STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095020	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stoddard Baptist Nursing Home	1818 Newton St. NW Washington, DC 20010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for two (2) of seven (7) sampled residents, the facility staff failed to report an allegation of abuse to the State agency in the required timeframe as evidenced by an incident involving a resident-to-resident altercation first documented by the facility on 02/25/25 but not reported to the State agency until 03/03/25. Resident #2 and #3. The findings included: A review of the facility policy titled Prohibition of Resident Abuse/Abuse Prevention updated in 2024, documented the following: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 'Willful' means the individual must have acted deliberately, not that he/she [NAME] have intended to inflict injury or harm. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Reporting/Response Anyone who suspects or witnesses an alleged incident of resident abuse (to include resident to resident) is required to report the incident to the Nursing Supervisor or department head immediately, but not less than 2 hours, if the alleged violation involves abuse or results in serious bodily injury. The Nursing Supervisor/department head will immediately initiate an investigation and give an oral report to the administrator. If the findings are substantial, a report will be submitted to the Department of Health Licensing Regulation Administration (DHLRA). 1A. Resident #2 was admitted to the facility on [DATE] with multiple diagnosis that included the following: Unspecified Dementia, Personal History of Traumatic Brain injury, Blindness Left Eye Category 4, Normal Vision Right Eye, Adjustment Disorder, and Age-Related Nuclear Cataract Right Eye. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Facility Reported Incident (FRI) DC ~13500 submitted to the state agency on 03/03/25 at 7:05 PM, documented the following: On February 25, 2025, (Resident #2) was noted with two scratches to his left hand. MD (medical doctor) was notified as week as RP (resident representative). New orders obtained for bacitracin treatment to the areas until resolved. The two areas that were noted on (Resident #2)'s left hand has since resolved and the treatment discontinued. On March 3 2025 (Resident #2) was interviewed regarding the areas noted. Upon being interviewed (Resident #2) stated that he was in a fight and that's how he sustained the scratches to his hand. During this interview (Resident #2) was asked if he had experienced any pain regarding these areas, in which he replied no. Investigation is in progress . On February 25, 2025, around 11:05p.m., (Resident #2) was involved in a verbal altercation with his roommate. (Resident #3), which was overheard by nursing staff. The nursing supervisor noted two scratches on resident's left hand. Initially, when (Resident #2) was asked about the etiology of the scratch, he told the nursing supervisor that he was not sure of how he sustained those scratches. Additionally, (Resident #3) was interviewed on the day of the incident about the scratched noted on Mr. (Resident #2)'s left hand and he stated that 'I don't know nothing'. On March 3, 2025 Mr. (Resident #2) was asked by the Director of Nursing about the two scratches that he has obtained to his left hand. Initially the resident stated that it is 'none of your business'. After continuing to speak to Mr. (Resident #2) he stated that he was in a fight. Mr. (Resident #2) was than asked who he was in a fight with, and he replied that he was in a fight with his previous roommate. Immediate Action(s): The two resident's were immediately separated when the altercation was observed, and Mr. (Resident #3) was transferred to another room. Both residents were interviewed at the time and none of the residents stated that they were in a physical altercation. Scratches on Mr. (Resident #2)'s hand were noted on February 25, 2025. The initial assessment of the scratches was done by the supervisor on duty. The supervisor noted that the scratches were superficial and that no active bleeding was noted .Education was started with staff with a focus on how to deal with resident-to-resident altercations and the reporting process. Currently Mr. (Resident #3) no longer resides at (Facility Name) . A review of Resident #2's medical record revealed the following: A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 5 which indicates severe cognitive impairment. The facility staff coded the resident as having no impairment in the upper and lower extremity. A review of a Health Status Progress Note dated 02/25/25 at 11:39 PM, documented the following: At 11:12pm, writer was called to room [ROOM NUMBER] by staff, getting in both (Resident #2) and his room mate were facing each other. Mr. (Resident #2) verbalized go out of his room. Writer tried to calm them down, then noticed scratch from his LT (sp) upper hand, cleanse with NSS (normal saline solution) then said it ok. Refused to be measured. Room mate taken out of the room to the Nurses station. A review of a e-Interact SBAR (Situation Background Assessment Recommendation) Progress noted dated 02/25/25 at 11:46 PM documented the following: Nursing observations, evaluation, and recommendations are: no more bleeding, Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: Cleanse with NSS (normal saline solution), Pat dry and apply bacitracin (antibiotic) ointment BID (twice daily) until resolved. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Health Status Progress Note dated 02/26/25 at 3:05 AM, documented the following: Observed resident has scratch 3cm (centimeters) x(times) 0.1 x(times) 0 cm LT (sp) upper hand, no active bleeding, assess resident, alert and orient x3, verbally responsive, denies pain and discomfort, resident stated 'My roommate coming to my bed making trouble'. Cleanse with normal saline pat and dry, apply bacitracin ointment as Order, MD made aware, on duty nurse was unable to communicate with POA (power of attorney), safety precautions maintained separate both roommate, monitor 1/1, resident remained stayed in 108-B no room change for Mr. (Resident #2), resident verbalized to remain quite and stated 'I do not want MR. (Resident #3) in my room' . staff will continue to provide assistance and support It is noted that the facility reported the incident on 03/03/25 in which resident was observed with scratches on his hand, however this was first documented in the medical record on 02/25/25. A review of a Health Status Progress Note dated 03/03/25 at 1:24 PM documented the following Late Entry Resident verbalized he got he had and altercation with his roommate. A review of a Nursing Progress Note dated 03/03/25 at 5:17 PM, documented the following: Writer went to assess resident's scratches and asked resident how he sustained them. Resident stated that he was in a fight. After resident said he was in a fight, writer asked resident with who in which he replied, none of your business. Writer thenasked (sp) if he was in a fight with the previous roommate and he stated 'yes'. He also stated that the persons name was 'on the door'. MD (medical doctor)/RP (resident representative) updated. An observation was conducted on 04/24/25 at approximately 10:30 AM in which Resident #2 was observed in his assigned single occupancy room sitting in a chair and wearing sweat pants and a sweatshirt. Resident was observed sleeping. 1B. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Alzheimer's Disease with Early Onset, Unspecified Dementia Unspecified Severity, With Other Behavioral Disturbance, and Transient Ischemic Attack (TIA) and Cerebral Infarction Without Residual Deficits. It is noted that Resident #3 was transferred from the facility on 02/26/25 due to a psychiatric emergency and the Resident #3 has not returned to the facility. A review of Resident #3's medical record revealed the following. A review of a Nursing Progress Note dated 02/26/25 at 2:28 AM, documented the following: The writer was called by nursing staff, observed Mr. (Resident #3) is standing in common dining area close to the dietary cart and holding metal bar in hand but quit and the staff standing away close to the elevator and nursing stations. The writer calmly/nicely communicate and able to redirect the resident and able get the metal bar, resident calmly and nicely put the metal bar. redirect the resident to the common area close to the nursing station, upon assessment resident has an argument with roommate, Mr. (Resident #3) 'I will not move out from my bed or room.' Observed Mr. (Resident#3) want to go to room [ROOM NUMBER] A, walked with client to prevent any harm or injury, but his roommate stopping him. The writer was able to redirect both clients and remain stayed between both client not to have any argument, successfully separate both resident nicely and calmly, called Mr. (Resident #3) spouse POA, resident agree to stay in room [ROOM NUMBER] A for the night. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Health Status Progress Note dated 02/26/25 at 2:15 PM, documented: Resident become very aggressive, Agitated, Paranoia, hitting kicking and scratching staffs. Staff were unable to redirect, after multiple times. Resident seeking exit, unit manager wascalled (sp) and also tried to redirect resident but was unsuccessful. Resident continue to swing at staff with on(un) (sp) steady gait. Resident refuse to sit down. Resident become danger to self and other. A review of a Health Status Progress dated 02/26/25 at 3:30 PM, documented the following: Resident was still in the hall way with uncontrolled behavior. Called Ms. (Resident Representative name), explained and informed her regarding resident behavior that earlier staff notified the writer that resident hit and spit on them. Resident was seen by the weiterat (sp) the exit door and tried to redirected to the dining area. called the nurse assigned on him (employee name) on other resident room near the exit door to help the writer redirected, resident was became combative and hit nurse (employee name) to. He keep speaking a different language which identified by the staff as Jamaican patois (sp). Staff and security came and help redirected the resident. Resident follow them at the dining area but unfortunately resident tried to escape again toward the exit doors which couldn't manage anymore that resident start kicking, hitting, scratching staffs and entering other resident room. Several behavioral redirection strategies has been offered, made and unsuccessful. Resident tried to enter room [ROOM NUMBER] DON (Director of Nursing) tried to redirectedthe (sp) resident and resident held pants and arms of DON that was so tight which she couldn't move at the door. Resident behavior couldn't be manage and R/P (resident representative) was informed that MD (medical doctor) made aware to and the recommendation was to sent to ER (emergency room) for further evaluation. 911 has been called as well. R/P verbalized understanding and agreed to sent the resident to the hospital. 2:49PM, 2 EMS (Emergency Medical Services) personnel came and they are awaiting for Police officer to come as well. 3:40PM, police came and they talk to wife to and wife consented them to bring resident to the hospital. resident left the unit at 4PM via stretcher accompanied by 2 EMS and 2 Police personnel. It is noted that the facility did not report Resident #3's combative behavior that is documented in the medical record on 02/26/25 at 3:30 PM, to the State Agency. A review of a Nursing progress Note dated 03/04/25 at 2:46 PM, documented the following: Resident is discharged from the facility. However, writer called wife to inform her of on ongoing investigation regarding the resident and his former roommate. It was mentioned by the other resident in room [ROOM NUMBER]B that he got into a physical altercation with the resident. Wife is aware. Investigation in progress. A review of a physician order dated 02/26/25 documented Transfer to nearest ER (emergency room) for further evaluation. It is noted that an altercation between Resident #3 and Resident #2 was first documented on 02/25/25 and the facility staff did not notify the state agency until 03/03/25 at 7:05 PM. It is also noted that the facility made no separate notifications to the state agency or the ombudsman office of Resident #3's combativeness and exit seeking behaviors documented on 02/26/25. During a face-to-face interview conducted on 04/24/25 at approximately 1:00PM, Employee #2 (Director of Nursing) stated that Do you need to report just a verbal altercation? I did not know that. I interviewed (Resident #2) and that is when I found out that he had an altercation with his roommate. Cross Reference 22B DCMR Sec. 3232.5 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**********

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for one (1) of seven (7) sampled residents, the facility staff failed to develop a care plan for a resident who required a 2-person physical assist when transferring from the wheelchair to the bed. Resident #1. The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Unspecified Dementia, Chronic Atrial Fibrillation and Muscle Weakness. A Facility Reported Incident (FRI) DC~13527 was submitted to the State Agency on 03/14/25 at 10:41 PM, that documented the following: On March 14, 2025, around 21:45 (9:45 PM), Nursing Assistant Ms. (Employee Name) was providing care for resident (Resident Name). After she transferred (Resident Name) on bed, she noted that he had blood coming from his mouth and nose. Once the nursing assistant observed the bleeding, she notified the nurse, nurses attempted to control the bleeding coming from the residents nose. Nurse (Employee name) performed a complete body and noted a hematoma to (Resident's) right lower leg, which showed no discoloration. A review of Resident #1's medical record revealed the following: A review of the State Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as needing a 2-person physical assist and extensive assistance for Transfers-how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. A review of Resident #1's care plan revealed that it lacked documented evidence that the resident required a 2-person physical assist and extensive assistance for transfers from the wheelchair to the bed. During a telephone interview conducted on 04/23/25 at 2:17 PM, with Employee #7 (MDS Coordinator stated that Resident #1's State Minimum Data Set assessment dated [DATE] indicates that the resident needed a 2-person physical assist for transfers from the bed to wheelchair. During a face-to-face interview conducted on 04/23/25 at 4:07 PM, Employee #2 (Director of Nursing) stated that the resident has notes from physical therapy that state he only needs a one person assist. The Surveyor asked Employee #2 if a significant change Minimum Data Set assessment was completed and Employee #2 stated No. Cross Reference 22B DCMR Sec. 3210.4 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews for one (1) of seven (7) sampled residents, the facility staff failed to ensure that a resident had adequate assistance while being transferred from the wheelchair to the bed in the resident's room and subsequently the resident sustained injuries and was transferred to the hospital emergency room. Resident #1. The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Unspecified Dementia, Chronic Atrial Fibrillation and Muscle Weakness. A Facility Reported Incident (FRI) DC~13527 was submitted to the State Agency on 03/14/25 at 10:41 PM, that documented the following: On March 14, 2025, around 21:45 (9:45 PM), Nursing Assistant Ms. (Employee Name) was providing care for resident (Resident Name). After she transferred (Resident Name) on bed, she noted that he had blood coming from his mouth and nose. Once the nursing assistant observed the bleeding, she notified the nurse, nurses attempted to control the bleeding coming from the resident's nose. Nurse (Employee name) performed a complete body and noted a hematoma to (Resident's) right lower leg, which showed no discoloration. A review of Resident #1's medical record revealed the following: A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as having impairment on one side in the upper extremities and impairment on both sides in the lower extremities. The facility staff coded that the resident was dependent on staff with a helper doing all the effort for toileting, personal hygiene and to transfer from chair (wheelchair) to bed. The facility staff coded that the resident uses a manual wheelchair. A review of the State Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident is sometimes understood- ability is limited to making concrete requests and for Cognitive skills for daily decision-making staff coded the resident as being severely impaired- never/rarely made decisions. The facility staff coded the resident as needing a 2-person physical assist and extensive assistance for Transfers-how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position. The facility staff coded that the resident does not have one or more unhealed pressure ulcers/injuries and as having no venous or arterial ulcers. The facility staff coded that the resident has no other ulcers wounds or skin problems present. It is noted that there was no significant change Minimum Data Set assessment in the resident's medical record dated from 11/25/2024 to 03/14/2025. A review of the documents titled Skin Monitoring: CNA (certified nurse aide) shower report dated 03/03/25 and 03/10/25 both show handwritten documentation that states skin intact and they are both signed by a charge nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the document titled Skin Check dated 03/03/25 at 7:29 PM, which is the weekly skin assessment showed that the facility staff did not code any skin issues on either legs or feet for the resident. A review of the document titled Skin Check dated 03/10/25 at 10:08 PM, which is the weekly skin assessment showed that the facility staff marked no skin issues for the resident. It is noted that Resident #1 had no skin issues documented in the medical record in three months prior to 03/14/25. A review of a nursing progress note dated 03/14/25 at 11:44 PM documented the following This writer was called to room [ROOM NUMBER]A by the assigned CNA (certified nursing assistant) reporting resident is bleeding upon assessment resident was observed bleeding from the nose and mouth. Hematoma also noted to his right foot. The write (r) (sp) was unable to control the bleeding. Howevernosebleed (spelling - however nosebleed) was managed with pressure but unresolved. The hematoma to his right leg was swollen but no active bleeding noted. Resident show signs of pain when right foot was touched /moved. No signs of dizziness or distress noted. Breathing is normal. Gentle pressure applied to stop nosebleed (sp). Assessed hematoma for changes in size, color, or pain. right foot elevated and cold compress applied. MD (medical doctor) notified. Order given to transfer resident to the ER for further evaluation. 911 was called and arrived at 22:30 (10:30 PM). Resident was transfer to (hospital name abbreviation) at 23:10 (11:10 PM) via stretcher. RP (Resident Representative) made aware. A review of a nursing progress note dated 03/15/25 at 12:57 AM, documented the following: Observed the resident is sitting in bed without gown and the charge nurse and the CNA (certified nurse aide) at the bedside, assisting Mr. (resident name) and providing care to stop bleeding from the nose and mouth. provide assistance to the resident r/t (related to) nose bleeding by applying gentle pressure nostrils and Ice cubes on the forehead/nose bridge to stop active bleeding for the duration of 5 to 15 mint (minutes) (sp) between 9:30pm to 9: 45pm, able to redirect resident, effective to calm, but unable to stop bleeding. Moderate amount of bleeding from nose and mouth noted via apply 4X4 gaze (gauze) (sp) multiple time. The resident was unable to provide statement regarding. The resident repeated the same word aaaa aaaa aaaa upon assessment observed bump/hematoma to the right lower extremity, no s/s (signs symptoms) of pain or distress noted. Resident was able to move the right leg without any pain, but unable to provide further detail. Provide assistance with incontinent care A physician order dated 03/14/25 documented Transfer to ER (emergency room) A review of a hospital face sheet showed that the resident was admitted to the hospital on [DATE] with an admitting diagnosis of leg hematoma. A review of a hospital document titled Progress Notes-Physician dated 03/17/25 at 2:44 PM, documented the following: presents as Trauma [NAME] (SIC) after being found down. Primary survey revealed no acute life -threatening injury. Secondary survey revealed dried blood over the upper lip, hematoma on the right anterior shin, dried blood bilateral digits. All trauma imaging negative for acute traumatic injury except for a mesentry (mesentery) (sp) contusion on CT (computed tomography). Concerns for elder abuse, so admitted for safe discharge plan. Now w (with) (sp)/ concerns for infection of RLE (right lower extremity) hematoma, plan for OR (operating room) for debridement Wednesday. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a hospital document titled Operative Reports dated 03/20/25, documented the following: Indication for surgery RLE (right lower extremity) infected hematoma Operation right lower extremity wound debridement 3X5CM2 (centimeters), wound vac placement, right. Findings superficial necrotic eschar excised, approx (approximately) (sp) 25 cc of old hematoma evacuated, no frank purulence noted. Fibular exposed with intact periosteum. white sponge was attached to black sponge with staple, laid along wound base with white sponge toward exposed fibula. Wound size 3x5 cm (centimeters) at the end of case with some tunneling superiorly. It is noted that the resident was assessed with a right leg wound, identified by facility staff as a hematoma sustained during transfer from wheelchair to bed. The right leg wound was assessed by hospital staff with areas of necrosis and required surgical intervention. An observation was conducted on 04/21/25 at approximately 11:00 AM, Resident #1 was observed in the day room on the first floor sitting in a wheelchair and looking out a large window. Resident #1 responded to his name and made incoherent speech and nodded head but otherwise not interviewable. A review of the facility's incident investigation which contained a typed telephone interview from Resident #1's assigned CNA (Employee #5). The typed telephone interview dated 03/17/25 at 2:15 PM, documented the following: On March 17, 2025, the DON (director of nursing) and ADON (assistant director of nursing) of (facility name) called (Employee #5 (certified nurse aide) to obtain her statement regarding the incident that occurred on March 14, 2025. She (Employee #5) mentioned that Resident #1 started to remove his brief and had feces all over himself and on the floor. Therefore when she transferred (Resident #1), she did not want to get her clothes soiled from the bowel movement. She then put her arms under his quickly transferred him to the bed. She did state that she held the resident a little further away from her body to prevent him from getting bowel movement onto her clothes. When she got to the bed, she placed him on the bed. Unfortunately, she stated that the resident hit his face. When asked what happened to the resident's leg, she mentioned that she forgot to take the foot rest off and that they were still up during transfer. (Employee #5) was asked why she continued to provide care if the resident was agitated and yelling. She stated that she felt she could transfer him to the bed quickly and get assistance to get him cleaned up. (Employee #5) stated that after she saw the resident's face bleeding, she called the nurse and began cleaning the blood noted on the bed. It is noted that Employee #5 attempted to transfer the resident on 03/14/25, without the assistance of at least 1 other staff member as required by the resident's State Minimum Data Set assessment dated [DATE]. Review of Employee #5's human resource record revealed a document titled Review Discussion Form dated 03/21/25 documented the following: Final written warning (performance) date of incident 03/14/25, Date of conversation 03/21/25, Description of incident: Employee transferred a resident from the wheelchair to the bed utilizing unsafe practices. As a result, the resident sustained facial and leg injuries. Because of this incident, the resident was hospitalized and will return to the facility with a wound vac for his leg injury. It is noted that the involved CNA Employee #5 was terminated from the facility on 03/25/25 and the last time Employee #5 clocked into work was 03/14/25 according to the time submission which was reviewed. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview conducted on 04/23/25 at approximately 11:30 AM, Employee #9 (LPN licensed practical nurse supervisor) stated that the residents nurse called him to the room, and he saw that the resident was bleeding from his nose, and he had a bruise on his right leg. Employee #9 went on to state that Resident #1 was yelling words he could not understand. The EMS (emergency medical services) would not take the resident until the police got there. During a face-to-face interview conducted on 04/23/25 at 4:07 PM, Employee #1 (Administrator) stated that the CNA (certified nurse aide) (Employee #5) was taken off the unit on 03/14/25 and never returned. Employee #1 went on to state that the employee (Employee #5) was terminated for violation of safety rules. During a face-to-face interview conducted on 04/24/25 at 12:57 PM, Employee #2 (Director of Nursing) stated that the resident did not have any wounds prior to the incident that occurred on 03/14/25 when a CNA attempted to transfer the resident from the wheelchair to the bed. When the surveyor asked about the necrotic tissue debridement that was documented in the hospital documentation Employee #1 stated that They did an evacuation of the hematoma, they opened it (hematoma) in the hospital. He did not have any wounds prior to when he went to the hospital. Cross Reference 22B DCMR Sec. 3211.1 (d) **********