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| L 000 | Initial Comments<br><br>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.<br><br>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.<br><br>After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities<br><br>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 onsite. | L 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. | |

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| L 000 | Continued From page 1<br><br>The following deficiencies are based on observation, record review, and resident and staff interviews.<br><br>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:<br><br>AMS - Altered Mental Status<br>ARD - Assessment Reference Date<br>AV- Arteriovenous<br>BID - Twice- a-day<br>B/P - Blood Pressure<br>cm - Centimeters<br>CFR- Code of Federal Regulations<br>CMS - Centers for Medicare and Medicaid Services<br>CNA- Certified Nurse Aide<br>CRF - Community Residential Facility<br>CRNP- Certified Registered Nurse Practitioner<br>D.C. - District of Columbia<br>DCMR- District of Columbia Municipal Regulations<br>D/C- Discontinue<br>Dl- Deciliter<br>DMH - Department of Mental Health<br>DOH- Department of Health<br>EKG - 12 lead Electrocardiogram<br>EMS - Emergency Medical Services (911)<br>F - Fahrenheit<br>FR.- French<br>G-tube- Gastrostomy tube<br>HR- Hour<br>HSC - Health Service Center<br>HVAC - Heating ventilation/Air conditioning<br>ID - Intellectual disability<br>IDT - Interdisciplinary team | L 000 | | |

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| L 000 | Continued From page 2 | L 000 | | |

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
SCC Special Care Center
Sol- Solution
TAR - Treatment Administration Record

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| L 000 | Continued From page 3<br>Ug - Microgram | L 000 | | |
| L 051 | 3210.4 Nursing Facilities<br><br>A charge nurse shall be responsible for the following:<br><br>(a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;<br><br>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;<br><br>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;<br><br>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;<br><br>(e)Supervising and evaluating each nursing employee on the unit; and<br><br>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents.<br>This Statute is not met as evidenced by:<br>Based on record review, resident interview, and staff interview, the charge nurse failed to ensure a resident's care plan included goal and approaches a behavior of sexual inappropriateness for one (1) of 42 sampled residents. (Resident #90)<br><br>The findings included: | L 051 | 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.<br><br>2. All Residents that have potential to be affected by this deficiency were identified by October 6, 2023. No one was identified to be impacted by this practice.<br><br>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.<br><br>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.<br><br>5. Completion Date: 11/1/2023<br><br>6. Person (s) Responsible: Unit Managers and Social Work Director. | |

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| L 051 | Continued From page 4<br><br>Resident #90 was admitted to the facility on 02/05/18. The resident had a history of multiple diagnoses including Alcohol Use.<br><br>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."<br><br>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 #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]."<br><br>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. | L 051 | 1. Resident # 124 was assessed, and the care plan was reviewed .Unable to retrospectively correct.<br><br>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.<br><br>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.<br><br>4. Monitoring log initiated to monitor nursing documentation of pain to include pain location and frequency, care plans Intervention and implementing of Interventions.<br><br>5. Completion Date: 11/1/2023<br><br>6. Person (s) Responsible: Unit Nursing Managers. | |

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| L 051 | Continued From page 5<br><br>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."<br><br>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."<br><br>Cross reference: 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600.<br><br>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.<br><br>A review of Resident #124's medical record revealed:<br>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."<br><br>A physician order dated 12/31/22 at 11:20 AM that directed: "Pain assessment every shift. Pain | L 051 | | |

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| L 051 | Continued From page 6<br>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."<br><br>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."<br><br>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. Approach: Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors."<br><br>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.<br>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."<br><br>A physician order dated 09/01/23 directed: " X-ray of both knees due to pain."<br><br>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 | L 051 | | |

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| L 051 | Continued From page 7<br>neuropathic pain."<br><br>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.<br><br>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, 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.<br><br>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. | L 051 | | |

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| L 051 | Continued From page 8<br>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.<br><br>[Cross reference F656] | L 051 | | |
| L 052 | 3211.1 Nursing Facilities<br><br>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:<br><br>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;<br><br>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:<br><br>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;<br><br>(d) Protection from accident, injury, and infection;<br><br>(e)Encouragement, assistance, and training in self-care and group activities; | L 052 | Compliance during Survey: No plan of Correction Required. | |

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| L 052 | Continued From page 9<br>(f)Encouragement and assistance to:<br><br>(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;<br><br>(2)Use the dining room if he or she is able; and<br><br>(3)Participate in meaningful social and recreational activities; with eating;<br><br>(g)Prompt, unhurried assistance if he or she requires or request help with eating;<br><br>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;<br><br>(i)Assistance, if needed, with daily hygiene, including oral acre; and<br><br>j)Prompt response to an activated call bell or call for help.<br><br>This Statute is not met as evidenced by:<br>Based on observation, record review and staff interviews, the facility's staff failed to provide protection from accidents to Resident #144 who subsequently gained access to elope through a broken patio door due to a defective alarm.<br><br>The findings included:<br><br>A facility policy titled 'Resident Elopement' documented, "The facility is responsible for being knowledgeable of the location of all residents at all times."<br><br>Resident #144 was admitted to the facility on 03/21/22 with multiple diagnoses that included: | L 052 | | |

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| L 052 | Continued From page 10<br>Dementia, Human Immunodeficiency Virus (HIV) Disease, History of Fall with Fractur of Right Radius and Glaucoma.<br><br>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."<br><br>A Physician order dated 03/21/22 documented, "Elopement risk assessment on admission" and "Hourly rounding."<br><br>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."<br><br>A care plan problem dated 03/21/22 documented, "Dementia" and "difficulty understanding others, following commands r/t (related to) cognitive loss."<br><br>A physician order dated 03/22/22 documented, "Target behavioral symptoms: (Confusion, wandering."<br><br>A care plan problem dated 03/22/22 documented, "[resident's name] experiences wandering (moves with no rational purpose)."<br><br>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, | L 052 | | |

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| L 052 | Continued From page 11<br>"intermittent confusion" and "resident frequently walks around and says she wants to go home and asks for exit."<br><br>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."<br><br>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."<br><br>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"<br><br>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 | L 052 | | |

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| L 052 | Continued From page 12<br>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."<br><br>A document titled 'Medication Administration History' dated 03/01/22 - 03/31/22 documented, "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.<br><br>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"<br><br>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."<br><br>A Nurse Practitioner note dated 03/27/22 AT 11:18 PM documented, "resident now placed in | L 052 | | |

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| L 052 | Continued From page 13<br>memory unit following episode of elopement yesterday" and "Plan: resident is a candidate for long term care."<br><br>An Admission Minimum Data Set (MDS) dated 03/28/22 documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "6," indicating the resident had a severely impaired cognitive status.<br><br>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 | L 052 | | |

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| L 052 | Continued From page 14<br>pain. MD (medical doctor), RP made aware. Administrator and DON (Director of Nursing) was called."<br><br>According to the facility's 'Investigation Report 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."<br><br>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."<br><br>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 | L 052 | | |

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| L 052 | Continued From page 15<br><br>(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 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."<br><br>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."<br><br>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. | L 052 | | |

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| L 052 | Continued From page 16<br><br>During a face-to-face interview conducted on 09/11/23 AT 4:15 PM, Employee #28 stated that, "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."<br><br>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." | L 052 | | |

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| L 052 | Continued From page 17<br><br>During a face-to-face interview conducted on 09/13/23 AT 10:58 AM, Employee #32 (Security 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."<br><br>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."<br><br>A review of the Security's log book on 09/13/23 documented the following timeline of events for 03/26/22:<br>- "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<br>- 1730 (5:30 PM) [Security officer's name] returns from break, assist with looking for missing resident<br>- 1800 (6:00 PM) All units are made aware of missing resident<br>- 1900 (7:00 PM) [Security Supervisor's name] arrived to play back cameras in assistance with | L 052 | | |

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| L 052 | Continued From page 18<br><br>finding missing resident<br>- 1930 (7:30 PM) [Security Supervisor's name] has arrived to facility to assist as well<br>- 2000 (8:00 PM) Officers still reviewing play back<br>- 2005 (8:05 PM) Missing resident [Resident's name] was returned back to facility<br>- 2030 (8:30 PM) MPD (Metropolitan Police Department) [Police officer's name and Bage number] has left facility<br>- 2155 (9:55 PM) [Security Supervisor's name] completed play back. Resident was seen leaving secondary smoking area [at] 1651 (4:51 PM) hours"<br><br>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]."<br><br>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."<br><br>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."<br><br>During a telephone interview conducted on | L 052 | | |

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| L 052 | Continued From page 19<br><br>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."<br><br>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."<br>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."<br><br>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."<br><br>During a face-to-face interview conducted on 09/13/23 AT 3:15 PM, Employee #37 (Maintenance worker) stated that, "Further back, I don't recall exactly when, the magnetic piece with | L 052 | | |

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| L 052 | Continued From page 20<br>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."<br><br>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."<br><br>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."<br><br>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 would approve the repairs for the contractors to come in and fix the door that was broken" and "I | L 052 | | |

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| L 052 | Continued From page 21<br>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."<br>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."<br><br>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."<br><br>- 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 | L 052 | | |

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| L 052 | Continued From page 22<br><br>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.<br>- 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."<br>- 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."<br><br>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."<br><br>Past Non-compliance Information<br><br>During a face-to-face interview conducted on 09/14/23 AT 5:30 PM, Employee #1 (Administrator) indicated the following interventions were implemented to address the deficient practice:<br><br>- Resident #144 was reported missing. A complete facility search was initiated by staff and | L 052 | | |

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| L 052 | Continued From page 23<br><br>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.<br>- Resident was immediately assessed upon return to facility, no injury or discomfort.<br>- Resident's POA (power of attorney) agreed to place resident in a secured unit.<br>- Resident was placed on secured unit (Dementia Care Unit) immediately upon arrival into facility.<br>- 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.<br>- Plan in place to ensure doors are checked on a daily basis.<br>- Care plan updated.<br>- Nursing staff were in-serviced and completed Elopement Education.<br>- No other residents were affected by this deficient practice.<br>- No other incidents of Elopements since 03/26/22.<br><br>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 after Resident #144 had eloped from the facility through a defective door on 03/26/22.<br><br>The aforementioned interventions were implemented prior to the State Agency's on-site survey on 08/20/23. | L 052 | | |

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| L 052 | Continued From page 24<br><br>Cross reference: 42 CFR§ 483.25, Quality of Care, F689. | L 052 | | |
| L 056 | 3211.5 Nursing Facilities<br><br>Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.<br><br>This Statute is not met as evidenced by:<br>Based on record review and staff interview, during a review of staffing [direct care per resident day hours], it was determined that the facility failed to meet the four and one-tenths (4.1) hours of direct nursing care per resident per day on 15 of 24 days reviewed and the 0.6 [six-tenths] hour for Registered Nurses /Advanced Practice Registered Nurse hours on 19 of 24 days reviewed in accordance with Title 22 DCMR Section 3211 Nursing Personnel and Required Staffing Levels.<br><br>The findings include:<br><br>According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six-tenths (0.6) | L 056 | 1. A review of the staffing was conducted unable to retrospectively correct.<br>2. A review of all staffing documentation was reviewed, no resident was impacted by this practice.<br>3. HR department reviewing additional recruitment options including advertising, implementation of sign and referral bonuses. HR Director also reviewing staffing agency contracts.<br>4. DON and ADON monitor staffing on a daily basis. A report will be submitted at the QAPI meetings, and performance improvement plan will be monitored and reported.<br>5. Completion Date:11/1/2023<br>6. Person (s) Responsible: DON | |

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| L 056 | Continued From page 25 | L 056 | | |

hour shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.

1. The facility failed to meet the minimum Registered Nurse/ Advanced Practice Registered Nurse rate of 0.6 [six-tenths] hours per resident per day on 19 of 24 days reviewed as outlined below:

July 4, 2023 -0.46hours
August 19, 2023 - 0.56hours
August 20, 2023, -0.46 hours
August 21, 2023 - 0.46 hours
August 22, 2023, -0.56 hours
August 23, 2023, - 0.46 hours
August 24, 2023, -0.56 hours
August 25, 2023, -0.56 hours
August 26, 2023 - 0.37 hours
August 27, 2023 - 0.37 hours
August 28, 2023 -0.49 hours
August 29, 2023 - 0.56 hours
August 31, 2023 - 0.55 hours
September 2, 2023, 0.27 hours
September 3, 2023, 0.27hours
September 4, 2023, 0.41 hours
September 6, 2023, 0.59 hours
September 9, 2023 - 0.35 hours
September 10, 2023, 0.35 hours

2. The facility failed to meet the minimum direct nursing care staffing rate of four and one-tenths (4.1) hours per resident per day, for 15 of 24 days reviewed as outlined below:

July 4, 2023 - 3.97 hours
August 19, 2023 - 3.92 hours
August 20, 2023, - 4.0 hours
August 21, 2023 - 4.0 hours

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| L 056 | Continued From page 26<br>August 23, 2023, - 3.90 hours<br>August 26, 2023 - 3.97 hours<br>August 27, 2023 - 3.62 hours<br>August 28, 2023 - 3.34 hours<br>August 31, 2023 - 4.0 hours<br>September 2, 2023, - 3.39 hours<br>September 3, 2023, -3.44 hours<br>September 4, 2023, -3.95 hours<br>September 5, 2023, -4.04 hours<br>September 6, 2023 - 4.08 hours<br>September 9, 2023, - 3.84 hours<br><br>During the review of staffing on September 14, 2023, in the presence of Employee #1, who acknowledged the findings. | L 056 | 1. All items in refrigerator that were unlabeled and not dated were discarded immediately.<br>2. A review of all refrigerator units was conducted, and no residents were impacted by the practice.<br>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.<br>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 Management and reported to QAPI quarterly.<br>5. Completion Date: 11/1/2023.<br>6. Person (s) Responsible: Food Services Director, Food Production Manager and Food Service Supervisors. | |
| L 099 | 3219.1 Nursing Facilities<br><br>Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by:<br>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. | L 099 | | |

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| L 099 | Continued From page 27<br>The findings include:<br><br>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 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.<br><br>Employee #39 acknowledged the findings during a face-to-face interview on August 22, 2023, at approximately 7:00 AM. | L 099 | | |
| L 128 | 3224.3 Nursing Facilities<br><br>The supervising pharmacist shall do the following:<br><br>(a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services;<br><br>(b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;<br><br>(c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;<br><br>(d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate | L 128 | | |

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| L 128 | Continued From page 28<br>reconciliation; and<br><br>(e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled.<br>This Statute is not met as evidenced by:<br>Based on observation, record review and staff interviews, facility staff failed to establish a system of records of all controlled substances in sufficient detail to enable an accurate reconciliation for the resident's narcotic medication.<br><br>The findings included:<br><br>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."<br><br>A review of a document titled 'Shift Verification of Accuracy of Controlled Drug Record' documented, "August 2023" with the following data:<br><br>" 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.<br>" 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, | L 128 | 1. A review of the controlled policy was conducted. Unable to retrospectively correct this deficiency.<br><br>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.<br><br>3. The licensed staff were re-educated by staff educator on narcotic counts during change of shifts.<br><br>4. A narcotic count audit tool is done by unit managers. This report is submitted to ADON to report in QA meeting.<br><br>5. Completion Date: 11/1/2023<br><br>6. Person (s) Responsible: ADON. | |

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| L 128 | Continued From page 29<br>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.<br>" 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.<br>" 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.<br>" 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.<br>" 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 off duty nurse signatures were the same for | L 128 | | |

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| L 128 | Continued From page 30<br>consecutive shifts indicating there was no second licensed nurse present to verify the accuracy of the resident's controlled drug record.<br>" 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.<br>" 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.<br><br>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.<br><br>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."<br><br>During a face-to-face interview conducted on 09/07/23 AT 12:37 PM on Three Blue regarding only one licensed nurse signing alone for the narcotic count, Employee #7 (RN 3 Blue Unit | L 128 | | |

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| L 128 | Continued From page 31<br>Manager) stated, "if there's an issue with the count then we can get the Nursing Supervisor."<br><br>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]."<br><br>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."<br><br>A review of a document titled 'Shift Verification of Accuracy of Controlled Drug Record' documented, "September 2023" with the following data:<br><br>" 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.<br>" 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 accuracy of the resident's controlled drug record.<br>" Unit Three Blue: 09/01/23, 09/05/23 and 09/07/23 documented, Day shift beginning at 7 | L 128 | | |

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| L 128 | Continued From page 32<br><br>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.<br>" 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.<br><br>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."<br><br>Cross reference: 42 CFR§ 483.45, Pharmacy Services, F755. | L 128 | | |
| L 199 | 3231.10 Nursing Facilities<br><br>Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. | L 199 | | |

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| L 199 | Continued From page 33<br>This Statute is not met as evidenced by:<br>Based on observation, record review and staff interviews for one (1) of 42 sampled residents, facility staff failed to document the course of Resident #20's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident.<br><br>The findings included:<br><br>Resident #20 was admitted to the facility on 10/27/22 with multiple diagnoses that included: Dementia, Diabetes Mellitus, Hypertension and Atherosclerotic Heart Disease.<br><br>Review of Resident #20's medical record revealed:<br><br>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."<br><br>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."<br><br>A Quarterly Minimum Data Set Assessment (MDS) dated 06/20/2023 documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "07," indicating the resident had a severely impaired cognitive status; | L 199 | 1. A review of resident #20 insulin administration was conducted. Unable to retrospectively correct this deficiency.<br><br>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.<br><br>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.<br><br>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.<br><br>5. Completion Date:11/1/2023<br><br>6. Person (s) Responsible: Nursing Management. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD02-0007 | 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 |

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| L 199 | Continued From page 34<br>facility staff coded "Medications: Insulin injections since admission" and "Orders for Insulin."<br><br>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."<br><br>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."<br><br>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."<br><br>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 progress notes."<br><br>During a review of Resident #20's record, Employee #21 acknowledged that there was no | L 199 | | |

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| L 199 | Continued From page 35<br>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.<br><br>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."<br><br>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."<br><br>Cross reference: 42 CFR§ 483.70, Administration, F842. | L 199 | | |
| L 410 | 3256.1 Nursing Facilities<br><br>Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.<br>This Statute is not met as evidenced by:<br>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, | L 410 | | |

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|---|---|---|---|---|
| L 410 | Continued From page 36<br><br>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.<br><br>During an environmental walkthrough of the facility on July 10, 2023, between 10:00 AM and 4:00 PM the following were observed:<br><br>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.<br><br>In the pantry on unit 2 Orange, six (6) of six (6) eight-ounce Osmolite nutritional drinks were expired as of August 1, 2023.<br><br>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.<br><br>Employee #1 acknowledged the findings during a face-to-face interview on August 24, 2023, at approximately 4:00 PM. | L 410 | 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.<br><br>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.<br><br>3. Inservice was conducted to Material Manager and Unit clerk, regarding nutritional supplements and expiration date. This was done by DON and ADON.<br><br>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.<br><br>5. Completion date: 11/1/2023<br><br>6. Person(s) responsible: Administrator Laison and Operations Manager. | |