STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interviews, for two (2) of 41 sampled residents, facility staff failed to immediately notify the resident's primary physician or their representative when there was a change in the resident's condition that required physician intervention. Resident #52 and Resident #243. The findings included: 1. Facility staff failed to immediately notify Resident #52's primary physician and their representative of a facility acquired sacral pressure ulcer/wound. Resident #52 was admitted to the facility on [DATE] with diagnoses that included: Adult Failure to Thrive, History of Falling, and Weakness. Review of the resident's medical record revealed the following: A face sheet that showed the resident had a legal guardian as her Responsible Party (RP), substitute decision maker and emergency contact #1. A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 07, indicating severe cognitive impairment; at risk for pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries, wounds, or other skin problems. A Wound Care Physician's Note dated 02/28/24 at 8:16 AM documented: Wound rounds; Stage 3 sacral decubitus ulcer; moderate drainage with necrotic tissue and slough. Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl ointment (debridement ointment used on dead tissue) and dry dressing daily. A physician's order dated 03/01/24 at 3:32 PM directed, Dakin's 1/2 strength External Solution 0.25 %, cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl and cover with border gauze daily. A physician's order dated 03/01/24 at 3:38 PM directed, Santyl External Ointment 250 Unit/GM (gram), apply to sacral ulcer topically every day shift for wound care. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record from 02/28/24 to 03/01/24, approximately 48 hours, showed that facility staff failed to immediately notify Resident #52's primary care physician of a change in condition (stage 3 pressure ulcer). Additionally, as of 03/06/24 there was no documented evidence that facility staff notified the resident's representative. During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, Once a new wound area is observed, the process is to immediately call the resident's [primary] medical doctor and get new orders. The nurse will write a progress note with a description of the wound that includes size, location, drainage, what the surrounding area looks like and then also indicate that the family was notified. 2. Facility staff failed to immediately notify Resident #243's primary physician or their representative of an x-ray result that showed a left hip fracture. Resident #243 was admitted to the facility on [DATE] with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility. Review of Resident #243's medical record revealed the following: A face sheet that showed the resident had a legal guardian as her RP and emergency contact #1. An Annual MDS assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 12, indicating mild cognitive impairment and had no falls since the prior assessment. A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A Nursing Progress Note dated 05/29/23 at 7:36 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A physician's order dated 05/29/23 directed, Left hip/left knee x-ray. Left knee x-ray results dated 05/30/23 at 1:21 PM documented: - No acute fracture, dislocation or degenerative disease. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Left hip x-ray results dated 05/30/23 at 1:21 PM documented:

- There is a fracture of the neck of the proximal femur without significant displacement.

- Clinical Correlation and follow-up imaging recommended as indicated.

A Nursing Progress Note dated 05/30/23 at 2:01 PM written by Employee #7 (Licensed Practical Nurse/LPN) documented:

- X-Ray for left hip/knee done this shift, results received: No acute fracture, dislocation, or degenerative disease.

- Physician's Assistant (PA) made aware; no new order given.

It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture.

A Night Shift Nursing Progress Note dated 05/31/23 at 6:56 AM documented:

- Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift (day shift, 7:00 AM - 3:30 PM) to follow-up with primary physician.

A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM written by Employee #8 (Night Shift Nursing Supervisor) documented:

- Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Please follow-up with primary medical doctor.

A Day Shift Nursing Progress Note dated 05/31/23 at 12:22 PM documented:

- Status post fall, order given on 05/29/23 as follows: left hip/left knee x-ray to rule out fracture. X-ray result received and indicated a fracture of the neck of the left proximal femur without significant displacement.

- [Physician's Name] made aware, new order given to transfer resident to the nearest emergency room for further evaluation.

- 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware before and after transfer.

The evidence showed that facility staff received Resident #243's left hip and left knee x-ray results on 05/30/23 at 1:20 PM, during the day shift (7:00 AM - 3:30 PM). There is no documented evidence that the assigned day shift nurse, Employee #7, made the resident's physician or representative aware of the left hip x-ray result that showed fracture of the neck of the proximal [left] femur.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The evidence also showed that on 05/30/23, the assigned night shift nurse and nursing supervisor both documented that Resident #243's left hip x-ray showed a fracture but neither notified the resident's physician or her representative. It was not until 05/31/23, at approximately 10:30 AM, 21 hours later, that facility staff notified Resident #243's primary care physician and their RP of the left hip x-ray results. During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN) stated, The process for when x-ray results are received is to call the medical doctor with the results. When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time. During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Nursing Supervisor) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated, We don't have an on-call list. Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00/7:30 AM because most of the doctors get angry when we call them in the middle of the night. During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated, There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts. During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 45102 Based on record reviews and staff interviews for one (1) of 41 sampled residents, facility staff failed to ensure Resident #192 was free from neglect as evidenced by the resident leaving the facility without staff knowledge. The findings included: Review of the policy titled, Missing Resident #99M-010, documented, A resident is considered missing from the facility whenever their whereabouts cannot be ascertained. This situation is an elopement. Resident #192 was admitted to the facility on [DATE] with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A care plan dated 01/01/23 that documented, Problem: [Resident #192] has risk for Elopement related to wandering evidenced by trying to enter the elevator. Goal: Resident will not elope. Approach: Monitor resident's movements closely while out of bed. Encourage resident to verbalize feelings of boredom/loneliness at all times. Encourage resident to participate in group activities of choice. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living. A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: At 6:55 am, resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process. Please note, According to World Weather, the temperature in the District of Columbia on 04/04/23 during the daytime ranged from 55 to 75 degrees (Fahrenheit). https://world-weather.info/forecast/usa/washington_1/april-2023/ (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 04/04/23 at 11:22 AM documented, Resident was received in bed at 11:00 pm, alert, oriented and verbally responsive. During routine round, Resident was in bed through the night. Breathing even and unlabored. No sign of respiratory distress or shortness of breath noted. No complain of pain or discomfort voiced. Around 5:30 am when I pushed my medication cart down the hall to start from room [ROOM NUMBER] where I normal start. Resident was in his room. When I got to his room at 6:40 am to give him his medication, I could not see him, I checked the bathroom, he was not there, then I alert other staffs and the supervisor, then called the security officer to found out if Resident left the facility. The staffs(sp) begin to search for him all rooms and bathrooms. I left the facility with other staffs in search of him to nearby bus-stops and metro stations. A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, At 6.55 am, I was informed that the resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. According to the investigation packet, the following employees wrote statements dated 04/04/23:? Employee #14 (CNA) documented, I [employee's name] worked last night April 3, 2023, and [resident's name] was assigned to me. The last time I saw [resident's name] was at 5:30 AM in his room. We the nurses on the night shift on unit (Unit2) left the floor and went to the street and metro station looking [for him] after he left the facility. We did not find him. Employee #15 (Housekeeping Director) documented, I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1. I asked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting. Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an Incident Report dated 04/04/23 that documented, [Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] was at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident stated] 'I have been here for too long; I was told at the other facility that I could leave.' Remains on 1:1 monitoring. Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days. Encourage participation in different activities on unit. A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented: - It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where. - I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number. - I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility). - The officer agreed to hold him. My daughter went and picked him up from Metro Center and took him back to the nursing home. - I feel that this is a neglect on the staff that's on the 2nd floor where he's on and security for allowing him to get out. Review of Employee #16's (Security Guard) personnel record showed the employee was hired on 05/16/22. The employee signed his initials on the Training Checklist dated 05/17/22 indicating he received training on Never leaving the front desk unattended. Moreover, the employee signed an Employee Warning Notice dated 04/12/23 that documented that, Date of incident 04/03/23 between 5AM to 5:30 AM. [Employee's name] you [were] supposed (sp) to been (sp) posted at the front desk during this time [resident's name] from room [ROOM NUMBER] walked thru the lobby past the front desk and out of the front door which caused an elopement. On 03/08/24 at approximately 11:00 AM, an observation of the lobby area revealed a security desk located adjacent to the facility's front door. At the time of the observation, a security guard and receptionist were seated at the desk. Behind the security desk, was a closet that's used by security staff. Additionally, there was a three-ring binder labeled Wanders and a security logbook (where security staff write notes about rounds and concerns in the facility) was noted on the desk. The security logbook lacked documented evidence of Resident #192's elopement incident on 04/04/23. During a telephone interview on 03/13/24 at 8:30 AM, Employee #17 (Nursing Supervisor) stated that Resident #192's assigned nurse called and informed her that staff could not locate the resident (on 04/04/23). After Employee #16 (Security Guard), who was posted at the front desk of the lobby, informed her that he did not see the resident leave out the front door, she called a Code Pink and continued looking for the resident with other staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/13/24 at 9:30 AM, Employee #16 (Security Guard) stated that he believed when he walked into the closet behind the security desk, the resident exited the facility through the front door. The employee stated that he was wrong for leaving the front desk unattended. He should have called the other security guard to cover the front desk. The employee also stated that he wrote an incident report related to Resident #192's elopement, and he thought he wrote the information in the security logbook. During a face-to-face interview on 03/13/24 at approximately 10:00 AM, Employee #18 (Security Supervisor) stated that Employee #16 (Security Guard) did not follow the company's policy when he left his post at front desk unattended on 04/04/23. He was to call the other security guard in the building to cover his post. Employee #18 reviewed that logbook and stated that she did not see documented evidence that Employee #16 documented Resident #192's elopement incident. When asked if that incident should have been documented in the logbook, Employee #18 replied Yes. Cross reference 483.25 Quality of Care F689

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45102

Based on observations, record reviews and resident and staff interviews, for four (4) of 41 sampled residents, facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect. Resident #192, Resident #40, Resident #25 and Resident #294.

The findings included:

A policy titled Prohibition of Resident Abuse/Abuse Prevention (#99-12) documented the following but not limited to: Each resident has the right to be free from neglect. Neglect- means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

A review of the facility's policy titled Resident Abuse reviewed on 08/23/23, documented the following: each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents and Abuse means the willful infliction of injury and resulting in physical harm, pain or mental anguish and Physical abuse includes hitting, slapping, pinching and kicking and Each resident has the right to be free from mistreatment, neglect and This includes the facility's identification of residents, whose personal histories render them at risk for abusing other residents.

Identification

Identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation.

Investigation

Investigate different types of incidents; and identify the staff member responsible for initial reporting, investigation of alleged violations and reporting of results to the proper authorities.

Protection

Protect residents from harm during an investigation.

Reporting/Response

Anyone who suspects or witnesses an alleged incident of resident abuse is required to report the incident to the Nursing Supervisor or department head immediately. The Nursing Supervisor/department head will immediately initiate and investigation and give an oral report to the Administrator.

1. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #192.

Resident #192 was admitted to the facility on [DATE] with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed the following: A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living. A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: At 6:55 am, resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20 am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process. A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, At 6.55 am, I was informed that the resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually, we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented: - It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where. - I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number. - I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER: Stoddard Baptist Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The officer agreed to hold him. My daughter went and picked him up from Metro Center and took him back to the nursing home. - I feel that this is a neglect on the staff that's on the 2nd floor where he's on and security for allowing him to get out. During a face-to-face interview on 03/08/24 at approximately 1:00 PM, Employee #2 (DON) stated that the facility staff failed to implement their prohibition of resident abuse/abuse prevention policy when Resident #192 eloped from the facility without staff knowledge. Cross reference 483.25 Quality of Care F689 2. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #40 and Resident #25's physical altercation. During an observation on first floor resident day room on 03/05/24 at 3:14 PM, the following was noted by two (2) State Agency Surveyors: Resident #25 was walking into the dayroom toward Resident #40, who was seated in a wheelchair and watching television. Resident #25 was then observed grabbing the push handles of Resident #40's wheelchair and pushing the wheelchair forward. Resident #25 then started hitting Resident #40 on the left side of his body. Resident #40 responded by attempting to raise his arms to block the hits. At this time, three (3) facility staff came running from the nursing station to the day room to separate the 2 residents. The surveyors observed Employee #23 (Registered Nurse) walk away with Resident #25 and another employee rolled Resident #40 to the opposite side of the dayroom. 2A. Resident #40 was admitted to the facility on [DATE] with multiple diagnoses that included: Other Seizures, Anemia, Hypotension, and Personal History of Other Venous Thrombosis and Embolism. Review of Resident #40's medical record revealed the following: A Quarterly MDS assessment dated [DATE], revealed that the facility staff coded that the resident's preferred language is Russia and that the resident needs an interpreter to communicate with a doctor or health care staff; had unclear speech, sometimes makes self-understood, sometimes is able to understand others, impaired vision; Moderately impaired cognitive skills for decision making; dependent on staff for self-care; used a manual wheelchair and had no impairment in the upper extremities. Review of the medical record showed there was no documented evidence of the physical altercation involving Resident #40 and Resident #25 that was observed by the facility's staff on 03/05/24. 2B. Resident #25 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Unspecified Dementia, Altered Mental Status, Blindness Right Eye Category 5, Normal Vision in Left Eye, and Cognitive Communication Deficit. Review of Resident #25's medical record revealed the following: (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set assessment dated [DATE] showed that the facility staff coded: adequate hearing, clear speech, usually make self-understood, understands others, and had highly impaired vision; severely impaired cognitive skills for daily decision making; behavior symptoms not directed toward others (e. g. physical symptoms such as hitting or scratching self, pacing rummaging), rejection of care, and wandering, occurred 1 to 3 days; and no impairment on the upper or lower extremities. A nursing progress note dated 03/05/24 at 5:56 PM documented, Resident is alert and verbally responsive with intermittent confusion. Resident kept pacing and wandering around the unit and wandering to other resident's rooms. Resident attempted to leave the unit 2 times during the AM (morning) shift; via the exit door behind and also via the exit door at the dining area. A nursing progress note dated 03/06/24 at 10:28 AM documented, Late entry 3/5/25 [3/5/24] at 18:36 [6:36 PM] [Resident #25] noted with escalating behaviors, redirected by staff to include diversional activities. Resident noted pushing a chair and this writer redirected resident by ambulating with resident around unit for redirection. Review of Resident #25's medical record lacked any documented evidence that the facility staff noted or investigated the observed resident to resident altercation on 03/05/24. On 3/6/2024 at 10:15 AM during an attempt to interview Resident #25; He was observed laying in bed and was non-responsive verbally to the writer's question, Good morning how are you? On 3/6/2024 at 10:30 AM during an attempt to interview Resident #40; He was observed sitting up in bed and unable to verbally respond to the writer's baseline questions such as, Good morning how are you? During a face-to-face interview conducted on 03/07/24 at 10:54 AM, Employee #30 (Certified Nurse Aide) stated, Resident #25 is erratic he goes into other resident's rooms and he has hit people and he has hit me. Employee #30 went on to say that Resident #25 is redirectable. During a face-to-face interview conducted on 03/07/24 at 2:59 PM, Employee #2 stated, I don't know of any incidents that occurred with (Resident #25) and he (Employee #23) should have followed the necessary protocols (report the incident to Administration, notify physician and resident representative, and start an investigation). 3. The facility staff failed to implement its policies and procedures for reporting and investigating allegations or incidents of abuse and neglect for Resident #294's allegation of staff abuse. Resident #294 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2. Review of Resident #294's medical record revealed the following: (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission MDS assessment dated [DATE] showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15 which indicates intact cognition; required extensive assistance of two (2) person physical assist for bed mobility, transfer, dressing, eating, and toilet use; required extensive assistance of one (1) person physical assist for personal hygiene; was dependent on staff for bathing and the resident; and had impairment on both sides in the upper and lower extremities. A care plan focus area of Post-traumatic stress disorder/panic attack initiated on 07/20/23 had the following interventions, Approach resident with caution, explain all procedures to resident, and encourage activity. Report behavior. A Nursing progress note dated 08/06/23 at 10:38 PM, documented Resident remain alert and verbally responsive. And ADL (activities of daily living) cares provided, due medications administered and tolerated well. PO (by mouth) fluids offered. Resident c/o (complained of) pain this shift. A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/07/23 that documented: - Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023. - Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, I hit my head on the bed rail 3 times when I was being changed. When asked if he told the nurse about it, he stated, she came and gave me my medications. Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said yes she cleaned my eyes and gave me medications When asked if he told charge nurse at that time about his head, he stated no. Resident went on to say that his aide for that Sunday was a male. A follow-up submission from the facility to the State Agency on 08/17/23 documented the following: Report of investigation into the incident on August 6th (2023). After thorough clinical review with statements from staff, there was no evidence of abuse or neglect related to the resident's complaint. (Resident #294) continues to remain stable, and all due care provided to the resident before discharge to the hospital. It should be noted that the resident's medical record lacked documented of Resident #294's allegation of physical abuse by staff member. A review of the facility's investigation packet related to this incident/allegation, lacked documented evidence that the facility assessed Resident #294, notified the physician of the resident's allegation of abuse, interviewed all the staff that worked the shift on the day of the allegation, and obtained interviews from other residents. During a face-to-face interview conducted on 03/18/24 at approximately 3:00 PM, Employee #2, (Director of Nursing) stated that the facility leadership has changed, and she was not able to locate any additional documentation concerning Resident #294's allegation of abuse. Cross Reference 22B DCMR sec. 3269.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
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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	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** 41645 45102 Based on record reviews and staff interviews, for two (2) of 41 sampled residents, facility staff failed to report the results of their investigations to the State Agency within 5 (five) working days of the incident. Resident #192 and Resident #294. The findings included: A review of a facility policy titled Prohibition of Resident Abuse/Abuse Prevention revised on 12/16/22 documented the following: The facility will designate an Abuse prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect or exploitation to the state survey agency and other officials in accordance with state law and An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: Identifying staff responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation (e.g. (for example) not tampering or destroying evidence); Investigating different types of alleged violations; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations. 1.The facility staff failed to report the results of Resident #192's elopement incident to the State Agency within 5 working days. Resident #192 was admitted to the facility on [DATE] with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: At 6:55 am, resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
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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 nursing supervisor note dated 04/04/23 at 12:16 PM documented that, At 6.55 am, I was informed that the resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. A State Survey Agency 5-day Follow-up Intake Form dated 04/04/23 at 12:11 PM documented, [Resident's name] returned to the unit at around 8:50 am after much encouragement. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. A review of the facility's investigation packet lacked documented evidence describing the results of the investigation for Resident #192's elopement incident on 04/04/23. During a face-to-face interview on 03/12/24 at approximately 3:00 PM, Employee #2 (Director of Nursing/DON) reviewed the investigation packet and stated that she did not see the results of the investigation that was conducted by the facility. Cross reference 483.25 Quality of Care F689 2. The facility staff failed to report the results of their investigation into Resident #294's allegation of staff abuse. Resident #294 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2. Review of Resident #294's medical record revealed the following: An Admission MDS assessment dated [DATE] showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15 which indicates intact cognition. A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/08/23 that documented: (continued on next page)

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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	- Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023. - Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, I hit my head on the bed rail 3 times when I was being changed. When asked if he told the nurse about it, he stated, she came and gave me my medications. Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said yes she cleaned my eyes and gave me medications When asked if he told charge nurse at that time about his head, he stated no. Resident went on to say that his aide for that Sunday was a male. A follow-up submission from the facility to the State Agency on 08/17/23 10 days after the initial intake documented the following: Report of investigation into the incident on August 6th (2023). After thorough clinical review with statements from staff, there was no evidence of abuse or neglect related to the resident's complaint. (Resident #294) continues to remain stable, and all due care provided to the resident before discharge to the hospital. During a face-to-face interview conducted on 03/18/24 at approximately 3:00 PM, Employee #2, (Director of Nursing) stated that the facility leadership has changed, and she was not able to locate any additional documentation concerning Resident #294's allegation of abuse. Cross Reference 22B DCMR sec. 3269.1

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 43776 45102 Based on record reviews and staff interviews, for four (4) of 41 sampled residents, facility staff failed to have documented evidence that they conducted thorough investigations. Resident #'s 192, 294, 244 and 63. The findings included: Review of the facility's policy Prohibition of Resident Abuse/Abuse Prevention revised 09/24/22 documented: - Investigation: Identifying and interviewing all involved persons including the alleged victim, alleged perpetrator and others who might have knowledge of the allegations Review of a facility policy titled, Prohibition of Resident Abuse/Abuse Prevention (#99-12) documented the following but not limited to: Neglect-means failure to the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Investigation of alleged Abuse and Neglect - Focusing the investigation on determining if neglect has occurred, the extent, and the cause. Providing complete and thorough documentation of the investigation. A policy entitled, Missing Residents (#99M-010) documented in part, The Search Director is to assign personnel to search the boiler, storage, and equipment rooms, laundry and kitchen areas, the roof and basement, if any, beneath beds and other furniture, beneath stairways, parked vehicles and shrubbery. 1. Facility staff failed to have documented evidence that they conducted thorough investigations of Resident #192's elopement from the facility. Resident #192 was admitted to the facility on [DATE] with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: At 6:55 am, resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process. A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, At 6.55 am, I was informed that the resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. A review of the facility's investigation packet dated 04/04/23 lacked documented evidence of the following: -The staff findings when they searched the boiler, storage, and equipment rooms, laundry and kitchen areas, the basement, beneath beds and other furniture, beneath stairways, parked vehicles, shrubbery, parking lot, bus stops, and the neighborhood, as outlined in the Missing Resident policy. - If neglect occurred, the extent and cause of the neglect, as outlined in their Prohibition of Resident Abuse/Abuse Prevention policy. - Interviews of Unit #1's night shift staff (person who might have knowledge of the incident) and Interview of ex-wife and daughter. As outlined in their Prohibition of Resident Abuse/Abuse Prevention policy. It should be noted that the resident got off the elevator on Unit 1 to exit the front door. This showed that facility staff failed to have documented evidence that a thorough investigation was conducted for Resident #192's elopement incident on 04/04/23. (continued on next page)

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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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a face-to-face interview on 03/12/24 at approximately 3:00 PM, Employee #2 (DON) reviewed the investigation packet and stated that she did not see that a thorough investigation was conducted by the facility. The employee also stated that she looked through other facility investigative documents and could not find any additional documents related to the investigation for Resident #192's elopement on 04/04/23.

Cross reference 483.25 Quality of Care F689

2. The facility staff failed to conduct a thorough investigation into Resident #294's allegation of staff abuse.

Resident #294 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Non-Dominant Side, Pressure Ulcer of Sacral Region Stage 2, and Diabetes Mellitus Type 2.

Review of Resident #294's medical record revealed the following:

An Admission MDS assessment dated [DATE] showed facility staff coded: A Brief Interview for Mental Status (BIMS) summary score of 15 which indicates intact cognition.

A Facility Reported Incident (FRI) DC~12177 was submitted to the State Agency on 08/08/23 that documented:

- Resident's wife called writer and stated that her husband's head was hit on the wall 3 times during care on the weekend (Sunday) 08/06/2023.

- Writer went to resident's room accompanied by the charge nurse that worked with him on the said day. When resident was asked how it happened, he stated, I hit my head on the bed rail 3 times when I was being changed. When asked if he told the nurse about it, he stated, she came and gave me my medications. Charge nurse stated that she came into resident's room, to pass his routine medications which she did after wiping his face because he had some crusts on his eyes. resident nodded his head and said yes she cleaned my eyes and gave me medications. When asked if he told charge nurse at that time about his head, he stated no. Resident went on to say that his aide for that Sunday was a male.

A review of the facility's investigation packet, showed no documented evidence that the facility assessed the resident, notified the physician, interviewed all the staff present at the time of the alleged incident, or that they interviewed other residents.

During a face-to-face interview conducted on 03/18/24 at approximately 3:30 PM, Employee #2 (Director of Nursing) stated that the facility leadership has changed, and she was not able to locate any additional documentation concerning Resident #294's allegation of abuse.

Cross Reference 22B DCMR sec. 3269.1

3. Facility staff failed to thoroughly investigate Resident #244's allegation of a verbal threat of harm by Resident #63.

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3A. Resident #63 was admitted to the facility on [DATE] with diagnoses that included: Vascular Dementia, Cognitive Communication Deficit, and Symptoms and Signs Involving Cognitive Functions and Awareness. Review of Resident #63's medical record revealed: A census tracking form showed that Resident #63 resided on unit 1, room [ROOM NUMBER], A bed, since 03/14/2023. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 09, indicating moderate cognitive impairment; no potential indicators of psychosis; no behavioral symptoms directed at others; limited assistance for locomotion on the unit; no functional limitations in range of motion in upper/lower extremities; used a walker for mobility; received antianxiety and antidepressant mediations 7 times during the last 7 days. A Facility Reported Incident (FRI), DC~12019, received by the State Agency on 06/09/23 at 8:10 PM documented: - At the dinner area at around 6:15 PM, Resident [#63] made a verbal threat to shoot another resident in room [ROOM NUMBER]A [Resident #244] with a gun, making an attempt to reach for something under her clothing. Immediately, the staff called 911. - Police officers came at 6:30 PM and searched Resident #63 and her belongings. No guns or any related injurious objects found. - The physician was notified and referred to the psychiatrist for review. - Representative aware. - Police officers advise nursing staff to separate the residents and departed at 7:00 PM. 3B. Resident #244 was admitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Deficit, Mild Cognitive Impairment and Muscle Weakness. Review of the resident's medical record revealed the following: A census tracking form showed that Resident #244 resided on unit 1 room [ROOM NUMBER], A bed, since 04/11/23. An Annual MDS assessment dated [DATE] showed facility staff coded: a BIMS summary score of 15, indicating intact cognition; no indicators of psychosis; no behavioral symptoms directed towards others; no functional limitations in range of motion for upper extremities; independent with walking and picking up objects. A FRI, DC~12018, received by the State Agency on 06/09/23 at 7:58 PM documented: - This event occurred at the dinner area at around 6:15 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #244 reported to the charge nurse that another resident in room [ROOM NUMBER] A (Resident #63) told her that she will shoot her with a gun, making attempt to reach for something under her clothing. - Immediately, the staff called 911. - Police officers came at 6:30 PM and searched Resident #63's room and her belongings. No guns or any related injurious objects found. - The physician and representative were made aware. - Police officers advise nursing staff to separate the residents and departed at 7:00 PM. Review of the investigation documents provided to the surveyor on 03/11/24 showed that Resident #244 reported the incident to Employee #3 (Assistant Director of Nursing/ADON). Further review of the investigation documents showed facility staff failed to conduct a thorough investigation as evidenced by no documented interviews or statements from the involved persons (alleged victim and alleged perpetrator) and no interviews from the staff present at the time of the alleged incident. During a face-to-face interview on 03/12/24 at 10:35 AM, Employee #3 acknowledged the finding and stated, When there's an incident on my shift, I do the incident report to Department of Health (DOH), collect statements from the residents and staff. All that gets forwarded to the DON. I can't remember if I got statements from anyone when this incident happened. Cross Reference 22B DCMR Sec. 3232.2

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to provide Resident #66's representative with written information that specified the duration of the state bed-hold policy before transfer to the hospital. The findings included: Review of the facility's Bed Hold policy, last reviewed on 04/26/23, documented that: - The admissions office will mail out the Bed Hold notification form to each resident/point of contact each time they are out of the facility. - The form will be mailed out the next business day. - The notification shall provide the number of [bed-hold] days remaining. Resident #66 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Hypertension and Hyperlipidemia. Review of the Resident #66's medical record revealed the following: It was noted that the face sheet documented Resident #66's wife as his responsible party and emergency contact. A Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 03 indicating severely impaired cognitive status. An eInteract Situation Background Assessment Request (SBAR) note dated Sunday, 02/04/24 at 1:48 AM documented: - Situation: fever nausea/vomiting; blood pressure (BP): 87/53, pulse 122. - At about 9:30 PM, writer was notified by charge nurse that resident did vomit after dinner, and supra pubic catheter drainage bag observed with mild blood, bloody discharge from urethra too. - Order given to send resident to nearest emergency room for further evaluation. - Wife notified at 1:30 AM. A Health Status Note dated 02/04/24 at 2:38 PM documented, Telephone call was place by the writer to [Hospital name] and it was confirmed that resident has been admitted . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/24, the State Surveyor asked facility staff to provide documented evidence of written information given to Resident #66's representative specifying the state bed-hold policy and number of bed-holds available however, they did not have any documentation. During a face-to-face interview on 03/07/24 at 9:29 AM, Employee #4 (Social Services Director) stated that the written notice of bed-hold policy and number of bed-hold days was done by Admissions Department. I am not sure who does that (provide bed-hold policy/days) on the off hours or weekends. A face-to-face interview was conducted on 03/07/24 at 11:05 AM with Employee #12 (Admissions Director) and Employee #13 (Director Sales and Marketing). Employee #12 stated, The process is to review and check the nurse's notes and physician's orders to see what residents were transferred out. The residents who were transferred out are then discussed during stand down meeting (conducted on weekdays), at which time, a 6-108 [Notice of discharge, transfer, relocation] form is generated. I can't answer as to why Resident #66 does not have one for February [2024]. I was told that it was completed, but the ball was dropped on that one. Cross Reference 22B DCMR Sec. 3270.1 (Facility staff failed to discharge Resident #66 in accordance with the Nursing Home and Community Resident's Protection Act of 1985 (District of Columbia Law 6-108)).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to complete a quarterly (every 3 months) assessment for Resident #72. The findings included: Review of the facility's contracts showed that [Company name], effective on 02/12/24, was responsible for completing the facility's Minimum Data Set (MDS) assessments. The contract documented: - [Company Name] shall provide the facility with ongoing MDS department support, specifically, to organize, review, encode and confirm timely completion of all admission, quarterly, annual and significant change in status MDS assessments. Resident #72 was admitted to the facility on [DATE] with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 3, Dysphagia, Aphasia, Pain, and Cerebral Infarction. Review of Resident #72's MDS transmittal sheet provided to this surveyor on 03/08/24 documented: - Annual MDS assessment - dated 10/03/23 showed Accepted, indicating that it was accepted by Center for Medicare and Medicaid Services (CMS). - Quarterly MDS assessment - with an assessment reference date (ARD) of 02/16/24 showed In progress, indicating that it had not been completed by facility staff. It should be noted that this Quarterly assessment should have been completed within 14 calendar days of the ARD (03/01/24). However, review of Section Z (Assessment Administration) of the Quarterly MDS with an ARD of 02/16/24 documented: Sections A1005 (Ethnicity), A1010 (Race), and A1110 (Language) were not completed until 03/04/24 (3 days late). During a telephone interview on 03/14/24 at 12:36 PM, Employee #21 (Director of MDS Support Systems) stated, There is a 14-day window from the ARD to complete all the information in all sections of the assessment. Anything after that time frame is considered late. If the ARD end date is February 16th, [2024] and the section is signed on March 4th, [2024], per the regulation, yes, that is considered late. The evidence showed that facility staff failed to complete a quarterly MDS assessment every 3 months for Resident #72.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47555 Based on record review and staff interviews for one (1) of 41 sampled residents, facility staff failed to have documented evidence a resident's Admission Minimum Data Set (MDS) Assessment was completed as evidenced by not coding the resident's cognitive patterns in Section C. Resident #89. The findings included: Resident #89 was admitted to the facility on [DATE] with multiple diagnoses that included: Cerebral Infarction and Multiple Sclerosis. Review of Resident #89's medical record revealed: An Annual MDS assessment dated [DATE] documented: Section C - Cognitive Patterns, Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be conducted? 1. Yes. However, there was no documented evidence that facility staff conducted the BIMS, as evidenced by Sections C0200, C0400 and C0500 were blank. Additionally, there was no documented evidence of the resident's BIMS summary score that indicated the resident's cognitive status. During a face-to-face interview conducted on 03/07/24 at 2:07 PM, Employee #4 (Director of Social Services) reviewed the Admission MDS and stated that it was her role to complete section C (Cognitive Patterns) which she completes on the day residents are admitted or the next day. As of the date of this interview (38 days after Resident #89's admission), facility staff had not completed the previously mentioned section of the Admission MDS.

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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** 43776 45102 Based on record review and staff interview, for two (2) of 41 sampled residents, facility staff failed to develop a care plan with goals and approaches to address a resident's use of a central intravenous (IV) line and a cholecystectomy tube and failed to implement a resident's care plan intervention for falls. Resident #66 and Resident #71. The findings included: Review of the facility's Interdisciplinary Care Plans policy, last reviewed on 11/10/22, it documented: - An individualized interdisciplinary care plan will be maintained for each resident. - Information recorded on the care plan includes date problems and/or needs first addressed, active problems and current needs of the resident. 1. Facility staff failed to develop care plans with goals and approaches for Resident #66's use of a central intravenous (IV) line and a cholecystectomy tube. Resident #66 was admitted to the facility on [DATE] with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia. Review of the resident's medical record revealed the following: A Health Status Note dated 02/14/24 at 4:21 PM that documented: - Resident was readmitted from [Hospital name] to the facility. - Central line placed on 02/09/24 on the right upper arm. - Resident underwent Cholecystostomy tube placement on 02/04/24. - Right gallbladder drainage bag. Physician's orders dated 02/14/24 directed: -Cholecystectomy tube care (abdomen, right upper), flush with 10 ml (milliliters) of 0.9 Sodium Chloride two times a day; irrigate with 60 CC's (milliliters) of saline every shift. -Peripherally inserted central catheter (PICC), 1 lumen brachial right, for antibiotic treatment; monitor PICC line dressing daily for redness, swelling and drainage every shift; change PICC line dressing every week, every evening shift every on Friday. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #66's medical record on 03/07/24, (22 days after readmission) showed no documented evidence that facility staff developed a comprehensive resident-centered care plan with goals and approaches to address the Resident's use of a PICC or the cholecystectomy tube with a drainage bag. During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, Those care plans should've been started on readmission (02/14/24). 2. Facility staff failed to implement Resident #71's care plan interventions for falls. A Facility Reported Incident (FRI), DC~11512, submitted to the State Agency on 01/17/23, documented the following: Charge Nurse called writer to room [ROOM NUMBER]b to see Resident lying on the floor on her back with a pillow under her head at 5.10 am. When asked what happened Resident stated that two men carried her on the wheelchair to upstairs. Resident is alert and responsive with intermittent confusion. Head to toe assessment was done. A small cut noted on left side of the head with minimal bleeding. Area measured 0.1 cm (centimeters) and no depth. Area was cleansed. Ice pack applied. Resident #71 was admitted to the facility on [DATE], with multiple diagnoses that included: Parkinson's Disease, Cognitive Communication Deficit, and Personal History of Non-[NAME] Lymphomas. During an observation on 03/04/24 at approximately 10:15 AM with Employee #7 (Licensed Practical Nurse/LN), Resident #71 was noted in her room lying in bed with the head of bed raised and bed in lowest position. The following was observed: -The call light device was hanging in a loop, on the wall behind the bed, not within the resident's reach. -The bedside table was noted at the foot of the bed with a thermos cup on top of it not within the resident's reach. -A floor mat was noted on the left side of the bed, however, there was not one on the right side of the bed. Instead, a floor mat was noted rolled up, placed against the wall and covered by a white sheet. At the time of the observation, the State Surveyor asked Resident #71 if she was able to press the call light for assistance and the resident stated she does not know where the call light is. A review of Resident #71's medical record revealed the following: A physician's order dated 01/17/23 directed, Floor mats (left and right) to bedside when resident is in bed every shift for safety. A Quarterly MDS assessment dated [DATE] showed that the facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 10 indicating moderate cognitive impairment; was totally dependent on staff for toileting, bathing and dressing; and had 2 falls since the last MDS assessment. A care plan dated 01/09/24 documented, Focus Area: Falls- [Resident #71] had an alleged fall on 1/8/2024. Interventions included: Continue to monitor resident. Continue to educate resident on the use of call light. Encourage resident to call for help when needed, Call light within reach and Floor Mats at bedside when resident is in bed for safety q (every) shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The evidence showed that facility staff failed to implement the following interventions of Resident #71's care plan: call light within reach and floor mat at the bedside. During a face-to-face interview at the time of the observation, Employee #7 acknowledged the findings, placed the call light and bedside table within the resident's reach, and placed the floor mat bedside the resident's bed. Cross Reference 22B DCMR Sec. 3210.4

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to ensure that Resident #52 received care to prevent pressure ulcer development that was first observed at a Stage 3. This deficiency resulted in actual harm to Resident #52 on 02/28/2024. The findings included: Review of the facility's Wound Care Consultant Contract dated 09/14/22 documented,The Wound Care Consultant agrees to serve as the Wound Care Consultant to coordinate medical care in the facility and provide clinical guidance and oversight regarding wound care; provide diagnosis and treatment recommendations for wounds; and sign and date all orders, such as medications. Review of the facility's Pressure Ulcers, Prevention and Care policy revised on 11/10/22 documented: - Skin integrity alteration will be reported to the physician for treatment orders. - Classification of pressure ulcers: Stage 2: a partial thickness of skin is lost (epidermal layer has been lost, but dermis is at least partially intact); may present as blistering surrounded by an area of redness and/or indurations. Stage 3; a full thickness of skin is lost, exposing the subcutaneous tissues; present as a shallow crater (unless covered by eschar - thick brown, black or yellow crust); may be draining. There is also depth at this stage. - A specific plan of care must be developed by nursing and the interdisciplinary care team. Review of the Resident Assessment - Pressure Injuries policy revised on 11/10/22 documented, Accurate assessments addressing each resident's skin status will be conducted by qualified staff and correctly documented in the medical record; and a qualified health professional will document the presence, number, stage and pertinent characteristics of any pressure injury on the wound documentation form in the medical record. Resident #52 was admitted to the facility on [DATE] with diagnoses that included: Adult Failure to Thrive, History of Falling, and Muscle Weakness. Review of the resident's medical record revealed the following: A face sheet that showed Resident #52 had listed a legal guardian, substitute decision maker and emergency contact #1. Physician's orders dated 01/19/24 directed: Apply barrier cream to sacrum, buttocks and peri-area every shift for skin protection; weekly skin assessment, every evening shift every Friday; resident to have shower every day shift, every Monday and Thursday, Licensed nurse will validate and ensure skin assessment is completed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Hospital Discharge Summary dated 01/27/24 documented: - Admission on 01/20/24 at 1:57 PM. - Chief complaint - altered mental status, low oxygen and blood pressure. - Physical exam at discharge - skin: warm and dry. A Readmission Note dated 01/27/24 at 9:01 PM documented: - Resident readmitted into the facility. - Warm to touch skin, mass around the mid-arm and in the inguinal area was noted, IV (intravenous) related bruises on bilateral upper arm were noted. A Readmission Braden Scale Evaluation dated 01/27/24 documented: - Resident's score 11. - Interpretation of score: 10-12 indicates high risk. - Continue current plan of care. A care plan documented: [Resident #52] has impaired skin integrity related to bilateral upper arm bruises/mass in the mid arm/inguinal area that was initiated on 01/27/24. A Focused Observation Note dated 01/30/24 at 11:21 PM documented, complete bed bath given, no new skin issue noted. A quarterly Braden Scale (a tool used to foster early identification of residents at risk for developing pressure ulcers) dated 02/01/24 at 5:42 PM documented: - Resident's score 11 (interpretation of score: 10-12 indicates high risk). - No referrals necessary. - Continue current plan of care A physician's order dated 02/02/24 directed, Turning and repositioning every 2 hours as tolerated and PRN (as needed) every shift. A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 07 indicating severe cognitive impairment; no rejection of care behaviors; required substantial/maximal assistance for toileting hygiene, shower/bathing; frequently incontinent of bowel and bladder; at risk for pressure ulcers/injuries; and had no unhealed pressure ulcers/injuries, wounds or other skin problems. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A [nursing] Skin Observation Tool Assessment on Tuesday, 02/06/24, at 8:20 PM documented, complete bed bath given, no new skin issue noted. A [nursing] Skin Observation Tool Assessment on Tuesday, 02/13/24, at 10:53 PM documented, Complete bed bath given. A Skin Observation Tool Assessment on Friday, 02/16/24, at 11:55 PM documented, complete bed bath given, no new skin issue noted. A [nursing] Skin Observation Tool Assessment on Friday, 02/23/24, at 10:37 PM documented, complete bed bath given, no new skin issue noted. A care plan focus area: The resident has limited physical mobility r/t (related to) weakness, that was initiated on 02/23/24 had approaches/interventions that included, monitor/document/report any s/sx (signs and symptoms) of immobility: contractures forming or worsening, skin-breakdown. The Treatment Administration Record (TAR) for February 2024 showed that on Monday, 02/26/24, facility staff documented a check mark and their initials to indicate that Resident #52 had a shower and that the nurse validated and ensured that a skin assessment was completed. A Nursing Progress Note dated 02/26/24 at 2:24 PM documented: - Upon assessment, skin is dry and warm to touch. - Resident turned and repositioned every 2 hours for comfort and pressure relief. A care plan focus area: [Resident #52] is at risk for bladder incontinence related to deconditioning that was initiated on 02/26/24, that had approaches/interventions that included, weekly skin assessment. An Attending Physician's note on Tuesday, 02/27/24, at 10:58 AM documented: - Subjective: [Resident #52] spends most of her time in bed because she has become frailer. There have been no new issues regarding her care. - Objective: remains a well-developed thin black female, in no acute distress when seen. There are no new labs available for analysis. - Assessment: continues to do well and remains clinically stable. We will continue with the current management. A [nursing] Skin Only Evaluation Note on Tuesday, 02/27/24, at 10:50 PM documented: - Skin warm & dry, skin color within normal limits (WNL) and turgor is normal; complete bed bath given, no new skin issue noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Care Physician's Note on Wednesday, 02/28/24, at 8:16 AM documented: Wound rounds: Stage 3 sacral decubitus ulcer, moderate drainage with necrotic tissue and slough; Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl (debridement agent used on dead tissue) ointment and dry dressing daily. Although the Wound Care Physician documented a treatment order for Resident #52's new Stage 3 sacral ulcer, the medical record lacked documented evidence that the resident's primary care physician was notified about Resident #52's new Stage 3 sacral pressure ulcer/wound on 02/28/24. As a result, no new orders or interventions were implemented until 03/01/24 (over 48 hours later). A Skin Only Evaluation Note dated 02/29/24 at 4:45 PM documented, Skin warm & dry, skin color WNL (within normal limits) and turgor is normal; no skin issues; complete bed bath given. Review of the February 2024 Treatment Administration Record (TAR) dated from 02/01/24 to 02/29/24 showed that facility staff documented a check mark and their initials to indicate that Resident #52: 1. Received a shower everyday shift on Mondays and Fridays and that a licensed nurse validated and ensured that the skin assessment was completed. 2. Received weekly skin assessments every Friday on the evening shift; and 3. Barrier cream was applied to the resident's sacrum, buttocks, and peri-area every shift for skin protection. A Health Status Note dated 03/01/24 at 2:25 PM documented: - Resident remains alert and verbally responsive with intermittent confusion and generalized weakness. - Upon assessment skin is dry and warm to touch. - Resident turned and repositioned every 2 hours for comfort and pressure relief. A [nursing] Skin Only Evaluation Note dated 03/01/24 at 3:06 PM documented, Skin warm & dry, skin color WNL and turgor is normal; no skin issues; complete bed bath given. A physician's order dated 03/01/24 at 3:32 PM directed, Dakin's 1/2 strength External Solution 0.25 % (Sodium Hypochlorite) cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl and cover with border gauze daily. A physician's order dated 03/01/24 at 3:38 PM directed, Santyl External Ointment 250 Unit/GM (gram), apply to sacral ulcer topically everyday shift for wound care. A Wound Care Physician Note dated 03/04/24 at 8:18 AM documented: - Late Entry: created on 03/07/24 at 8:21 AM. - [AGE] year-old female with cachexia (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Stage 3 sacral decubitus ulcer. Decreased slough and drainage. 8 cm (centimeters) long by 6 cm wide by 2 cm deep. - Plan: Continue Santyl dressings daily. A Skin Observation Tool assessment dated [DATE] at 1:08 PM documented: - Site: Sacrum - Type: Pressure - Length: 8 cm - Width: 6 cm - Stage II (Stage 2) [It should be noted that wound care physician staged the resident's sacral wound as a Stage 3 on 02/28/24.] - Notes: Cleanse with [NAME] solution, apply Santyl. Cover with dry gauze. A Health Status Note dated 03/06/24 at 7:56 AM documented: - Fluids offered but poorly tolerated encouraged to take more fluids but refused after several attempts. - Resident on oxygen at 2 liters via nasal cannula for shortness of breath for shortness of breath. - A call was placed to medical doctor in reference to resident with poor intake with order to transfer resident to the nearest emergency room for evaluation and treatment. - A call was placed and spoke with the resident's representative. A Health Status Note dated 03/06/24 at 10:52 PM documented: - Call placed to [Hospital name] at 10:30 PM to check on resident status, resident has been admitted . During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) stated, Skin assessments are done weekly in PCC (Point Click Care, the facility's electronic health record system). That form is used to assess the wound for any changes. Once a new wound area is observed, the process is to immediately call the medical doctor and get new orders. The nurse will write a progress note with a description of the wound that includes size, location, drainage, what the surrounding area looks like and then also indicate that the family was notified. A new care plan is either initiated or revised. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director/Resident #52's primary physician) stated, The wound doctor is allowed to put in orders. Any provider that provides services at this facility is credentialed and can put in orders. I can't answer as to why [Wound Doctor] did not directly put in the wound care orders. I did see the resident (on 02/27/24). The nursing staff did not communicate any skin issues to me, and I did not turn her over to do any assessment of her skin during my time with her. During a face-to-face interview on 03/20/24 at approximately 12:30 PM, Employee #1 (Administrator) and Employee #2 acknowledged the findings. Cross reference 22B DCMR Sec. 3211.1 (Facility staff failed to ensure that Resident #52 received sufficient nursing care and services to prevent pressure ulcer development that was first observed at a Stage 3.)

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F 0689 Level of Harm - Minimal harm or potential for 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** 41645 Based on observation, record reviews, staff interviews, and a family interview, for one (1) of 41 sampled residents, the facility's staff failed to provide adequate supervision for a resident. As a result, the resident left the facility without staff knowledge (Resident #192). The findings included: Review of the policy titled, Missing Resident #99M-010, documented, A resident is considered missing from the facility whenever their whereabouts cannot be ascertained. This situation is an elopement. Resident #192 was admitted to the facility on [DATE] with multiple diagnoses including: Encephalopathy, Seizures, Muscle Weakness and Cirrhosis of the Liver. Review of the medical record revealed the following: A care plan dated 01/01/23 that documented, Problem: [Resident #192] has risk for Elopement related to wandering evidenced by trying to enter the elevator. Goal: Resident will not elope. Approach: Monitor resident's movements closely while out of bed. Encourage resident to verbalize feelings of boredom/loneliness at all times. Encourage resident to participate in group activities of choice. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the following: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating the resident had an intact cognitive status. Additionally, the resident was coded for requiring supervision from staff with activities of daily living. A Facility Reported Incident Intake form (DC~11829) received by the State Agency that was dated 04/04/23 at 10:59 AM documented the following but not limited to: At 6:55 am, resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink (Missing Resident) was initiated and 911 was called at 7:20am and residents detailed information provided to the police. A search team comprising of nursing staff and security were dispatched to search the community area, especially at the bus stops and metro stations. Resident [was] wearing a white sweat pants and white hooded top long sleeve sweater. Temperature outside at the time is 58 degrees at 7:30 am. MD (medical director), DON (Director of Nursing), and the responsible party (ex-wife) was notified. Eventually we got a call from the facility security that the police found resident. Investigation is still in the process. Please note, According to World Weather, the temperature in the District of Columbia on 04/04/23 during the daytime ranged from 55 to 75 degrees (Fahrenheit). https://world-weather.info/forecast/usa/washington_1/april-2023/ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 04/04/23 at 11:22 AM documented, Resident was received in bed at 11:00 pm, alert, oriented and verbally responsive. During routine round, Resident was in bed through the night. Breathing even and unlabored. No sign of respiratory distress or shortness of breath noted. No complain of pain or discomfort voiced. Around 5:30 am when I pushed my medication cart down the hall to start from room [ROOM NUMBER] where I normal start. Resident was in his room. When I got to his room at 6:40 am to give him his medication, I could not see him, I checked the bathroom, he was not there, then I alert other staffs and the supervisor, then called the security officer to found out if Resident left the facility. The staffs(sp) begin to search for him all rooms and bathrooms. I left the facility with other staffs in search of him to nearby bus-stops and metro stations. A nursing supervisor note dated 04/04/23 at 12:16 PM documented that, At 6.55 am, I was informed that the resident in room [ROOM NUMBER]B was not in his room. The security was alerted, all the rooms were searched. Code pink was initiated. 911 was called at 7:20am and information about resident given. Search team comprising of nursing staff and security were dispatched to search for him around bus stops and metro stations. The DON was notified. [Responsible party's name] was called, and she said [resident's name] call(ed) her from bus stop around the facility. The search team converged around the community area. Eventually we got a call from the facility security that the police found resident at a bus stop. Upon returning to the facility, resident was found at the parking lot accompanied by the police officer. At this point, resident refused coming into the facility, it took about 40 to 45 minutes to encourage and convince resident to come into the facility. At 8:50am, [Resident's name] returned to the unit after much encouragement. Resident remains alert and verbally responsive, not in acute distress. Head to toe assessment done. Denied pain, no discomfort noted. Skin warm to and dry. Respiration is even and non-labored. Temperature 98.0, Pulse 62, Respirations 18, Blood Pressure 128/81, Oxygen Saturations 96%. When asked why he eloped from the facility, resident stated that he does not want to stay here and verbalized that he will walk out again. New order given to monitor resident one on one until seen by the psychiatric team. Close monitoring in progress and maintained. According to the investigation packet, the following employees wrote statements dated 04/04/23:? Employee #14 (CNA) documented, I [employee's name] worked last night April 3, 2023, and [resident's name] was assigned to me. The last time I saw [resident's name] was at 5:30 AM in his room. We the nurses on the night shift on unit (Unit2) left the floor and went to the street and metro station looking [for him] after he left the facility. We did not find him. Employee #15 (Housekeeping Director) documented, I [employee's name] entered the building at 5:36 AM, after signing in on the covid machine (kiosk) I walked thru the door (left of the security desk) leading to the bird (cage) area and a resident wearing a white sweat suit and carrying a bag was coming off of Unit 1. I asked where he was going, and he stated that his brother was picking him up front up front. He continued to the front desk area where security was sitting. Continued review of the facility's investigation packet showed Employee #16 (Security Guard) wrote an Incident Report dated 04/04/23 that documented, [Resident daughter's name] called [Facility name] at 6:44 AM and confirmed [resident's name] was at the bus stop. I went to go look for [resident's name] at the bus stop and I returned to the nursing home at 7:20 AM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A psychiatric nurse practitioner note dated 04/05/23 at 6:58 PM documented that, Resident seen secondary to elopement on 04/04/23 and review of 1:1 monitoring order. [Resident stated] 'I have been here for too long; I was told at the other facility that I could leave.' Remains on 1:1 monitoring. Alert and oriented to place, person, time, and situation. Does not present with any psychiatric disorder. Pleasant, not confused but appears to make poor and irrational judgement occasionally. Ambulates with steady gait. Continue 1:1 monitoring every shift for now and reassess for elopement risk in 4-5 days. Encourage participation in different activities on unit. A State Survey Agency Complaint Intake (DC~11872) dated 04/10/23 at 3:30PM documented: - It was on April 4, 2023 [Resident #192] called me at 7:00 AM stating that he's out of the nursing home and was at a bus stop and didn't know what bus stop or where. - I called the nursing home asking them was my husband in the facility, because he called and told me that he's at a bus stop. They asked me what bus stop he was at and for his cell phone number. - I called [Resident #192] back, an officer from MPD (Metropolitan Police Department) got on the phone and stated that they were at the Metro Cener train station (approximately 3.1 miles from the facility). - The officer agreed to hold him. My daughter went and picked him up from Metro Center and took him back to the nursing home. - I feel that this is a neglect on the staff that's on the 2nd floor where he's on and security for allowing him to get out. Review of Employee #16's (Security Guard) personnel record showed the employee was hired on 05/16/22. The employee signed his initials on the Training Checklist dated 05/17/22 indicating he received training on Never leaving the front desk unattended. Moreover, the employee signed an Employee Warning Notice dated 04/12/23 that documented that, Date of incident 04/03/23 between 5AM to 5:30 AM. [Employee's name] you [were] supposed (sp) to been (sp) posted at the front desk during this time [resident's name] from room [ROOM NUMBER] walked thru the lobby past the front desk and out of the front door which caused an elopement. On 03/08/24 at approximately 11:00 AM, an observation of the lobby area revealed a security desk located adjacent to the facility's front door. At the time of the observation, a security guard and receptionist were seated at the desk. Behind the security desk, was a closet that's used by security staff. Additionally, there was a three-ring binder labeled Wanders and a security logbook (where security staff write notes about rounds and concerns in the facility) was noted on the desk. The security logbook lacked documented evidence of Resident #192's elopement incident on 04/04/23. During a telephone interview on 03/13/24 at 8:30 AM, Employee #17 (Nursing Supervisor) stated that Resident #192's assigned nurse called and informed her that staff could not locate the resident (on 04/04/23). After Employee #16 (Security Guard), who was posted at the front desk of the lobby, informed her that he did not see the resident leave out the front door, she called a Code Pink and continued looking for the resident with other staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/13/24 at 9:30 AM, Employee #16 (Security Guard) stated that he believed when he walked into the closet behind the security desk, the resident exited the facility through the front door. The employee stated that he was wrong for leaving the front desk unattended. He should have called the other security guard to cover the front desk. The employee also stated that he wrote an incident report related to Resident #192's elopement, and he thought he wrote the information in the security logbook. During a face-to-face interview on 03/13/24 at approximately 10:00 AM, Employee #18 (Security Supervisor) stated that Employee #16 (Security Guard) did not follow the company's policy when he left his post at front desk unattended on 04/04/23. He was to call the other security guard in the building to cover his post. Employee #18 reviewed that logbook and stated that she did not see documented evidence that Employee #16 documented Resident #192's elopement incident. When asked if that incident should have been documented in the logbook, Employee #18 replied Yes.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on observation, record review and staff interviews, for one (1) of 41 sampled residents, facility staff failed to follow the physician's order to change Resident #66's peripherally inserted central catheter (PICC) line dressing every Friday. The findings included: Review of the facility's PICC/Midline/CVAD (central venous access device) Dressing Change policy dated 10/05/22, it documented: - It is the policy of this facility to change PICC, midline or CVAD dressing weekly or if soiled, in a manner to decrease potential for infection. - Physician's orders will specify type of dressing and frequency of change. Resident #66 was admitted to the facility on [DATE] with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia. Review of Resident #66's medical record revealed: A Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 03, indicating severely impaired cognitive status. A Health Status Note dated 02/14/24 at 4:21 PM that documented: - Resident was readmitted from [Hospital name] to the facility. - Central line placed on 02/09/24 on the right upper arm. Physician's order dated 02/14/24 directed, - PICC, 1 Lumen brachial right, for antibiotic treatment, monitor PICC line dressing daily for redness, swelling and drainage every shift. - Change PICC line dressing every week, every evening shift, on Friday. Review of the Treatment Administration Record (TAR) for February 2024 showed facility staff documented a check mark and their initials to indicate that the central line dressing change was completed on Friday, 02/16/24, Friday, 02/23/24 and on Friday, 03/01/24 and that they were monitoring the dressing site every shift. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/04/24 at 10:30 AM with Employee #5 (Licensed Practical Nurse/LPN), Resident #66 was observed with a single lumen PICC to his right upper arm with a dressing that was dated, 2/9/24. When asked why the resident's central line dressing had not been changed since 02/09/24, the employee stated, The dressing does not get changed on my shift (day shift, 7:00 AM - 3:30 PM) and only a Registered Nurse (RN) is allowed to change the dressing. I will get an RN to come and change the dressing now. The evidence showed that from 02/14/24 to 03/04/24, facility staff failed to follow the physician's order to change Resident #66's central line dressing. It should be noted that the last documented central line dressing change was performed by hospital staff on 02/09/24. The first-time facility staff changed Resident #66's central line dressing was on 03/04/24 (24 days after the resident's readmission). During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, The physician's order was not followed and the nurses documented that they did something they in fact did not complete. Cross Reference 22B DCMR Sec. 3211.1 (Facility staff failed to ensure that sufficient time was given ensure that Resident #66's central line dressing was changed as ordered by the physician.)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27689 Based on record review and staff interview, for one (1) of 1 residents sampled for pain management, facility staff failed to ensure that Resident #243 received effective pain assessments/evaluation for a known left hip fracture. The findings included: According to National Institute of Health (NIH): - Assessment of pain is a critical step to providing good pain management. - Nurses working with patients with acute pain must select the appropriate elements of assessment for the current clinical situation. - The most critical aspect of pain assessment is that it is done on a regular basis (e.g., once a shift, every 2 hours) using a standard format. The assessment parameters should be explicitly directed. - To meet the patients' needs, pain should be reassessed after each intervention to evaluate the effect and determine whether modification is needed. The time frame for reassessment also should be directed. - Pain assessment should include intensity, location, and quality. https://www.ncbi.nlm.nih.gov/books/NBK2658/ Review of the facility's Pain Management policy (not dated) showed: - The facility will provide optimal pain control, assessment, and monitoring for all identified residents with pain. - Pain will be measured on a 0-10 scale. Cognitively impaired residents will be assessed utilizing behavioral or visual indicators. - Pain assessment will occur with the onset of new pain. Review of the facility's Documentation Criteria policy revised on 07/22/22 showed: - Clinical notes for pain control include location, severity, quality, duration, and cause. - Note when pain medication is given (very important) and note if/when pain relief is obtained and length of relief. Resident #243 was admitted to the facility on [DATE] with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's medical record revealed the following: A care plan focus area: [Resident #243] has chronic pain to back and knees related to Osteoporosis, that was initiated on 05/16/19, had interventions that included: administer medications as ordered. Monitor and record effectiveness; monitor and record any complaints of pain: location frequency, intensity, effect on function, alleviating factors, aggravating factors; monitor and record any non-verbal signs of pain (guarding, withdrawal, crying, restlessness, etc.). A physician's order dated 05/24/19 directed: Turn and reposition every 2 hours, every shift. A care plan focus area: [Resident #243] has complaints of acute pain to right hip related to post fall, that was initiated on 07/07/21, had interventions of: administer medication routine and as needed, as ordered. Evaluate/record/report effectiveness. Monitor and record any complaints of pain: location frequency, intensity. Monitor and record any non-verbal signs of pain (guarding, restlessness). Handle gently and try to eliminate any environmental stimuli. A physician's order dated 08/16/21 directed: Tramadol (narcotic pain reliever), 100 mg (milligrams), 1 tablet, twice a day PRN (as needed) A physician's order dated 08/19/21 directed: Monitor pain every shift. A physician's order dated 03/23/23 directed: Tramadol 50 mg, twice a day. A physician's order dated 04/07/23 that directed, Acetaminophen (pain reliever) 500 mg, 2 tablets three times a day, as needed for pain. An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 12, indicating mild cognitive impairment; received scheduled pain medication regimen; no falls since the prior assessment and did not receive any opioid medications. A Pain Assessment Note dated 05/29/2023 at 5:51 PM documented: - Pain site - left lower extremity. Received scheduled pain medication regimen. - Resident pain interview intensity rating on the Numeric Rating Scale (0-10) 3. - Resident pain interview: verbal descriptor scale severe. A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - Resident refused to be assessed by the nurse supervisor, she said she will be fine but verbalized feeling pain to the left thigh, 4/10. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A physician's order dated 05/29/23 directed Left hip/left knee x-ray A Nursing Progress Note dated 05/30/23 at 6:50 AM documented: - Range of motion within normal limits bilateral upper and right lower extremities with limited mobility left lower extremity. - Denies any pain at rest but complained of moderate pain with guarding to left hip upon assessment. Given PRN Tylenol (Acetaminophen) 1000 mg with good effect. - X-ray to left hip to be done in the morning. Left knee x-ray result dated 05/30/23 at 1:21 PM documented: - No acute fracture, dislocation or degenerative disease. -There is soft tissue swelling and vascular calcification. Left hip x-ray result dated 05/30/23 at 1:21 PM documented: - There is a fracture of the neck of the proximal femur without significant displacement. - Clinical Correlation and follow-up imaging recommended as indicated. A Nursing Progress Note dated 05/30/23 at 2:01 PM documented: - X-ray for left hip/knee done this shift, results received: No acute fracture, dislocation or degenerative disease, there is a swelling tissue and vascular calcification. - Physician's Assistant (PA) made aware; no new order given. - Resident was able to get transferred from the bed to wheelchair with assistance. It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture. The Restorative Point of Care documentation dated 05/30/23 showed that Resident #243 received 15 nursing minutes of walking on the day shift (7:00 AM - 3:30 PM). A Nursing Progress Note dated 05/30/23 at 11:37 PM documented: - Day 1 post fall, pain to left hip/knee. Routine pain medication administered as ordered. (continued on next page)

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

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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 0697 Level of Harm - Actual harm Residents Affected - Few	The Treatment Administration Record (TAR) showed that on 05/30/23, day shift (7:00 AM - 3;30 PM), facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the same date and shift also showed that in the section that directed, monitor for pain every shift, Employee #7 documented her initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture. The TAR also showed that on 05/30/23, evening shift (3:00 PM - 11:30 PM), facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the same date and shift also showed that in the section that directed, monitor for pain every shift, facility staff documented their initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture. A Night Shift (11:00 PM - 7:30 AM) Nursing Progress Note dated 05/31/23 at 6:56 AM documented: - Range of motion within normal limits bilateral upper and right lower extremities with limited mobility left lower extremity. - Complaints of pain upon assessment. Given Tramadol 50 mg with good effect. No visible injuries noted. - Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift to follow-up with primary physician. It should be noted that although the employee documented that Resident #243's left hip x-ray results showed a fracture, he failed to notify the resident's primary care physician. The TAR showed that on 05/30/23, night shift, facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours. The TAR for the same date and shift also showed that in the section that directed, monitor for pain every shift, facility staff documented their initials to indicate that this task was completed however, there is no evidence that the pain characteristics such as intensity, pattern, frequency, and duration were assessed even though the resident had a known left hip fracture. A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM, written by Employee #8 documented: - Status post fall, no bruise, no redness noted. - Resident guarding her left leg/hip. Medicated for complaints of pain to left upper leg with Tramadol 50 mg and effective. - Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Please follow-up with primary medical doctor. (continued on next page)

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Stoddard Baptist Nursing Home	1818 Newton St. NW Washington, DC 20010

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F 0697

Level of Harm - Actual harm

Residents Affected - Few

It should be noted that although Employee #8 documented that Resident #243's left hip x-ray results showed a fracture, she failed to notify the resident's primary care physician.

The Restorative Point of Care documentation dated 05/31/23 showed that Resident #243 received 15 nursing minutes of walking on the day shift.

The TAR showed that on 05/31/23, day shift, facility staff documented their initials to indicate that they were turning and repositioning Resident #243 every two hours.

A Nursing Progress Note dated 05/31/23 at 12:22 PM documented:

- Status post fall, order given on 5/29/23 as follows: left hip/ Left knee x-ray to rule out fracture. X-ray result received and indicated a fracture of the neck of the left proximal femur without significant displacement.

- [Physician's Name] made aware, new order given to transfer resident to the nearest emergency room for further evaluation of fracture of the neck of the left proximal femur.

- 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware of before and after transfer.

A Hospital Discharge Summary dated 06/12/23 at 6:00 AM documented:

- 05/31/23 - Computed Tomography (CT) Scan of pelvis without contrast: acute appearing mildly impacted subcapital left femoral neck fracture.

- Percutaneous fixation of left femoral neck fracture completed (the insertion of pins or wires through the skin to hold the bones in a proper position while they heal).

During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN who worked on 05/30/23, day shift) stated, The process for when x-ray results are received is to call the medical doctor with the results. I don't think I received both results for [Resident #243] at the same time, or else I would have documented the results in my note. When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time.

During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Supervisor who worked on 05/30/23) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated that the facility did not have a physicians on-call list [list of physicians to call on specific days and time frames]. The employe also said Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00-7:30 AM because most of the doctors get angry when we call them in the middle of the night.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated, There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. If there's an abnormal result that is not critical, it makes sense to call in the morning and not at 3:00 AM. If there is an abnormal lab, x-ray, or incident, that should be reported to the provider during that shift when it happens. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts. During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (DON) acknowledged the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43776 Based on observations and staff interviews, for two (2) of two (2) oxygen storage rooms, facility staff failed to ensure that empty oxygen tanks were not stored in the same area as full oxygen tanks intended for patient use. The findings included: According to the Joint Commission: - Storing oxygen cylinders, as per the National Fire Protection Association (NFPA) 99-2012, 11.6. 5.2, is about ensuring full and empty cylinders are not comingled. - Those cylinders defined as 'empty' by the organization shall be segregated from all other cylinders that are intended for patient care use. https://www.jointcommission.org/standards/standard-faqs/home-care/environment-of-care-ec/000001261/#:~:text=Storing%20oxygen%20cylinders%2C%20as%20per,intended%20for%20patient%20care%20use. 1. An observation on 03/05/24 at 10:09 AM of the 2nd floor oxygen storage room, with Employee #22 (Licensed Practical Nurse/LPN) showed, one (1) empty oxygen tank was stored in the same area with four (4) full oxygen tanks that were stored for resident use. At the time of the observation, Employee #22 stated, I'm not sure who checks the oxygen tanks in the supply room, but a nurse is supposed to look and check the tank before taking it out to use for a patient (resident), which means they shouldn't grab one if it's empty. Empty tanks are kept in the basement for pickup. 2. An observation on 03/05/24 at 10:47 AM of the 1st floor oxygen storage room with Employee #7 (LPN) showed two (2) empty oxygen tanks were stored in the same area with three (3) full oxygen tanks. At the time of the observation, Employee #7 stated, Empty [oxygen] tanks are stored downstairs. I would have to refer you to my DON (Director of Nursing) about whether empty and full oxygen tanks can be stored together. I will remove the empty oxygen tanks and bring them downstairs. During a face-to-face interview conducted on 03/05/24 at 10:56 AM, Employee #2 (DON) acknowledged the findings and stated, The facility did not have a policy or procedure for storage of oxygen tanks. Best practice is for whoever checks the code carts to also ensure that there are only full tanks in the oxygen storage room. Cross Reference 22B DCMR Sec. 3215.4(f) (Facility staff failed to ensure the effective and safe storage of equipment for administering oxygen.)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47555 Based on record review and staff interview, for one (1) of 41 sampled residents, facility staff failed to promptly notify the ordering physician of radiology results that fell outside of clinical reference range. Resident #243. The findings included: Resident #243 was admitted to the facility on [DATE] with diagnoses that included: Muscle Weakness, Other Abnormalities of Gait and Balance and Age-Related Physical Debility. Review of Resident #243's medical record revealed the following: An Annual MDS assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 12, indicating mild cognitive impairment and had no falls since the prior assessment. A Facility Reported Incident (FRI), DC~11996, received by the State Agency on 05/29/23 at 6:30 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A Nursing Progress Note dated 05/29/23 at 7:36 PM documented: - At 4:40 PM, the resident got up on her seat to give another resident a hug and she missed her step and fell on her left side. - The physician was called and gave an order for an x-ray of the affected leg. - Resident RP was called and was made aware of the fall accident. A physician's order dated 05/29/23 directed, Left hip/left knee x-ray. Left knee x-ray results dated 05/30/23 at 1:21 PM documented: - No acute fracture, dislocation or degenerative disease. Left hip x-ray results dated 05/30/23 at 1:21 PM documented: - There is a fracture of the neck of the proximal femur without significant displacement. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Clinical Correlation and follow-up imaging recommended as indicated. A Nursing Progress Note dated 05/30/23 at 2:01 PM written by Employee #7 (Licensed Practical Nurse/LPN) documented: - X-Ray for left hip/knee done this shift, results received: No acute fracture, dislocation, or degenerative disease. - Physician's Assistant (PA) made aware; no new order given. It should be noted that although Employee #7 documented that she received the results of the left knee/hip x-rays, she failed to inform the PA of the left hip fracture. A Night Shift Nursing Progress Note dated 05/31/23 at 6:56 AM documented: - Received results of left hip x-rays with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Morning shift (day shift, 7:00 AM - 3:30 PM) to follow-up with primary physician. A Night Shift Nursing Supervisor Note dated 05/31/23 at 8:47 AM written by Employee #8 (Night Shift Nursing Supervisor) documented: - Result of left hip x-rays received with impression of non-displaced fracture of neck of left proximal femur. Clinical correlation and follow-up imaging indicated. Please follow-up with primary medical doctor. A Day Shift Nursing Progress Note dated 05/31/23 at 12:22 PM documented: - Status post fall, order given on 05/29/23 as follows: left hip/left knee x-ray to rule out fracture. X-ray result received and indicated a fracture of the neck of the left proximal femur without significant displacement. - [Physician's Name] made aware, new order given to transfer resident to the nearest emergency room for further evaluation. - 911 called at 10:40 AM, resident left at 11:20 AM via stretcher. Representative made aware before and after transfer. The evidence showed that facility staff received Resident #243's left hip and left knee x-ray results on 05/30/23 at 1:20 PM, during the day shift (7:00 AM - 3:30 PM). There is no documented evidence that the assigned day shift nurse, Employee #7, made the resident's physician aware of the left hip x-ray result that showed fracture of the neck of the proximal [left] femur. The evidence also showed that on 05/30/23, the assigned night shift nurse and nursing supervisor both documented that Resident #243's left hip x-ray showed a fracture but neither notified the resident's physician or her representative. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was not until 05/31/23, at approximately 10:30 AM, 21 hours later, that facility staff notified Resident #243's primary care physician and their RP of the left hip x-ray results. During a face-to-face interview conducted on 03/12/24 at 12:20 PM, Employee #7 (Licensed Practical Nurse/LPN) stated, The process for when x-ray results are received is to call the medical doctor with the results. When asked if she received both x-ray results as documented in her progress note on 05/30/23 at 2:01 PM, she replied, I don't remember. I talked about the left knee, not both. So, I don't believe that I had both results at the time. During a telephone interview on 03/13/24 at 8:30 AM, Employee #8 (Night Shift Nursing Supervisor) was asked why there was no notification made to Resident #243's physician or their representative regarding the left hip x-ray result. The employee stated, We don't have an on-call list. Since I have been working here, the instruction has been to not call the medical doctors during the night unless there's an emergency and the patient is at risk of dying. We wait until around 7:00/7:30 AM because most of the doctors get angry when we call them in the middle of the night. During a face-to-face interview on 03/13/24 at 11:25 AM, Employee #6 (Medical Director) stated, There is no on-call schedule for the medical providers at this facility, but I am available 24/7. During off shifts (evening and night), nursing staff are to contact the assigned medical provider and if they can't reach them, then they are to call me. An x-ray result that comes back with a fracture, should not wait until morning, that should be reported immediately. Anything that affects the resident's well-being should be reported immediately. It has not been reported to me that there are any issues with reaching any of the medical providers during the evening or night shifts. During a face-to-face interview conducted on 03/13/24 at 12:25 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27689 Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 135 degrees Fahrenheit (F) on six (6) of six (6) observations, two (2) of two (2) convection ovens, and two (2) of two (2) grease fryers that were soiled throughout, ready-to-eat (RTE), open bags of foods such as two (2) of two (2) packs of cold cuts, one (1) of two (2) bags of shredded yellow cheese, three (3) of five (5) packs of sliced yellow cheese, one (1) of one (1) bag of feta cheese, one (1) of one (1) jar of applesauce stored in the walk-in refrigerator, that were not labeled to indicate a use-by ' date, pieces of frozen chicken that were being thawed improperly, and a sanitize water solution in the 3 compartment sink that tested below the recommended 200 parts per million (PPM). The findings include: Test tray food temperatures were inadequate as puree hot foods such as chicken (106.5), spinach (104.1), potatoes (105.8), and regular hot foods such as fried chicken (134.4), spinach (114.4), and potatoes (106.6) tested at less than 135 degrees. Cooking equipment such as two (2) of two (2) convection ovens, and two (2) of two (2) grease fryers, were soiled with cooked food residue. Ready-to-eat foods such as two (2) of two (2) open packs of cold cuts, one (1) of two (2) open bag of shredded yellow cheese, three (3) of five (5) open packs of sliced yellow cheese, one (1) of one (1) open bag of feta cheese, and one (1) of one (1) open jar of applesauce stored in the walk-in refrigerator, were not labeled to indicate a use-By ' date. Numerous pieces of chicken meat were submerged in a sink full of water for thawing, with no running water or water velocity to create constant movement. The water 'sanitize' solution from the three-compartment sink tested at less than 100 parts per million (PPM) on March 4, 2024, at approximately 10:30 am. The recommended water sanitize solution in the 3 compartment sink is 200 parts per million (PPM). These observations were acknowledged by Employee #9 during a face-to-face interview on March 11, 2024, at approximately 3:30 PM.

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47555 Based on record review and staff interviews, facility staff failed to provide documented evidence that the Nurse Staffing Agency used to supplement the facility's nursing staff was operating in compliance with applicable Federal, State, and local laws and regulations, as evidenced by providing services in the District of Columbia (D.C.) on an expired business license. The facility's census on the first day of the survey was 90. The findings included: A review of a letter addressed to [Nurse Staffing Agency's Name] dated [DATE] from the D.C. Department of Health documented, Enclosed is your Certificate of Licensure that covers the period [DATE], through [DATE]. A review of the Staffing Agency's business license issued by the District of Columbia revealed a license number with an expiration date of [DATE]. A review of the Service Contract between Nurse Staffing Agency and the facility, signed on [DATE] by Employee #19 (Chief Human Resources Officer) documented, Thank you for choosing [Nurse Staffing Agency's Name] to assist with your staffing needs. A review of the facility's invoices for the Staffing Agency revealed that the facility used 14 nursing staff (RN's, LPN's and CNA's) from [DATE] to [DATE], a combined total of approximately 150 shifts. During a face-to-face interview conducted on [DATE] at 1:04 PM Employee #2 (DON) reviewed the Nurse Staffing Agency's expired business license and stated, I didn't know their license was expired. During a face-to-face interview conducted on [DATE] at 1:21 PM Employee #19 (Chief Human Resources Officer) stated that, I initiated the relationship between [Nurse Staffing Agency's Name] and the facility started using CNA's and RN's February 2023. The employee further stated that she didn't ask about the Nurse Staffing Agency's license until the State Surveyors entered the facility on [DATE]. It should be noted that the nursing staff from the Nurse Staffing Agency all had current licenses to practice in D.C. Cross Reference 22B DCMR Sec. 3212.4

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record reviews and staff interviews, for three (3) of 41 sampled residents, facility staff failed to accurately document in the residents' medical record. Resident #66, The findings included: Review of the Documentation Criteria policy last reviewed on 07/22/22, documented: - The objective is to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. 1. Facility staff failed to accurately document n Resident #66's Treatment Administration Record (TAR). Resident #66 was admitted to the facility on [DATE] with multiple diagnoses that included: Retention of Urine, Hypertension and Dementia. Review of Resident #66's medical record revealed: A Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 03, indicating severely impaired cognitive status. A Health Status Note dated 02/14/24 at 4:21 PM that documented: - Resident was readmitted from [Hospital name] to the facility. - Central line placed on 02/09/24 on the right upper arm. Physician's order dated 02/14/24 directed, - PICC, 1 Lumen brachial right, for antibiotic treatment, monitor PICC line dressing daily for redness, swelling and drainage every shift. - Change PICC line dressing every week, every evening shift, on Friday. Review of the Treatment Administration Record (TAR) for February 2024 showed facility staff documented a check mark and their initials to indicate that the central line dressing change was completed on Friday, 02/16/24, Friday, 02/23/24 and on Friday, 03/01/24 and that they were monitoring the dressing site every shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/04/24 at 10:30 AM with Employee #5 (Licensed Practical Nurse/LPN), Resident #66 was observed with a single lumen PICC to his right upper arm with a dressing that was dated, 2/9/24. When asked why the resident's central line dressing had not been changed since 02/09/24, the employee stated, The dressing does not get changed on my shift (day shift, 7:00 AM - 3:30 PM) and only a Registered Nurse (RN) is allowed to change the dressing. I will get an RN to come and change the dressing now. The evidence showed that from 02/14/24 to 03/04/24, facility staff failed to failed to accurately document on Resident #66's TAR. During a face-to-face interview on 03/07/24 at 9:21 AM, Employee #2 (Director of Nursing/DON) acknowledged the finding and stated, The physician's order was not followed and the nurses documented that they did something they in fact did not complete. 2. Facility staff failed to accurately document the stage of Resident #52's sacral pressure ulcer/wound on the comprehensive resident care plan. Resident #52 was admitted to the facility on [DATE] with diagnoses that included: Adult Failure to Thrive, History of Falling, and Muscle Weakness. Review of the resident's medical record revealed the following: A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 07 indicating severe cognitive impairment and had no unhealed pressure ulcers/injuries, wounds, or other skin problems. A Wound Care Physician's Note dated 02/28/24 at 8:16 AM documented: Wound rounds; Stage 3 sacral decubitus ulcer; moderate drainage with necrotic tissue and slough; Plan: clean with Dakins solution (used to prevent and treat skin and tissue infections), apply collagenase Santyl ointment (debridement ointment used on dead tissue) and dry dressing daily. A Wound Care Physician Note dated 03/04/24 at 8:18 AM documented: - Stage 3 sacral decubitus ulcer. Decreased slough and drainage. 8 cm (centimeters) long by 6 cm wide by 2 cm deep. A care plan focus area initiated on 03/05/24 documented, [Resident #52] has sacral ulcer Stage 2. During a face-to-face interview on 03/06/24 at 11:15 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated that the resident's care plan would be revised. Cross Reference 22B DCMR Sec. 3231.12 (Facility staff failed to accurately document the stage of Resident #52's sacral pressure ulcer on the comprehensive care plan.) 3. Facility staff failed to accurately document in Resident #72's December 2023 monthly summary report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER: Stoddard Baptist Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1818 Newton St. NW Washington, DC 20010	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72 was admitted to the facility on [DATE] with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 3, Dysphagia, Aphasia, Pain, and Cerebral Infarction. Review of the resident's medical record revealed the following: An Annual MDS assessment dated [DATE] showed facility staff coded: severely impaired cognitive skills for decision making and received 51% or more of nutrition via a feeding tube. A physician's order dated 12/24/23 directed, Transfer resident to nearest ER (emergency room) for G (gastrostomy) - tube replacement. A Nursing Progress Note dated 12/24/23 at 12:42 PM documented: - Resident G tube was dislodged. - The Physician's Assistant (PA) made aware, new order given to transfer resident to the nearest emergency room for G-tube replacement. - A call was placed call to non-emergency ambulance and the resident was transferred to [Hospital name] via stretcher. A Nursing Progress Note dated 12/25/23 at 4:18 AM documented: - Resident returned to unit at 5:10 PM from [Hospital name]. - New G-tube noted to be intact/patent and dry, no bleeding noted. A Resident Monthly Summary Report dated 12/30/23 at 4:45 AM documented: - No ER visit/hospitalization this month. - Continue plan of care. This evidence showed that facility staff inaccurately documented that Resident #72's had no ER visits for the month of December 2023. During a face-to-face interview on 03/14/24 at 12:46 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated OK. Cross Reference 22B DCMR Sec. 3231.10 (Facility staff failed to accurately document the course of treatment in Resident #72's monthly summary report for December 2023.)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41645 Based on record review and staff interview, for 12 out of 25 Infection Control policies and procedures, facility staff failed to have documented evidence that they were reviewed at least annually. The findings included: A review of the facility's Infection Control Policy and Procedure binder on 03/19/24 revealed that the following policies lacked review dates: Admission of Residents During an Outbreak Control of Methicillin-Resistant Staphylococcus Aureus (MRSA) Colonization (#11-015) Control of Vancomycin-Resistant Enterococcus (VRE) Infection (#06-003) Discharge Room Cleaning (Non-Isolation/Infection Precaution Room) Handling Infectious Waste Infection Outbreak Response and Investigation Infectious Waste Material Exposure Control (#99-013) Multiple Drug Resistant Organisms (MDRO) (#06-002) Reporting of In-House Infection and Communicable Disease (#99-01) Treatment of Urinary Tract Infection Visitation During a Communicable Disease Outbreak. This binder also showed a policy titled, Antibiotic Stewardship (#19-007) that had a review date of 07/22/22. During a face-to-face interview on 03/18/24 at approximately 2:00 PM, Employee #28 (Infection Preventionist) reviewed the policies and stated that she did not see the dates the policies were reviewed. The employee also said that she would work on reviewing the policies and ensuring they are based on national standards and the facility's assessment. Cross Reference 22B DCMR Sec. 3217.5

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 Based on record review and staff interviews, for two (2) of 41 sampled residents, facility staff failed to have documented evidence that the residents or their responsible party received education on Influenza vaccination. (Resident #4 and Resident #49). The findings included: Review of the Immunization of Residents for Flu (Influenza) and Pneumococcal (#10-00) Policy with a review date of 07/20/23 documented the following but not limited to, The resident or the resident's legal representative is provided education regarding the benefits and potential side effect of immunizations. 1. Resident #4 was admitted to the facility on [DATE] with multiple diagnoses including Dementia. A review of the face sheet showed that Resident #4's son was her responsible party. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident had a severely impaired cognitive status. A review of a document titled, Preventive Health Care Report (Influenza Vaccine) dated 09/27/23 documented the following but not limited to, Administered Yes-In house, Administration Date/Time 09/27/23 at 10:43 AM, Route - Intramuscular, Site - Left Deltoid. Continued review of the document showed that sections: Education Provided to Resident/Family/POA (power-of-attorney) and Education Provided By- were blank indicating that education was not provided by staff. A review of a nursing progress note dated 09/27/23 at 12:16 PM documented, Alert and verbally responsive. Agreed to take the Flu (Influenza) shot 0.5 ml (milliliters) IM (intra-muscular) given to left deltoid, no adverse reaction. V/S (vital signs) [blood pressure]118/58, [pulse] 64, [respiration] 18, [temperature] 97.6. Resident #4's medical record lacked documented evidence that education regarding the benefits and potential side effect of the Influenza vaccination (immunization) was provided to the resident or her responsible party. 2. Resident #49 was admitted to the facility on [DATE] with multiple diagnoses including Dementia. A review of the face sheet showed that Resident #9's daughter was her responsible party. A Quarterly MDS assessment dated [DATE] documented a Brief Interview for Mental summary score of 7, indicating the resident has a severely impaired cognitive status. (continued on next page)

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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a document titled, Preventive Health Care Report (Influenza Vaccine) dated 09/26/23 documented the following but not limited to, Administered Yes-In house, Administration Date/Time 09/26/23 at 12:24 PM, Route - Intramuscular, Site - Left Deltoid, and Education Provided to Resident/Family/POA (power-of-attorney) - No. Continued review of the document showed that section and Education Provided By- was blank indicating that education was not provided by staff. A nursing progress note dated 09/26/23 at 2:17 PM documented, VSS (vital signs). [blood pressure]123/78, [pulse] 67, [respiration] 18, [temperature] 98. Resident received 0.5 ml (milliliters) flu vaccine left deltoid IM (intra-muscular) lot#370274 exp, (expiration) 5/2024, no adv (adverse) reaction. Resident #49's medical record lacked documented evidence that education regarding the benefits and potential side effect of the Influenza vaccination (immunization) was provided to the resident or her responsible party. During a face-to-face interview on 03/18/24 at approximately 10:00 AM, Employee #22 (LPN/Charge Nurse) stated that the facility's protocol is residents and/or their responsible parties are provided education on the benefits and potential side effect of vaccines on admission and prior to administration of all vaccines. During a face-to-face interview on 03/18/23 at approximately 2:00 PM, Employee #2 (DON) reviewed Resident #4's and Resident #49's documents and stated that she did not see that the residents or their responsible parties were provided education on the Influenza vaccine.

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	03/20/2024

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 27689 Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by one (1) of one (1) defective food pellet warmer, and two (2) of four (4) burners from one (1) of one (1) gas stove that did not function when tested . The findings include: During a walkthrough of dietary services on March 4, 2024, at approximately 9:00 am: One (1) of one (1) food pellet warmer was inoperative. Two (2) of four (4) burners from one (1) of two (2) gas stoves did not light up when the knob was activated. These observations were acknowledged by Employee #9 during a face-to-face interview on March 11, 2024, at approximately 3:30 PM.