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 07/16/2024

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L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility from June 24, 2024, to July 16, 2024. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 187 and the survey sample included 59 residents. The following complaints were investigated during this survey: DC~12678, DC~12444, DC~12509, DC~12878 The following facility reported incidents were investigated during this survey: DC~12663, DC~12434, DC~12657, DC~12844, DC~12367, DC~12548, DC~12409, DC~12858, DC~12350, DC~12337, DC~12407, DC~12423, DC~12793, DC~12424, DC~12508, DC~12820, DC~12786, DC~12281, DC~12448, DC~12735, DC~12736, DC~12422, DC~12361, DC~12662, DC~12907, DC~12944 Federal and Local deficiencies were cited related to the investigation of: DC~12508, DC12509, DC12448, DC12736, DC12907 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status	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	L 000		

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
DI- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)

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L 000	Continued From page 2 mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for	L 051		

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L 051	Continued From page 3 completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record reviews, and staff interviews for one (1) of 47 sampled residents, facility staff failed to implement Resident #21's person centered comprehensive care plan to monitor the resident on a one-to-one to prevent the resident from smoking while using supplemental oxygen. Resident #21. The findings included: A review of the facility's policy titled "Nursing Services Resident Care Plan" dated revised on 03/21/24, documented the following: "There shall be a written care plan for each resident. It shall contain information of importance concerning resident needs. The care plan shall include (1) problem list (2) measurable goals, (3) Approaches to address the problem." "The problem list shall include but not be limited to: The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing as	L 051		

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L 051	Continued From page 4 required." Resident #21 was admitted to the facility on 03/11/21 with multiple diagnoses that included the following: Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Heart Failure, and bipolar disorder. A review of Resident #21's medical record revealed the following: A care plan dated 04/29/24, documented in part, "Focus- (Resident #21) has a behavior of smoking while on oxygen ...Interventions Resident is on one-to-one monitoring Q (every) shift." A physician order dated 05/06/24 directed, "Resident is on one-to-one monitoring Q (every) shift to prevent a resident from smoking while on oxygen." On 07/02/24 at 10:54 AM Resident #21 was observed in her room lying in bed with oxygen in use. At the time of the observation, Resident #21 stated "I do smoke, but I haven't been outside to smoke. I don't smoke in the room." It should be noted that there was no 1:1 staff monitoring Resident #21 at the time of the Surveyor observation. On 07/02/24 at approximately 3:30 PM, Resident #21 was observed in her room laying in bed while receiving supplemental oxygen via nasal cannula. There were no staff present in the resident's room or near the doorway. During a face-to-face interview conducted on 07/02/24 at approximately 3:55 PM, Employee #4 (Unit Manager) stated that all the staff is monitoring the residents, and the resident has not been observed smoking since being placed on	L 051		

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L 051	Continued From page 5 monitoring. The surveyor asked how all staff monitor the resident if they cannot see the resident and Employee #4 made no further comment. Cross Reference F656	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from bodyodor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and	L 052		

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L 052	Continued From page 6 (3)Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations, record reviews, and staff and resident interviews for one (1) of 47 sampled residents, facility staff failed to ensure that adequate supervision was provided to Resident #21, as evidenced by documentation in the resident medical records of staff observing Resident #21 smoking and possessing smoking paraphernalia while using supplemental oxygen continuously and the surveyor observing the facility staff failing to provide one to one monitoring of Resident #21 as instructed by physician orders on multiple occasions during the survey. Resident #21. The findings included: According to the National Center on Aging and the American Lung Association, " ...While oxygen itself is not flammable, it can make flammable materials ignite faster and burn more rapidly. While using supplemental oxygen, always stay at least five feet away from an open flame or heat source. You should also never smoke (cigarettes,	L 052	**3211.1 Nursing Facilities** 1. Resident #21 was reassessed by Unit Manager as it pertained to smoking on 07/09/24. She has remained one on one and has not smoked since 07/09/2024. 2. A review of all residents noted in the facility was conducted on 07/10/24 and rechecked on 08/22/24 by Unit Mangers on 08/22/24. No current resident who smokes uses oxygen. Resident #21 indicated on 08/22/24 that she did not want any cigarettes, nor did she want/ need the nicotine patch. No additional smoking concern noted since 07/09/24. 3. All staff were re-educated on facility smoking policy on 08/16/24 by Staff Educators. Staff will also be re-educated by Unit Managers beginning 08/22/24. The care plan for smokers will be updated on a quarterly basis by Unit Managers are/ or social work staff. 4. A review of all smokers' care plan intervention and implementation was done by Unit Mangers and Social Services. There were no findings. Additionally, any resident that smokes cannot share a room with a resident on oxygen. Any deficiency will be corrected immediately. The responses will be reported to QAPI quarterly. 5. Completion Date: 08/31/24. 6. Responsible Party: Unit Managers and Social Work Staff	

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L 052	Continued From page 7 vape pens, or otherwise) while using oxygen, and prohibit smoking nearby." https://www.ncoa.org/adviser/oxygen-machines/home-oxygen-safety/ A review of the facility's policy titled Oxygen Administration-Nasal Cannula that was undated [#NSD04-12] documented in part, "Oxygen is administered according to the physician's orders and in observance of all safety precautions ... post "No smoking" sign on the door and in the resident's room-oxygen is highly combustible." A review of the facility's policy titled "One-to-One Monitoring for Residents" was undated and documented the following: "One-to-one monitoring is a type of care that can be provided to residents at (facility name abbreviation) to ensure their safety whenever they are alone especially in their room." "One-to-one monitoring can help staff prevent falls, redirect residents from harmful actions," A review of the facility's policy titled "Smoke Free Environment" with a review date of 01/03/24 documented the following: "Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read No Smoking or with the international symbol for no smoking." Resident #21 was admitted to the facility on 03/11/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Heart Failure, and bipolar disorder. On 07/02/24 at 10:54 AM Resident #21 was observed in her room lying in bed with oxygen in	L 052		

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L 052	Continued From page 8 use. At the time of the observation, Resident #21 stated "I do smoke, but I haven't been outside to smoke. I don't smoke in the room." It should be noted that there was no one-to-one (1:1) staff monitoring Resident #21 at the time of the Surveyor observation. Review of Resident #21's medical record revealed the following: A Smoking Assessment dated 03/12/21 indicated that the resident was an "unsafe smoker." A physician order dated 03/01/24 directed, "Oxygen at 2 liter per minute via nasal cannula continuously every shift for COPD (chronic obstructive pulmonary disease)"A nursing progress note dated 03/27/24 at 5:10 PM documented "Social worker was informed by security staff that [Resident #21] was smoking in the facility on 3/23/2024 and on today 3/27/2024 ...it appeared she was in the crystal room in a corner smoking with an oxygen tank on the back of her chair." A nursing progress note dated 03/28/24 at 11:25 PM documented, "[Resident #21] came to unit twice with cigarettes. The charge nurse took the cigarettes from her. Security police reported to her twice that she was trying to smoke in the living room. Resident educated that she is on oxygen and the risks explained to her. Continue O2 (oxygen) therapy at 2L (liters) via (by) nasal cannula with SPO2 (Saturation of peripheral oxygen) 96%. Continue hourly monitoring, resident propel herself throughout the building." There was no documented evidence in the resident medical record of new interventions or orders after these incidents. A social services progress note dated 04/19/24 at 10:32 AM	L 052		

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L 052	Continued From page 9 documented, "SW (social worker) smelled the odor of smoke around 10:12 AM, coming from the far-left corner of the Crystal room and observed [sitting] in her wheelchair smoking a cigarette. The resident had a lighter and plastic bag with portions of other cigarettes. The resident agreed to give the smoking items to the social worker and was counseled on the dangers of smoking and jeopardizing the health and safety of all persons in the building." A health status progress note dated 04/20/24 at 10:21 PM documented, "At around 10:10 PM the writer was alerted by a security guard that the resident was seen downstairs smoking a cigarette while on oxygen." A nursing progress note dated 04/24/24 at 3:25 PM documented, "[Resident #21- who resides in room ## A] assisted with care, out of bed and propel self around the unit. Continuing oxygen at 2 liters, [Resident #21] was found in another resident bathroom in room ## trying to smoke. The writer found three cigarettes and a lighter with the resident and took it to a social worker. Later [Resident #21] went to another resident room ##, the resident in ## gave [Resident #21] another cigarette and was asking for a lighter, and in the process, writer took the cigarette and made social worker aware ..." It is important to note that following the unsupervised smoking incidents reported on 04/19/24, 04/20/24, and 04/24/24, staff began documenting on an hourly log that the resident was on one-to-one monitoring as of 4 PM on 04/26/24. A care plan dated 04/29/24 documented in part, "Focus- [Resident #21] has a behavior on oxygen ... Interventions- Resident on One-to-One monitoring, involve psych[iatric services] and	L 052		

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L 052	Continued From page 10 psycho-therapy, resident was transfer room ... closer to nursing station.."A social services progress note dated 04/29/24 at 3:28 PM documented, "Resident continues to violate regulatory and facility smoking policies. Resident acknowledges she is unable to control urges to smoke, even around her oxygen... Staff reported she continued to smoke ... Due to persistent involvement with smoking, resident is currently monitored by a 1:1 staff assigned as of April 26, 2024. Smoking observed ... on 4/25/2024, 4/23/2024, 4/19/2024, and 3/27/2024." A physician order dated 05/06/24 directed, "Resident is on one-to-one monitoring Q (every) shift to prevent a resident from smoking while on oxygen." A review of the Quarterly Minimum Data (MDS) assessment dated 04/29/24 revealed that the facility staff coded the following for Resident #21: intact cognition, rejected an evaluation or care occurred 1-3 days, has no impairment in the upper or lower extremity, and receives oxygen therapy. A physician order dated 05/02/24, directed "Target behavior: 1) Monitor for refusal of medications. 2) Refusal of care. #) Smoking while on continuous oxygen." A nursing progress note dated 05/2/24 at 1:25 PM documented, "Resident was noted with cigarette stick on her and the CNA (certified nursing assistant) monitoring her retrieved it and gave it to the charge nurse, but she did not have lighter or matches on her..." During an observation on 07/03/24 at 09:10 AM, Resident #21 was observed in her room without staff present or in proximity. The resident was	L 052		

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L 052	Continued From page 11 lying in bed with oxygen in use. During a face-to-face interview on 07/03/24 at 9:10 AM, Employee #4 (Unit Manager 3 Blue) acknowledged there was no one-to-one staff present with Resident #21. During a face-to-face interview on 07/03/24 at 9:24 AM, Employee #2 (Director of Nursing) was made aware that the resident was observed without a one-to-one monitor. The employee then said that one-to-one monitoring means for resident safety we have to monitor the resident. The employee failed to explain why the one-to-one was not in place at the time of the surveyor's observation. Cross Reference F689-22B DCMR 3211.1(d) B. Based on observation record reviews and staff interviews for one (1) of 47 sampled residents, facility staff failed to ensure that the resident received respiratory care, consistent with professional standards of practice, in accordance with the physician's orders to place a date and initials on the resident's oxygen tubing once each week and lack of no smoking and oxygen sign inside resident room, Resident #21. The findings included: A review of the facility's policy titled "Oxygen Administration-Nasal Cannula" that was undated documented the following: "Oxygen is administered according to physician's orders and in observance of all safety precautions." "Equipment Nasal cannula, no smoking signs, portable oxygen tank, connector. Procedure: Place water in humidifier to indicated level and post the "no smoking" sign on the door and in the	L 052	**3211.1 Nursing Facilities** **B.** 1. The 02 tubing for resident #21 was immediately changed. The date and the initials were placed on the tubing. This was completed by the Unit Manager on 07/03/24. An oxygen in use and no smoking sign was placed in the resident's room. This was completed by the charge nurse on July 3, 2024. 2. All residents with oxygen were identified. The tubing was dated and labeled, and oxygen signs and no smoking signs were in place. No deficient practice was noted for the other residents. 3. The unit managers and licensed nurses were re-educated by the Director of Nursing on facility oxygen policy on 07/3/24. 4. A monthly monitoring tool was initiated on 07/03/24 for Unit Managers to track and monitor to ensure all oxygen tubing was dated and oxygen and no smoking sign were in place. Any deficiency will be corrected immediately. The responses will be reported to QAPI quarterly. 5. Completion Date: 08/31/24. 6. Responsible party: Unit managers.	

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L 052	Continued From page 12 resident's room-oxygen is highly combustible ...Chart the time, procedure, rate of flow and residents' reaction. Change nasal cannula every week as needed." Resident #21 was admitted to the facility on 03/11/21 with multiple diagnoses that included the following: Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Heart Failure, and bipolar disorder. On 07/02/24 at 10:54 AM Resident #21 was observed in her room lying in bed with oxygen via nasal cannula in use. At the time of the observation, Resident #21 stated "I do smoke, but I haven't been outside to smoke. I don't smoke in the room."It was noted that Resident #21's oxygen tubing did not have any date initial or time to show when the tubing had last been changed and there was no sign in or near residents' room that stated oxygen was in use and that there is no smoking allowed. A review of Resident #21's medical record revealed the following: A physician order dated 02/27/23 directed, "Nebulizer change tubing weekly every night shift every Mon (Monday)" A physician order dated 03/01/24 directed, "Oxygen at 2 liter per minute via nasal cannula continuously every shift for COPD (chronic obstructive pulmonary disease)" A physician order dated 04/28/24 directed, "Change oxygen and nebulizer tubing, mask, humidifier and ear wraps weekly on Sunday night shift. Initial and date. Every shift every Sun. "A review of the Quarterly Minimum Data (MDS)	L 052		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 052	Continued From page 13 assessment dated 04/29/24 revealed that the facility staff coded the following for Resident #21: The resident uses a manual wheelchair, receives oxygen therapy and has the following active diagnoses of debility, cardiorespiratory conditions, chronic obstructive pulmonary disease, and heart failure. During a face-to-face interview conducted on 07/02/24 at 3:40 PM Employee #21 (Licensed Practical Nurse) stated that there was no oxygen in use and no smoking sign on the resident's door because the resident had recently changed rooms. Employee #21 also stated that they change the tubing once a week or as needed but acknowledged that it was not documented on the tubing. During a face-to-face interview conducted on 07/02/24 at approximately 3:40 PM, Employee #4 (Unit Manager 3 Blue) acknowledged the findings and placed a oxygen in use/no smoking sign on Resident #21's door. Cross Reference F695 Sec 3211.1 (a) C. Based on observation, record review and staff interviews for one (1) of 59 sampled residents, facility staff failed to ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Resident #105. Resident #105 was admitted to the facility on 08/10/2019 with multiple diagnoses that included: Blindness Both Eyes, Psychotic Disorder with Delusions, Hallucinations, Morbid Obesity and Muscle Weakness. A review of Resident #105's medical record	L 052	**3211.1 Nursing Facilities** C. 1. On July 16, 2024, Resident #105 was immediately provided grooming and personal hygiene. 2. All residents were assessed by Unit Managers for ADL care (grooming and hygiene) on 07/16/24. No other resident was impacted by this practice. 3. All nursing staff were re-educated on ADL Care by the Staff Educator on 07/19/24. 4. The Unit Managers monitored all residents pertaining to ADL monthly. The information is included on a QA tool and is reported to DON, ADON and QAPI. Any deficiency will be corrected immediately. The responses will be reported to QAPI quarterly. 5. Completion Date: 08/22/24.Responsible Party: Unit Managers	

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L 052	Continued From page 14 revealed: A Care Plan Problem dated 05/17/2023 documented, "Category: ADLs (Activities of Daily Living) Functional Status/Rehabilitation Potential, Self-care deficit" and "Evaluation Notes: 11/16/2023, Staff will continue to provide total ADL care." A Physician Note dated 05/10/2024 at 11:44 pm documented, "debilitated, bedbound and dependent with all ADLs." A Discharge Minimum Data Set (MDS) Assessment dated 05/17/2024 showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '11,' indicating the resident was moderately impaired and coded functional abilities and goals of '01,' indicating the resident was totally dependent on staff for the following Self-Care activities: --Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. --Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self. --Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing/drying face and hands. During an observation conducted on 06/26/24 at 10:30 am, Resident #105 was wearing a soiled facility-issued gown, and her fingernails were not cleaned. During a face-to-face interview conducted on	L 052	**D.** **A.** 1. Resident #76 was assessed by Unit Managers on 07/16/24, and oncology appointment rescheduled for 08/21/24. There were no negative findings. Unable to retrospectively correct the deficiency. 2. A review of all oncology appointments from 06/17/24 to present was conducted by Unit Managers. There were no findings. 3. All licensed staff, Nurse managers and Unit Secretaries were in-service by the Staff Educator on 08/17/2024 regarding the importance of keeping up with all residents' schedule appointments. 4. Monthly monitoring log initiated by QA coordinator for the Unit Secretaries to monitor all scheduled appointments. Any deficiency will be cored immediately. The responses will be reported to QAPU quarterly. 5. Completion Date: 08/31/24. 6. Responsible Party: Nurse Managers	

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L 052	Continued From page 15 06/26/24 at approximately 11:00 am, Employee #22 ((3) Three Green Unit Manager) acknowledged the findings and stated, "I will send someone there now." During an observation conducted on 07/16/24 at approximately 11:45 am, Employee #22 was in the room with Resident #105 who was still wearing a facility-issued gown soiled with a dried coffee stain on the front. When the resident was asked if she had been offered to get bathed and cleaned up, she stated, "No." Employee #22 acknowledged the findings. Cross Reference F677 22B DCMR Sec 3211.1 (i) D.Based on observation, record review, and staff interviews for one (1) of 59 sampled residents, facility staff failed to provide needed care and services that are resident-centered, as evidenced by not ensuring side rails were in place as ordered. Residents #496. The findings included: Resident #496 was admitted to the facility on 06/28/2024 with multiple diagnoses that included: Squamous Cell Carcinoma of Skin, Secondary Malignant Neoplasm of Inguinal and Lower Limb Lymph Nodes, Malignant Neoplasm of Prostate, Malignant Neoplasm of Lung, Muscle Weakness, and Difficulty Walking. A review of Resident #496's medical record revealed: A Discharge Minimum Data Set (MDS) Assessment dated 06/07/2024 documented: that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '11,' indicating	L 052	**3211.1 Nursing Facilities** **B.** 1. Resident #496 siderail was immediately provided on 07/03/24. 2. All residents with orders for siderails were checked. No findings. 3. Monitoring tool for side rails initiated by QA for Unit Managers to report monthly to ensure MD orders for side rails are implemented. 4. All nursing staff were educated on siderails for bed mobility on 08/05/24. Monthly audit monitoring tool for siderails initiated by QA for Unit Managers. Any deficiency will be corrected immediately. The responses will be reported to QAPI quarterly. 5. Completion Date: 08/31/24. 6. Responsible Party: Nurse Managers	

Health Regulation & Licensing Administration

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L 052	Continued From page 16 the resident was moderately impaired. Section GG - Functional Abilities and Goals: Supervision for Sit to stand, walking 10 feet, walking 50 feet with (2) two turns, Walk 150 feet, and Toilet transfer. Section J - Health Conditions: Has the resident had any falls since admission/entry or reentry or the prior assessment? No. A Physician Order dated 06/21/2024 documented, "Bilateral quarter side rails up in bed every shift for enhancement of turning and repositioning. Monitor every shift." A Care Plan Focus Area dated 06/22/2024 documented, "The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Disease Process. Interventions: SIDE RAILS: full/half rails up as per Dr.s (doctor's) order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use." During an observation of Resident #496's room conducted on 06/25/24 at 2:38 pm and 07/03/24 at 12:15 pm, the resident was lying in bed, and it was noted that there were no side rails in place on the resident's bed. During an interview conducted on 07/03/24 at 1:23 pm, Employee #9 was made aware of the physician's order for quarter side rails, and that she had also documented the same in Resident #496's care plan. Employee #9 acknowledged the findings and stated, "I guess that was a mistake." Cross Reference F684 22B DCMR Sec 3211.1 (a) E. Based on record review and resident and staff	L 052		

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L 052	Continued From page 17 interviews for two (2) of 59 sampled residents, facility staff failed to ensure that residents received the proper treatment and assistive devices to maintain vision and hearing abilities as evidenced by failure to schedule an ophthalmology consult appointment for a resident with Diabetes and Glaucoma, and failure to schedule an initial audiology consult appointment for a resident with impaired hearing. Residents #112 and #162. The findings included: 1)Resident #112 was admitted to the facility on 02/03/24 with diagnoses that included: Type 2 Diabetes Mellitus with Hyperglycemia, Partial Amputation of Left Foot, and Chronic Angle -Closure Glaucoma, Right Eye, Stage Unspecified. A review of the resident's medical record revealed: A review of a physician's order dated 02/03/24 directed: "Consult: Ophthalmology consult eval(evaluation) and treat as needed." A review of a physician's order dated 04/02/24 directed: "Azopt Ophthalmic Suspension 1% (Brinzolamide) [eyedrops] Instill 1 drop in right eye two times a day/ Place 1 drop into the right eye 2 times daily for glaucoma." A review of a physician's order dated 04/02/24 directed: "Combigan Ophthalmic Solution 0.2-0.5 (Brimonidine Tartrate-Timolol Meleate) [eyedrops]. Instill 1 drop in the right eye two times a day for glaucoma." A review of a physician's order dated 04/02/24 directed: "Latanoprost Ophthalmic Solution 0.005	L 052	**3211.1 Nursing Facilities** **E.** 1. Residents #112 & #162 were assessed by Unit Managers on 07/09/24. There were negative findings. The follow up audiology appointments for Resident #162 was completed 07/09/24; Resident #112 vision appointment is rescheduled for 09/17/24. 2. A review of all follow-up appointments was conducted by Unit Managers and Unit secretaries on 07/31/24. There were no findings. 3. All licensed staff, Nurse managers and Unit Secretaries were in serviced by the Staff Educator on 8/17/2024 regarding the importance of keeping up with all residents scheduled medical appointments. 4. Monthly monitoring log initiated by QA coordinator for the Unit Secretaries and Unit Managers to monitor all scheduled appointments. Any deficiency will be corrected immediately. The responses will be reported to QAPI quarterly. 5. Completion Date: 08/31/24. 6. Responsible Party: Nurse Managers	

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L 052	Continued From page 18 (Latanoprost) [eyedrops]. Instill 1 drop in the right eye at bedtime for glaucoma." A review of a Quarterly Minimum Data Set (MDS) assessment dated 05/01/24 showed that Resident #112 had a Brief Interview for Mental Status (BIMS) summary score of "13" indicating intact cognition, required setup for eating and oral hygiene, and was dependent on staff for assistance with all other activities of daily living (toileting, personal hygiene, bathing and dressing. A review of a care plan implemented on 07/15/24 documented: "Focus: [Name of Resident #112] has impaired visual function r/t (related to) glaucoma on the right eye; Goal: The Resident will show no decline in visual function through the review date ...Ophthalmology Appointment scheduled for March 7th, 2025 ...Report to MD (Medical Director). Sudden visual loss. Pupil dilated, gray or milky, c/o (complaint of) halos around lights, double vision, tunnel vision, blurred or hazy vision." Of note, there was no documented evidence that facility staff initiated a care plan that addressed the resident's visual impairment/glaucoma until 07/15/24 after the writer asked for a copy of Resident#112's comprehensive care plan. During an observation and a face-to-face interview on 06/24/24 at 4:04 PM, Resident #112 was observed awake, laying in her bed supine (on her back). To the left side of the resident's bed was a bedside table. A lunch tray was sitting on top of the bedside table. When asked if she liked the food served at lunch, the resident replied that she did not see or know that her tray was sitting there. The surveyor observed that during the entire interview, the resident kept her right	L 052		

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L 052	Continued From page 19 eye closed. When asked if she could see from the right eye, she stated, "Not really, it is blurry. I get drops for dry eyes, but it doesn't seem to help." When asked if she had an appointment with the eye doctor the resident stated that she was not aware of one and she had never had an appointment scheduled since she got to the facility." During a face-to-face interview on 07/15/24 at 1:45 PM, Employee # 20, (Unit Manager of 2 Blue), stated that care plans are reviewed and updated quarterly and prn (as needed). She then reviewed Resident #112's comprehensive care plan and acknowledged that the care plan did not address the resident's visual impairment. She also stated that she would check to see if the Resident had an ophthalmology appointment since her admission. At 3:30 PM the Employee returned with an updated care plan that had an implementation date of 07/15/24 and included an ophthalmology appointment. When asked what delayed the resident from obtaining an appointment sooner, the Employee made no further comment and acknowledged the finding. 2)Resident #162 was admitted to the facility on 06/07/23 with diagnoses that included: Acute Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Tobacco Use, and Generalized Muscle Weakness. A review of the resident's medical record revealed: A review of a Quarterly Admission Minimum Data Set (MDS) assessment dated 09/24/23 showed that Resident #162 had a Brief Interview for	L 052		

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L 052	Continued From page 20 Mental Status (BIMS) summary score of "14," indicating intact cognition. A review of a physician's order dated 08/01/23 at 3:30 PM, directed:" Clarification order for Debrox otic [ear] solution: Debrox otic solution. Apply 5 drops to bilateral ears twice daily x 4 days for cerumen impaction, Flush with lukewarm water with a bulb syringe twice on the 5th day." A review of a Nurse Progress Note dated 08/02/2023 04:57 PM documented: "Resident S/P (status post) in-house transfer was seen by [Name of Physician Assistant] during doctor's rounds on 8/1/23. Debrox otic solution was ordered. Order clarified today ...Resident has been notified of the new order. Resident's sister [Name of Sister/resident's representative] was notified ..." A review of a care plan implemented on 08/02/23 documented: "Cerumen impaction ...Approach(es) created 08/02/23: Debrox otic solution. Apply 5 drops to bilateral ears twice daily x 4 days for cerumen impaction; Flush with lukewarm water with a bulb syringe twice on the 5th day; Follow-up with Audiology, if recommended. Monitor for changes in hearing and report to physician ..." Of note the care plan showed a reviewed and revision date of 07/01/24, after the surveyor asked for a copy of the resident's care plan. A review of a Physician's Note dated 09/26/23 at 06:57 PM documented, "Patient has multiple medical problems and is hearing impaired and reports numbness in both lower limbs after taking a certain medication ..."	L 052		

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L 052	Continued From page 21 A review of a physician's order dated 02/06/24 directed:" Audiology consult for hearing loss/difficulty-possible hearing aid -evaluate and treat." A review of a Nursing Note on 05/30/24 at 4:27 PM documented: "Resident had an audiology appointment today at [Name of Local Hospital], hospital called to reschedule the appointment for September 6th, 2024, at 1:30 PM. Resident/RP (representative /PMD (primary medical doctor) made aware." Of note, there was no documented evidence that facility staff monitored the resident's hearing and reported it to the physician from 08/02/23 to 02/06/24 (6 months). In addition, there was no documented evidence that the care plan was revised or reviewed again until 07/01/24 at 2:11 PM, after the writer asked for a copy of Resident#162's comprehensive care plan. During a face-to-face interview on 06/24/24 03:13 PM, Resident #162, stated, "They [facility staff] get on me, because I talk loudly. I can hardly hear sometimes and asking people to repeat themselves makes me upset. I have asked to see the doctor. I think I may need hearing aids or something to help me hear. I told the charge nurse, so they know about it." During a face-to-face interview on 07/03/24 at 4:12 PM, Employee #19, (Former Unit Manager of 2 Blue), stated that care plans are reviewed and updated quarterly and as needed. When asked about the when asked about the interventions on the care plan, the Employee stated that the nurses should have documented that they were monitoring for changes to the resident's hearing in the progress notes and, they should have let the physician know. The	L 052		

Health Regulation & Licensing Administration

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L 052	Continued From page 22 Employee had no response when asked what delayed the resident from obtaining an appointment from 02/06/24 to 05/30/24, and she had no explanation for not reviewing the interventions on the care plan until 07/01/24 when the survey was ongoing. Cross Reference F685 22B DCMR Sec 3211.1 (a)	L 052	**3211.5 Nursing Facilities** 1. A review of the staffing was conducted unable to retrospectively correct. 2. A review of all staffing documentation was reviewed, no resident was impacted by this practice. 3. HR department reviewing additional recruitment options including advertising, implementation of sign referral bonuses. Aggressive hiring campaign generated an increase nursing staff: 9 RN, 1 LPN, 13 CNAs. 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. 5. Completion Date: 08/31/24. 6. Responsible Party: DON and HR Department	
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practice registered nurse per Resident per day hours], it was determined that the facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for 8 of 29 days and sixth tenths (0.6) Advance practiced registered nurse per Resident per day for 8 of 29 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included:	L 056		

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L 056	Continued From page 23 According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of the Nurse Staffing was conducted on July 16, 2024, at approximately 11:00 AM. Of the 29 days reviewed, eight (8) of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day, and eight (8) of the days failed to provide a minimum daily average of six-tenths (0.6) hours of an advanced practiced registered nurse as follows: Hours of Direct Care per resident per day Saturday, June 22, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.42 hours. Sunday, June 23, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.27 hours. Monday, June 24, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.97 hours. Sunday, June 30, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.41 hours.	L 056		

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L 056	Continued From page 24 Saturday, July 6, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.78 hours. Sunday, July 7, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.59 hours. Saturday, July 13, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.85 hours. Sunday, July 14, 2024, showed that the facility provided direct nursing care per resident at a rate of 3.74 hours. Hours of Advanced Practice Registered Nurse per resident per day: Saturday, June 22, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.50 hours. Sunday, June 23, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.42 hours. Saturday, June 29, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.42 hours. Sunday, June 30, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.54 hours. Saturday, July 6, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.51 hours. Sunday, June 7, 2024, showed that the facility	L 056		

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	HFD02-0007	A. BUILDING: _____ B. WING _____	C 07/16/2024

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L 056	Continued From page 25 provided advanced practiced registered nurses per resident at a rate of 0.34 hours. Saturday, July 13, 2024, showed that the facility provided advanced practiced registered nurses per resident at a rate of 0.50 hours. Sunday, July 14, 2024, showed that the facility provided direct advanced practiced registered nurses per resident at a rate of 0.50 hours. A face-to-face interview was conducted on 7/16/2024 at approximately 2:00 PM with the Administrator, DON, ADON concerning staffing at the time of the staff review and they	L 056	**3216.1 Nursing Facilities** 1. Side rails for resident # 105 was immediately removed by Engineer department on 7/17/2024 to reflect proper physician order of bilateral quarter siderails for bed mobility. 2. All other residents' rooms were checked by unit managers and Maintenance Department by 7/17/2024 for side rails at the foot of the bed to ensure compliance. No other resident was impacted by this practice. 3. All licensed staff were re-educated regarding side rails and restraints by the Director of Nursing on 08/16/24. Additionally, the Unit Managers reviewed all side rails to ensure compliance. 4. Monitoring tool for siderails initiated by QA on 08/14/24. Unit managers utilize the tool to check side rail compliance monthly. Any deficiency will be corrected immediately. The responses are reported to QAPI quarterly. 5. Completion Date: 8/31/2024. Response Party: Unit Managers	
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on observation, record review and staff interviews for one (1) of 59 sampled residents, facility staff failed to ensure that a resident was free from physical restraint not required to treat the resident's medical symptoms, as evidenced by a siderail up at the foot of the resident's bed. Resident #105. The findings included: Resident #105 was admitted to the facility on 08/10/2019 with multiple diagnoses that included: Blindness Both Eyes, Psychotic Disorder with Delusions, Hallucinations, Morbid Obesity and Muscle Weakness. A review of Resident #105's medical record	L 080		

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L 080	Continued From page 26 revealed: A review of the facility's policy titled 'Restraint Usage 00 - 008' with a review and revised date of June 7, 2024, documented, "Definition and Philosophy of Use: The RAI (Resident Assessment Instrument) User's Manual defined restraint as "Any manual method of physical or mechanical device, material or equipment attached or adjacent to resident's body that the individual cannot remove easily, which restricts freedom or normal access to one's body (Chap. 3 p P-1)." And "In 42 CFR (Code of Federal Regulations) 4183-18(a) under Resident behavior and center practices (a) it is recognized that the "resident has the right to be free of any physical or chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms." "Restraints will not be applied without first obtaining an order from the resident's physician." A Physician Order dated 05/15/2021 documented, "Bilateral quarter side rails up in bed every shift for enhancement of turning and repositioning. Monitor every shift." A Care Plan Problem dated 05/17/2023 documented, "Category: ADLs Functional Status/Rehabilitation Potential, Self care deficit; Approach: Half side rails when in bed to enhance turning and repositioning." A Physician Note dated 05/14/2024 at 11:35 pm documented, "The resident at baseline is debilitated, bedbound and dependent with all ADLs (Activities of Daily Living)." A Discharge Minimum Data Set (MDS) Assessment dated 05/17/2024 showed facility	L 080		

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L 080	Continued From page 27 staff coded a Brief Interview for Mental Status (BIMS) summary score of "11", indicating the resident was moderately impaired; coded "0" for Restraints and Alarms, indicating there were no bedrails used in bed as a form of restraint. During an observation of Resident #105's room that was conducted on 06/26/24 at 10:30 am and 07/16/24 at 11:45 am, the resident was lying in bed with (3) three siderails in the upward position - there were (2) two siderails up at the head of the bed, one on each side; and one siderail that was up at the foot of the resident's bed on the left side. During a face-to-face interview conducted on 07/16/24 at 2:32 pm, Employee #2 (Director of Nursing/DON) stated, "Only persons who are able to reposition themselves have quarter side rails in place at the head of the bed. No resident should have siderails up at the foot of the bed." Cross Reference F604	L 080	**3219.1 Nursing Facilities** 1. The Food Warmer was checked. It was determined that the food warmer is operational, but the temperature gauge is not working. The food was checked with a manual thermostat and was noted to be at 180 degrees. 2. The temperature gauge was monitored on all food warmers and the food content was checked and noted to be at 180 degrees. No resident was impacted by this practice. 3. The equipment in the kitchen has been added to the PM schedule for the maintenance department. Repairs will be made. 4. The kitchen equipment is monitored quarterly by the Dietary management staff including cooks and supervisors. The food service Director reports the status of food service equipment quarterly and/ or monthly if equipment is noted to be broken. Any deficiency will be corrected immediately. The responses are reported to QAPI quarterly. 5. Completed: September 16, 2024. 6. Responsible party: Food Service Director and management staff.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, facility staff failed to distribute foods under sanitary condition, as evidenced by two (2) of two (2) defective temperature gauges from one (1) of one (1) food warmer, that failed to register the upper and lower internal temperatures of the food warmer.	L 099		

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L 099	Continued From page 28 The findings include: During observations in dietary services on June 25, 2024, at approximately 10:30 AM, two (2) of two (2) temperatures gauges from one (1) of one (1) food warmer were broken and did not display the correct upper and lower internal temperatures of the food warmer. During a face-to-face interview on July 1, 2024, at approximately 2:00 PM, Employee #12 acknowledged the findings. CROSS REFERENCE: F812	L 099		
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by: Based on record reviews and staff interviews for one (1) of 47 sampled residents, facility staff failed to accurately document the residents current prescribed use of supplemental oxygen on the "State Optional Minimum Data Set (MDS) assessment dated 04/29/24. Resident #21. The findings included: Resident #21 was admitted to the facility on 03/11/21 with multiple diagnoses that included the following: Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Heart Failure, and bipolar disorder. A review of Resident #21's medical record revealed the following:	L 200		

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L 200	Continued From page 29 A review of a State Optional Minimum Data Set (MDS) assessment dated 04/29/24, showed that the facility staff did not code that the resident uses supplemental oxygen. A physician order dated 03/01/24 directed, "Oxygen at 2 liters per minute via nasal cannula continuously every shift for COPD (chronic obstructive pulmonary disease)"It is noted that the surveyor observed the resident on supplemental oxygen via Nasal cannula on 07/02/24 and 07/03/24. During a face-to-face interview conducted on 07/03/24 at 1:36 PM, Employee # (MDS Coordinator) stated that not coding that the resident receives supplemental oxygen was an oversight and human error. Cross Reference F641-22B DCMR Sec 3231.11	L 200		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a) The date, time, and description of the incident; (b) The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and	L 204		

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L 204	Continued From page 30 (e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record reviews and staff interviews for (1) of 47 sampled residents, facility staff failed to show documented evidence that thorough investigations were conducted after incidents in which Resident #128 was found unresponsive on 11/14/23 and 3/5/24. Resident #128. The findings included: A review of the facility's policy titled "Incident and Accident" dated revised on 01/03/24 documented the following: "When an actual incident occurs: Complete head-to-toe nursing assessment must be completed by the licensed nurse for both witnessed and unwitnessed incidents. Perform neurological assessments for all if appropriate" "Incident will be reviewed by the clinical team. Notification of physician and responsible party. Incident reports must be sent to the Department of Health (DOH) for all incidences. Investigation using the incident and accident form. Witness statement if appropriate." A review of the facility's policy titled "Prohibition of Abuse" that was updated directed "Staff will complete an incident /accident form for any unusual occurrences and submit it to the director of nursing or designee" "All alleged violations, substantiated incidents; corrective actions depending on the results of the investigation are reported verbally within 8-72 hours and in writing within 5 working days to the State Agency" A review of the facility's policy titled "Use of	L 204	**3231.11 Nursing Facilities** 1. A review of the resident assessment for residents #496, #501, #95, #45, #133 and #21. This was done the assessment for residents #496, #95, #45, #133 and #21 were modified and transmitted. Based upon the RAI manual definition for resident #501 and was noted that she did not meet the criteria for coding turning and positioning on the MDS. 2. A house wide audit tool was conducted on 07/27/24 for surgical wounds, 08/19/24 for psychotropic medicals, falls, and weight loss. This was done by the MDS staff and dietary. Any resident with inaccurate assessment MDS were modified and transmitted. 3. The MDS Manager re-educated MDS staff, and dietary managers by 08/23/24. This included the accuracy coding on MDS. 4. The MDS Manager audits the MDS monthly and reports the information to the QAPI monthly. 5. Completion Date: 08/31/24. 6. Responsible Party: MDS Manager	

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L 204	Continued From page 31 Naloxone/Narcan" dated revised on 01/24 documented the following: "All nurses responsible for the care and management of residents at (Facility name Abbreviation) can administer Narcan and monitor for potential complications associated with the medication use. Narcan will be available for use for residents with past or current history of drug use." A) The facility staff failed to thoroughly investigate an incident in which Resident #128 was found unresponsive on 11/14/23. Resident #128 was admitted to the facility on 12/13/21 with multiple diagnoses that included the following: Diabetes Mellitus Type 2, Opioid Dependence, and Acquired Absence of Right Leg above the Knee. A review of a Facility Reported Incident (FRI) DC# 00012281, submitted to the State Agency on 09/08/23 documented the following: "Around 9:25 PM today 9/7/2023, nursing supervisors were called to the 2 Blue unit by the charge nurse, informing them that the resident had called 911. Upon arrival, 911 had already left the unit. According to the charge nurse, the resident reported that he had a bump on his forehead and a scratch on his chest. The Resident also verbalized that he had an encounter with the staff earlier today. 911 offered to take him to the hospital, but he declined. Upon assessment, the resident was noted with a small bump on his mid-forehead and a scratch on his chest. The resident was offered pain medication, but he refused. When asked for further information about the encounter, the resident became agitated and loud. Nursing supervisors calmed the resident down and left the room." A review of a Facility Reported Incident (FRI) DC# 00012448, submitted to the State Agency on	L 204		

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L 204	Continued From page 32 11/14/23, documented the following: "At about 5:00 PM the charge nurse called the writer to resident's room. On arrival, the resident was observed in bed unresponsive to name calls or tactile stimuli. A resident has a history of unresponsiveness and is on Narcan nasal spray as needed for signs of drug overdose. Narcan was given to both nostrils immediately. The resident was breathing have a palpable pulse but unresponsive. Blood sugar was checked it was 231mg/dl(milligram/deciliter), T (temperature) 98.5 P (pulse) 98 R (respirations) 22 B/P (Blood Pressure) 132/76. Assessment findings were communicated to PA-C (physician assistant) order was given to transfer the resident to the nearest ER (emergency) via 911 for further evaluation of unresponsiveness. EMS was immediately activated. Residents continue to breathe and have a palpable pulse until the arrival of 911 at about 5:15 PM which takes over the care of the resident. Additional Narcan (an opiate antagonist) was given by 911 and the resident regained consciousness though he was very drowsy. Resident initially refused to be transferred but later he agreed to go with the emergency crew." A review of a Facility Reported Incident (FRI) DC#00012735 submitted to the State Agency on 03/05/24 documented the following: "At about 8:00 PM the charge nurse called the writer to the resident's room. On arrival, the resident was observed unresponsive to his name or tactile stimuli. Residents have a history of unresponsiveness and are on Narcan nasal spray as needed for signs of drug overdose. Narcan was given to both nostrils immediately. The resident was breathing and had a palpable pulse but was unresponsive. He is diabetic blood sugar was checked and it was 370mg/dl. T 98.5 P 97 R	L 204		

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L 204	Continued From page 33 02 B/P 136/76. Assessment findings were communicated to the MD and the resident to the nearest ER via 911 for further evaluation of unresponsiveness. EMS was immediately activated at about 8:10 PM. " A review of a Facility Reported Incident (FRI) DC# 00012736, submitted to the State Agency on 04/10/24, documented the following: "Resident propels himself in and out of his unit on his wheelchair independently. He was closely monitored during the day shift for signs of drug overdose. No signs of drug overdose were noted during the day shift. At about 8:00 PM the charge nurse called the writer to the resident's room. On arrival, the resident was observed unresponsive to his name or tactile stimuli. Residents have a history of unresponsiveness and are on Narcan nasal spray as needed for signs of drug overdose. Narcan was given to both nostrils immediately. The resident was breathing and had a palpable pulse but was unresponsive. He is diabetic blood sugar was checked and it was 370mg/dl. T 98.5 P 97 R 02 B/P 136/76. Assessment findings communicated to MD and ordered to transfer the resident to the nearest ER via 911 for further evaluation of unresponsiveness. EMS was immediately activated at about 8:10PM. Resident continued to breathe and had a palpable pulse until the arrival of 911 at about 8: 20PM" A review of Resident #128's medical record revealed the following: A transfer progress note dated 11/14/23 at 6:25 PM, documented in part "On arrival the resident was observed in bed unresponsive in bed unresponsive to his name or tactile stimuli. Residents have (sp) (Has) a history of unresponsiveness and on Narcan nasal spray as	L 204		

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L 204	Continued From page 34 needed for signs of drug overdose. Narcan was given to but (sp) (Both) nostrils immediately. Resident was breathing has a palpable pulse but unresponsive." "Ordered to transfer the resident to the nearest ER (emergency room) via 911 for further evaluation of unresponsiveness." A review of the facility's investigation of the incident involving Resident #128 on 11/14/23 consisted of a handwritten form titled "For (facility name) Personnel Use". It is noted that there is no documented evidence of witness statements, statements from Resident #128 once he returned to the facility, updated care plan or any other follow up investigations to the incident that occurred on 11/14/23. B. The facility staff failed to thoroughly investigate the incident that occurred on 03/05/24 in which the resident was found unresponsive and Narcan (Opiate Antagonist) was administered. Review of Resident #128's medical record revealed the following: A physician order dated 06/06/22, documented "Narcan Nasal Liquid 4mg/0.1ML (Naloxone HCL) 1 spray in each nostril as needed for signs of opioid overdose Administer 1 time." A nursing progress note dated 03/05/24, documented "He (Resident #128) was closely monitored during the day shift for signs of drug overdose. No signs of drug overdose were noted during the day shift. At about 8:00 PM the charge nurse called the writer to the resident's room. On arrival the resident was observed unresponsive to his name or tactile stimuli. Residents have a history of unresponsiveness and on Narcan nasal spray as needed for signs of drug overdose. Narcan was given to both nostrils immediately. Resident was breathing and had a palpable pulse but was unresponsive." "MD (Medical Doctor)	L 204		

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L 204	Continued From page 35 ordered transfer the resident to the nearest ER (emergency room) via 911 for further evaluation of unresponsiveness. A physician order dated 03/05/24 at 8:15 PM, directed "Transfer resident to the nearest ER (emergency room) via 911 for further evaluation of unresponsiveness." A care plan initiated on 03/05/24 documented in part "(Resident #128) has a history of substance abuse hence potential for ineffective Health Maintenance and risk for injury related to substance intoxication or withdrawal as evidenced by opioid/narcotics overdose. Interventions/tasks Monitor resident for safety each shift, give medication as ordered Narcan (Nasal Naloxone) (Narcan-Opiate Antagonist)" A review the Annual Minimum Data Set (MDS) assessment dated 03/14/24 revealed that the facility staff coded that Resident #128 as having a Brief Interview for Mental Status Summary Score of "15" indicating intact cognition, being independent in eating and using a manual wheelchair 150 ft (Feet) once seated, required supervision for toileting, shower bath, Upper and lower body dressing and personal hygiene, and receives antidepressant medication. A review of the facility's investigation dated 03/05/24, showed that it consisted of 4 handwritten statements from the facility's staff, a handwritten form titled "For (Facility Name) Personnel Use, and an updated care plan submission dated created on 03/05/24. It is noted that the facility's investigation did not contain any of the following: statements from Resident #128 or other residents, visitor logs, physical or neurological assessments of Resident #128 and there was no follow up investigation	L 204		

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L 204	Continued From page 36 submitted to the State Agency. There was also no follow up Interdisciplinary team meeting or notes from the social worker. During a face-to-face interview conducted on 07/16/24 at 4:03 PM, Employee #1 (Administrator) acknowledged the findings and stated that do we need to write an incident report and do an investigation for a resident who is unresponsive and has a history of drug abuse? Cross Reference F610- 22B DCMR Sec.3232.2 (b) (c)	L 204		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations on June 25, 2024, at approximately 2:30 PM, and staff interview, it was determined that facility staff failed to maintain essential equipment in good working condition, as evidenced by three (3) of seven (7) hopper sinks, that failed to operate as intended. Three (3) of seven (7) hopper sinks, each located in the soiled utility room on each unit, did not flush when tested. Employee #25 acknowledged the findings during a face-to-face interview on July 1, 2024, at approximately 4:00 PM. CROSS REFERENCE: F908	L 442	**3258.13 Nursing Facilities** 1. The hopper sinks on each unit are no longer being used. They were removed and no resident was impacted by this practice. 2. All hoppers on each unit were removed and plumbing components capped off. 3. The maintenance was educated regarding the equipment by the supervisor of maintenance on 08/21/24. This includes checking the equipment even if it is no longer used. 4. The maintenance staff conduct QA monitoring to include equipment on the units and in the kitchen. This is reported to QAPI by the maintenance supervisor quarterly. 5. Completion Date: 08/31/24. 6. Responsible Party: Maintenance Supervisor	