Medicaid transportation ... At about 11:36 AM on 11/3/2021, the escort who accompanied the resident for the appointment called the facility and stated, 'When we got into the van, the residents ('s) wheelchair was secured by the van driver. The car in front of us made an illegal stop to make a left turn, the driver of our van made an abrupt stop to prevent hitting the car in front of us, and [Resident #3] fell from his chair and landed on the floor... I then called the facility, and the facility asked for the resident to be transferred to the emergency room for further evaluation and	F 689	ADON or designee will audit all resident's transportation log for appointments, and accidents log for the past six months (May 2022 to October 2022), to ensure that there were no other residents who were adversely affected by the deficient practice. Unit Managers or DON will conduct a house wide audit of all resident care plans requiring one on one supervision to ensure that this is properly implemented. All negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct in-service/education to transportation aides on facility transportation policy to ensure that the resident is safe and secure in the transport van prior to leaving and ensure that staff are encouraged that for any reason they cannot validate the resident is secure, the transportation driver will be made aware and to escalate the situation to the DON/house supervisor or administrator if unable to verify the resident's safety. This will be completed by 12/5/22. Staff Educator/Designee will educate the Interdisciplinary team regarding the proper implementation of the care plan on 1:1 supervision to ensure resident safety. Staff Educator/designee will educate staff on the elopement policy and ensure that residents who are at risk for elopement are monitored and care plans are implemented. Education will be completed by 12/5/2022.	12/5/2022

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treatment.'...the resident was transported to hospital... Per ER (Emergency Room) nurse, "a CT (Computed Tomography), spine cervical w/o contrast and a CT Head w/o (without) contrast were completed with the result showing: 'Comminuted fractures of the right lateral mass of C1 and anterior and posterior ring of C1. Nondisplaced fracture of the right lateral mass of C3' ..."

A review of Resident #3's medical record revealed:

11/03/21 at 5:02 PM, SBAR "Situation: The resident had a motor vehicle accident (MVA) on the way to a scheduled vascular appointment at [Local Hospital] and sustained a fracture ...Additional Comments: The resident left the facility this morning at about 10:20 AM for a scheduled vascular appointment ...At about 11:00 AM on 11/3/2021, per the escort, 'The car in front of us made an illegal stop to make a left turn, the driver of our van made an abrupt stop to prevent hitting the car in front of us and [Resident #3] fell from his chair and landed on the floor. I immediately told the driver to pull over and stop so we can attend to [Resident #3] which he did.' ...."

During a face-to-face interview on 09/22/22 at 2:03 PM, Employee #27 (CNA and escort assigned to Resident #3) stated, "The driver put the resident on the van using the lift, and I locked the resident's wheelchair." When asked who secured the resident with the seatbelt, the Employee responded, "I went to secure the resident, but the driver said, 'Sit down, I got it.' Normally, I would have grabbed the seatbelt to put it on the resident, but the driver told me to sit

4. MONITORING CORRECTIVE ACTION

ADON or designee will audit all resident's transportation log for appointments, and accidents log for the past six months (May 2022 to October 2022), to ensure that there were no other residents who were adversely affected by the deficient practice.
Unit Managers or DON will conduct a house wide audit of all resident care plans requiring one on one supervision to ensure that this is properly implemented. All negative findings will be corrected upon discovery. This will be completed weekly for four weeks then monthly for three months. Findings will be brought to QAPI monthly meeting for further recommendations and review. All negative findings will be corrected upon discovery.

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down, so I did ...The driver was on his phone and wasn't paying attention. I tried to let him [the driver] know that my resident was not secure as we pulled off, but he continued to ignore me. The next thing I knew, the driver hit the brakes. [Resident #3] was thrown out of his wheelchair, and [was] lying beside me on the floor of the van. I yelled, 'Sir, Stop, Stop, my resident,' The van driver then pulled over. I called the Nurse Manager to let her know what happened and to see if the resident needed to be transported to the hospital."

Facility staff failed to ensure that Resident #3 was well strapped and secure with a seatbelt prior to the transport van being put into motion. Subsequently, when the van drive hit the brakes on the van, the resident was thrown out of his wheelchair and sustained a fracture. These failures resulted in harm to the resident.

2. Facility staff failed to provide Resident #505 with a 1:1 monitor on 09/20/22, subsequently the resident went missing for 30 minutes in the facility.

Resident #505 was admitted to the facility on 09/02/22 with diagnoses that included: Other Symptoms and Signs Involving Cognitive Awareness, Altered Mental Status, Anxiety Disorder, Schizoaffective Disorder, Unspecified Dementia with Behavioral Disturbance, and Disorientation.

Review of Resident #505's medical record revealed:

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F 689	Continued from page 112 09/02/22 [Admission Minimum Data Set (MDS)] documented that facility staff coded Resident #505 with a Brief Interview for Mental Status (BIMS) summary score of "07," indicating severely impaired cognition. Under Section E (Behaviors), facility staff coded the resident for displaying behavior symptoms of hitting, kicking, pushing, scratching, grabbing, threatening, screaming, and cursing others, as well as wandering and intruding on the privacy of others. 09/02/22 [Physician's Order]: "Psychological consult and treatment as needed." 09/03/22 [Physician Order] "Resident on 1:1 Nursing Supervision for Elopement and Fall Risk every shift..." During a unit tour of 3 North conducted on 09/20/22 at 2:52 PM, the surveyor observed that Resident #505 was not in his room. At the time of the observation when asked where Resident #505 was Employee #33 (Unit Manager) stated that she thought the resident was attending a group activity on the first floor. A second observation on 09/20/22 at approximately 2:53 PM revealed that Resident #505 was not in the activity room on the first floor. Employee #34 (Activities Staff), confirmed that the resident was not in attendance for the activity. During a face-to-face interview on 09/20/22 at 3:00 PM, when asked if Resident #505 was still on 1:1 monitoring, Employee #2 (DON) stated, "Yes." The surveyor then informed Employee #2 that at approximately 2:55 PM, Resident #505 was not observed in his room, or in the activity group on the first floor. The Employee then	F 689		12/5/2022

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stated that she would go to the unit to investigate this herself.

At 3:15 PM on Unit 3 North, the surveyor observed Employee #2 (DON) checking the unit's assignment board. Employee #2 then asked Employee #33 (Unit Manager), "Who was assigned as the one to one monitor for [Resident #505] today? " Employee #33 replied, "I asked Employee #35 (Staffing Coordinator) about this, and he told me there was no one to one coverage for residents on the unit today."

It should be noted at 3:20 PM, a "Code Pink-Elopement Risk" was initiated and Resident #505 was located by staff at 3:25 PM in the 3 North dining room.

During a second face-to-face interview on 09/20/22 at 3:40 PM, Employee #2 (DON) stated that both Employee #33 (3rd Floor Unit Manager) and Employee #35 (Staffing Coordinator) knew that Resident #505 had orders for 1:1 monitoring, and should have called her if there was any question. Employee #2 acknowledged that facility staff failed to provide adequate 1:1 monitoring and supervision to Resident #505.

3. Facility staff failed to provide 1:1 supervision of Resident #176 while in the courtyard.

Review of the facility's policy titled "Smoking policy" with a revision date of 10/01/21, documented "Residents will be supervised by staff when smoking..."

Resident #176 was admitted to the facility on 08/25/15 with diagnoses that included: Alcohol Abuse with Intoxication, Anemia and Atrial

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F 689	Continued from page 114 Fibrillation. Review of Resident #176's medical record revealed the following: Care plan focus area, "[Resident #176] has a behavior problem of drinking liquor in the facility r/t (related to) life style" revised on 08/19/22 showed, " ...can go to [Store] with facility staff or family member ...1:1 supervision while in courtyard (initiated 06/08/22) ..." A Quarterly Minimum Data Set (MDS) dated 08/23/22 showed facility staff coded: intact cognition; no physical or verbal behavioral symptoms directed towards others; independent with activities of daily living (ADLs); required supervision for locomotion off the unit; and used a wheelchair for mobility. The facility's visitor log for 09/20/22 showed that Resident #176 had a visitor that took him out of the facility at 12:21 PM and returned at 2:00 PM. During an observation on 09/22/22 at approximately 4:30 PM on unit 4 South, Resident #176 was observed yelling profanities at facility staff as he wheeled himself past the nurses' station with two security officers behind him. When asked what was going on, Employee #12 (Security Officer) stated, "I saw [Resident #176] coming in from the courtyard (smoking area) with a bottle of alcohol in his lap that was 75% already drunken. I said to him he's not allowed to have that and he started yelling and cussing at me and got in the elevator. I called [Employee #1/Administrator]. The other security officer came with me and we followed him up here."	F 689		12/5/2022

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F 689	Continued from page 115 Review of the smoke aide schedule for 09/22/22 evening shift 3:00 PM - 11:00 PM showed that two employees were scheduled for the courtyard, Employees' #16 and #17, both Smoke Aides. During a face-to-face interview conducted on 09/23/22 at 11:39 AM, when asked if she was aware that Resident #176 required 1:1 supervision at all times when in the courtyard, Employee #16 stated, "No." During a telephone interview conducted on 09/23/22 at 11:45 AM, Employee #17 stated that he also was not aware that Resident #176 required 1:1 supervision while in the courtyard. During a face-to-face interview conducted on 09/23/22 at 5:49 PM, Employee #2 (Director of Nursing) stated that administration and the IDT have been trying to work with Resident #176 regarding his drinking alcohol on the premises. Regarding the 1:1 supervision, the employee stated, "We don't have the staff for it."	F 689		12/5/2022
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 695		

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F 695 Continued from page 116

interview, for three (3) of 63 sampled residents, facility staff failed to ensure that residents received oxygen/respiratory care in accordance with the physician order. Residents' #123, #132 and #185.

The findings included:

Review of the policy entitled "Oxygen Concentrator Utilization" revised 10/01/21 documented, " ...Procedure and Implementation ... Weekly change cannula and tubing as to reduce the risk of respiratory infections and other contamination..."

1. Facility staff failed to ensure Resident #123's trach mask was positioned over his trach and that the oxygen therapy level was set at the ordered level for administration.

Resident #123 was admitted to the facility on 10/19/20 with diagnoses that included Acute Respiratory Failure, Acute Respiratory Distress Syndrome, Tracheostomy and Cerebral Infarct.

During an observation on 09/19/22, Resident #123's trach mask was observed placed away from the trach area, on the side of the resident's neck. The humidified oxygen level was noted at 3.5L [Liters].

Review of the medical record revealed:

A physician's order dated 10/19/20 that directed," O2 (oxygen) via tracheostomy mask at 4L(liters)/min (minute) continuously."

F 695

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1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS

Resident #123 had no adverse outcomes due to this deficient practice. Resident will be checked every 4 hours by the licensed nurse to ensure that trach mask is properly positioned over his trach and that the oxygen therapy level is set at the ordered level for administration. Resident #123 the tubings were replaced and dated appropriately upon discovery.

Resident was made aware of risk and benefits related to not changing oxygen settings on 9/19/2022, Head to toe assessment performed by licensed nurse on 9/21/2022. Resident suffered no negative outcomes.

Resident #132 oxygen therapy was set at the ordered level for administration. Licensed nurse will check oxygen levels Q shift to ensure oxygen therapy is set at the ordered level for administration based on physician orders.
Resident #132 was made aware of risk and benefits related to not changing oxygen settings on 9/19/2022. Head to toe assessment performed by licensed nurse on 9/21/2022. Resident suffered no negative findings.

Resident #185 was discharged to the hospital on 10/2/22. This deficiency cannot be corrected retroactively.

2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED

All residents on Oxygen and tracheostomy, have the ability to be affected.

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F 695 Continued from page 117

Care plan with a revision date of 08/01/22 showed, "[resident name] is on oxygen therapy O2 at 4L/min r/t (related to) ineffective gas exchange."

During a face-to-face interview conducted at the time of the observation, Employee #45 [charge nurse] stated, "The resident keeps moving the trach mask from the position of the trachea." When asked about the oxygen not being at the prescribed level, the employee did not provide an answer.

There was no evidence that facility staff ensure Resident #123 received the 4 liters of oxygen as prescribed by the physician.

2. Facility staff failed to ensure Resident #132's oxygen therapy was set at the ordered level for administration.

Resident #132 was admitted to the facility on 10/19/20 with diagnoses that included Unspecified Asthma, Chronic Respiratory Failure and Acute Respiratory Failure.

According to the Quarterly Minimum Data Set dated 08/29/22 the resident was coded as being cognitively intact, required extensive assistance with transferring, with dressing and personal hygiene, had no impartment with range of motion to upper or lower extremities, uses a wheel chair for mobility and was receiving oxygen therapy.

F 695

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Unit Managers/Designee will conduct a house wide audit of all residents on oxygen administration, respiratory care and trach mask. All negative findings will be completed upon discovery.

3. **MEASURE TO PREVENT REOCURRENCE**

Staff Educator/Designee will conduct In-service for licensed nurses on following Physician orders ensure that proper oxygen therapy administration, proper respiratory care and trach mask placement is in its proper place according to the physician's orders. Education will be completed by 12/5/2022.

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F 695	Continued from page 118 Review of the care plan initiated 02/24/22 showed focus: "[Resident name] is on continuous oxygen therapy at 2L/m [liters per minute] r/t (related to) Respiratory illness..." Review of the physician's order dated 06/09/22 directed, "Continuous oxygen 2L via nasal cannula every shift for Hypoxia" During an observation made on 09/13/22 at 2:00 PM, the resident's oxygen level was noted at 3 Liters. During a face-to-face interview conducted at the time of the observation, Employee #45 (Registered Nurse) stated, "The resident must have changed it, I will educate her." 3. Facility staff failed to provide respiratory care per physician's orders and per the facility's "Oxygen Concentrator Utilization" policy for Resident #185. During an observation on 09/19/22 at 4:30 PM, Resident #185 was lying in bed, receiving 3 liters of humidified oxygen via nasal cannula. The humidifier bottle and nasal cannula tubing had a date of "09/11/22" and no initials of the last nursing staff who changed the tubing or humidifier bottle. Resident #185 was admitted to the facility on 05/07/21 with diagnoses that included: Acute and Chronic Respiratory Failure, Diastolic Congestive	F 695	**4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct a house wide audit of all residents on oxygen and trach mask in the past 3 months(August 2022-October 2022), then weekly for four weeks and three times monthly for three months. To ensure that resident is administered with the correct oxygen level, proper respiratory care and trach mask placed in the appropriate position. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	12/5/2022

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F 695	Continued from page 119	F 695		12/5/2022

Heart Failure, Obstructive Sleep Apnea, and Obesity.

Review of Resident #185's medical record revealed:

An Annual Minimum Data Set (MDS) dated 03/21/22 showed facility staff coded: intact cognition. Under Section O (Special Treatments), requiring oxygen therapy...while a resident within the past 14 days.

06/15/22 [physician's order]: "Change humidifier bottle weekly every night shift every Friday for humidification."

06/15/22 [physician's order]: "Change and replace oxygen concentrator filter weekly every night shift every Friday."

06/15/22 [physician's order]: "Change oxygen tube weekly every night shift every Friday for infection prevention."

08/18/22 [physician's order]: "Date and initial tubing and humidifier bottle, as needed."

08/18/22 [physician's order]: "Oxygen at 3 LPM (liters per minute) via nasal cannula continuously every shift for SOB (shortness of breath)."

The Treatment Administration Record (TAR) from 09/01/22 to 09/15/22 showed that facility staff initialed to indicate that Resident #185's nasal cannula tubing and humidification bottle were changed.

Although facility staff documented that they were changing the nasal cannula tubing and humidifier

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F 695	Continued from page 120 bottle weekly, the resident's nasal cannula tubing and humidifier bottle were dated on 09/11/22 (more than a week prior to the surveyor's observation on 09/19/22). During a face-to-face interview on 09/19/22 at 4:55 PM, Employee #38 (Weekend Supervisor) stated, "I spoke with the Charge Nurse last night and left supplies. Every Sunday night shift, we are supposed to change it. I am not sure what happened."	F 695		12/5/2022
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

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§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to ensure that licensed nurses had the competency and skill sets necessary to implement, assess and document. Resident #204.

The findings included:

Review of the "Change in Condition/Notification of Physician & Responsible Party" policy revised on 10/01/21 showed, " ... [Facility name] must immediately ... consult with the resident's physician, and notify responsible party/appointed guardian when there is ... a significant change in the resident's physical, mental, or psychosocial status ... a need to alter treatment significantly (that is, a need to discontinue or change existing form of treatment ..."

Review of the "Wound/Pressure Ulcer Management" policy, revised on 10/01/21 showed, "... Any alteration in skin integrity will be reported to the physician immediately..."

Resident #204 was admitted to the facility on 04/21/16 with multiple diagnoses that included: Mild Protein-Calorie Malnutrition, Dementia, Altered Mental Status, Muscle Weakness and Osteoporosis.

F 726 | 12/5/2022

1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS**

   Resident #204 is discharged on 7/23/22. This deficiency cannot be retroactively corrected and resident cannot be reassessed.

2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**

   All resident has the potential to be affected. House wide skin sweep assessments were completed on 11/16/22 on all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep.

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F 726	Continued from page 122	F 726		

Review of a Complaint, DC00010905, received by the State Agency on 07/29/22 showed, "... [Facility Name] failed to provide the proper care and appropriate care owed to its long-term resident ... [Resident #204] was neglected and sustained significant physical injuries over an unknown period which resulted in her current hospitalization ..."

Review of Resident #204's medical record revealed the following:

An Annual Minimum Data Set (MDS) dated 04/13/22, showed that facility staff coded: severe cognitive impairment; required total dependence with one to -two persons' physical assist for bed mobility, transfers; extensive assistance with one-person physical assist for toilet use and personal hygiene; frequently incontinent of urine and bowel; active diagnoses of Anemia; no significant weight loss; at risk for pressure ulcers; and no pressure ulcers, wounds or other skin problems.

04/28/22 at 4:56 PM "Podiatry Note ... Patient is seen bedside for thick, elongated toenails and wound right foot ... Skin: Distal aspect of right hallux with noted sanguineous (sp) scab and eschar (dead tissue) to distal aspect, noted purulence and deep probing sinus ... distal aspect of right 5th toe with noted dry sanguineous scab and eschar to distal aspect ... recommend vascular consult to evaluate for healing potential. Ulcer right 5th toe. Dry eschar right 5th toe ... Ulcer right Hallux. Pain right Hallux. Partial debridement of ulcer to patient tolerance. Noted deep probing and purulence during exam ...Recommend starting antibiotics. Please obtain labs: CBC (complete blood count) with Diff (differential), ESR (erythrocyte sedimentation

3. MEASURE TO PREVENT REOCURRENCE: — 12/5/2022

House wide skin sweep assessments were completed on 11/16/22, for all residents by licensed nurses to identify any skin issues. No new findings from the skin sweep.

The licensed nurses will complete a skin assessment upon admission and the wound nurse/designee will complete a thorough skin assessment within 24-48 post-admission and validate all impaired areas were documented and treatments are ordered and care plan is initiated.

Staff Educator/Designee will conduct in-service/education to all licensed nursing staff and certified nursing assistants on following MD orders regarding skin assessment, prevention of skin breakdown and communicating skin issues to the licensed nurse to ensure the care plans and treatments are in place. Education will be completed by 12/5/2022.

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rate), CMP (complete metabolic panel). Please obtain x-rays of right foot to rule out osteomyelitis of right hallux..."

04/29/22 at 1:55 PM "Tissue Analytics Right great toe ... Length: 1.40 cm, width: 1.60 cm; Wound Acquired 4/28/22, [percent] slough/eschar 100.00 ...Status - New; Acquired in House? Yes; Etiology Arterial ...Dressing change frequency BID (twice a day), cleanse wound with- Normal Saline, dressing- Betadine..."

04/29/22 at 2:21 PM "Skin/Wound Note Late Entry... MD, R/P... made aware of resident's right heel wound and right great toe (podiatry-caused) wound. Nursing staff aware."

05/02/22 [physician's order] "Right great toe surgical site- Paint with Betadine (antiseptic) and secure with bordered gauze twice daily every day and evening shift for wound healing"

05/02/22 [physician's order] "Right heel DTI - Apply Skin prep and leave open to air daily every day shift for wound healing"

06/08/22 at 10:04 PM "Laboratory Note Results. Date of test: 6/8/2022. Type of test ... CBC W/Diff ... Actions/New Orders: Waiting for doctor's review ..."

07/03/22 at 11:35 PM "Nurses Note ...Skin is warm to touch, well moisturized. No skin bruising, bleeding noted. Continue monitoring skin wound on right foot. Changed wound dressing on right heel and right great toe ...Provide incontinent care with each incontinent episode. Wash peri- area with soap and water, pat dry and apply barrier cream in the evening shift. The pressure ulcer is

F 726

Staff Educator/Designee will conduct in-service/education to all licensed nurses on their responsibility regarding monitoring the nursing assistants to ensure showers are being given and skin assessment completed timely for residents and turning, and positioning is properly implemented per physician orders. Completed by 12/5/22. — 12/5/2022

Staff Educator/Designee will conduct an in-service/education to all licensed nurse and certified nursing assistants to ensure that documentation on bath and shower sheets and skin assessments accurately reflect the resident's condition. This will be completed by 12/5/2022

4. **MONITORING CORRECTIVE ACTION**
Unit Managers/Designee will conduct an audit of the bath and shower sheet weekly x 4, then monthly x 3 and will continue with the weekly skin assessment to ensure that these are completed timely and accurately. All negative findings will be addressed upon discovery. Findings will be brought to QAPI monthly for recommendations and review.

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F 726	Continued from page 124 a little wider in the resident's coccyx area. Dressing done..." Care plan focus area, "[Resident #204] has potential for impairment to skin integrity r/t fragile skin and Aspirin use" showed, " ...07/04/22 IDT meeting held. Care plan reviewed and updated ...Patient has an actual wound/sacral DTI." 07/05/22 at 10:44 PM "SBAR...Communication Tool... Situation Pressure ulcer on coccyx, approx. 10cm*10cm*0.2...Date problem or symptom started 7/3/2022... Identify whether the problem/symptom has gotten worse/better/stayed the same since it started- Worse... Pressure ulcer of coccyx area got wider and worse...Assessment: In my opinion, residents need active pressure ulcer treatment and care ..." Further review of this document showed that the licensed nurse completing the form was also the name listed under the section "person contacted" instead of the RP or medical doctor's name. 07/06/22 at 3:30 PM "SBAR...Communication Tool... Situation suspected DTI on the sacral ... Date problem/symptom started 07/06/2022 ...Person contacted ... son [RP] ... Provider visit [medical doctor's name] ..." 07/07/22 at 11:22 AM "Tissue Analytics ... Location; sacrum; length 10.80 cm; width 9.48 cm; depth 0.10 cm ... Date wound acquired 7/6/22; [percent] slough/eschar 30.00; Wound status - new; acquired in house? Yes ..." For Resident #204's right foot, the evidence mentioned above revealed that although facility staff documented to implementing the interventions for Resident #204 from 04/01/22 to	F 726		12/5/2022

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F 726	Continued from page 125 04/27/22, the resident was first observed with a right great toe wound at 100 percent eschar and a right 5th toe wound at 30 percent eschar on 04/28/22. Facility staff failed to have a doctor's order for dressing changes to the right foot for 4 days and failed to obtain ordered labs in a timely manner. For Resident #204's sacrum area, the above evidence revealed that facility staff failed to: accurately assess, document on the resident's skin on 07/03/22 and report signs of worsening skin breakdown. Additionally, facility staff failed to notify the physician for 3 days after the sacrum wound was first documented as "more wider", subsequently, when seen by the wound Nurse Practitioner on 07/07/22, the sacral area measured 10.80 cm by 9.48 cm by 0.10 cm deep with 30% eschar. During a face-to-face interview conducted on 09/16/22 at 9:32 AM, Employee #7 (Staff Educator/1 north Unit Manager) reviewed the July 2022 progress notes and the 07/05/22 SBAR for Resident #204 and stated, " ...The staff documented to doing skin assessments but there's no mention of anything being on her sacrum area until July 3rd [2022]. Whoever first notices the change in the skin is the one who makes the doctor and family aware. The nurses know to notify the doctor immediately for any changes and to document it in the progress notes. This SBAR [dated 07/05/22] was not done properly. Another one was done on the 6th [07/06/22] where the family and doctor were notified."	F 726		12/5/2022
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued from page 126 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for four (4) of eight (8) nursing units, the facility staff failed to account for the receipt, usage, disposition, and reconciliation of controlled medications.	F 755	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Narcotic count completed and all narcotics were presented and accounted for on 9/12/2022. No residents had any negative findings related to this deficient practice. Resident #188 narcotic medication was properly administered on 9/14/22, however the failure to document in the narcotic log cannot be retroactively corrected. Resident #188 was assessed head to toe by the licensed nurse on 9/20/22. Resident suffered no negative findings as a result of this deficiency. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents receiving narcotics have the potential to be affected. ADON or designee will conduct house wide audit of all narcotic counts and will audit the narcotic count log book to ensure the narcotic count matches the logs. Any negative issues will be corrected upon discovery.	12/5/2022

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F 755	Continued from page 127	F 755		12/5/2022

The findings included:

Review of the "Receiving Controlled Substances" policy revised August 2020 showed, " ...The following information is completed ...upon receipt of the controlled substance: name of resident ... drug name, strength and dosage, date received, quantity received, name of person receiving medication ...

Review of the "Controlled Substances" policy revised August 2020 showed, " ... Accurate inventory of all controlled medications is maintained t all times. When a controlled substance is administered, the licensed nursing personnel administering the medication immediately enters the following information on the accountability record ... date and time of administration; amount administered, remaining quantity, signature of the nursing personnel administering the dose ..."

1. A review of the Shift Count Narcotic records on Unit 3 North was completed on September 12, 2022, at approximately 9:10 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates:

8/4/2022 11-7 shift same nurse signed coming on and going off duty
8/14/2022 11-7 shift same nurse signed coming on duty and going off duty
8/16/2022 7-3 shift same nurse signed coming on and going off duty
8/20/2022 11-7 shift same nurse signed coming on and going off duty
8/21/2022 7-3 shift one nurse signed coming on and going off duty was left blank

3. MEASURE TO PREVENT REOCURRENCE

Staff Educator/Designee will conduct In-service for licensed nurses on the policy to ensure accurate narcotic counts are reconciled per the standards of practice. Education will be completed by 12/5/2022.

During shift change, the outgoing nurse will complete a narcotic count/reconciliation with the incoming nurse and both nurses will sign the narcotic count log book validating that the narcotic count is accurate.

4. MONITORING CORRECTIVE ACTION

ADON or designee will conduct house wide audit of all narcotic counts and will audit the narcotic count log book to ensure the narcotic count matches the logs weekly for four (4) weeks and monthly times three (3), to ensure facility staff reconcile controlled medications per the standards of practice findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.

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8/27/2022 11-7 shift same nurse signed coming on and going off duty
8/30/2022 7-3 shift same nurse signed coming on and going off duty
8/31/2022 7-3 shift one nurse signed coming on and going off duty was left blank
8/31/2022 11-7 shift count and nurse coming on duty left blank and one nurse signed going off duty
9/4/2022 11-7 shift same nurse signed coming on and going off duty
9/8/2022 7-3 shift same nurse signed coming on and going off
9/9/2022 7-3 shift same nurse signed coming on and going off
9/10/2022 11-7 shift same nurse signed coming on and going off

2. A review of the Shift Count Narcotic records on Unit 3 South was completed on September 12, 2022, at approximately 9:30 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates:

8/2/2022 3-11 shift same nurse signed coming on and going off duty
8/6/2022 3-11 shift same nurse signed coming on and going off duty
8/6/2022 11-7 shift nurse coming on duty left blank and one nurse signed going off duty
8/7/2022 7-3 shift one nurse signed coming on duty and going off duty was left blank
8/14/2022 3-11 shift same nurse signed coming on duty and going off duty
8/15/2022 11- 7 shift same nurse signed coming on duty and going off duty
8/16/2022 3-11 shift same nurse signed coming on duty and going off duty
8/18/202211-7 shift same nurse signed coming

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F 755	Continued from page 129 on and going off duty 8/19/2022 7-3 shift same nurse signed coming on and going off duty 8/19/2022 3-11 shift same nurse signed coming on and going off duty 8/19/2022 11-7 shift same nurse signed coming on and going off duty 8/20/2022 3 -11 shift same nurse signed coming on and going off duty 8/22/2022 3-11 shift one nurse signed coming on duty and going off duty was left blank 8/23/2022 3-11 shift same nurse signed coming on and going off duty 8/25/2022 3-11 shift same nurse signed coming on and going off duty 8/25/2022 11-7 shift coming on duty was left blank and one nurse signed going off duty 8/26/2022 7-3 shift one nurse signed coming on duty and going off duty was left blank 8/28/2022 3-11 shift same nurse signed coming on duty and going off duty 8/29/2022 7- 3 shift one nurse signed coming on duty and going off duty was left blank 8/29/2022 3-11 shift same nurse signed coming on duty and going off duty 9/1/2022 3-11 shift same nurse signed coming on and going off duty 9/3/2022 3-11 shift same nurse signed coming on and going off duty 9/5/2022 3-11 shift same nurse signed coming on and going off duty The review of the above-mentioned dates showed that the Shift Count Narcotic on the Unit 3North and Unit 3South was missing the two (2) nurse's signatures (indicating it was not done) in the space allotted for one (1) nurse to sign coming on duty and another nurse to sign going off duty, and coming on/ going off spaces allotted	F 755		12/5/2022

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F 755	Continued from page 130	F 755		12/5/2022

for two (2) nurses' signatures were left blank [no signatures].

A review of the facility Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count Policy states, "Reconciliation Controlled Drug Count Verification Form" directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift".

The evidence showed that licensed nursing staff failed to adhere to an acceptable standard of practice to reconcile the verification of controlled substances on the aforementioned dates and shifts.

A face-to-face interview was conducted with Employees #2 (Director of Nursing) and #3 (Assistant Director of Nursing) on September 23, 2022, at approximately 3:00 PM. They acknowledged the findings.

3. Facility staff failed to reconcile controlled medications per the standards of practice in two (2) observations on unit 4 south.

3A. During an observation on 09/11/22 at 6:12 AM on unit 4 south, the Controlled Drug Count Verification Form" showed: "9/11/22"; shift "7:00 AM"; correct drug count "yes"; balance verified by nurse coming on duty - this area was blank; balance verified by nurse going off duty - "[Employee #20's (Licensed Practical Nurse) " signature.

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F 755	Continued from page 131 3B. During a controlled medication count on 09/11/22 at 6:12 AM on Unit 4 south with Employee #20, it was noted that there was one blister packet of Pregabalin (for nerve pain) and one blister packet of Lorazepam (antianxiety) in the narcotic lock box that were not logged into the "Controlled Drug Count Verification Form". During a face-to-face interview conducted at the time of the observations, Employee #20 stated, "I cross checked the narcotic count with myself so I can leave a little early today. The supervisor was going to sign, and I was going to give him the keys." When asked is this the standard of practice for counting controlled medications, Employee #20 stated, "No." Regarding the two controlled medications not logged into the count, Employee #20 stated, "These medications were delivered last night. I forgot to log them into the book." 4. Facility staff failed to reconcile controlled medications per the standards of practice in one observation on unit 4 north. During a medication administration observation on 09/16/22 at approximately 1:53 PM on unit 4 north, Resident #188 was administered Phenobarbital (anti-seizure) Solution. Resident #188 was admitted to the facility on 08/21/96 with multiple diagnoses that included: Seizures, Encephalopathy and Psychotic Disorder with Delusions. Review of Resident #188's medical record showed a physician's order starting on 09/03/21	F 755		12/5/2022

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F 755	Continued from page 132 that directed, "Phenobarbital Solution 20 MG (milligrams)/5ML (milliliters), give 7.5 ml by mouth every 8 hours for Seizures" with administration times of 5:00 AM, 1:00 PM and 9:00 PM. Review of the September 2022 Medication Administration Record (MAR) showed that facility staff documented a check mark and then initialed to indicate that the Phenobarbital was administered as ordered to Resident #188 at 1:00 PM on 09/14/22. However, review of Resident #188's narcotic log for the Phenobarbital showed "... 9/14/21 [at] 5 AM 7.5 ml, [Nurse signature], 9/14/21 [at] 9 PM, [Nurse signature] ..." The evidence showed that although it was documented as administered, facility staff failed to document that a dose was taken out on 09/14/22 at 1:00 PM in the narcotic log. During a face-to-face interview conducted on 09/16/22 at approximately 2:00 PM, Employee #10 (4th Floor Unit Manager) reviewed the document and made no further comment.	F 755		12/5/2022
F 770 SS=E	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by:	F 770		

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F 770	Continued from page 133 Based on record review and staff interview, for two (2) of 63 sampled residents, facility staff failed to provide laboratory services in a timely manner to meet resident needs. Residents' #158 and #204. The findings included: 1. Resident #158 was admitted to the facility on 06/30/20 with multiple diagnoses including Sarcoidosis, Hypertension, Chronic respiratory failure, Diabetes Mellitus, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #158's medical record revealed the following: Care plans focus area, "[Resident #158] has a diagnosis of painful urination (dysuria)" initiated on 04/30/22. 04/30/22 at 3:41 PM "Nurses Note ...Complaining of pain in vagina when she urinates. Writer called out to [MD name] to make her aware. Order given to increase fluids and monitor notify Md if condition changes after pushing fluids ..." 04/30/22 [physician's order] "Please push fluids q shift complain of burning in vagina when urinating every shift for burning when urinating for 3 days' call MD with updates [Started 4/30/22 end 5/3/22] " 05/20/22 at 13:26 [1:26 PM] Nurse's Notes " ...New order given to in and out cath (catheter) for U/A (urinalysis) C&S (culture and sensitivity) send urine out stat ..." 05/20/22 at 18:43 [6:43 PM] Nurses notes "U/A	F 770	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #158 resident was discharge to the hospital and treated on 7/7/2022. Returned on 7/13/22 with readmission. Head to toe assessment performed by licensed nurse completed on 10/12/22. Resident suffered no negative outcomes. Resident #204 is discharged on 7/23/22. This deficiency cannot be retroactively corrected, and resident cannot be reassessed. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. ADON or designee will audit laboratory orders beginning August 2022 to ensure that the facility provide laboratory services in a timely manner to meet resident needs. Any issues will be corrected if applicable upon discovery.	12/5/2022

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F 770 Continued from page 134

C&S successful in obtaining x3 staff members Diamond lab technician obtained specimen at 6:15 PM. Will follow up on results."

05/20/22 at 23:44 [11:44 PM] Nurses notes " ... U/A C&S unable to process due to urine level gathered, urine was very cloudy with "feces" will re -collect and re-submit."

05/20/22 [Physician's order] "Please obtain urine may in and out cath for U/A C&S for possible UTI (urinary tract infection) one time only for possible UTI (urinary tract infection). Please [Physician ' s order] "Please obtain urine may in and out cath for U/A C&S for possible UTI every night ..." urine out stat to the Lab. one time only for lab ..."

05/21/22 [Physician ' s order] "Please obtain urine may in and out cath for U/A C&S for possible UTI every night ..."

05/28/22 at 15:48 [3:48 PM] Infection Preventionist Note "...Urinalysis and urine culture done 5/23/22 and results were reported on 5/27/22. Her Urinalysis revealed cloudy urine with moderate blood, large leukocyte esterase, negative nitrate, moderate bacteria. The urine culture revealed 50,000-100,000 Proteus Mirabilis"

The evidence showed that Resident #158's labs were ordered on 04/30/22 however, they were not obtained until 05/27/22, 27 days later.

2. Resident #204 was admitted to the facility on 04/21/16 with multiple diagnoses that included: Mild Protein-Calorie Malnutrition, Dementia, Altered Mental Status, Muscle Weakness and Osteoporosis.

F 770

3. MEASURE TO PREVENT REOCURRENCE

Staff Educator/Designee will conduct In-service for licensed nurses on ensuring laboratory services are provided in a timely manner to meet resident needs. This will be completed by 12/5/22.

During the clinical morning meeting the clinical team will review all lab orders to ensure that labs are obtained in a timely manner as ordered by the physician and results are reported to the physician timely and families are notified to meet resident needs.

4. MONITORING CORRECTIVE ACTION
ADON or designee will audit laboratory orders beginning August 2022 to October 2022, then weekly for four (4) weeks, monthly for three (3) months to ensure that laboratory services were provided in a timely manner per the standards of practice. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be addressed upon discovery.

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F 770	Continued from page 135	F 770		12/5/2022

Review of a Complaint (DC00010905) received by the State Agency on 07/29/22 showed, "... [Facility Name] failed to provide the proper care and appropriate care owed to its long-term resident ... [Resident #204] was neglected and sustained significant physical injuries over an unknown period which resulted in her current hospitalization ..."

Review of Resident #204's medical record revealed the following:

Care plan focus area, "[Resident #204] has abnormal lab results" reviewed on 04/22/22 showed, " ...laboratory tests as ordered ..."

05/05/22 at 6:02 PM "Podiatry Note...follow-up wound right foot ... Please obtain labs... order has been placed. Please obtain X-rays of right foot to rule out osteomyelitis of right hallux (noted order has been placed) ..."

05/05/22 [physician's order] "CBC (complete blood count) with Diff (differential), ESR (erythrocyte sedimentation rate), CRP (c-reactive protein) next lab day"

06/08/22 at 10:04 PM "Laboratory Note Results. Date of test: 6/8/2022. Type of test ... CBC W/Diff ... Actions/New Orders: Waiting for doctor's review ..."

06/09/22 at 1:04 PM "Nurse Practitioner Progress Note...Labs and medications reviewed."

The evidence showed that Resident #204's labs were ordered on 05/05/22 however, they were not obtained until 06/08/22, 34 days after they were

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F 770	Continued from page 136 ordered. During a face-to-face interview conducted on 09/16/22 at 10:45 AM, Employee #2 (Director of Nursing) acknowledged that Resident #158's and #204's labs were not done timely and stated that the facility had switched lab services around that time and that quite a few lab requests had gotten missed.	F 770		12/5/2022
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1) -(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F 803		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIQUE REHABILITATION AND HEALTH CENTER LLC	901 FIRST STREET NW WASHINGTON, DC 20001

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F 803	Continued from page 137 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews for two (2) of 63 sampled residents, facility staff failed to provide food that reflected the resident's food preferences and failed to ensure that the residents' menu was current and posted in plain sight for a resident to review and failed to make a reasonable effort to provide Resident #152 with double portions of food. Residents' #199 and #152. The findings included: 1.Facility staff failed to provide Resident #199 with foods of her choice/preference. Resident #199 was admitted to the facility on 05/15/22 with diagnoses including Obesity, Diabetes Type 2 Without Complications, Sick-Euthyroid Syndrome, Dysphagia, and Gastroesophageal Reflux Disease. During a face-to-face interview on 09/11/22 at 8:57 AM with Resident #199's she stated, "I have to call the kitchen just about every day. I don't eat scrambled eggs because sometimes they upset my stomach. I have asked for two hard-boiled eggs instead. I am also supposed to get fresh fruit like oranges for breakfast, and I hardly ever get them." At the time of the interview, an observation of Resident #199's breakfast tray was conducted. The resident's breakfast tray contained the following items: two scrambled eggs, one slice of whole wheat bread, one sausage patty, grits, one cup of hot tea, and no fruit. A copy of the	F 803	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #199 Double portions provided as requested per preference on 9/11/2022. No negative finding as a result of this deficient practice. Psych Evaluation on 9/27/2022 with no negative findings. Resident's menu is current and posted in plain sight of the resident for viewing. Resident #152 Double portions provided as requested per preference on 9/11/2022. No negative findings as a result of this deficient practice. Psych Evaluation on 10/14/2022, with No negative finding. Resident's menu is current and posted in plain sight of the resident for viewing. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Food Services Manager or designee will audit menu preferences and portions to ensure that residents are provided with food of their choice/preference. Any negative issues will be corrected upon discovery.	12/5/2022

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F 803	Continued from page 138 resident's menu was also on the resident's tray. The menu indicated that the resident had ordered an orange (missing from the tray) and two hard-cooked (scrambled) eggs. A review of Resident #199's medical record revealed: A Quarterly Minimum Data Set dated 08/21/22 showed that facility staff coded the resident as having intact cognition. 09/07/21 [Physician's Order: "NAS (No Added Salt) diet. Regular texture diet. Thin liquids consistency" During an interview on 09/21/22 at 12:40 PM, Employee #40, Assistant Director of Food Services acknowledged the findings and said she conducted an in-service training this morning after hearing that the residents complained about not receiving their food choices. 2. Facility staff failed to ensure the resident menu was current and posted in plain sight for a resident to review and failed to make a reasonable effort to provide Resident #152 with double portions of food. Resident #152 was admitted to the facility on 05/03/22 with multiple diagnoses that included: Pressure-Induced Deep Tissue Damage to Left Heal, Acute Kidney Failure, and Anemia.	F 803	**3. MEASURE TO PREVENT REOCURRENCE** Food Services Manager or designee will audit menu preferences and portions twice weekly times four for one month then weekly for three months to ensure menu of the provided food reflected the resident's food preferences and also ensure that the residents' menu was current and posted in plain sight for all residents. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	12/5/2022

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F 803	Continued from page 139 Review of the Quarterly Minimum Data Set (MDS) dated 08/09/22, revealed that the facility staff coded: intact cognition. In section K (Swallowing/Nutritional Status) Resident #152 was coded as having a therapeutic diet and no signs or symptoms of swallowing disorder. During a face-to-face interview conducted on 09/20/22 at approximately 3:15 PM, Employee #31 (Licensed Nutritionist) regarding the process for residents to get double portions of food. Employee #31 stated, "The nutritionists input the meal tickets and then it's up to the tray line staff to make sure the residents get double portions. A double portion is two entrées and two vegetables and two starches." During a tour of Unit 1 South on 9/20/22 at approximately 3:15 PM the menus were observed posted on a wall behind an activities calendar, and the posted menu was for a previous month. The menu was not accessible to the residents and the print font was small. Employee #31 was asked if Resident #152 received double portions. Employee #31 stated that Resident #152 was not getting the double portions or food alternatives and acknowledged the concerns regarding the food menu was not in plain sight for the resident to review. An observation and resident interview were conducted on 09/21/22 at approximately 9:40 AM, Resident #152 stated, "I am supposed to get double portions and I have not been getting them, they do not follow the menu and yesterday I got a cup of beans for dinner." At this time, a review of Resident # 152's menu that was located on	F 803	**4. MONITORING CORRECTIVE ACTION** Food Services Manager or designee will audit menu preferences twice weekly for one (1) month then weekly for three (3) months to ensure provided menu reflected the resident's food preferences and to ensure that the residents' menu was current and posted in plain sight for resident. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	12/5/2022

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F 803	Continued from page 140 resident tray documented "2X" which indicates resident is to get a double portion. However, the resident had a single portion of food on his breakfast tray. During an interview on 09/21/22 at 12:40 PM, Employee #40, Assistant Director of Food Services acknowledged the findings and said she conducted an in-service training this morning after hearing that the residents complained about not receiving their food choices.	F 803	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The following items were corrected immediately by Food Service Manager: 1) 16 of 16 six-inch half-pans were and placed on the dry in rack shelf, ready for use. 2) Two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards were immediately cleaned upon discovery.	12/5/2022
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility	F 812		

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F 812	Continued from page 141 staff failed to prepare, serve, and distribute foods under sanitary conditions as evidenced by 16 of 16 six-inch half-pans that were stored wet and ready for use, soiled equipment such as two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards, dishwasher temperature logs that were improperly documented, six (6) of six (6) stained fire suppression nozzle covers, and food temperatures that tested below 135 degrees Fahrenheit on two (2) of two (2) food trays assessment. The findings included: 1. 16 of 16 six-inch half-pans were stored wet, on a shelf, ready for use. 2. Two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards were soiled throughout with food deposits. 3. Dishwashing machine daily temperature logs were improperly documented and failed to show a final rinse temperature of at least 180 degrees Fahrenheit (F) from January 2022 to present. 4. Six (6) of six (6) fire suppression nozzle covers located above the gas stove and the fryers were soiled with grease and lint. 5. Breakfast and lunch food temperatures were inadequate and failed to test above 135 degrees Fahrenheit (F)	F 812	3) Dishwashing machine was repaired immediately upon discovery, and the daily temperature logs are now reflecting the final rinse temperature of at least 180 degrees Fahrenheit. 4) Six (6) of six (6) fire suppression nozzle covers located above the gas stove and the fryers were cleaned and free from grease and lint. 5) Breakfast and lunch food temperatures are adequate and are now testing above 135 degrees Fahrenheit, based on a test tray and food temperature log. 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Food Services Manager or designee will conduct a house wide audit on all identified equipment by 12/5/2022. Any issues will be corrected upon discovery.	12/5/2022

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F 812	Continued from page 142 or more during food trays assessment on September 11, 2022, 9:10 AM and on September 13, 2022, at approximately 1:30 PM on seven (7) of 12 observations. Employee #14 acknowledged the findings during a face-to-face interview on September 19, 2022, at approximately 3:30 PM.	F 812	**3. MEASURE TO PREVENT REOCURRENCE** Food Services Manager or designee will conduct an in-service to all dietary staff on the preparation, storage, distribution and serving resident meals in accordance with professional and regulatory standards by 12/5/22. Food Service Manager will in-service all dietary staff to ensure equipment in the kitchen is in sanitary conditions. All equipment will be assessed daily for proper functioning and if repair is required it will be communicated immediately. In service will be completed by 12/5/22 Food Services Manager will conduct an in- service to Food Service staff to take food temperatures before putting it on the food truck and log it. All negative findings will be addressed immediately. All findings will be discussed at the QAPI meeting monthly. Education will be completed by 12/5/2022.	12/5/2022
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1) -(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;			

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F 842	Continued from page 143 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842	**4. MONITORING CORRECTIVE ACTION** Food Services Manager or designee will conduct a house wide audit on all equipment weekly for four weeks and monthly for 3 months, then will also do an audit of temperature of food when it arrives on the unit weekly for 4 weeks. Negative findings will be addressed upon discovery, and all other findings will be discussed at the QAPI meeting monthly. F842 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #102 Resident order was checked for accuracy. Resident was assessed head to toe by licensed nurse on 9/20/22. Staff in-service to be completed by 12/5/2022 by Staff Development/Designee to ensure that blood pressure is taken on the proper arm as ordered by the physician. Resident suffered no negative outcome from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents on dialysis have the potential to be affected. Unit Managers/Designee will conduct an audit for all dialysis patients to ensure the blood pressure is to being taken and documented according to the physician order by 12/5/22. Any negative findings will be corrected upon discovery.	12/5/2022

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F 842	Continued from page 144 Based on record review and staff interview, for one (1) of 63 sampled residents, facility staff failed to accurately document the location where Resident #102's blood pressure was being taken. The findings included: Review of the policy "Charting/Documentation Nursing Notes" revised 0n 10/02/21 showed, "It is the responsibility of licensed nurses to make sure that information relevant to the care of the resident is recorded ..." Resident #102 was admitted to the facility on 11/19/20 with diagnoses that included: End Stage Renal Disease (ESRD) and Dependence on Dialysis. Review of Resident #102's medical record revealed the following: A Quarterly Minimum Data Set (MDS) dated 07/21/22 showed facility staff coded: intact cognition and received dialysis while a resident. 09/04/22 [physician's order] "No blood pressure, no blood draw, no finger stick, no invasive procedure on right upper arm because of the AV (arteriovenous) graft site every shift ..." Review of the September 2022 vital signs for Resident #102 showed facility staff documented the following blood pressure readings: 09/04/22 at 1:36 PM 132/79 mmHg (millimeters of mercury); Lying r (right)/arm 09/04/22 at 5:59 PM 116/74 mmHg; Lying r/arm 09/07/22 at 2:28 PM 133/83 mmHg; Lying r/arm 09/08/22 at 11:38 AM 119/73 mmHg; Lying r/arm	F 842	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator/Designee will conduct In-service for licensed nurses on following Physician orders for taking blood pressure on the appropriate sites. Education will be completed by 12/5/2022. **4. MONITORING CORRECTIVE ACTION** Unit Managers/Designee will conduct an audit for all dialysis patients on to ensure that blood pressure is being taken and documented accurately in the residents' charts per physician orders, weekly for four (4) weeks then monthly for three months' findings will be brought to QAPI monthly for recommendations and review. All negative findings will be corrected upon discovery.	12/5/2022

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F 842	Continued from page 145 09/10/22 at 2:09 PM 124/67 mmHg; Lying r/arm 09/14/22 at 3:31 PM 139/79 mmHg; Lying r/arm 09/16/22 at 10:26 AM 130/70 mmHg; Lying r/arm 09/16/22 at 7:49 AM 131/73 mmHg; Sitting r/arm 09/17/22 at 1:32 AM 127/73 mmHg; Lying r/arm 09/18/22 at 8:18 PM 128/78 mmHg; Lying r/arm 09/19/22 at 2:30 AM 122/74 mmHg; Lying l/arm 09/19/22 at 5:18 PM 131/83 mmHg; Lying r/arm During a face-to-face interview conducted on 09/21/22 at 2:48 PM, Employee #10 (4th floor Unit Manager) reviewed the vital signs and stated, "It's a documentation error. The nurses know not to take the blood in that resident's arm."	F 880	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Employee #21 was in-serviced on the infection control policy which included appropriate footwear. 9/11/2022 employee corrected this deficient practice, with proper shoe wear. Employee #22 was in-serviced on how disinfect the glucose monitor machine in between residents; and perform hand hygiene. In-service to all staff will be completed by 12/5/2022, conducted by the Staff Development/Designee.	12/5/2022
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following		**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All facility residents have the potential to be affected. House wide audit will be conducted by IP, Unit managers and department heads on monitoring facility staff to ensure proper hand washing techniques are demonstrated before doffing and while providing care to residents, ensuring that blood glucose monitor machines are cleaned/disinfected before, during and after resident use, and to ensure staff are always wearing proper footwear during resident care. All negative findings will be corrected upon discovery.	

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F 880	Continued from page 146 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	**3. MEASURE TO PREVENT REOCURRENCE** ADON or designee will conduct in services with the facility staff to ensure the facility infection prevention and control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. All staff will be educated on proper hand washing techniques before doffing and while providing care to residents, proper handling of blood glucose monitor machines ensuring that they are cleaned/disinfected before, during and after resident use, and to ensure staff are always wearing proper footwear during resident care Education will be completed by 12/5/2022.	

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F 880	Continued from page 147 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to follow accepted standards of infection control practices to prevent potential contamination and spread of infection related to failure to wear the appropriate shoe and failed to sanitize the blood glucose machine between residents. The resident census on the first day of survey was 208. The findings included: 1. Facility staff failed to follow infection control practices when administering medications. During an observation on 09/11/22 at 9:28 AM, Employee #21 (Registered Nurse) was observed passing medications while wearing open toe sandals. The employee was stopped by the surveyor. In an interview conducted at the time of the observation, the employee was asked why she did not have on proper footwear. Employee #21 stated, "I broke my toe and it's been hard for me to put shoes on. Everyone has been aware. I gave the doctor's letter to HR (Human Resources). They said it was okay to wear sandals." During a face-to-face interview on 09/11/22 at 10:18 AM, Employee #18 (Director of	F 880	4. **MONITORING CORRECTIVE ACTION** House wide audit will be conducted by IP, Unit managers and department heads on monitoring facility staff to ensure proper hand washing techniques are demonstrated before doffing and while providing care to residents, ensuring that blood glucose monitor machines are cleaned/disinfected before, during and after resident use, and to ensure staff are always wearing proper footwear during resident care. All negative findings will be corrected upon discovery. ADON or designee will conduct random rounds and audit a sample of residents to ensure the facility is practicing infection control surveillance of hand hygiene and glucometer cleaning between residents to prevent the spread of communicable diseases or infections. This will be conducted 4 times weekly then 3 times monthly and findings will be brought to QAPI monthly for recommendations and review. All negative findings will be addressed upon discovery	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING ______ B. WING ______	C 09/26/2022

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F 880	Continued from page 148	F 880		

Finance/HR) stated, "The facility's policy is no open toe shoes. It's in the Employee Handbook. She [Employee #21] knows she's not supposed to wear those shoes [open toe sandals]. HR never gave her an okay to do so. We are addressing it now."

2. Facility staff failed to follow hand hygiene and standard infection control practices while conducting blood glucose testing.

During an observation on 09/20/22 at 5:15 PM on unit 1 north, the following was observed: Employee #22 (RN) exited room 107 after checking the resident in Bed-A's blood glucose using a handheld glucose monitor. The employee doffed her gloves and put them in the trash receptacle. Employee #22 then walked into room 109 Bed-B, donned gloves and was about to check that resident's blood glucose levels when the surveyor stopped her.

Employee #22 failed to: perform hand hygiene after doffing gloves in room 107 (Resident in bed-A); disinfect the glucose monitor machine in between residents; and perform hand hygiene before donning gloves to obtain the blood glucose level of the resident in room 109 Bed-B.

During a face-to-face interview conducted at the time of the observations, Employee #22 stated, "I usually use the alcohol hand rub. I just forgot." When asked why she didn't disinfect the glucose monitor machine in between residents, the employee made no comments but proceeded to use an alcohol prep pad to wipe down the machine. The employee was then asked to step

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F 880	Continued from page 149 out of the resident's room. Now at the medication cart, Employee #22 was asked what is the standard infection control practice for medical equipment that is shared, the employee pulled out a container of "Super Sani-Cloth Germicidal Disposable Wipe" and stated, "We are supposed to use this."	F 908	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The following items were corrected immediately by Food Service Manager: 1) 16 of 16 six-inch half-pans were and placed on the dry in rack shelf, ready for use. 2) Two (2) of two (2) convection ovens, two (2) of two (2) grease fryers, one (1) of one (1) meat slicer, and six (6) of seven (7) cutting boards were immediately cleaned upon discovery. 3) Dishwashing machine was repaired immediately upon discovery, and the daily temperature logs are now reflecting the final rinse temperature of at least 180 degrees Fahrenheit. 4) Six (6) of six (6) fire suppression nozzle covers located above the gas stove and the fryers were cleaned and free from grease and lint. 5) Breakfast and lunch food temperatures are adequate and are now testing above 135 degrees Fahrenheit, based on a test tray and food temperature log	12/5/2022
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) dishwashing machine that did not reach 180 degrees Fahrenheit and failed to complete the fill cycle during start-up, one (1) of six (6) steam well covers with no handle, four (4) of six (6) steam well covers with a loose handle, one (1) of eight (8) unsecured baffle from the kitchen hood system, and four (4) of four (4) curtains from the dishwasher that were marred. The findings included: 1. Dishwasher final rinse temperatures failed to reach 180 degrees Fahrenheit on numerous consecutive cycles. 2. The dishwasher failed to automatically complete the fill cycle during start-up. Staff was observed filling the			

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F 908	Continued from page 150 machine manually with water. 3. One (1) of six (6) steam well pan cover was missing a handle and four (4) of six (6) steam well pans cover had a loose handle. 4. One (1) of eight (8) baffles form the kitchen hood located above the fryers was hanging loose due to a missing locking pin. 5. Four (4) of four (4) dishwasher curtains were stained throughout. Employee #14 acknowledged the findings during a face-to-face interview on September 19, 2022, at approximately 3:30 PM.	F 908	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Food Services Manager or designee will conduct a house wide audit on all identified equipment by 12/5/2022. Any issues will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Food Services Manager or designee will conduct an in-service to all dietary staff on the preparation, storage, distribution and serving resident meals in accordance with professional and regulatory standards by 12/5/22. Food Service Manager will in-service all dietary staff to ensure equipment in the kitchen is in sanitary conditions. All equipment will be assessed daily for proper functioning and if repair is required it will be communicated immediately. In service will be completed by 12/5/22 Food Services Manager will conduct an in-service to Food Service staff to take food temperatures before putting it on the food truck and log it. All negative findings will be addressed immediately. All findings will be discussed at the QAPI meeting monthly. Education will be completed by 12/5/2022. 4. **MONITORING CORRECTIVE ACTION** Food Services Manager or designee will conduct a house wide audit on all equipment weekly for four weeks and monthly for 3 months, then will also do an audit of temperature of food when it arrives on the unit weekly for 4 weeks. Negative findings will be addressed upon discovery, and all other findings will be discussed at the QAPI meeting monthly.	12/5/2022