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F 000	INITIAL COMMENTS An unannounced recertification survey was conducted at the Washington Center for Aging Services facility from August 20, 2023, through September 14, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 170 and the sample included 42 residents. Substandard quality of care was identified, and the survey team conducted an extended survey on September 1, 2023. The following complaint and facility-reported incidents were investigated during this survey DC00010615, DC00010707, DC00010819, DC00011668, DC00011708, DC00011709, DC00011711, DC00011714, DC00011974, DC00011977, DC00012209, DC00010897, DC00010939, DC00011092, DC00010319, DC00010556, DC00010647, DC00010725, DC00010748, DC00011389, DC00011801, DC00011798, DC00011972, DC00012068, DC00010737, DC00011831, and DC00012281. 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 this survey, an immediate jeopardy (IJ) was identified at 42 CFR §483.12 Investigate/prevent/correct alleged violation, F600 on August 31, 2023, at 2:33 PM. The facility provided a plan of action to address the immediate concerns on August 31, 2023, at 11:41 PM and it was accepted. After the plan was verified the IJ was removed on September 6, 2023, at 1:20 PM while the survey team was	F 000	Washington Center for Aging Services makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees, or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State laws.	

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

TITLE DON

(X6) DATE 10/16/23

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

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F 000	Continued From page 1 onsite.	F 000		

The following deficiencies are based on observation, record review, and resident and staff interviews.

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

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F 000	Continued From page 2 ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal 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 QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation	F 000		

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F 000	Continued From page 3 SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
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 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;	F 584		

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F 584	Continued From page 4 §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 expired nutritional food items such as seven (7) of nine (9) eight-ounce containers of Jevity, 1.5 calories nutritional drinks that expired on May 2022, two (2) of nine (9) eight-ounce containers of Jevity, 1.5 calories nutritional drinks that expired on May 2023, six (6) of six (6) eight-ounce Osmolite nutritional drinks that expired on August 1, 2023, 19 of 19 eight fluid ounce containers of Jevity, 1.5 calories nutritional drinks that expired on November 1, 2021, and six (6) of six (6) eight fluid ounce containers of Nestle boost nutritional drinks that expired on August 19, 2023, that were stored on three (3) of eight (8) resident care units. During an environmental walkthrough of the facility on July 10, 2023, between 10:00 AM and 4:00 PM the following were observed: In the pantry of unit 1 Orange, seven (7) of nine (9) eight-ounce containers of Jevity, 1.5 calories nutritional drinks were expired as of May 2022, two (2) of nine (9) eight-ounce containers of Jevity, 1.5 calories nutritional drinks were expired as of May 2023.	F 584	1. The nutritional supplements were checked on all eight(8) units by the unit managers and charged nurses for expiration on August 19th, 2023. All expired supplements were removed from the unit and discarded. 2. All Residents receiving oral nutritional and G-tube supplements have potential to be impacted by this deficiency. All nutritional supplements were checked for expiration dates by the unit clerks and material management. There were no findings. 3. Inservice was conducted to Material Manager and Unit clerk, regarding nutritional supplements and expiration date. This was done by DON and ADON. 4. A delivery log has been implemented for the material management personnel and the unit clerk to document weekly check of expiration date on all nutritional supplements available on the unit. Expired nutrition supplements to be discarded. Reports of findings to be presented in quarterly QA meeting. 5. Completion date: 11/1/2023 6. Person(s) responsible: Administrator Laison and Operations Manager.	

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F 584	Continued From page 5 In the pantry on unit 2 Orange, six (6) of six (6) eight-ounce Osmolite nutritional drinks were expired as of August 1, 2023. In the pantry on unit 3 Green, 19 of 19 eight fluid ounce containers of Jevity, 1.5 calories nutritional drinks were expired as of November 1, 2021, and six (6) of six (6) eight fluid ounce containers of Nestle boost nutritional drinks were expired as of August 19, 2023. Employee #1 acknowledged the findings during a face-to-face interview on August 24, 2023, at approximately 4:00 PM.	F 584		
F 600 SS=J	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s staff failed to protect vulnerable residents from Resident #90, evidenced by 1. Resident #90 being found kissing Resident #16	F 600		

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F 600	Continued From page 6 who did not have capacity to consent, and 2. Resident #90 allegedly opened Resident #151 ' s incontinent brief, inappropriately touching the resident, and verbalizing he wanted to perform oral sex, as per Resident #151. This was evident for 2 of 42 sampled residents. The findings include: 1a. Resident #90 was admitted to the facility on 02/05/18. The resident had a history of multiple diagnoses including Alcohol Use. A review of a facility policy titled, "Prohibition of Resident Abuse/ Abuse Prevention" (Policy NO: 99-12) with a revision date of 09/24/22 instructed the following but not limited to: "Report the incident to the Nursing Supervisor or Department Head immediately, but not less than 2 hours, if the alleged violation involves abuse or results in serious bodily injury. The Nursing Supervisor/Department Head will immediately initiate an investigation and give an oral report to the Administrator", "If suspected abuse/inappropriate behavior between two residents, resident will be immediately separated from each from each other and monitored until appropriate interventions are implemented", and "Notify DC Regulatory Agency and Ombudsman". A review of Resident #90 ' s a quarterly Minimum Data Set Assessment dated 09/01/22 documented a Brief Interview for Mental Status (BIMs) summary score of "12," indicating moderate cognitive impairment. A nursing note dated 09/03/22 12:31 AM [Recorded as Late Entry on 09/06/22 12:49 AM] documented, "At around 2:35 AM call light was on	F 600	1. Resident #90 was transferred to another unit in March. No additional concerns noted since admission to that unit. 2. Interviews were conducted with residents that resided on unit 2 green, 3 orange and 2 blue by DON. No other residents were impacted by this practice. 3. All staff on unit 2 green, 3 orange and 2 blue were re-educated regarding abuse including types of abuse reporting and investigation of abuse. The care plan was reviewed and updated on 3/30/2023. The intervention continues to be effective. 4. The investigation committee led by the abuse coordinator will meet and review any allegations of abuse weekly. The review will include ensuring the investigation form is complete and accurate with statement as necessary as well as reporting of abuse. This will be reported to QAPI quarterly by the Abuse coordinator. 5. Completion date: 11/1/2023. 6. Person(s) Responsible: Abuse Coordinator, DON, or designee, Nurse Managers.	

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in room 270A, when caregiver [Employee #12, Certified Nursing Assistant] went there. Care giver called the nurse [Employee #13, Licensed Practical Nurse] and reported that he saw [Resident #90] kissing [Resident #16]. By the time the nurse went there [Resident #90] was leaving the room. The nurse explained to [Resident #90] that is very late to be in a female room. [Resident #90] verbalized understanding and promise not to go there anymore."

A social worker ' s note dated 09/05/22 10:59 AM [Recorded as Late Entry on 09/15/2022 4:11 PM] documented, "While conducting business with residents on 2 Green Unit [Employee #14, Social Worker] was approached by [Resident #90] who asked if [pronoun] could leave the facility on a date with another resident [Resident #16]. At that time [pronoun] explained [pronoun] interest in [Resident #16] living across from [pronoun] stating that they were "seeing each other" [Resident #90] was advised not to go into [pronoun] room and that they could talk with each other from the hallway, in part because there are two other female residents in the room. [Resident #90] acknowledged and understanding of what was said to him."

It should be noted according to this social worker ' s note the conversation with Employee #14 and Resident #90 occurred on 09/05/22 which was two days after the incident where Resident #90 was found kissing Resident #16 on 09/03/22. The note was entered into Resident #90 ' s electronic health record on 09/15/22 which was 12 days after the incident (09/03/22).

A unit manager ' s [Employee #18] progress note dated 09/06/22 at 3:20 PM documented,

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"[Resident #90] was transferred from Unit 2 Green room 271A to unit 3 Orange room 356B. He was transferred off the unit because he was caught several times in room 270 inappropriately touching [Resident #16] on the A bed. [Resident #90] is alert and oriented x3 (name, time, and place), [pronoun] was advised not to go into room 270 the first time [pronoun] was caught in the room in a compromised position with the resident [Resident #16] in question. [Resident #90] verbalized understanding and promise to stay away from [Resident #16], but [Resident #90] continued to sneak into the room during the odd hours of the night. [Resident #90] was caught on 9/6/22 at 2:25 AM in the room inappropriately feeling on [Resident #16]. All related disciplines were notified. [Resident 90 ' s responsible party] was called and message was left for him to call the unit. NP (nurse practitioner) was also informed."

It should be noted that review of Resident #90 ' s progress notes including nursing, physician and social work notes dated from 09/03/22 to 09/15/22 revealed Resident #90 was moved to a different unit on 09/06/22, three days after the incident. Additionally, the previously mentioned progress notes lacked documented evidence that the facility ' s staff made the State Agency or the Ombudsman Office aware of Resident #90 ' s kissing and inappropriately touching Resident #16 that was observed by staff on 09/03/22 or that the staff on Unit 3 Orange where Resident #90 was transferred to was made aware of his previous behaviors.

A review of Resident #90's current and discontinued care plans revealed the facility ' s staff failed to develope care plans to address the

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incident when Resident #90 was found in a "compromised position" with Resident #16 and the incident when Resident 90 was found sneaking in Resident #16's room at "odd hours at night" as documented in the unit manager ' s note dated 09/06/22. However, it should be noted that after the second incident staff developed the following care plan dated 03/30/23.

"Problem: [Resident #90] has inappropriate sexual behavior toward female residents/staff.

Goal: Resident will behave appropriately toward female resident/staff.

Approach: Hourly monitoring to know whereabout of the resident on every shift. and Social service to look for community replacement for resident. "

1b. Resident #16 ' s medical record revealed the resident was admitted to the facility on 02/11/20 with multiple diagnoses including Dementia and Bipolar. Additionally, the medical record showed the resident had a court appointed guardian.

A review of a quarterly Minimum Data Set Assessment dated 08/18/22 documented Resident #16 had a Brief Interview for Mental Status summary score of "13", noting intact cognition. The resident was coded for requiring extensive assistance from staff with bed mobility, transfers, dressing, toilet use, and personal hygiene.

A review of the progress notes from 09/01/22 to 09/15/22 lacked documented evidence the facility staff documented the incidents incident when Resident #90 was found in a "compromised position" with Resident #16, the incident when

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F 600	Continued From page 10 Resident 90 entered Resident #16's room at "odd hours at night" and the incident on 09/03/23 when Resident #90 was observed by staff in Resident #16 ' s room inappropriately touching (kissing) the resident. Additionally, the progress note lacked documented evidence the facility made the resident ' s physician or legal guardian aware of the previously mentioned incidents. A review of Resident #16's current and discontinued care plans revealed that the facility's staff did not develop a care plan to protect the resident from Resident #90 ' s sneaking into her room at odd hours at night and Resident #90 ' s inappropriate physical behavior toward her. However, Employee #18 (Unit Manager) developed the following care plan dated 09/01/23 that documented the following but not limited to: "Problem: [Resident #16] has a behavior of being attracted to the opposite sex. Goal: Resident will interact with others using social and cultural acceptable behavior. Approach: maintain resident ' s safety by monitoring her whereabouts on the units, redirect inappropriate sexual behavior, and staff to ensure that resident is not in any scheduled [secluded] area with males." During a face-to-face interview on 08/29/23 at 4:16 PM, Employee #18 (Unit Manager/LPN) stated that Resident #90 and Resident #16 would talk and laugh with each other in the hallway but at night Resident #90 would sneak into Resident #16 ' s room. The employee said that Employee #12 (CNA) and Employee #13 (LPN) informed her that Resident #90 was observed in Resident	F 600		

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F 600	Continued From page 11 #16 ' s room in compromising position during the night shift on 03/06/23, Later that day Resident #90 was moved to 3 Orange. In addition, the employee said that she did not develop a care plan to address protecting the resident from Resident #90. However, she did develop a care plan to address Resident #16 ' s "behavior of being attracted to the opposite sex" on 09/01/23. During a face-to face interview on 08/30/23 starting at approximately 8:00 AM, Employee #13 (LPN) and Employee #12 (CNA) stated that around 2:00 AM Resident #90 was observed in Resident #16 ' s room trying to kiss her. When asked what date this happened, they stated that they believed it was the day Resident #90 was moved to 3 Orange (03/06/22). Employee #12 (CNA) said when he walked in Resident #16 ' s room Resident #90 was standing beside the resident ' s bed. Resident #16 ' s covers were pulled down and the resident ' s gown was pulled up. Employee #13 stated that she instructed Resident #90 not to be in the resident ' s room "this late". It should be noted that Employee #13 wrote a nursing note related to the incident on 03/06/23 which was three days after the incident. During a telephone interview on 08/30/22 starting at 9:46 AM, Employee #23 (Social Worker) stated that staff did not inform her of the incident that happened between Residents #90 and #16 on 03/03/22. Employee #23 said she learned about the incident when she looked at the electronic record and saw the nursing progress notes. The employee also stated that Resident #90 made her aware that he wanted to take Resident #16 out on a date, but she informed him that he could not do that, and he verbalized understanding. Employee #23 stated that she did inform Employee #18	F 600		

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(Unit Manager) of Resident #90 ' s interest in Resident #16.

During a face-to-face interview on 08/31/23 at 11:06 AM, Resident #90 stated that Resident #16 was his girlfriend and "everybody" [staff] knew it. Additionally, Resident #90 admitted to kissing Resident #16.
During a face-to-face interview on 09/01/23 starting at 11:08 AM, Employee #1 (Administrator), Employee #2 (DON) and Employee #3 (ADON) stated that the incident of sexual inappropriateness occurred during the night shift on 03/03/23. The nurse (Employee #13, LPN) failed to inform the nursing supervisor or administration about the incident. Instead, she informed Employee #18 (Unit Manager) during morning report on 03/06/22. After learning about the incident, Employee #18 had Resident #90 transferred to Unit 3 Orange.

During a telephone interview on 09/07/23 starting at 11:26 AM, Resident #16 ' s legal guardian stated that she found it "weird" that the facility recently made her aware of an incident that happened a year ago between Resident #16 and a male resident. The legal guardian said, "I asked them how are you going to treat something that happened a year ago

2a. Resident #90 was admitted to the facility on 02/05/18. The resident had a history of multiple diagnoses including Alcohol Use.

A review of a DC Facility Reported Incident Form (DC00011801) dated 03/30/23 documented the following but not limited to: "On 03/29/23 a female resident alleged and identifies [Resident 90] who lives across [the hall] coming into her room fondly

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F 600	Continued From page 13 (sp) with her [expletive]. The complaint was reported to the social worker. DC Metropolitan police and Adult Protective Services were called and made aware. 3 officers along with a detective came to the unit to investigate the compliant." "[Resident #90] was interviewed and he denied the allegation." and "He was later transferred to another unit from 3 Orange Room 356B to [unit] 2 blue room 203 A for safety precautions." Follow Up Report dated 04/04/23 documented, "On March 29th, 2023, Mr. Smith had been accused by a female resident [Resident #151] of sexually abused (sp) her on 03/27/2023 around 4:00 AM. Facility investigation had immediately started, [Resident #90] was interviewed, he denied the allegation. Long Term care Ombudsman and Adult Protective Services were informed. The police was immediately called, two officers came & later the Sergeant arrived. Much later Detective arrived at the unit. [Resident #90] was interviewed by the police officers, and the detective, which he denied the allegations he had been accused of. Based on facility investigation, the resident ' s [Resident #151] story (the accuser) appeared to be inconsistent with time reporting to staff and location of incident. Upon review of the statements, it was observed that the date the incident occurred did not match. Resident stated that she reported the incident on March 27, 2023, to a staff that did not work that shift. Later, during another interview, the female resident stated that the incident did ot happen at the facility, but at her sister ' s house. The following actions were taken by the facility. 1. [Resident #90] was relocated to another unit on the same day 03/29/2023 and his whereabouts is being monitored hourly with a monitoring tool. 2.Plan to discharge [Resident #90] to the	F 600		

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community in collaboration with resident [Resident #90] who is alert and oriented and his own responsible party to look for alternative placement option. 3. RP [responsible party] was made aware of the outcome."

A review of a quarterly Minimum Data Set Assessment dated 06/01/23 documented in section C (Cognitive Patterns), Resident #90 had a Brief Interview for Mental Status (BIMS) summary score of "13", noting the resident was cognitively intact.

A unit manager ' s [Employee #15] progress note dated 03/29/23 at 5:18 PM documented the following but not limited to:" Resident is alert and oriented X3 admitted to the facility 02/05/18 with multiple diagnosis (sp) Alcohol use, Unspecified with Intoxication." "Resident is ambulatory and uses rolling walker." "On 03/29/23 a female resident alleged and identifies [Resident 90 ' s name] who lives across [the hall] coming into her room fondly (sp) with her expletive. The complaint was reported to the social worker. DC Metropolitan police and Adult Protective Services were called and made aware. 3 officers along with a detective came to the unit to investigate the compliant." "[Resident #90 ' s name] was interviewed and he denied the allegation." and "He was later transferred to another unit from 3 Orange Room 356B to [Unit] 2 blue room 203 A for safety precautions."

A social worker [Employee #24] progress note dated 03/31/23 at 12:09 PM documented the following but not limited to: "Resident (Resident #90) was relocated to the 2 Blue Unit 03/29/23 room 203A." and "Resident was relocated because another resident on the 3 Orange Unit

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where he was reported that he sexually assaulted her 03/27/23. Staff were not notified of the incident until 03/29/23. Immediate action was taken the police and Adult Protective Services were notified 03/29/23 & Ombudsman ' s office was notified 03/30/23."

A review of a care plan with an edited date of 03/31/23 documented the following:

Problem: Resident has inappropriate sexual behavior toward female residents/staff.

Interventions: hourly monitoring to know whereabout of the resident on every shift. and Social Services to look for community replacement for resident.

It should be noted, that after the second allegation of sexual misconduct, Resident #90 was relocated to Unit 2 Blue, and hourly rounds were implemented for staff to track his location at all times. However, interviews with staff on Unit 2 Blue revealed that all staff were not informed about Resident #90's sexual inappropriateness to other residents. In addition, they were not told about the rationale for tracking Resident #90's location hourly.

2b. Resident #151 was admitted to the facility on 09/30/22 with multiple diagnoses including Dementia, Bipolar, Schizophrenia, Difficulty Walking and Somnolence.

A review of Resident #151 ' s care plan dated 09/30/22 documented the following: Problem-Psychotropic Drug Use. Resident has a diagnosis of Schizophrenia, Bipolar, Depression, and Dementia" and "She says things not real making

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F 600	Continued From page 16 up stories". Intervention - "Monitor thoughts and experiences that seems to be out of touch with reality." and "If resident has delusions/hallucination, do not try to reason with or confront resident." A review of a quarterly Minimum Data Set (MDS) assessment dated 02/15/23 documented, the resident had a BIMS (Brief Interview for Mental Status) summary score of 12, noting moderative cognitive impairment. The resident was not coded for hallucination or delusions. In addition, the resident was coded for requiring extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene. A review of the unit manager ' s [Employee #15] progress note dated 03/29/23 at 5:18 PM documented the following but not limited to: "[Resident #151 ' s name] alleged and identified [Resident #90 ' s name] who lives across [the hall] coming into her room fondly (sp) with her [expletive]. The complaint was reported to the social worker, DC Metropolitan Police, and Adult Protective Service were called and made aware." A social work [Employee #24] note dated 03/30/2023 at 5:08 PM documented the following but not limited to: "Incident: On 3/29/23, this S.W. (social worker) was informed by the Unit Manager that the resident [Resident #151] reported a male resident [Resident #90] made sexual advances to her on 3/27/23 at about 4:00 AM. A male resident [physical description of alleged resident] went into her room opened her incontinent brief fondled her vagina & told her he wanted to eat her "p***y". Resident said that he only stopped because she had some feces in her brief. This S.W. asked her if she screamed, she said no that she fought	F 600		

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him."

During a face-to-face interview on 08/22/23 at approximately 11:30 AM, Resident #90 stated that police came to [pronoun] room and talked with [pronoun] about [Resident #151] saying I touched [pronoun]. I told them, "It ' s no way in hell. I would touch [pronoun]." The resident stated that [pronoun] believed Resident #151 got mad with [pronoun] because [pronoun] refused to go to the gift shop for [pronoun].

During a face-to-face interview on 08/25/23 at 12:41 PM, Resident #151 stated, "When I was sleeping a man came in my room and had his hands in my pamper. I woke and asked him what he was doing."

During a face-to-face interview on 08/25/23 at 9:30 AM, Employee #4 (CNA) said Resident #151 told her, "A man came into my room playing with my vagina." The employee said she immediately reported the allegation to her unit manager. As reported by Employee #4, Resident #151 made the allegation against Resident #90 during the dayshift on 03/29/23. It was asked of the employee whether she knew of the sexual inappropriate behavior of Resident #90 before this accusation was made. She stated that she had worked with Resident #90 since he moved into the Unit (3 Orange). She had not been informed that he had been sexually inappropriate previously.

During a face-to face interview on 08/29/23 at 10:41 AM, Employee #10 (Social Worker) stated, "[Employee #151] said a male came into her room. He opened her diaper and said he wanted to eat my [expletive] but he stopped because he

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saw feces." Employee #10 (Unit Manager/ RN) said that she spoke with [Resident #90] but the resident denied the allegation.

During a face-to-face interview on 08/29/23 at 1:40 PM, Employee #15 (Unit Manager) stated that Employee # 4 (CNA) told her [Resident #151] said a man across the hall came in [pronoun] room and opened [pronoun] brief. The man ran away when he saw BM (bowel movement). According to the employee, when she interviewed [Resident #151], the resident repeated the story. Employee #15 reported that when she interviewed [Resident #90] [pronoun] denied going into the resident's room. Employee #15 was asked whether she knew of the sexual inappropriate behavior of Resident #90 before this accusation was made. Employee #15 stated that since November 2022, she worked with Resident #90 on Unit 3 Orange, but was not informed about his sexual inappropriateness.

During a face-to-face interview on 08/30/23 at 9:43 AM, Employee #27 (Certified Nurse Aide/CNA) assigned to Resident #90, stated that the CNAs monitor Resident #90 by documenting the Resident ' s location in the [pronoun] hourly monitoring book. When asked if she knew why the Resident was being monitored, the CNA said, "I am not sure. I really don ' t know. We just put where [Resident #90] is at in the book."

During a face-to-face interview on 08/30/23 at 10:29 AM, Employee #26 (Charge Nurse/Licensed Practical Nurse/(LPN) stated that Resident #90 was moved to Unit 2 Blue because he required long-term care services, and he wanted a private room.

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The employee was then asked who educates CNAs about new residents transferred to the floor, the employee said, that because she was a charge nurse, she was responsible for educating the CNAs.

During a face-to-face interview on 08/30/23 at 11:06 AM, Employee #25 (2 Blue Unit Manager/Registered Nurse) stated that she was informed that Resident #90 was being transferred to her unit due to an allegation of sexual inappropriateness with Resident #151. In addition, the employee said that she was responsible for educating nurses and CNAs about Resident #90 ' s sexual inappropriateness. However, Employee #25 had no documented evidence of education provided to her staff related Resident #90 ' s sexual inappropriateness.

Based on these findings, on August 31, 2023, at 2:33 PM, an Immediate Jeopardy (IJ)-"J" situation was identified. On August 31, 2023, at 11:41 PM, the facility's Administrator provided a corrective action plan to the State Agency Survey Team that was accepted. The plan included:

1. Immediate Action Taken - Resident was moved to another unit in March - no additional issues since he was moved.

I. Resident #90 identified in the survey was transferred to a different unit, from 2 Green to unit 3 orange, after the first incident on 9/6/2022.

II. The residents on unit 2 green were interviewed and it was determined that no other resident was found to have a similar situation on 9/6/2022.

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F 600	Continued From page 20 III. Hourly monitoring program for resident #90 continued 9/6/2022. IV. Resident #90 identified in the survey was transferred to different unit, from unit 3 orange to 2 Blue, after the second alleged incident reported by resident #151 on 3/29/2023. V. Resident #151 was assessed by unit manager on 3/29/2023, and the NP on 3/30/2023. She denied pain or injury. VI. The staff on 3 Orange were to monitor for resident #90 from coming back to resident #151. VII. The residents on 3 Orange were interviewed on 3/29/2023 and it was determined that no other resident was found to have similar concern A meeting was conducted on 3/29/2023 with the Administrator, DON, ADON, Social work staff and nurse managers. All components of abuse investigation form (tool) were addressed including resident to resident abuse. VIII. The staff on unit 2 blue, on 8/30/2023, were re-educated regarding the resident ' s #90 prior history. During this training, the staff acknowledged that he had not exhibited any of that behavior since being moved to unit 2 blue. IX. Meeting with resident #90 was held 3/29/203. Revised hourly rounding documentation was implemented on 3/29/2023 to include a signage sheet located in the nursing station. This is in addition to the TAR. This is to ensure safety of other female residents. As a result, it is believed that it would be unlikely that this behavior would occur again.	F 600		

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F 600	Continued From page 21 2. Immediate Action Taken - Monitoring of the Resident I. The unit managers, charge nurses will monitor residents who exhibit abuse toward another resident, including sexual abuse every shift. The residents identified to exhibit abusive behavior will be corrected immediately and provide safety for the victim. The affected residents will be monitored every 30 minutes to ensure the safety of other residents. This information will be provided to the DON who will provide the information to QAPI committee quarterly and more frequently as indicated. II. A review of the care plan of resident #90 was developed and updated to reflect the potential issues as it pertains to sexual inappropriateness. III. All Staff were informed on 8/30/2023 of resident #90 sexual inappropriateness, and they indicated willingness to monitor resident #90 sexual inappropriateness. IV. Assigned caregiver would ensure resident #90 location, whereabout is know at all times.. 3. INVESTIGATION - Decision Making § Facility Administration - identification of Abuse and actions taken during/following an investigation I. Meeting held with Administrator, DON and ADON regarding resident #90 sexual inappropriateness. II. The DON and ADON reviewed all incidences of unusual occurrences from January 2023 through	F 600		

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F 600	Continued From page 22 March 2023. No other allegations of sexual abuse were noted. III. Each month the Investigation Committee will review any allegations of abuse. This committee ensures that all aspects of the Investigation form/tool is complete. This is reported to the QAA Committee Quarterly and/or more often as needed. 4. SUPPORTING DOCUMENTS 1. Hourly monitoring from March 29th, 2023, to present. 2. Updated care plan March 30th, 2023, to present. 3. Re-education on Abuse prevention for staff 3/31/23 4. The need for every thirty-minutes monitoring of resident #90 behavior of sexual inappropriateness (previously was hourly) 5. Evidence of Abuse Training 3/31/23 6. Updated Care Plan 7. Investigation Tool 8. MOU between resident #90 and SBGC regarding consequences for sexual inappropriateness The plan was verified by the State Agency on 09/06/23 at 1:20 PM.	F 600		
F 641 SS=D	Accuracy of Assessments	F 641		

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F 641	Continued From page 23 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) out of 42 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) assessment of two (2) Residents for drug regimen reviews, of one (1) resident for dialysis, and of one (1) resident for a fall,Resident #44, #47, #125, and #37. The findings included: 1.Facility staff failed to accurately code Resident #44's MDS Assessment for Drug Regimen Review. Resident #44 was admitted on 02/11/2014 with multiple diagnoses including Non-Alzheimer's Dementia, Unspecified Cerebrovascular Disease, Depression, and Anxiety. Pharmacy drug regimen review dated 05/03/2023 documentation showed, "It is noted that patient slipped out of chair today. It seems that this was after dialysis. In review of medications, she takes Ativan 0.5mg before dialysis. Recommend consider if her health condition warrants a decrease in the Ativan prior to dialysis. Ativan 0.25mg may be efficacious with fewer side effects." Review Psych Progress note dated 05/06/2023 at 12:52 PM showed that the resident was on Ativan 0.5mg tablet PRN for management of Anxiety	F 641	1. A review of the resident assessment for resident #44 and #47 was conducted. Unable to make modification to MDS as the RAI manual indicates that these section of the MDS are only completed on specific MDS. This deficient practice cited does not exist. 2. No other resident was affected by this practice. 3. MDS coordinators were re-educated on 10/10/2023 ensuring they understood the requirement for MDS as it pertains to Drug Regime Review. 4. The MDs manager monitor MDS for accuracy and report findings to QA. 5. Completion Date: 11/1/2023 6. Responsible Person(s): MDS Manager	

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F 641	Continued From page 24 associated with dialysis, present with some progressive substantial cognitive decline with minimal interaction due to Dementia, the resident being managed with Aricept 10mg for Dementia and Citalopram 20mg for depression, has been on these medication therapies for some time and is very helpful and compliance with dialysis also gets Ativan 1mg on dialysis days and there is no change in treatment plan. Review of the Annual (MDS) Minimum Data Set Assessment dated 06/08/2023, showed that facility staff coded the following: In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "01", indicates severely impaired cognition. In Section N (Medications) N2001 "Did a complete drug regimen review identify potential clinically significant medication issues is "left blank" indicating not coded". The MDS lacked documented evidence that the facility staff accurately coded the MDS to reflect that Resident #44 had a complete drug regimen review that identified potential clinically significant medication issues. During a face-to-face interview conducted on 09/06/2023 at 3:40 PM, Employee #16 (MDS Coordinator) stated that he would review the MDS assessment." 2. Facility staff failed to accurately code Resident #47's MDS Assessment for Drug Regimen Review.	F 641	1. The MDS coordinator reassessed resident #125 and #37 and modified the assessments with correct coding on 10/10/2023. 2. Residents on dialysis and residents with falls and injury have the potential to be affected by this practice. Upon checking these residents no other resident was impacted by this practice. 3. MDS coordinators were re-educated on 10/10/23 by the MDS manager on accurate coding of all MDS assessments specific to falls and dialysis. 4. The MDS Manager will audit MDS for accuracy specifically residents on dialysis and falls with injury. This information will be presented to the QAPI coordinator quarterly. 5. Completion Date : 11/1/2023 6. MDS Manager (Supervisor).	

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Resident #47 was admitted on 12/08/22 with multiple diagnoses including Depression, Mild intellectual disabilities, and Schizophrenia.

Pharmacy drug regimen review dated 03/05/23 documented, "Recommend evaluate continue need for 2 antidepressants: bupropion and lexapro. Can one of them be tapered?"

Review Psych Progress note dated 04/30/23 at 12:01 AM showed that the resident is alert and verbally responsive, the resident reported that sleep and appetite vary, thought process is slightly linear and logical, mood-congruent with affect, resident is on Risperdal 1mg for Psychosis, and Lexapro 5mg for Depression. Will continue with admission medication. Nurse to continue to monitor and document to direct treatment plan.

Review of the Quarterly (MDS) Minimum Data Set Assessment dated 06/30/2023, showed that facility staff coded the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "12", indicates moderately impaired cognition.

In Section N (Medications) N2001 "Did a complete drug regimen review identify potential clinically significant medication issues is "left blank" indicating not coded".

The MDS lacked documented evidence that the facility staff accurately coded the MDS to reflect that Resident #47 had a complete drug regimen review that identified potential clinically significant

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F 641	Continued From page 26 medication issues. During a face-to-face interview conducted on 09/06/2023 at 2:40 PM, Employee #16 (MDS Coordinator) stated that he would review the MDS assessment. 3.Facility staff failed to accurately code Resident #125's dependent on Dialysis Resident #125 was admitted on 05/17/2022 with multiple diagnoses including Hypertension, Diabetes Mellitus 2, and End-stage renal disease dependent on Dialysis. Reviewed Admission progress note dated 5/19/2022 at 05:10 PM documentation showed that the resident receives dialysis treatment (M [Monday] -W [Wednesday -F [Friday]) in-house from Davita Dialysis. Review of the Admission (MDS) Minimum Data Set Assessment dated 05/24/2022 showed that facility staff coded the following: In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "15", indicates intact cognition. In Section O (Special Treatments, Procedures, and Programs) O0100 "Check all of the following treatments, procedures, and programs that were performed while a resident at this facility and within the last 14 days, Dialysis was "left blank" indicating not coded". The MDS lacked documented evidence that the facility staff accurately coded the MDS to reflect that Resident #125 received dialysis treatment	F 641		

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(M-W-F) in-house from Davita Dialysis.

During a face-to-face interview conducted on 09/06/2023 at 2:40 PM, Employee #16 (MDS Coordinator) stated that he would review the MDS assessment."

4. Resident # 37 was admitted to the facility on 02/04/2022 with diagnoses including: Dementia, Altered Mental Status, Insomnia, Anorexia, Unspecified Fall, and Presence of Right Artificial Knee.

A review of Resident #37's medical record revealed:

An Admission Falls Risk Assessment dated 02/04/22 documented that the Resident had three or more contributing factors for falls. Based on the contributing factors, facility staff scored the Resident's Risk for Falls as "15," indicating the Resident was at high risk for falls.

A Department of Health (DOH) Complaint/Incident Report Received 02/07/22 at 4:46 PM documented: " ...On 02/04/2022, during assessment, the resident was noted agitated and combative Later, resident was brought to the nursing station for close monitoring ...transferred to bed around 1:00AM due to resident noted sleeping. Bed was left in low position and call bell within reach. Charge nurse reported that during round at 3 PM, resident was still in bed sleeping. Around 3:45 AM, she was observed in a sitting position on the floor close to her bed. Resident was unable to explain what happened due to confusion. On head-to-toe assessment ...was noted with slight swelling on the left eyebrow with small laceration and moderate amount of bleeding. Pressure dressing was applied to stop

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the bleeding. No apparent change in vision was noted ... MD made aware ordered to transfer resident to ER for evaluation. RP was informed ...Resident returned to the facility on 02/05/2022 around 7:15 PM from [Local Hospital] with two stitches around [pronoun] left eyebrow ..."

A review of an Admission Minimum Data Set (MDS) assessment dated 02/11/22 documented that Resident # 37 had a Brief Interview for Mental Status (BIMS) summary Score of " 06," indicating the Resident had severely impaired cognition. In addition, facility staff coded that the Resident required extensive assistance from two (2) staff for bed mobility and transfers, required extensive assistance from at least one (1) staff for locomotion on/off the unit, dressing, toilet use, and personal hygiene, used a wheelchair for mobility, was frequently incontinent for bowel and bladder, and had no falls with or without injury since admission.

A review of Resident #37's medical record lacked evidence that the Resident's Admission MDS assessment on 02/11/22 captured the Resident's fall with injury on 02/04/22.

During a face-to-face interview on 09/06/23 at 1:45 PM, Employee #16 (Nursing MDS Manager) stated that the Resident's fall with injury on 02/04/22 was missed on the 02/22/23 Admission MDS assessment.

F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered

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F 656	Continued From page 29 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 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656		

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F 656	Continued From page 30 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility's staff failed to develop a care plan how staff were to address Resident #90 sexual inappropriateness toward Resident #16 on 09/03/22 and failed to implement approaches to monitor and record Resident #124's complaint of pain as indicated on the comprehensive care plan. Residents #90 and #124 The findings included: 1. Resident #90 was admitted to the facility on 02/05/18. The resident had a history of multiple diagnoses including Alcohol Use. A nursing note dated 09/03/22 12:31 AM [Recorded as Late Entry on 09/06/22 12:49 AM] documented the following but not limited to, "At around 2:35 AM call light was on in room 270A, when caregiver [Employee #12, Certified Nursing Assistant] went there. Care giver called the nurse [Employee #13, Licensed Practical Nurse] and reported that he saw [Resident #90] kissing [Resident #16]. By the time the nurse went there [Resident #90] was leaving the room." A unit manager's [Employee # 18] progress note dated 09/06/22 at 3:20 PM documented, "[Resident #90] was transferred from Unit 2 Green room 271A to unit 3 Orange room 356B. He was transferred off the unit because he was caught several times in room 270 inappropriately touching [Resident #16] on the A bed. [Resident	F 656	1. Resident # 90 was reassessed, and the Care plan was immediately developed by the Nurse Manager to include sexual inappropriateness and the approaches to monitor Resident on---9/4/23. 2. All Residents that have potential to be affected by this deficiency were identified by October 6, 2023. No one was identified by this practice. 3. All nursing staff were in-serviced by the staff educator on abuse, including sexual abuse and sexual allegation. This includes training on transferring of any residents from one unit to another unit. 4. Any allegation of abuse in the facility will be reported to the abuse investigative team immediately. The abuse coordinator will monitor for accuracy and report to the QA meeting quarterly. 5. Completion Date: 11/1/2023 6. Responsible person(s): Unit Managers and Social Work Director.	

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#90] is alert and oriented x3 (name, time, and place), he was advised not to go into room 270 the first time he was caught in the room in a compromised position with the resident [Resident #16] in question. [Resident #90] verbalized understanding and promise to stay away from [Resident #16], but [Resident #90] continued to sneak into the room during the odd hours of the night. [Resident #90] was caught on 9/6/22 at 2:25 AM in the room inappropriately feeling on [Resident #16]."

A review of Resident #90's current and discontinued care plans revealed the facility's staff failed to developed care plans to address the incident when Resident #90 sexual inappropriateness with Resident #16 observed by staff on 09/03/22.

During a face-to face interview on 08/30/23 starting at approximately 8:00 AM, Employee #13 (LPN) and Employee #12 (CNA) stated that around 2:00 AM Resident #90 was observed in Resident #16's room trying to kiss her. When asked what date this happened? They stated that they believe it was date (03/06/22) Resident #90 was moved to 3 Orange. Employee #12 (CNA) said when he walked in Resident #16's room Resident #90 was standing beside the resident's bed. Resident #16's covers were pulled down and [pronoun] gown was pulled up."

During a face-to-face interview on 09/6/23 at 8:38 PM, Employee #18 (Unit Manager/LPN) stated that she did not develop a care plan for Resident #90's sexual inappropriateness with Resident #16. The employee said, "I only put a note in his chart."

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F 689	Continued From page 44 - 1930 (7:30 PM) [Security Supervisor's name] has arrived to facility to assist as well - 2000 (8:00 PM) Officers still reviewing play back - 2005 (8:05 PM) Missing resident [Resident's name] was returned back to facility - 2030 (8:30 PM) MPD (Metropolitan Police Department) [Police officer's name and Bage number] has left facility - 2155 (9:55 PM) [Security Supervisor's name] completed play back. Resident was seen leaving secondary smoking area [at] 1651 (4:51 PM) hours" When asked how was Resident #144 able to get out of that door, Employee #31 stated, "the door was easily pushed open, it had an alarm, but couldn't hear it too far away" and "can now only be opened with key pad code that only Security staff have the code" and "Engineering department knew about but that person is deceased (Director of Engineering), he was the main person that knew about it [the broken door]." When asked about documentation showing when the door was repaired, Employee #31 stated, "I will see if I can find a copy of the work order that we sent requesting the repair work" and "we would usually go through engineering to get things repaired, but that person is no longer here so I don't know where to find that paperwork." A review of the Security's log book on 09/13/23 documented, "03/28/22 7AM - 3PM Morning Shift; 9:35am Called ESSI (Electronic Security Services, Incorporated) for service for malfunctioning doors." During a telephone interview conducted on	F 689		

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09/13/23 AT 1:20 PM, Employee #33 (Security Guard) stated that, "they (the residents) must be signed out by someone escorted by family member or nursing home staff; they all have an escort; very rare residents are authorized to leave by themselves."

During a telephone interview conducted on 09/13/23 AT 1:55 PM, Employee #34 (Security Guard) stated that, "[Resident's name] wandered all the time" and "she got out because the door wasn't fixed" and "yes, I was aware it [the door from which the resident eloped] was broken the alarm wasn't working" and "all of us [security officers] that make the rounds knew the door wasn't working the alarm was broke" and "but she was new and a wanderer so that's how she got out."
During a face-to-face interview conducted on 09/13/23 AT 2:55 PM, Employee #35 (Environmental Director) stated that, "I took over in April of this year [2023]" and "Engineering is informed by Security about contacting a Contractor" and "recently this year not sure what month, but I vaguely remember not sure what was wrong with the door."

During a face-to-face interview conducted on 09/13/23 AT 3:12 PM, Employee #36 (Maintenance worker) stated that, "Normally we don't handle anything with code doors, a company comes out to handle issues involving that door" and "I came back around June 2022, since I've been back [working here], I don't know of any problems with that door."

During a face-to-face interview conducted on 09/13/23 AT 3:15 PM, Employee #37 (Maintenance worker) stated that, "Further back, I

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F 689	Continued From page 46 don't recall exactly when, the magnetic piece with the security system was broken" and "we don't have anything to do as far as those doors, that's all a security issue. They (Security) call the Contractors for all security doors." During a face-to-face interview conducted on 09/13/23 AT 3:40 PM, Employee #38 (Security Guard) stated that, "That door was broken for about 2 months before it was fixed around 2022 going into the fall because I think it was starting to get a little chilly and summer had passed." During a follow-up, face-to-face interview conducted on 09/14/23 AT 6:40 AM, Employee #34 stated that, "its got a magnetic alarm system inside of it and it will not go off because of the magnetic piece was broken" and "it was reported to the facility" and "the engineers, when we find something wrong that's who we report it to; to the head person who is deceased now that was reported to him before he passed away" and "they have a group that they call to come in to fix it called ESI and they came to fix" and "engineering doesn't fix that type of door and I don't have no idea why but they don't fix those type of doors we call ESI" and "we only report to the engineering that's the chain of command; we don't report to the Administrator" and "We turned the work order in, but I don't know who [Security Supervisor's name] turned them in to." During a follow-up, face-to-face interview conducted on 9/14/23 AT 7:12 AM, Employee #31 was asked again about getting the workorder for the date when the broken door was repaired and the response was, "A lot of times the work order requests were verbal and I told the head person of engineering who is now deceased and he	F 689		

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F 689	Continued From page 47 would approve the repairs for the contractors to come in and fix the door that was broken" and "I did look through my phone last night and I have multiple emails for different things that the contractor had to fix, but I did find the one for that door when they sent me a quote to fix that door back in April of last year 2022" and "As soon as I can get that email printed out from my phone, I'll give you a copy." A review of a document presented to the Surveyor titled 'ESSI Sales Agreement' dated 03/29/22 (which was three days after Resident #144 eloped through the broken door) revealed, "Job Name: [Nursing Home Name] Scope of Work: Based on information provided by [Nursing Home Name], ESSI will furnish and install the following equipment to add keypads" and "Door 30: One (1) IEI keypad to be installed" and "The Customer shall be responsible for the cost" and "All work under this proposal" and "Forty percent (40%) of the contract cost will be due upon acceptance of the contract. The balance is due in increments as Progress Payments during the installation phase" and "All prices are firm for 45 days from the date of this proposal." During a face-to-face interview conducted on 09/14/23 AT 2:00 PM, Employee #1 stated that, "We don't do chair alarms (referring to elopement risk assessment dated 03/21/22), that must've been a mistake" and "we rely on the hospital discharge summary and family to determine if resident is high risk" and "if at risk and require monitoring we would not accept that person if we don't have a bed on 1Blue" and "our Admission person would see that and report to me about the resident at risk."	F 689		

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-Employee #1 was then shown the hospital discharge summary dated 03/21/22 AT 13:35 (1:35 PM) that documented, "3/20 Pending discharge to [Nursing Home name]. Patient was disoriented overnight requiring 1:1 (one-to-one) observation" indicating Resident #144 had exhibited altered mental status that required supervision while pending acceptance to the nursing home facility. There was no response.
-Employee #1 was then asked how did Resident #144 elope from the facility and the response was, "Post investigation showed she went out the side door" and "probably the alarm malfunction" and "I'm not sure they made me aware of that door prior to elopement" and "Engineering checked all doors looking for alarm working and the locks are working" and "they fixed it right away."
-When asked what was meant by "right away," Employee #1 stated, "immediately." When asked to produce work order showing the date when that door was repaired, Employee #1 stated, "Engineering would know that."

A review of a document presented to Surveyor on 09/14/23 AT 5:28 PM by Employee #1 and signed by Employee #35, it documented that, "To the best of my knowledge since I started here on April 18, 2023 all doors are secure and working properly as designed" and "Environmental Care Rounds are done daily which include daily rounds to ensure the alarms and locks are in good working condition."

Past Non-compliance Information

During a face-to-face interview conducted on 09/14/23 AT 5:30 PM, Employee #1 (Administrator) indicated the following

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interventions were implemented to address the deficient practice:

- Resident #144 was reported missing. A complete facility search was initiated by staff and Security team within facility and surrounding areas. DON (Director of Nursing), Administrator, Police and family were notified. The resident's niece provided the resident's cell phone number. The resident was called and was located at home address. Facility staff and police picked up the resident and was brought back to facility.
- Resident was immediately assessed upon return to facility, no injury or discomfort.
- Resident's POA (power of attorney) agreed to place resident in a secured unit.
- Resident was placed on secured unit (Dementia Care Unit) immediately upon arrival into facility.
- All entry doors to the facility were checked to ensure alarms and or locks were in good working condition. One was noted to be defective and repaired immediately.
- Plan in place to ensure doors are checked on a daily basis.
- Care plan updated.
- Nursing staff were in-serviced and completed Elopement Education.
- No other residents were affected by this deficient practice.
- No other incidents of Elopements since 03/26/22.

A review of a document titled 'Invoice' revealed the facility paid "40% [$3,126.80] of contract ($7,817.00) due upon acceptance" indicating the facility accepted ESSI's proposal to start scope of work to repair defective doors on 04/20/22, leaving residents at risk for elopement for 25 days

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 50 after Resident #144 had eloped from the facility through a defective door on 03/26/22. The aforementioned interventions were implemented prior to the State Agency's on-site survey on 08/20/23. 22 B DCMR sect. 3211.1(d)	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		

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	095014	A. BUILDING ______ B. WING ______	C 09/14/2023

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F 755	Continued From page 51 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, facility staff failed to develop a narcotic count sheet that identified two (2) licensed nurses to reconcile the resident's narcotic medications. The findings included: A document titled 'Daily Narcotic count QA (quality assurance) data analysis report form' documented, "Month August 2023" and "Off-going no holes On-coming no holes" and "All narcotic count sheets must have incoming and outgoing nurse signatures every shift." A review of a document titled 'Shift Verification of Accuracy of Controlled Drug Record' documented, "August 2023" with the following data: " Unit One Blue: 08/05/23, 08/06/23, 08/07/23, 08/08/23, 08/11/23, 08/14/23, 08/19/23 and 08/20/23 documented, Evening shift beginning at 3 PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit One Brookland: 08/01/23, 08/04/23, 08/09/23, 08/12/23, 08/13/23, 08/14/23, 08/15/23, 08/16/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23, 08/26/23, 08/27/23, 08/28/23 and 08/30/23 documented, Day shift beginning at 7 AM,	F 755	1. A review of the controlled policy was conducted. Unable to retrospectively correct this deficiency. 2. All residents have the potential to be impacted by this practice. A review of all narcotic counts was conducted by the unit manager, no additional units were identified. 3. The licensed staff were re-educated by staff educator on narcotic counts during change of shifts, and purpose of narcotic count. 4. A narcotic count audit tool is done by unit managers. This report is submitted to ADON and reported in QA meeting. 5. Completion Date:11/1/2023 6. Person(s) Responsible: ADON	

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F 755	Continued From page 52 Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit Two Blue: 08/03/23, 08/06/23, 08/08/23, 08/12/23, 08/13/23, 08/14/23, 08/15/23, 08/18/23, 08/20/23, 08/21/23, 08/22/23, 08/25/23, 08/26/23, 08/27/23 and 08/29/23 documented, Day shift beginning at 7 AM, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit Two Orange: 08/01/23, 08/04/23, 08/05/23, 08/06/23, 08/12/23, 08/13/23, 08/15/23, 08/19/23 and 08/20/23 documented, Day shift beginning at 7 AM, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit Two Green: 08/07/23, 08/08/23, 08/13/23 and 08/27/23 documented, Day shift beginning at 7 AM, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit Three Blue: 08/01/23, 08/03/23, 08/08/23, 08/10/23, 08/13/23, 08/15/23, 08/17/23, 08/19/23, 08/22/23, 08/24/23, 08/29/23 and 08/31/23 documented, Day shift beginning at 7 AM, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and	F 755		

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off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record.

" Three Orange: 08/07/23 documented, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record.

" Unit Three Green: 08/02/23, 08/05/23, 08/06/23,08/13/23, 08/09/23, 08/16/23, 08/18/23, 08/19/23, 08/20/23, 08/23/23 and 08/29/23 documented, Day shift beginning at 7AM and Evening shift beginning at 3 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record.

During an observation of the narcotic count conducted on 09/07/23 AT 11:52 AM with facility staff on Three Green, it was noted that the narcotic count book contained narcotic count sheets that documented one licensed nurse performing the narcotic reconciliation for consecutive shifts.

During a face-to-face interview conducted on 09/07/23 AT 11:52 AM, Employee #19 (LPN, 3 Green Unit Manager) stated, "narcotic counts should be 2 people, the person leaving [at end of shift] and person coming [at beginning of shift]" and "if I'm the person staying over [working 2 consecutive 8-hour shifts] then I'm signing alone."

During a face-to-face interview conducted on 09/07/23 AT 12:37 PM on Three Blue regarding

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F 755	Continued From page 54	F 755		

only one licensed nurse signing alone for the narcotic count, Employee #7 (RN 3 Blue Unit Manager) stated, "if there's an issue with the count then we can get the Nursing Supervisor."

During a face-to-face interview conducted on 09/07/23 AT 1:20 PM on Brookland regarding the resident's narcotic count, Employee #20 (RN 1 Brookland Nurse Manager) stated, "There should be somebody that can initial to show second person witness [the narcotic count]."

During a face-to-face interview conducted on 09/07/23 AT 3:25 PM regarding the process to ensure the accuracy of the narcotic count by two licensed nurses, Employee #2 (Director of Nursing/DON) stated, "We're monitoring for staff to make sure they are signing as they come on the shift and when they are leaving the shift."

A review of a document titled 'Shift Verification of Accuracy of Controlled Drug Record' documented, "September 2023" with the following data:

" Unit One Blue: 09/02/23 and 09/03/23 documented, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record.
" Unit One Brookland: 09/01/23, 09/02/23, 09/03/23 and 09/04/23 documented, Day shift beginning at 7 AM, Evening shift beginning at 3PM and Night shift beginning at 11 PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the

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F 755	Continued From page 55 accuracy of the resident's controlled drug record. " Unit Three Blue: 09/01/23, 09/05/23 and 09/07/23 documented, Day shift beginning at 7 AM and Evening shift beginning at 3PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. " Unit Three Green: 09/01/23 documented, Day shift beginning at 7 AM and Evening shift beginning at 3PM, the on duty nurse and off duty nurse signatures were the same for consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record. The State Surveyor then showed the narcotic count sheets to Employee #2 that showed documented evidence that the nurse who signed off to completing the narcotic count for the Off-Duty shift, was the same nurse who signed off to completing the narcotic count for the On-Duty shift which indicated the nurse did not leave the facility for consecutive shifts and a second licensed nurse was not present to perform the narcotic reconciliation. Employee #2 then stated, "Oh I see now, you're right they're not leaving when they sign [on the off duty space] so we have to fix that" and "at first we would just leave it blank, but we don't want any holes [blank spaces] on the paper." 22B DCMR sect. 3224.3(d)	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 56 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 interview, facility staff failed to store and distribute food under sanitary condition as evidenced by food items such as one (1) of one (1) bag of shredded carrots, approximately 50 of 50 containers of apple sauce and approximately 120 cold sandwiches of tuna, turkey and cheese, ham and cheese, and/or peanut butter that were observed undated in one (1) of one (1) walk-in refrigerator, one (1) of (1) bag of provolone cheese in reach-in refrigerator #2 that was not labeled, and two (2) of two (2) open packs of yellow cheese in the cook refrigerator that also was not labeled or dated. The findings include: During a tour of dietary services on August 20, 2023, at approximately 6:30 AM, food items including one (1) of one (1) bag of shredded	F 812	1. All items in refrigerator that were unlabeled and not dated were discarded immediately. 2. A review of all refrigerator units was conducted, and no residents were impacted by the practice. 3. The Management staff were re-educated regarding the monitoring of the refrigerated units to ensure that food items are labeled/dated. And discard any outdated food item as indicated immediately. 4. A checklist will be part of the supervisor's duties for each shift prior to the start of the tray line with regards to monitoring for labeling/dating of food items that are to be served to the resident and staff members. The information will be reviewed by Food Services Management and reported to QAPI quarterly. 5. Completion Date: 11/1/2023. 6. Person(s) Responsible: Food Services Director, Food Production Manager and Food Service Supervisors.	

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F 812	Continued From page 57 carrots, approximately 50 of 50 containers of apple sauce and approximately 120 cold sandwiches of tuna, turkey and cheese, ham, and cheese, and/or peanut butter observed in one (1) of one (1) walk-in refrigerator were not labeled or dated. Employee #39 acknowledged the findings during a face-to-face interview on August 22, 2023, at approximately 7:00 AM.	F 812		
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	F 842		

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F 842	Continued From page 58 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and 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.	F 842	1. A review of resident #20 insulin administration was conducted. Unable to retrospectively correct this deficiency. 2. All Residents who receive insulin with sliding scale order were Identified to potentially be affected by the deficiency by Nursing Managers. Areas of concern were corrected immediately. 3. One on one in-service was conducted by DON/Unit Manager with Employee #22. The importance of following doctor's sliding scale and ensuring its documentation was done on 9/15/23. All Licensed staff were in serviced by the Nurse educator on the importance of following physicians order when administering Insulin. 4. Insulin administration and documentation will be monitored by the nurse Management. The Nurse Mangers will report the findings to QA coordinator. The findings will be reported quarterly during the QA meeting. 5. Completion Date: 11/1/2023 6. Person (s) Responsible :Nursing Management.	

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews for one (1) of 42 sampled residents, facility staff failed to show documented evidence that Resident #20's Humalog insulin was administered as ordered by the physician to treat finger stick blood glucose results greater than 250mg (milligram)/dl (deciliter).

The findings included:

Resident #20 was admitted to the facility on 10/27/22 with multiple diagnoses that included: Dementia, Diabetes Mellitus, Hypertension and Atherosclerotic Heart Disease.

Review of Resident #20's medical record revealed:

A Physician order dated 10/27/22 documented, "Humalog U(unit)-100 Insulin (insulin lispro) solution; 100 unit/mL (milliliter); amt (amount): 3 units; subcutaneous Special Instructions: Fingersticks AC (before meals) and HS (at bedtime), give 3 units of Humalog Insulin Subq (subcutaneous) if BS (blood sugar) > (greater than) 250 Call MD (medical doctor)/NP (nurse practitioner) if BS < (less than) or > 400 for DM (Diabetes Mellitus) Before Meals and At Bedtime; 07:30 AM, 12:30 PM, 05:30 PM, 09:00 PM."

A Care Plan Problem dated 10/27/22 documented, "Potential for complications related to Diabetes Mellitus" and "Monitor/record/report blood glucose per MD order."

A Quarterly Minimum Data Set Assessment (MDS) dated 06/20/2023 documented: facility

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F 842	Continued From page 60 staff coded a Brief Interview for Mental Status (BIMS) summary score of "07," indicating the resident had a severely impaired cognitive status; facility staff coded "Medications: Insulin injections since admission" and "Orders for Insulin." A Medication Administration History dated 08/01/23 - 08/25/23 documented, "Sat (Saturday) 19 (August 19th) 9:00 PM BE (Employee #22's (LPN, 1 Blue) initials) Results 356 mg(milligram)/dl (deciliter) site 0 Units 0" and "Sun (Sunday) 20 (August 20th) 9:00 PM BE (Employee #22's initials) Results 343 mg(milligram)/dl (deciliter) site 0 Units 0." A staff schedule documented, "Shift 4:00 PM to 12:00 AM 1 Blue Assignment Date: 08/19/23 Employee #22's name" and "Shift 4:00 PM to 12:00 AM 1 Blue Assignment Date: 08/20/23 Employee #22's name." During a face-to-face interview conducted on 09/12/23 AT 10:45 AM, Employee #22 stated that, "it depends on the sliding scale, if 250 and above you have to administer 3 units" and "if I didn't give it, it's because I didn't write it there" and "I have to look at the documentation and see what happened." During a face-to-face interview conducted on 09/12/23 AT 11:08 AM, Employee #21 (LPN, 1 Blue Assistant Manager) stated that, "The resident has a standing order to give 3 units Humalog if greater than 250" and "it's only documented in Matrix [facility's electronic medical records system] and "if there's a reason that it wasn't given if it's high you must let the unit manager know and let the doctor know why it wasn't given, then you must write a note in the	F 842		

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F 842	Continued From page 61 progress notes." During a review of Resident #20's record, Employee #21 acknowledged that there was no documented evidence during the evening shift of 08/19/23 and 08/20/23 by Employee #22 of the reason why the resident's Humalog Insulin was not administered as ordered. During a face-to-face interview conducted on 09/12/23 AT 11:55 AM, Employee #7 (RN, 3 Blue Unit Manager) stated that "You go by the standing order" and "the nurse only notifies the doctor when [the fingerstick result] over 400 or below 70." During a face-to-face interview conducted on 09/12/23 AT 12:00 PM, Employee #2 (Director of Nursing/DON) stated that, "There's a sliding scale the doctor says they should give [insulin] that's the normal process, it's the standard practice" and "the nurse on the unit is responsible for following the doctor's order." 22B DCMR sect. 3231.10	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		

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F 867	Continued From page 62 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867	1. A review of prior plans of correction was conducted related to abuse policy, reporting and investigation of abuse was conducted. Unable to retrospectively correct. 2. The abuse coordinator reviewed all prior incidents of abuse to ensure that all areas of abuse protocols are being followed. No additional findings were identified. 3. Re-education of all Staff by the Nurse educator on abuse, including abuse policy, reporting and investigation of abuse and statement require from staff when allegation of abuse. This includes ensuring that they understood the importance of ensuring QAPI plans were followed. 4. The abuse coordinator will review all allegations of abuse for accuracy. This will be reported to the QAPI coordinator. 5. Completion Date: 11/1/2023. 6. Person(s) Responsible:DON Or Designee.	

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F 867	Continued From page 63 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).	F 867		

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Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility's staff failed to ensure that the comprehensive Quality Assurance and Performance Improvement (QAPI) plan was implemented to correct identified deficiencies related to implementing abuse policy, reporting allegation of abuse, or thoroughly investigating abuse. The resident census on the first day of the survey was 170.

The findings included:

A review of the facility's complaint/facility reported incident survey that ended on 05/18/23 showed that the facility was cited for the following

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deficiencies: F607, F609, and F610- Freedom from Abuse, Neglect, and Exploitation. An onsite recertification, complaint, and facility reported incident survey was conducted from 08/20/23 to 09/14/23. The onsite survey determined the facility remained out of compliance.

The facility submitted a plan of correction for the complaint/facility reported incident survey dated 05/18/23 survey and alleged compliance as of 07/31/23. The facility's accepted plan of correction for F607, F609, and F610 included the following:

F607 - Implement Abuse Policy
- A review of all incidents with an allegation of abuse was conducted, no other resident was impacted by this practice.
- All staff were re-educated regarding abuse and the abuse policy.
- The Abuse Coordinator will review all allegation of abuse.
- This information will be presented to the QAPI committee quarterly.

F609 - Reporting Allegations of Abuse
- A review of all incidents with an allegation of abuse was conducted, no other resident was impacted by this practice.
- All staff were re-educated regarding abuse and the abuse policy.
- The Abuse Coordinator will review all allegation of abuse and investigation; this will include the time incidents were reported.
- This information will be presented to the QAPI committee quarterly.

F610 - Through Investigation
- A review of all incidents with an allegation of

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abuse was conducted.
- All staff were re-educated regarding abuse and the abuse policy, including the investigation process.
- The Abuse Coordinator will review all allegation of abuse and investigation.
-This information will be presented to the QAPI committee quarterly.

On 03/03/23 Resident #90 was observed by staff in Resident #16's room being sexual inappropriate with the resident. The facility staff failed to follow their Plan of Correction as follows:

1.The facility's staff failed to implement their Prohibition of Resident Abuse/ Abuse Prevention Policy by failing to notify the State Agency, the Ombudsman, and Resident #16's Legal Guardian about the sexual inappropriate incident that occurred on 09/03/22. Additionally, the facility staff did not immediately separate the residents after the incident. Instead, the facility's staff moved Resident #90 to another unit three days (09/06/22) after the incident.

2. The facility's staff failed to report the sexual inappropriate incident involving Resident #90 and Resident #151 to the State Agency of the Ombudsman.

3. The facility's staff failed to thoroughly investigate the sexually inappropriate incident involving Resident #90 and Resident #151, as evidenced by the lack of witness statements from those with knowledge of the incident,

According to Employee #3 (ADON), the QAPI team last quarterly meeting was on 08/18/23.

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F 867	Continued From page 67 During a face-to-face interview on 08/25/23 at 3:05 PM, Employees #1 (Administrator), #2 (Director of Nursing/DON), and #3 (ADON) were made aware of the findings. Cross reference: 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600.	F 867		

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F 656	Continued From page 32 Cross reference: 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600. 2. Resident #124 was admitted to the facility on 02/23/22 with diagnoses that included Diabetes Mellitus Type 2, Cerebral Infarct, Acute Embolism and Thrombosis of Unspecified DeepVeins of Right Lower Extremity, Localized Swelling, Mass and Lump, Lower Left Lump and Neuropathy. A review of Resident #124's medical record revealed: A physician's order dated 12/31/22 at 11:19 AM directed: "Has pain medication been given, Yes or No? Place Y or N in dated block." A physician order dated 12/31/22 at 11:20 AM that directed: "Pain assessment every shift. Pain severity scale 0 = No pain,1-2 = Mild pain, 3-4 = Moderate pain, 5-6 = Severe pain,7-8 = Very severe pain, and 9-10 = Worst pain possible." A physician order dated 12/31/22 at 11:21 AM that directed: "Nursing Observation every shift, 0 = No pain, V = Verbal indication of pain, A = facial grimacing, frowning, B = Restlessness, C = Agitation, D = Moaning or groaning, E = Guarding a body, F = Constant shifting, H = Other specify on the back, and I = crying." A care plan initiated on 02/25/23 documented: "Problem: Resident has complaints of chronic pain R/T (related to) osteoarthritis/osteopenia, neuropathy abdominal and back pain, left knee DJD, right foot pain, and right foot paralysis.	F 656	1. Resident # 124 was assessed, and the care plan was reviewed .Unable to retrospectively correct. 2. All Residents on pain management protocol were identified. The care plans and interventions were reviewed by Nurse Managers. There were no other residents impacted by the practice. 3. All licensed staff were in service by the nurse educator on pain assessment and documentation to include pain scale; location; intensity according to plan of care and on ensuring interventions are followed. 4. Monitoring log initiated to monitor nursing documentation of pain to include pain location and frequency, care plans Intervention and implementation of Interventions. 5. Completion date: 11/1/2023 6. Person(s) responsible: Unit Nursing Managers	

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F 656	Continued From page 33 Approach: Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors." An Annual Minimum Data Set Assessment dated 02/28/23 showed that Resident #126 had a Brief Interview for Mental Status (BIMS) Summary Score of "15," indicating that the Resident had intact cognition and was on a scheduled pain management regimen. A physician order dated 06/29/23 at 4:54 PM read: "Tramadol - Schedule IV tablet; 50 mg; amt (amount): 1 tablet; oral Tramadol. Administer one tablet by mouth every 8 hours for pain management." A physician order dated 09/01/23 directed: " X-ray of both knees due to pain." A physician order dated 09/01/23 at 1:59 PM read: "Gabapentin 300 mg capsule. One cap(sule) by mouth two times a day. Administer one capsule by mouth two times a day for neuropathic pain." During an observation and face-to-face interview on 09/14/23 at 2:32 PM, Resident # 124 was lying in bed watching television. When asked if [pronoun] was having pain, the Resident stated that [pronoun] was in pain and rated [pronoun] pain at an 11/10 on the pain scale (0-10). The Resident described the pain as a throbbing pain that [pronoun] felt all over [pronoun] body. A face-to-face interview with Resident #124 and a review of the Resident's medical record showed that the Resident had chronic pain and was on three medications to relieve pain: Tramadol,	F 656		

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Gabapentin, and Acetaminophen. The Resident's care plan included an approach to monitor and record any of the Resident's complaints of pain (including) the location, frequency, effect on function, intensity, alleviating factors, and aggravating factors. However, the Resident's medical record lacked documented evidence that the charge nurse implemented the approach in the care plan.

During a face-to-face interview on 09/12/23 at 3:03 PM, Employee #18, Unit Manager/Licensed Practical Nurse (LPN), stated that the Resident complained of pain-- to the knees, legs, and all over, at times. She noted that the Resident was on three pain medications and added the pain level was monitored on the MAR and the TAR. When asked where the facility's nurses documented the Resident's complaints of pain including the location, frequency, effect on function, intensity, alleviating factors, and aggravating factors for the Resident's pain per the care plan, the Employee said that information was documented in the nurse progress notes. The Employee then reviewed the August and September 2023 nurse progress notes. There was no documented evidence that the facility's nurses implemented the care plan approach that included recording the location, frequency, effect on function, intensity, alleviating factors, and aggravating factors for any complaints of Resident #126's pain. The Employee acknowledged that the nurses were not documenting the specific information regarding Resident #126 as outlined in the Resident's care plan.

Cross reference 22B DCMR sect.3210.4

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F 689	Continued From page 35	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility's staff failed to identify and eliminate environmental hazards (nonfunctioning alarm on exit door) and maintain consistent supervision and surveillance of Resident #144, who subsequently gained access to elope through a broken patio door. The findings included: A facility policy titled 'Resident Elopement' documented, "The facility is responsible for being knowledgeable of the location of all residents at all times." Resident #144 was admitted to the facility on 03/21/22 with multiple diagnoses that included: Dementia, Human Immunodeficiency Virus (HIV) Disease, History of Fall with Fractur of Right Radius and Glaucoma. A nursing progress note dated 03/21/22 AT 8:53 PM documented, "Upon admission, resident was observed going toward the elevator" and "she will not stay in her room or sit still. She was re-directed several times."	F 689	Past noncompliance: no plan of correction required.	

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A Physician order dated 03/21/22 documented, "Elopement risk assessment on admission" and "Hourly rounding."

An Elopement Risk Assessment dated 03/21/22 AT 9:33 PM documented, "New admission" and "Dementia" and "Moderately Impaired-decisions poor; cues/supervision required" and "Wandering with no rational purpose and attempting to open doors" and "Alzheimer's Disease" and "Chair/Wheelchair Alarm, Reality Orientation, Redirection" and "Based on assessment does resident present elopement risk? Yes."

A care plan problem dated 03/21/22 documented, "Dementia" and "difficulty understanding others, following commands r/t (related to) cognitive loss."

A physician order dated 03/22/22 documented, "Target behavioral symptoms: (Confusion, wandering."

A care plan problem dated 03/22/22 documented, "[resident's name] experiences wandering (moves with no rational purpose)."

Nursing progress notes dated 03/22/22 AT 8:04 AM documented, "[resident stated] I want to go home now" and 11:31 PM documented, "intermittent confusion" and "resident frequently walks around and says she wants to go home and asks for exit."

A nursing progress note dated 03/23/22 AT 10:29 PM documented, "Resident noted wandering around on the hallway and other resident room and refused to stay in her room."

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F 689	Continued From page 37 Nursing progress notes dated 03/24/22 AT 6:44 AM documented, "Wandering into other resident room" and 11:49 AM documented, "resident was redirected back to her room after finding her wandering around near the elevator." Nursing progress notes dated 03/25/22 AT 6:01 AM documented, "constant pacing in and out of the room requiring close and constant supervision and reorientation most of the night with no improvement" and 3:08 PM documented, "she gets up wanders around" and "attempting to open doors" and "redirected back to the unit by security [located at main entrance]" and "personal belonging packed up as she believes is time to go home" and 3:24 PM documented, "per MD (medical doctor) recommendations, resident is not a candidate to be discharged home" and "instead admit to long term care" and "RP (responsible party) on unit made aware of MD recommendations for long term care" and "1 Blue unit [secured Dementia care unit] was recommended and RP is open to the idea" Nursing progress notes dated 03/26/22 AT 5:48 AM documented, "she had no sleep during the night. Resident was confused and noted moving things around in her room" and 9:46 PM documented, "around 5:30 PM while serving dinner trays was unable to find resident from unit" and "she (the resident) told the officer that she at home in building where she lived. Staff and police officer went and was able to bring resident back to the facility" and "[resident] was transferred from 1Orange to 1Blue secured unit." A document titled 'Medication Administration History' dated 03/01/22 - 03/31/22 documented,	F 689		

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F 689	Continued From page 38 "Target Behavioral Symptoms (Confusion, wandering) Every Shift" and "Sat 26 (Saturday, March 26) Night (Night Shift 11 PM-7 AM) number of episodes-'0' Intervention-'0' Outcome-'0'" However, progress notes dated 03/26/22 AT 5:48 AM (Night Shift) documented that Resident #144 was exhibiting confusion. An Elopement Risk Assessment dated 03/26/22 AT 8:47 PM documented, "S/P (status post) Elopement" and "Elopement Successes in Past" and "History of Leaving Facility" and "Behavior Management Program-No use of restraints or psychotropic medication; Door Alarm Band Applied-Wanderguard; Personal Alarm-Motion Detector" and "Interventions somewhat effective; Resident was transferred from 1Orange to 1Blue and wanderguard was put in place" and "Based on assessment does resident present an elopement risk? Yes" A Psychiatry note dated 03/27/23 AT 1:03 PM documented, "She was seen in 1Orange (Unit on admission, prior to elopement and transfer to 1Blue Dementia Unit) upon request of nurse manager" and "She presents with flight of ideas and appear to talk out of tunes" and "Appear to struggle with some cognitive memory issues" and "Psychiatric Medication: Aricept 5mg (milligram) for Dementia." A Nurse Practitioner note dated 03/27/22 AT 11:18 PM documented, "resident now placed in memory unit following episode of elopement yesterday" and "Plan: resident is a candidate for long term care." An Admission Minimum Data Set (MDS) dated 03/28/22 documented: facility staff coded a Brief	F 689		

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Interview for Mental Status (BIMS) summary score of "6," indicating the resident had a severely impaired cognitive status.

The Department of Health (DOH) received the following incident report on 03/28/22: "This 78 year old female was admitted from [hospital name] on 03/21/22 with diagnoses of Dementia, s/p (status post) fall where she sustained fracture to right arm and cast before admission. Resident was seen at around 5PM during rounds. At around 5:30 PM while serving dinner trays resident was noted missing from unit. Elopement protocol was initiated, a complete search throughout the building was initiated. Writer called 911 who reported to facility and writer called emergency contact listed on face sheet, (resident's responsible party (RP)). In-house security and staff also searched the area around the building. Resident's RP reported that resident may have gone to her apartment. RP also gave writer the resident's cell phone number that she had with her. Resident was called and she answered the phone. [Police officer's name and badge number] was able to talk to resident on the phone. She told the officer that she was back home in the building where she lived. Staff and police officer went and was able to bring resident back calmly and safely to the facility. Resident was able to talk to [RP] on the phone who was able to get her to agree to be transferred to a secured unit. Resident was assessed from head to toes, vital signs within normal limit. Resident was noted in good spirit upon return. She denies pain. MD (medical doctor), RP made aware. Administrator and DON (Director of Nursing) was called."

According to the facility's 'Investigation Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095014	A. BUILDING ______ B. WING ______	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CTR FOR AGING SVCS	2601 18TH STREET NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40 Form' completed by Employee #29 (RN-1Orange) on 03/28/22, reviewed by Employee #1 (Administrator) and Employee #2 (Director of Nursing/DON) on 03/28/22, the report documented, "Incident Occurred: 03/26/22, Approx. (approximately) 5pm; Incident Witnessed by: N/A (not applicable); Type of Incident: Elopement; Behavioral Indicators: None; List of staff working in area at time of incident: Employee #28 (Certified Nursing Assistant/CNA-1Orange) and Employee #29." According to the written witness statement completed by Employee #28 (assigned CNA) on 03/26/22 per the stated, "She (the resident) was saying something like 1011, 1011. I told her that it's seven eleven not 1011. I did not know that she meant the number to her apartment. Dinner came and I asked her to go to her room and wait for her tray. I started serving dinner, when I reached her room she was not there" and "The Charge Nurse notified the Supervisor and the Security. There was a serious search throughout the facility. The resident was brough back by the police and taken straight to One Blue. I am the one who moved her belongings to One Blue." According to the Security's 'Incident Report' completed by Employee #30 (Facility's Security Guard) on 03/26/22, reviewed by Employee #31 (Security's Supervisor) on 03/26/22, the report documented, "Type of Incident: Elopement; Location of Incident: First Floor; At approximately 5:15 PM [Resident's name] was reported missing. [Security Guard's name] initiated Code Pink (Missing Resident). Director of Nursing, Assistant Director of Nursing and Administrator was notified. [Security Guard's name] immediately coordinated with all staff on duty to conduct	F 689		

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F 689	Continued From page 41 thorough search for resident inside and outside of building. A copy of resident photo was distributed and what she was wearing was provided as well to staff. MPD (Metropolitan Police Department) was called at 6:15pm. They arrived at 6:30pm. Director, CEO, Administrator, Director of Nursing jumped in search. MPD spoke with Nurse Supervisor, Charge Nurse and Unit Manager for additional information in regards to the resident. Security provided a walk through the facility with MPD. MPD called resident['s] cellphone, she answered phone said she was home. MPD retrieved her address from Nursing Supervisor and returned with Resident at 8:05pm." According to the Security's 'Incident Report' completed by Employee #31 on 03/26/22, the report documented, "Type of Incident: Elopement; Location of Incident: Patio Door; At approximately 5:15 PM [Resident's name] was reported missing. [Security Guard's name] initiated Code Pink (Missing Resident)" and "[Security Guard's name] immediately coordinated with all staff on duty to conduct thorough search for resident inside and outside of building" and "MPD (Metropolitan Police Department) was called at 6:15pm. They arrived at 6:30pm" and "MPD called resident's cellphone, she answered phone said she was home. MPD retrieved her address from Nursing Supervisor and returned with Resident at 8:05pm." During an observation on 08/24/23 at 8:05 AM, Resident #144 was noted walking on the unit toward the dining area, neatly dressed, interacted with staff and other residents during breakfast. During a face-to-face interview conducted on 09/11/23 AT 4:15 PM, Employee #28 stated that,	F 689		

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"I was the CNA on duty that day she was standing with me that evening" and "she (the resident) kept saying 1011 but I thought she was talking about wanting to go to the 7-11 (local convenience store)" and "then she left the nurse station to go back to her room because I was going to take her dinner tray to her room, but I went to another room first then went to her room to take her dinner tray and she wasn't there" and "we then learned that 1011 is the number to where she live, her address" and "when she came (was admitted) we didn't know she elopes, but she kept saying she would like to go home" and "we didn't think she would do that, we just thought she was here for her condition and she had HIV (Human Immunodeficiency Virus)" and "we didn't do any hourly rounds on her I didn't document hourly rounds on her" and "I don't know if there were orders for hourly rounds, she walks around like me and you" and "she had 2 phones that's how we manage to contact her and the [resident's] sister called her phone and she answered from her house" and "she went home, but she couldn't get in she didn't have a key she was sitting outside of her house, they (police officer and staff) brought her straight back to 1 Blue Secured Dementia Unit and we brought her belongings there."

During a telephone interview conducted on 09/12/23 AT 12:38 PM, Employee #29 stated that, "I don't remember her, eloped?" and "it must be a long time ago, I don't remember." Employee #29 completed the facility's incident report however, Employee #29 continued to state, "I just don't remember."

During a face-to-face interview conducted on 09/13/23 AT 10:58 AM, Employee #32 (Security

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Guard) was asked about the process when residents leave the facility and stated that, "All residents must sign out [at the security desk] to leave the building."

During a face-to-face interview conducted on 09/13/23 AT 11:12 AM, Employee #31 stated that, "Residents must check out first with Nurses on the unit, then at Security desk to sign a form with resident's name and the relative sign and date then sign back in on same form when return" and "We only had one resident that got out, her name was [Resident's name] from 1Orange. I got a call from the facility because I was off that day and was asked to come in to view the camera to see how she got out. I saw her go out a side door down by the living room. That door has since been repaired and nobody can go out that door without a code" and "we have an incident report and it's also logged into the [Security's] log book and anything unusual that happen on the site is documented in the log book."

A review of the Security's log book on 09/13/23 documented the following timeline of events for 03/26/22:

- "1700 (5:00 PM) [Security officer's name] goes on break. [Security officer's name] monitoring CCTVs (Security's surveillance cameras). Nurse Supervisor makes security aware of missing resident
- 1730 (5:30 PM) [Security officer's name] returns from break, assist with looking for missing resident
- 1800 (6:00 PM) All units are made aware of missing resident
- 1900 (7:00 PM) [Security Supervisor's name] arrived to play back cameras in assistance with finding missing resident