STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute and Rehab Capitol Hill	223 7th Street NE Washington, DC 20002

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and resident and staff interview, the Interdisciplinary Team (IDT) failed ensure a resident was safe to self-administer an Albuterol inhaler for one (1) of 1 sampled resident who self-administer medicine. (Resident #46). The findings included: Resident #46 was admitted on [DATE] with multiple diagnoses including Pulmonary Chronic Obstructive Disease, Bipolar, Schizophrenia, and Anxiety. A policy titled, Self-Administering Medications with a review date of 05/24/24 instructed, Residents have the right to self-administer medications if the interdispilinary team has determined that it is clincally appropiate and safe for the resident to do so . The staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medication is clincally appropiate for the resident .the nursing staff will determine who will be responsible (the resident or nursing staff) for document that medications were taken .medications must be stored in a safe and secure place, which is not accessible by other residents . A physician order dated 02/21/25 instructed, Albuterol -Budesonide Inhalation Aerosol 90-80 micrograms/actuation give 2 puffs by mouth every hour hours as need for shortness of breath. A quarterly Minimum Date Set assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status summary score of 11 indicating that the resident had a moderately impaired cognitive status. The resident was also coded for requiring supervision from staff with activities of daily living and having a diagnosis of Chronic Obstructive Pulmonary Disease. During an observation on 04/14/25 at approximately 2:30 PM, the resident was observed sitting up in bed watching tv. At the time of the observation, the resident showed the surveyors an Albuterol inhaler that she had in her purse. The employee then stated that she uses her Albuterol inhaler at least 2 times a day (2 puffs) daily for shortness of breath. The resident said, I can take my own medicine like I did at home. I don't want to answer any more questions. A review of the April 2025 Medication Administration Record (MAR) lacked documented evidence that the resident used her Albuterol inhaler from 04/01/15 to 04/14/15. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 04/15/25 at approximately 9AM, Employee #38 (assigned LPN) stated that the resident keeps her Albuterol at the bedside, so she can administer it herself. The employee said that the resident used to complain a lot that she wanted to keep her Albuterol at the bedside like she did when she was home. When asked who documents in the MAR when it is administered, the employee failed to provide an answer. During a face-to-face interview on 04/15/25 at approximately 10 AM, Employee #2 (DON) stated that the resident had not been assessed by the IDT to self-administer medication. The employee said she will ensure the Albuterol is removed from the resident's room.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, five (5) of 49 residents sampled, facility staff failed to have documented evidence that they provided information to the residents and/or their representatives (RP) regarding their right to formulate or refuse an advanced directive. Residents #87, #56, #91, #74, and #73. The findings included: Review of the facility's Advanced Directives policy dated 05/24/24 documented: - Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. - If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. - Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. - If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. 1. Resident #87 was admitted to the facility on [DATE] with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia. Review of the resident's medical record revealed the following: A face sheet that showed that listed the resident's daughter as her responsible party (RP), care conference person, emergency contact #1 and next of kin. A care plan focus area, last revised on 03/11/25 documented: [Resident #87] end of life wishes to remain a full code. Goal(s): Interdisciplinary team (IDT) team will honor [Resident #87's] wishes for end-of-life care. Interventions: Assist with pre-burial needs upon request; Honor spiritual and cultural wishes Inform resident of memorial services within the facility via flyer; Offer 5 Wishes (the facility's advanced directives form) quarterly. Review of Resident #87's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #87's RP information to formulate or refuse to formulate an Advanced Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #56 was readmitted to the facility on [DATE] with multiple diagnoses that included: Amyotrophic Lateral Sclerosis (ALS) and Chronic Respiratory Failure with Hypoxia. Review of the resident's medical record revealed the following: A face sheet that listed the resident's sister listed as her RP, care conference person and emergency contact #1. 01/14/25 at 12:20 PM Care Conference Note: - Care plan meeting was held for the resident. - The resident is alert, oriented, and communicates using an assistive device. - The resident's sister participated by phone. - Will remain full code. - Five Wishes were offered to resident and placed in her room per her request. A care plan focus area last revised on 03/14/25 documented: [Resident #56] end of life wishes are to remain a full code. Goal(s): IDT team will honor [Resident #56's] wishes for end-of-life care. Interventions: Honor spiritual and cultural wishes; Offer 5 Wishes quarterly. Review of Resident #56's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #56 or her RP information to formulate or refuse to formulate an Advanced Directive. 3. Resident #91 was admitted to the facility on [DATE] with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure. Review of the resident's medical record revealed the following: A face sheet that showed that she was her on responsible party. An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: adequate hearing; clear speech; makes self-understood; understands others; and a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. A care plan focus area revised on 03/17/25, [Resident #91] end of life wishes to be a full code, had interventions that included: assist with pre-burial needs upon request; honor spiritual and cultural wishes; and offer 5 Wishes quarterly. Review of the resident's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #91 information to formulate or refuse to formulate an Advanced Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #74 was admitted to the facility on [DATE] with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure with Hypoxia and Type 2 Diabetes Mellitus. Review of the resident's medical record revealed the following: A face sheet that listed the resident's daughter as her RP, care conference person and emergency contact #1. A care plan focus area revised on 04/07/25 documented: Family wishes for [Resident #74] to be a do not resuscitate (DNR). Goal: IDT team will honor family end of life wishes as a communicated by family. Interventions: Provide advanced care planning information to family; Provide spiritual care in accordance with family's faith; Review 5 Wishes with resident and family quarterly. Review of the resident's medical record on 04/14/25 showed no documented evidence that facility staff offered Resident #74's RP information to formulate or refuse to formulate an Advanced Directive. 5. Resident #73 was admitted to the facility on [DATE] with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure, and Adult Failure to Thrive. Review of the resident's medical record revealed the following: A face sheet that listed that she had a had a legal guardian who is her RP and emergency contact #1. A care plan focus area, last revised on 0317/25 documented: Guardian end of life wishes for the resident to remain a full code. Goal: IDT team will honor the wishes for end of life care. Interventions: Honor spiritual and cultural wishes; Offer 5 Wishes quarterly. Review of Resident #73's medical record on 04/14/25 showed no documented evidence that the facility staff offered the resident's guardian information to formulate or refuse to formulate an Advanced Directive. During a face-to-face interview on 04/14/25 at 12:17 PM, Employee #18 (Director of Social Services) acknowledged the findings and stated, I leave the advanced directive form (5 wishes) in the room for the resident or their RP. Once it's filled out, the resident or the family will give us (Social Services Department) a call to come get it. When asked who follows up if the advanced directive is not returned to the Social Services Department, Employee #XX stated that there is no follow-up done by him or anyone else in the Social Services Department if the Advanced Directive forms are not completed by the resident or their family/representative. Cross Reference 22B DCMR Sec. 3231.12

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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** Based on record reviews and staff and family interviews, the facility failed to have documented evidence that verbal abuse of resident did not occur after receiving an allegation of staff-to-resident verbal abuse for one (1) of 1 sampled residents. (Resident #158) The findings included: Resident #158 was admitted on [DATE] with multiple diagnoses including Altered Mental Status, Muscle Weakness, and Psychotic Disorder. During a telephone interview related to different concern (Complaint DC~12827) on 04/25/25 at approximately 10 AM, the resident daughter (complainant) stated that Employee #39 (CNA) said, My mom was pistol in front of my mom. After the employee said my mom was afraid and wanted to go home. The resident's daughter then said, I told her [Employee #39] that I would not tolerate any mistreatment of my mom. And then the employee said that she could tell I was from the streets. Additionally, the resident's daughter said that she made the Administrator aware and she never saw Employee #39 again. It should be noted that the resident's daughter could not remember the specific date of the incident. On 04/24/25 at approximately 11 AM, a review of Resident #158's medical record and the facility's incident binder lacked documented evidence of alleged incident of verbal abuse. During a face-to-face interview on 04/29/25 at 6:20 AM, Employee #39 stated that the Administrator and Human Resource Director called her into a few months. The meeting was held because Resident #158's daughter said, I verbally abused her and her mom. The employee stated that she did not verbally abuse anyone. She was suspended for 2 day during the investigation and moved to a different floor when she returned to work. During a face-to-face interview on 04/29/25 at approximately 10 AM, Employee #1 (Administrator) stated that he remembered the incident. The employee said that they conducted an investigation and could not substantiate that staff-to-resident verbal abuse occurred. However, the employee said that the Human Resource's Director who no longer works for the facility had the investigation documents. And he was not able to locate them. Additonally, the employee said that Empployee #39 (CNA) was suspended while the investgation was conducted, and she was moved to another floor when she returned to work.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews for one (1) of 49 sampled residents, facility staff failed to provide documented evidence that one resident's bedrails were not being used as a restraint for a non-ambulatory, cognitively impaired resident who required extensive assistance with bed mobility and transfers. Resident #308. The findings included: A facility document titled 'Physical Restraint Application' with a review date of October 2010 documented the following: Definition - Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body Documentation - The following information should be recorded in the resident's medical record: 1. The date and time the restraint was applied. 2. The name and title of the individual(s) who applied the restraint. 3. The type of physical restraint applied. 4. The specific reason the restraint was applied. 5. The length of time the restraint will be used. 6. Each time the device is released for resident exercise, toileting, and position change. 7. Each time the resident is monitored, per facility policy. 8. All assessment data (e.g., bruises, rashes, sores, etc.) observed during the procedure. 9. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 10. Any problems or complaints made by the resident related to the restraint application. 11. If the resident refused the treatment and the reason(s) why. 12. The signature and title of the person recording the data. A review of Resident #308's medical record revealed: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A siderail assessment dated [DATE] documented, Yes - Involuntary or voluntary movement where it is observed that body parts are able to touch or roll into side rails with a 2 person turn and reposition; Yes - Resident unable to maintain positioning in bed as placed by staff with the use of regular pillows. A physician's order dated 02/12/25 documented, SIDE RAILS 1/4 (one quarter) EVERY SHIFT AS ENABLER TO PROMOTE BED MOBILITY every shift. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff marked No that indicated that they were unable to conduct the brief interview for mental status. It should also be noted that the MDS revealed that the resident had impairment on both sides to upper and lower extremities; was dependent on staff for rolling left and right; and required 2+ person assist for bed mobility, transfers, and toileting. During an observation conducted of the resident's room on 04/13/25 at approximately 9:00 AM, the resident was observed lying in bed with all four (4) bedrails in the upward position. During a subsequent observation conducted on 04/22/25 at approximately 12:00 PM, the resident was observed lying in bed with all four (4) bedrails in the upward position. It should be noted that there was no documented evidence in Resident #308's medical record stating that the resident should have all four (4) bedrails in use and in the upward position. During a face-to-face interview conducted on 04/23/25 at approximately 8:45 AM, Employees' #1 (Administrator) and #2 (Director of Nursing) both acknowledged the findings. Employee #1 stated, We don't have a bedrail policy, because the standard is that we only use two (2) siderails up for all of the beds, otherwise it is entrapment and also a restraint and Employee #2 stated, He was transferred here from LTACH (Long-Term Acute Care Hospital) in that bed to accommodate his size, but he shouldn't have the two (2) siderails at the bottom because four (4) siderails would be a restraint. He doesn't get up all, he can't move.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for two (2) of 49 sampled residents, facility staff failed to report an incident of alleged staff-to-resident verbal abuse to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Residents #62 and #40 The findings included: A facility policy titled 'Abuse Investigation and Reporting' with a review date of 05/24/24 documented the following: Policy Statement - All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Reporting - 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 1.Resident #62 was admitted to the facility on [DATE] with diagnoses that included: Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Morbid (Severe) Obesity, Type 2 Diabetes Mellitus, Acute Kidney Failure, Anxiety Disorder and Schizophrenia. A review of Resident #62's medical record revealed: A PASRR (Pre-admission Screen/Resident Review) Level II determination letter dated 01/19/24 that justified the resident's nursing home placement in the facility. A significant change minimum data set (MDS) assessment dated [DATE] that documented that the Resident had a Brief Interview for Mental Status (BIMS) of, 11 indicating that the Resident had moderately impaired cognition. In addition, the assessment documented that the Resident experienced hallucinations, displayed verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) for 1 to 3 days, rejected care daily, was independent with most ADLs (activities of daily living), was occasionally incontinent and received supplemental oxygen. A review of physician's orders dated 02/12/25 that directed: Please document exact behavior exhibited under behavior note. every shift, and Psych Consult and PRN. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Psych Progress Note dated 02/19/25 that documented: 1. Mood and behavior: Upon today's evaluation in my opinion his symptoms of irritability and frustration tolerance are due to underlying anxiety and depression associated with poor self-control declined health, and long hospital stay. The patient is exhibiting episodic flares of depression and anxiety. Denies active passive SI (suicidal ideation). He is future-oriented and wants to get better. A review of a care plan initiated on 02/12/24 that documented: Focus: [Name of Resident # 62]:is dependent on staff etc, for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Physical Limitations; Interventions included: All staff to converse with resident while providing care. A review of a care plan initiated on 02/16/24 that documented: Focus: [Name of Resident # 62] is/has potential to be verbally aggressive r/t (related to) ineffective coping skills; Goal: [Name of Resident # 62] will verbalize understanding of need to control verbally abusive behavior through the review date. Interventions . When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. A review of a care plan initiated on 02/16/24 that documented: Focus: [Name of Resident # 62] is resistive to care r/t (related to) non adherent to medication and refusal of care; Goal: [Name of Resident # 62] will cooperate with care through next review date; Interventions: . Give clear explanation of all care activities prior to an as they occur during each contact.; Praise the resident when behavior is appropriate. A review of a facility reported incident (DC~13626) dated 04/22/25 that documented: . A review of the facility's investigation packet for the incident revealed the following: written statement by Employee #32/Certified Nurse Aide: The CNA [Employee #28] was passing trays, [Resident #62's Room #] came to the door. The CNA said, 'Oh you scared me. The resident said, I didn't do anything. The CNA said you crazy you talk to yourself. The resident said, yes, that's why I take medicine.' She [CNA/Employee #28] laughed and the resident said if it's a problem, don't come back to my room. The CNA 's name is [Name of Employee #28]. The resident's name is [Name of Resident #62]. A further review of the facility's investigative documents showed no documented evidence per the facility's policy that Employee#32 reported the alleged incident of verbal abuse immediately to the Administrator, DON, or a nurse or nursing supervisor in her department. Knowledge of the incident came as a result of the facility's ongoing investigation of a separate incident of alleged verbal abuse between Employee #28 and another resident on the unit. During telephone interview on 04/28/25 02:14 PM, Employee #32 stated: I was passing meal trays with the CNA who was training me. Resident #62 was standing at his door, Employee #28 said something like, Oh you scared me, you were talking to yourself. You're crazy. It was my first day and I was just trying to learn and do my job. I had received abuse training during orientation before I was allowed to work on to the unit, but I didn't think to report the incident with Resident #62 until I was questioned about an incident that involved Employee #28 and another resident. After the incident I never saw the CNA on the floor again, and I was told that I should not report to work until I was notified by my supervisor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 04/28/25 at 9:44 AM, Employee #2 Director of Nursing, she acknowledged the finding and stated that Employee #32 had been given a written and verbal warning for not reporting the alleged incident of staff-to-resident verbal abuse. 2. Resident #40 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Encephalopathy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Anoxic Brain Damage and Epilepsy. A review of Resident #40's medical record revealed: A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '01,' indicating the resident was severely impaired. Functional abilities that documented the resident required 1+ person assist with bed mobility and 2+ person assist with transfers and toilet use. During a review of Employee #28's (Certified Nursing Assistant, CNA) employment file, it revealed an 'Employee Warning Notice' dated 04/17/25 that documented, Removed from Schedule pending investigation 4/19/25, 4/20/25, 4/22/25 and On 4/17/25, in [room number] the RP (Responsible Party) for Resident #81 alleged that the person that brought her mother's tray called her a [expletive]. Employee #28 was assigned to the resident's room and was responsible for delivering the tray. [The] Employee was suspended pending investigation. A facility reported incident dated 04/22/25 at 6:32 PM documented, During an ongoing abuse investigation on 4/22/25 at about 12:25 PM it was discovered that Employee #29 (CNA) alleged that she witnessed [Employee #28's name] verbally abused [Resident #40's name]. A care plan dated 04/22/25 documented, Focus: A CNA alleged that [Resident #40's name] was verbally abused by another CNA on 04/22/25. Goal: Resident will be safe through the review date. Intervention: Resident will be treated with respect and dignity that he deserves during care. A review of Employee #29's (CNA) employment file showed an 'Employee Warning Notice' dated 04/22/25 that documented, Removed from schedule pending investigation and Violation of Policy/Procedure (Reference Policy HR (human resources) 401) and During the course of an abuse investigation [Employee #29's name] stated that she witnessed the alleged verbal abuse but failed to report it. The investigation is ongoing. During a face-to-face interview conducted on 04/24/25 at approximately 2:41 PM, Employee #3 (Nurse Supervisor) acknowledged the findings and stated, It didn't happen that day (04/22/25). We were investigating an incident with [Resident #81's name]. There was a new CNA, [Employee #29's name], we were just asking the staff about any issues of abuse with residents, and she stated she saw [Resident #40's name] being verbally abused by [Employee #28's name], but she said that it had happened a long time ago. We educated her on reporting right away and she should not wait even if she is a new employee. I don't know how long she has worked here or when she was hired. So that's being investigated to try to figure out when that happened. I don't know when that (verbal abuse) happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview conducted on 04/25/25 at approximately 10:14 AM, Employee #29 stated, I just started at this job, and [Employee #28's name] was training me. On my last week of two (2) week orientation, I witnessed her talking to [Resident #40's name]. He can be disrespectful, but I don't pay him know mind. He said, 'Get the [expletive] away, leave me the [expletive] alone, leave me alone I'mma (I'm going to) [expletive] you up.' Then [Employee #28's name] said to '[Resident #40's name] if you touch me I'mma (I'm going to) [expletive] you up, I don't have time for this.' Employee #29 further stated that, They (facility staff) have me under her training me and this is what they have me trained under. They came to me with a paper; it was a paper with questions about if I have ever witnessed [Employee #28's name] and I said Yes and that's when I told them what I witnessed. I have talked to [other staff] people in the workspace, and they just say things like 'I don't see nothing, I don't know nothing.' They don't care about the residents here. I was afraid of retaliation if I said anything and the [other staff] people here going against me, it's not confidential. Everybody was watching me, it was so uncomfortable because everyone knew what I [had] reported. During a Face-to-face interview conducted on 04/28/25 at approximately 11:40 AM, Employee #28 stated, There was an incident with the 'B' [expletive] word. I was passing the trays I went to [Resident #81's name] room first. I had worked with her before, and she would use the 'B' word, but I didn't call her that. Employee #28 was asked about her interaction with Resident #40 and she stated, Yes, I've worked with him before. He gets agitated when he's really wet or wants to eat. He has always said the 'B' word to me, but I have never been abusive to him. During a telephone interview conducted on 05/01/25 at approximately 2: 49 PM, Employee #30 (Nurse Educator) acknowledged the findings and stated, If there is a report of abuse allegation, the staff are informed to contact the charge nurse who will reach out to the nurse supervisor immediately. If the allegation is about an employee and the employee is working with the resident, then the employee will be sent home. It's repeated during my education and the facility's [Abuse] policy is also included in the education. What I say to the staff is if a resident reports abuse, even if you believe it's true or not, it must be reported within two (2) hours. The expectation if it's witnessed by another staff, they should tell the charge nurse and nurse supervisor and provide a statement before they leave for the day.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for two (2) of 49 residents sampled, facility staff failed to have documented evidence that they conducted thorough investigations for one resident's missing cellphone and one resident's allegation of staff-to resident verbal abuse. Residents #87 and #81. The findings included: Review of the facility's Abuse Investigation and Reporting policy dated 05/24/24 documented: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. -The role of the investigator includes interviewing staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 1. Facility staff failed to conduct a thorough investigation for Resident #87's missing cellphone. Resident #87 was admitted to the facility on [DATE] with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia, Asthma, Muscle Weakness. Review of the resident's medical record revealed the following: A Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: clear speech; makes self understood; clear comprehension of others; adequate vision; a Brief Interview for Mental Status (BIMS) summary score of 12, indicating mild cognitive impairment; no behavioral symptoms; and no functional impairment in range of motion in upper extremities. A Facility Reported Incident (FRI), DC~13314, submitted to the State Agency on 12/03/24 documented, -On December 2nd, 2024, at approximately 4:30 PM, [Resident #87] complained that she could not find her Samsung cell phone when she woke up from sleep at around 4:00 PM. A follow-up to FRI DC~13314, submitted to the State Agency on 12/09/24 documented: -This is the conclusion of the self-report that was sent on 12/03/2024. -During the investigation, staff were interviewed. -Based on the facility investigation, facility was unable to substantiate how the cell phone went missing. Review of the facility's investigation documents on 04/23/25 showed that not all the staff listed on the 5th floor assignment on the date of the incident (12/02/24) were interviewed or provided a statement, to include housekeeping and activities personnel, as part of the facility's investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The evidence showed that the facility staff failed to conduct a thorough investigation of Resident #87's missing cellphone. During a face-to-face interview on 04/23/25 at 11:44 AM, Employee #1 (Administrator/Abuse Coordinator) and Employee #2 (Director of Nursing/DON) reviewed the investigation documents and acknowledged the findings. Cross Reference 22B DCMR Sec. 3232.2 2. Resident #81 was admitted to the facility on [DATE] with diagnoses that included: Cerebral Infarction, Hemiplegia and Hemiparesis, Facial Weakness, Aphasia, Epilepsy, Chronic Respiratory Failure, Tracheostomy Status, Gastrostomy Status, Altered Mental Status, and Anxiety. A review of Resident #81's medical record revealed: A Quarterly minimum data set (MDS) assessment dated [DATE] that documented that the Resident had a Brief Interview for Mental Status (BIMS) of, 07 indicating that the Resident had severely impaired cognition. A physician's order dated 03/10/25 that directed: Psych Consult and PRN one time only for Evaluation/ Reassessment for 3 Days A Psych Progress Note dated 03/12/25 that documented: 1. Mood, and behavior: the patient is not a good historian and exhibits a combination of thought blocking and confusion. Given memory impairment, she remains vulnerable to agitation and care issues. No exacerbation of agitation was noted. The precipitating and perpetuating factors are a decline in health and memory. No evidence of active or passive SI (suicidal ideation) was noted. The patient denied overt s/s (signs and symptoms) of depression or psychosis. No evidence of mania or psychosis was noted . A physician's order dated 03/16/25 at 7: 00 AM that directed: Behaviors - Monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift. A physician's order dated 03/17/25 at 9:00 PM that directed: Trazodone HCl Oral Tablet 50 mg (milligrams). Give 1 tablet by mouth at bedtime for anxiety and difficulty sleeping. A physician's order dated 03/25/25 at 1:00 PM that documented: Clonazepam Oral Tablet 0.5 mg. Give 1 tablet by mouth three times a day for anxiety for 15 days. A review of a facility reported incident (DC~13619) dated 04/17/25 that documented: Initial report: At approximately 7:25 PM, Resident son in [Resident 381's room] stated that while using the bathroom in the patient('s) room that he heard someone used the word [expletive] on his mother. investigation is ongoing . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up report dated 04/23/25 documented; This is the follow-up of the self-report that was submitted on 04/17/2025. On 04/17/2025, at around 07:25 PM, [Resident # 81's son] reported that while he was in (his) mother (s) bathroom, A nurse came in to bring my/his mom her food, the nurse called her a girl, and my mom said she wasn't a girl and rejected her food. The nurse then called her [expletive] and walked out . Staff were interviewed, and statements were obtained . Her son, who initially reported the incident, confirmed that he overheard the comment from the bathroom but was unable to identify the specific staff member involved. During a follow-up on April 20, 2025, he maintained that he could not confirm who made the comment. Based on the statements and staff interviewed, none of the staff reported witnessing or hearing anyone referring to the resident using derogatory language on 04/17/2025. Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse .This is the final report. A review of the facility's investigation packet included the written statements of two CNAs, in response to the question: Was there any incident at all that you witnessed a staff member named [Employee #28/alleged perpetrator] (Nursing Assistant) treated any of the residents in any way that may indicate any form of abuse. Example: involuntary seclusion, financial, neglect physical, verbal, sexual, mental, or emotional abuse? 1) Employee #32 written statement response to the question dated 04/21/25 was: Answer: Yes Comments: The CNA was passing trays, [Room of alleged victim/resident] came to the door. The CNA said, 'Oh you scared me. The resident said, I didn't do anything. The CNA said you crazy you talk to yourself. The resident said, yes, that's why I take medicine.' She laughed and the resident said if it's a problem, don't come back to my room. The CNA 's name is [Name of Employee #28/alleged perpetrator]. 2) Employee #29's written statement/response: dated 04/22/25 was: Answer: Yes. Comments: I overheard her talk to {Name of alleged victim/resident] any kind of way. The words were. 'I don't have time [expletive], [Name of alleged victim/resident]. I will [expletive] you up if you touch me. The facility's final report was submitted to the state agency on 04/23/25 and concluded, .Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse . This is the final report. The facility's investigation lacked documented evidence that all alleged violations of the incident were thoroughly investigated. The two CNA statements dated 04/21/25 and 04/22/25 respectively, were new findings of alleged verbal abuse toward two other residents by Employee #28 , that were not documented in the final report of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 04/28/25 at 9:44 AM, Employee #2/ Director of Nursing stated that the facility was in receipt of the two CNA responses which alleged that Employee #28 , had verbally abused two other residents before submitting the final report of the alleged incident of verbal abuse between Employee #28 and Resident #81 to the State agency on 04/23/25. Employee #2 further stated that as a result of the CNA statements, two new investigations alleging that Employee #28 had verbally abused two other residents were initiated. Employee #2, then acknowledged that although the facility stated that .Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ., on 04/26/25 the facility initiated two new investigations of Employee #28's alleged verbal abuse toward two other residents. Employee #2 then acknowledged that final report of the alleged incident of verbal abuse between Employee #28 and Resident #81, was not complete, and should have included the fact that two new investigations of Employee #28's alleged verbal abuse toward two other residents were initiated. Cross Reference 22B DCMR Sec. 3232.2

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 5. Resident #91 was admitted to the facility on [DATE] with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure. Review of the resident's medical record revealed the following: An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. Physician's orders dated 02/10/15 directed, Established [central] line - Change dressing Q (every) 7 days, every night shift every Monday for IV-line care; Change dressing as needed if not intact or soiled as needed for IV care; Observe insertion site every shift for redness, warmth, swelling, drainage, coldness or irritation, every shift for IV care. Review of the April 2025 Treatment Administration Record (TAR) showed that on 04/07/25, facility staff documented a check mark and their initials to indicate that the resident's central IV-line dressing was changed during the night shift. During an observation on 04/13/25 at 2:28 PM, Resident #91 was noted with a left upper arm central IV line with a dressing that was dated 04/03/25. Review of the resident's medical record on 04/18/25 showed no documented evidence that facility staff developed a care plan with goals and interventions to address Resident #91's use of a left upper arm central IV line. During a face-to-face interview on 04/18/25 at 11:32 AM, Employee #6 (6th Floor Unit Manager) reviewed the resident's medical record, acknowledged the findings and stated that a care plan address Resident #91's use of a left upper arm central IV line will be developed. Cross reference 22B DCMR Sec. 3210.4(a) 2. Resident #65 was admitted to the facility on [DATE] with diagnoses that included: Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, Chronic Respiratory Failure; Traumatic Spinal Cord Dysfunction;) Quadriplegia, Contracture of the Knee (Unspecified), Contracture of the Foot (Unspecified); Neuromuscular Dysfunction Of Bladder; Urinary Tract Infection; Encounter for Attention to Gastrostomy; Encounter for Attention to Tracheostomy, Anxiety Disorder and Depression. A review of Resident #48's medical record revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS (Minimal Data Set) assessment dated [DATE] that documented the Resident had a Brief Interview for mental Status (BIMS) summary score of, 14 indicating that the Resident had intact cognition. In addition, the resident was coded for: impairment status on both sides to the upper and lower extremities; dependent status on for all (activities of daily living skills (ADLs) including turning and repositioning, having a fall in the last month prior to admission, having recent spinal surgery, having a gastrostomy tube, having a tracheostomy, and receiving speech and occupational therapies. An SBAR dated 01/02/25 that documented: Situation: Rt (Right) plantar foot swollen. Order for X-Ray of Rt plantar foot; Assessment (Registered Nurse/RN) or Appearance (Licensed Practical Nurse/LPN): Swollen Rt plantar foot; Request/Nursing Notes: Order given by NP (Nurse Practitioner) on duty for X-ray of the right plantar foot to rule out fracture. Resident aware, RP/Friend [Name of resident representative] notified . An X ray Report dated 01/02/25 that documented: Clinical History: [Resident] presents for fracture. Technique: 3 views of the right foot Comparison: None. Findings: Diffuse soft tissue swelling about the right foot. Diffuse osteopenia. Cannot exclude an acute fracture on this . A General Progress Note dated 01/03/25 at 6:57 PM that documented: Resident lab result received findings stated 'Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study. Suggestion of a fracture of the distal fibula. No dislocation.' [Name of Medical Director] was called by the 4th floor unit manager . She stated 'We need to send him to orthopedics. I don't think that is acute. [An] elective consultation arrangement will be made. I will contact [Rehab Director's Name] to put a boot on it. A care plan initiated on 01/03/25 that documented:: [Name of Resident #68] has Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study . No dislocation. Goal: Resident will verbalized reduction of pain by the next review date. Interventions initiated 01/04/25: Elective consultation arrangement will be made by MD ; Log roll resident during transfer and observe foot precaution; MD will follow up with rehab for boot . A revised care plan dated 01/03/25 that documented: [[Name of Resident #68] has diffuse osteopenia and at risk for fracture r/t x-tray of the right foot dated 01/03/2025 Date Intervention included: .Orthopedic consult; Provide with pillows, etc. to help maintain comfortable position; PT (Physical Therapy) evaluation and treatment as ordered. 01/06/25 physician's order that directed: PT (Physical Therapy) Consult and prn (as needed), right foot boot for immobilization, distal fibula fracture. A Physical Therapy Encounter Note dated 01/09/25 that documented: . Pt was seen in room and was given foot brace to wear to immobilize ankle. 01/09/25 Physical Therapy Encounter Note: . Pt (Patient) was seen in room and was given foot brace to wear to immobilize ankle. Pt tolerated foot brace well and NP (Nurse Practitioner) also said it was good for patient . A further review of Resident# 65's comprehensive care plan showed no documented evidence that facility developed or implemented a care plan with a focus, goals or interventions for the resident's right foot boot for immobilization. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a face-to-face interview on Employee #21, Director of Rehab stated that the Resident was given the immobilization boot on 01/09/25 from phyiscal therapy, and a care plan for the boot should have been implemented then. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 Director of Nursing (DON) stated that the Unit supervisors, unit managers, and the DON and all members of the disciplinary team were responsible for implementing the care plans. She further commented that since the fourth floor had currently had no unit Manager, implementing and updating resident care plans was primarily her responsibility. The Employee then acknowledged that a care plan for Resident # 65's right foot immobilization boot should have been implemented. 3. Resident #68 was admitted to the facility on [DATE] with diagnoses that included: History of Falling; Acute Respiratory Failure; Displaced Intertrochanteric Fracture of Right Femur, Atrial Fibrillation; Chronic Hepatitis, Orthostatic Hypotension, Restlessness and Agitation. A review of Resident #68's medical record revealed: An admission annual MDS (Minimal Data Set) assessment dated MDS 03-11-24 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, 05 indicating that the Resident had severely impaired cognition. In addition the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to communicate with a doctor or health care staff. An annual MDS (Minimal Data Set) assessment dated MDS 02-28-25 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, 13 indicating that the Resident had intact cognition. In addition, the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to communicate with a doctor or health care staff. During an initial tour of the 4th floor unit on 04/13/25 at 8:09 AM, a face-to-face interview was conducted with Resident #68 and a Spanish speaking interpreter (via the facility's language interpreter phone line service), the Resident stated he spoke very little English and he preferred to speak Spanish. The resident added that he could communicate with the staff, but sometimes he didn't understand what the staff and he was not sure if they could understand him. When asked if facility staff offered use of via Spanish interpreter via the language line he said, No, not so much. My brother speaks English, so if something happens I let my brother know. He talks to the facility staff. During an initial tour of the 4th floor unit on 04/13/25 at 8:25 AM, a face-to-face interview was conducted with Employee #46 /Licensed Practical Nurse assigned to Resident #68. When asked if the Employee used the language line to communicate with the Resident, she stated, No. The Resident is Spanish, but he understands and speaks English. A review of Resident #68's comprehensive care plan lacked documented evidence that facility staff implemented a care plan for the resident's preference to use a Spanish speaking interpreter when communicating with a doctor or health care staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then stated and acknowledged that although Resident #68 understands and speaks some English, a care plan for the Resident's preference to use an interpreter when communicating with a doctor or health care staff should have been developed, implemented and included in the resident's person-centered comprehensive care plan. 4. Resident #84 was admitted to the facility with the following diagnoses: Metabolic Encephalopathy; Quadriplegia;Traumatic Spinal Cord Dysfunction; Chronic Respiratory Failure; Dependence On Respirator [Ventilator] Status; Encounter for Attention to Tracheostomy; Dysphagia; Encounter for Attention to Gastrostomy, Anxiety Disorder and Depression. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #84 had a Brief Interview for Mental Status (BIMS) of, 15 indicating that the Resident had intact cognition. In addition, the resident was coded as having impairment s on both sides for the upper and lower extremities, limited range of motion; was dependent on staff for all ADLs (activities of daily living) including, had an indwelling urinary catheter, had a urinary tract infection within past 30 days of the assessment and had received antibiotic treatment. An SBAR Communication Form dated 01/02/25 that documented: Situation: Resident was noted with blood in Foley bag .Request/Nursing Notes: Patient was noted with blood in Foley bag, he denied pain or discomfort on the lower abdomen, abdomen soft, non-distended, temp of 98.0. MD (Medical Director) notified, after assessment, new order for UA (urinalysis) C/S (culture and specimen). RP (Representative) at the bedside made aware A physician's order dated 01/04/25 that directed: Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet via PEG-Tube (percutaneous endoscopic gastrostomy) every 12 hours for UTI (urinary tract infection)for 7 Days. A physician's order dated 01/07/25 that directed: Change 18Fr Foley catheter, tubing and drainage bag monthly. every night shift starting on the 7th and ending on the 7th every month. A physician's order dated 02/10/25 that directed: Foley catheter care q shift and record out put. every shift. An SBAR Communication Form dated 02/11/25 that documented: Situation: Sediments in urine . Request/Nursing Notes: Sediment noted in the urine bag, resident denied pain or abdominal discomfort. NP notified, order for Urinalysis Complete, urine culture. A review of Resident #84's comprehensive care plan lacked documented evidence that facility staff developed and implemented a comprehensive patient centered care planned that included a focus, goal, and interventions for the Resident's indwelling urinary catheter. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then acknowledged that a care plan for the Resident #84's indwelling urinary catheter care should have been developed, implemented, and included in the resident's person-centered comprehensive care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record reviews, for five (5) of 49 sampled residents, the facility staff failed to develop and/or implement care plans with goals and interventions to address: (1) Resident 38's use of a mechanically altered diet; (2) Resident#65's use of an orthotic foot brace for immobilization after the resident fractured his right foot; (3). Resident #68's preference to use an interpreter when communicating with a doctor or health care staff; 4) Resident #84's use of an indwelling urinary catheter; and (5) Resident # Resident #91's use of a left upper arm central intravenous (IV) line. (Residents #38, #65, # 68, #84, and #91) The findings included: 1. Resident #38 was readmitted to the facility on [DATE] with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Hemiplegia, Oropharyngeal Disease. Physician order dated 02/12/24 for Resident #38 instructed, Pleasure Feed Diet-Soft and Bite-Sized Texture (mechanically altered diet) .Assist feed, small bites/sips, slow rate intake, alternating consistencies. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in part that the resident has a Brief Interview for Mental Status (BIMS) summary score of 01, indicating that the resident cognitive status was severely impaired. Review of resident's care plans lacked documented evidence that the facility's staff developed a care plan to address the resident's mechanically altered diet and instruction for feeding assistance from staff. During an observation on 04/22/25 at approximately 11:30 AM, Resident #38 was sitting in bed at a 90-degree with a lunch tray in front of him on a bedside table. Additionally, Employee # 11 (assigned CNA) was standing by the side of the resident's bed preparing to feed the resident. During a face-to-face interview on 04/22/25 at approximately 11:30 AM, Employee #10 (RN/Nursing Supervisor) stated that she did not see that a care plan had been developed to address the resident's mechanically altered diet.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of 49 sampled residents, the facility staff failed to review the comprehensive person-centered care plan as required. (Resident #38) The findings included: Resident #38 was admitted on [DATE] with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Hemiplegia and Oropharyngeal Disease. A review of medical records for Resident #38 revealed that there were no care plans reviewed and implemented after MDS assessments were completed on the following dates: 04/01/24 (Quarterly), 07/02/24 (Annual) and 11/29/24 (Quarterly). During a face-to-face interview on 04/24/25 at approximately 2:50pm, Employee #18 (Director of Social Work) stated that the resident's care plans were not reviewed by the Inter-Disciplinary Team (IDT) after the quarterly MDS dated [DATE] and 11/29/24, the annual MDS dated [DATE]. Cross Reference 22B DCMR Section 3210.4

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, for two (2) of 49 residents sampled, facility staff failed to ensure that residents, who are unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. Residents #87, and #86. The findings included: Review of the facility's Activities of Daily Living (ADLs), Supporting policy dated 05/24/24 documented: - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. - Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). 1. Facility staff failed to ensure that Resident #87, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. Resident #87 was admitted to the facility on [DATE] with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia, and Muscle Weakness. Review of the resident's medical record revealed the following: A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: clear speech and comprehension of others; a Brief Interview for Mental Status (BIMS) summary score of 11, indicating mild cognitive impairment; no functional impairment in range of motion in upper extremities; and required extensive assistance of one person physical assist for ADLs. A care plan focus area last revised on 03/17/25 documented: [Resident #87] has an ADL self-care performance deficit with interventions that included to check nail length and trim and clean on bath day and as necessary, report any changes to the nurse. During an observation on 04/13/25 at 6:50 AM, Resident #87 was observed lying in bed. The resident's fingernails were noted to be long and appeared dirty, with a brown substance underneath seven out of 10 nailbeds. The resident stated, I have asked for them (fingernails) to be cut. During a face-to-face interview at the time of the observation, Employee #5 (Licensed Practical Nurse/LPN) was asked about Resident #87's fingernails. The employee admitted that she had noticed the resident's nails prior to this observation. However, when asked why she did not clean and trim Resident #87's nails, Employee #5 did not provide an answer. The evidence showed that facility staff failed to ensure that Resident #87, who is unable to carry out ADLs, received the necessary services to maintain good grooming and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Facility staff failed to ensure that Resident #86, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. Resident #86 was admitted to the facility on [DATE] with multiple diagnoses that included: Need for Assistance with Personal Care, Encephalopathy, and Chronic Respiratory Failure with Hypoxia. A physician's order dated 02/10/25 documented, Podiatry Consult and PRN (as needed). A Significant Change Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'No' for the question, 'Should Brief Interview for Mental Status (C0200-C0500) be Conducted?' that indicated the resident was severely impaired. Functional abilities that documented that the resident was dependent on staff for all ADL (Activities of Daily Living) care. During an observation conducted of the resident's room on 04/13/25 at approximately 9:30 AM, the resident was observed lying in bed and an observation of the resident's feet revealed that Resident #86 had long toenails. During a subsequent observation conducted on 04/30/25 at approximately 10:00 AM, the resident was observed lying in bed and an observation of the resident's feet revealed that Resident #86's toenails had not been addressed by facility staff. During a face-to-face interview conducted on 04/30/25 at approximately 11:38 AM, Employee #10 (Nurse Supervisor) stated that she entered the verbal order for a podiatry consult on 02/10/25 and further stated, If [it's a]podiatry consult you can call them in the morning or depending on the situation if urgent, we call right away because podiatry is in-house. If [it's a] verbal order then I put [the] order in PCC (Point Click Care-facility's electronic health record system) then call the consult doctor. The consult[ing] doctor will let us know what date he can make it to assess the resident. If there is a delay, then we call the primary doctor to see if another consult[ing] provider is available sooner. The same day the order is given by the primary doctor you [are] supposed to reach out to the Podiatrist. We have a book that list[s] the Podiatrist; it's just one Podiatrist that covers all three (3) floors, four (4), five (5) and six (6). A general progress note should be written whenever the consult[ing] provider is notified. The names of [the] residents are entered in[to] the [Podiatry] book by the nurse who puts the order in PCC, or the unit secretary if she is aware of the consult order. It's the unit manager's job to make sure that the consult[ation] is done; it's also on 24-hr (hour) report and there's a step-down meeting as well. During an observation conducted on the sixth-floor unit on 04/30/25 at approximately 12:13 PM, it revealed a [NAME] binder labeled 'Podiatry Book' and inside the Podiatry book it documented, You must place a Podiatry Consult Order in PCC for anyone you add to this list. It should read: Podiatry Consult for Nail Care one time only and print the order and place it in this book. All Care Foot and Ankle. It should be noted that for the months of February 2025 through April 2025, there was no documented evidence of Resident #86's name listed in the Podiatry book for a Podiatry consult or documented evidence that the resident was seen by the Podiatrist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview conducted on 04/30/25 at approximately 12:28 PM, Employee #27 (Facility's Podiatrist) stated, I've never seen that patient and There's a [Podiatry] book on each floor, the staff write down the names of the residents that need to be seen and I will see them, or they can call the office. That number is listed on the book as well and they can leave a message or speak with someone at my office if a resident has a consult [order] to be seen by me. I know of the [Podiatry] consults by checking the Podiatry consult book on each floor. I have never seen that resident and not aware of a [Podiatry] consult for that resident. During a face-to-face interview conducted on 04/30/25 at approximately 1:03 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated, The Podiatrist comes into the building. We put the consult[ation] order in the [Podiatry] book and Podiatry [the Podiatrist] goes to each floor. The Podiatrist will look in the book to ensure the resident is seen. I don't know how a resident would not get seen by Podiatry if there's an order because the name should be in the book.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, for two (2) of 49 sampled resident's the facility's staff failed to follow: (1) Professional Standards of Practice when preparing to administer a subcutaneous injection as evidenced by Employee #16 prepared who a Heparin [anticoagulant] injection using an intramuscular (IM) gauge and length needle instead of a subcutaneous (SQ) gauge and length needle. It should be noted that the surveyor intervened before Employee #16 administered Heparin with the IM gauge and length needle. And (2) failure to follow physician's orders and care plan for turning and repositioning Resident #74 every two (2) hours. The Findings included: Resident # 75 was admitted on [DATE]. The resident had a history of Deep Vein Thrombosis (DVT). According to Pfizer medication information leaflet titled, Heparin Sodium Injection, Solution Hospira, Inc. with a revision date of 05/2021 documented in part, Administer Heparin Sodium Injection by intermittent intravenous injection, intravenous infusion, or deep subcutaneous (intrafat, i.e., above the iliac crest or abdominal fat layer) injection. Do not administer Heparin Sodium Injection by intramuscular injection because of the risk of hematoma at the injection site . https://labeling.pfizer.com/ShowLabeling.aspx?id=4313 A policy titled, Subcutaneous Injections with a review date of 05/24/24 documented in part, The following equipment .will be necessary when performing this procedure .Needle (25 to 27 guage, 3/8 to 5/8 inch) . A policy tilted, Intramuscular Injections with a review date of 05/24/24 documented in part, The following equipment .will be necessary when performing this procedure .Needle (19 to 23 guage, 1 to 1 ½ inch) . A physician order dated 04/20/25 instructed, Heparin Sodium [anticoagulant] Injection Solution 5000 units/milliter. Inject 1 ml subcutaneously every 8 hours for DVT. A review of the employee's personnel file revealed the employee date of hire was 01/10/25. The employee received a training titled, Anticoagulant Therapy and Risk Reduction on 01/22/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on 04/18/25 starting at 8:55 AM, Employee #16 (RN) revealed the employee aspirated Heparin Sodium Injection Solution 5000 units per one (1) milliter into a syringe. The employee aspirated the medication using a 1 inch, 1 guage needle. After aspirating the medication, the employee capped the needle and took the medication into the resident's room to administer. When the employee was preparing to administer Heparin, the surveyor asked what site she was administering Heparin? The employee said subcutaneously at the left lower abdomen. The surveyor intervened and asked the employee not to administer the Heparin and step outside the resident's room. The employee was then asked what was the appropriate needle for administering a subcutaneous injection? The employee failed to provide an answer. At the time of the interview, Employee #6 (RN/Unit manager) stated that the employee should use a tuberculin (28 guage, ½ inch - equivalate to 4/8 of an inch) syringe to administer the Heparin. The needle that the employee had was for IM injections. It should be noted the employee was later observed by the surveyor administering Heparin using the tuberculin syringe. 2.Resident #74 was admitted to the facility on [DATE], with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure with Hypoxia and Type 2 Diabetes Mellitus. Review of the resident's medical record revealed the following: A face sheet that listed the resident's daughter was her Responsible Party/RP, care conference person and emergency contact #1. A physician's order dated 02/10/25 that directed, Turn and repositioning every two hours using wedges or pillows for pressure redistribution every shift. A Quarterly MDS assessment dated [DATE] showed that facility staff coded: functional limitations in range of motion on both sides for upper and lower extremities and was totally dependent on staff for all activities of daily living (ADLs). A care plan focus area revised on 04/07/25 documented, [Resident #74] has an ADL self-care performance deficit, and had interventions that included, The resident is totally dependent on 2 staff for repositioning and turning in bed Q2H (every two hours) and as necessary. During a face-to-face interview on 04/13/25 at 7:28 AM, Resident #74's daughter/RP stated, The staff are not turning my mother when I am not here, leaving her soiled for long periods of time. During an observation on the 6th floor on 04/24/25 starting at 11:30 AM, Resident #74 was observed lying in bed, positioned on her left side, with pillows on the right side of her body for pressure redistribution. During a second observation on the 6th floor on 04/24/25 at 1:31 PM, Resident #74 was observed lying in bed, positioned on her left side, with pillows on the right side of her body for pressure redistribution. During a third observation on the 6th floor on 04/24/25 at 2:33 PM, Resident #74 was observed lying in bed, still positioned on her left side, with pillows on the right side of her body for pressure redistribution. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A face-to-face interview was conducted on 04/24/25 at 2:35 PM, at Resident #74's bedside with Employee #23 (her assigned Certified Nurse Aide/CNA) and Employee #6 (6th floor Unit Manager). When asked, Employee #23 stated that she repositioned Resident #74 at 1:30 PM. Employee #23 was further asked why Resident #74 was still positioned on the same side (the left) as when first observed by the surveyor at 11:30 AM (three hours prior), if she in fact had repositioned the resident. The employee did not respond and proceeded to reposition Resident #74 on her right side, with pillows on the left side of her body for pressure redistribution, with help from Employee #6. The evidence showed that for three hours, facility staff failed to turn and reposition Resident #74 as instructed by the physician's order and her comprehensive care plan.

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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 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** Based on observation, record reviews and staff interviews for one (1) of 39 sampled residents, facility staff failed to consistently assess and document changes in the skin of Resident #47 who developed an in-house, acquired pressure injury/ulcer that was first identified at an advanced stage (Stage 3). (Resident #47) These failures resulted in actual harm to Resident #47. The findings include: A policy titled, Prevention of Pressure Ulcers/Injuries with a revision date of 05/24/24 instructed staff to, Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living); Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) .Moisturize dry skin daily; and Reposition resident as indicated on the care plan . 1. Resident #47 was admitted to the facility on [DATE] with multiple diagnoses including Quadriplegia, Encephalopathy, Chronic Respiratory Failure (Hypoxia) and Muscle Weakness. A quarterly Minimum Data Set assessment dated [DATE] documented that the Brief Interview for Mental Status summary score was blank indicating that the resident did not respond to the test questions. The resident was coded for bilateral impairment of upper and lower extremities and being totally dependent on staff for all activities of daily living, being at risk for developing pressure ulcers, being on a turning and repositioning program, and using a pressure reducing bed. Also, the resident's height was documented as 74 inches [6.1 feet] and weight was 176 pounds. A physician order dated 11/06/24 instructed, Aquaphor External Ointment (Emollient) apply to bilateral lower extremities topically two times a day for wound care. Off-load bilateral heel with off-loading device every shift for pressure redistribution .Turn and reposition every two hours using wedges or pillows for pressure redistribution every shift. A care plan with a review date of 11/07/24 documented in part, Focus- [Resident #47] is activity of daily living dependent secondary to Quadriplegia with incontinence of bladder and bowel with inability to communicate needs .Interventions - assess, record, report and treat for any abnormality to skin during incontinent care, dependent on 2 staff to provide bath/shower and turning and repositioning every 2 hours and as necessary . totally dependent on 1 staff for personal hygiene . A physician order dated 11/08/24 instructed, Perform skin assessments on shower days twice a week and notify MD of any new changes every Tuesday and Friday. A quarterly Braden Scale for Predicting Pressure Score Risk dated 11/21/24 documented that the resident had a score of 15 indicating that the resident was at risk for developing pressure ulcers. Progress notes dated 11/22/24 to 01/07/25, lacked documented evidence of an alteration in the skin integrity of Resident #47's left foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment Administration Records dated 11/22/24 to 01/07/25, licensed nursing staff documented that the following tasks were performed for the resident: Skin assessments (head-to-toe) conducted by licensed staff twice a week on shower days; Aquaphor ointment was applied to bilateral lower extremities twice a day; Turned and repositioned daily, every two hours; Bilateral heels were off loaded (elevated) with off-loading devices (wedges/pillows) daily, every shift. However, the facility staff failed to identify the resident's left foot pressure ulcer until 01/08/25 when it was an advanced stage (Stage 3). A Situation, Background, Assessment, Request (SBAR) form dated 01/08/25 at 7:29 PM signed by Employee #14 (LPN) documented in part, Discovery of wound on left lateral aspect of the left foot started on 01/08/25 . resident properly repositioned and turned every 2 hours for purpose of proper weight distribution and prevention of further skin injury. Nurse Practitioner notified of wound and wound consult placed and order obtained for treatment of wound . A wound care nurse practitioner progress note dated 01/09/25 at 7:23 PM documented in part, Reason for visit: new skin and wound consult .Patient with new stage 3 pressure injury to the left lateral distal foot . Lower Extremity Exam .Texture: dry, flaky, thickened, Perfusion: diminished pedal pulses, left foot cool to touch, Sensation: Bilateral lower extremity insensate, Associated Findings: generalized dryness . Wound Status: Odor Post Cleansing: None, Size: 1 cm (centimeters) x 0.8 cm x 0.2 cm. Calculated area is 0.8 sq (square) cm, Wound Base: 20% epithelial , 70% granulation , 10% slough , 0% eschar, Wound Edges: Attached Periwound: Fragile, Callous, Exposed Tissues: Subcutaneous, Exudate: Moderate amount of Serosanguineous .Treatment- cleanse wound with wound cleanser, apply Iodosorb (topical antiseptic ointment) to base of wound, secure with boarder gauze, change daily . An observation with the wound nurse on 04/22/25 at approximately 12:30 PM showed the resident lying in bed, awake, non-verbal, and well groomed. The resident had a dressing to the left foot. The dressing was dry and intact. When the wound nurse practitioner removed the dressing, the wound had no smell, was approximately 1 inch in width and no depth, red tissue in center with pink surrounding tissue. During a face-to-face interview on 04/22/25 at approximately 12:30 PM, Employee #35 (Nurse Practitioner - Wound Specialist) stated that staff informed him on 01/08/25 that the resident had a new wound on his left foot. On 01/09/25, he assessed the resident and determined that he had a Stage 3 pressure wound to the left lateral foot. Also, Employee #35 said that he requested a longer bed for the resident because the resident's left foot was pressing against the bed's footboard which likely contributed to pressure at the site of the pressure injury. As a result, Resident #47 subsequently was issued a new bed with an extended footboard. During a face-to-face interview on 04/30/25 at approximately 3 PM, Employee #14 (assigned LPN) stated that he should have documented the characteristics of the resident's wound (size, depth, color, odor) on the SBAR dated 01/08/25. Additionally, the employee said that he conducts head-to-toe-assessments skin assessments twice a week and as needed. And he ensures that the resident is turned and reposition every-two-hours daily and heels are always elevated off the mattress to prevent pressure. During a face-to-face interview on 04/30/25 at approximately 3:30 PM, Employee #10 (RN/Nurse Supervisor) reviewed the resident's medical record and said that she did not see documentation of a skin integrity issue with the resident's left foot before 01/08/25. (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 05/01/25 around 3:30 PM, Employee #36 (Central Supply Technician) indicated that he had received an electronic work order for a longer bed for Resident #47. According to the employee, he did not keep a copy of the work order and could not recall the exact date when he received it. However, he remembered that he provided the resident with a bed that extended at the foot portion on 02/18/25. Cross reference 22B DCMR Sec.3211.1(b)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 2. A policy titled, Smoking Policy with a review date of 12/2024 instructed in part, To protect the health, safety, and comfort of our residents, visitors, medical staff and employees . Bridge Point is a smoke free facility. Smoking may not occur with the facility. This policy is applicable to all employees, staff, visitors, and residents, both smokers and non-smokers. The information in this policy will be reviewed with all staff during orientation and on an annual basis .Residents receive information regarding policy during the admission process .Residents and visitor compliance with the policy is a shared responsibility of all Bridge Point employees and staff .The nursing facility acts to minimize the smoke (sp) to the greatest extent possible. The nursing facility will provide smoking jackets for resident use for safety . 2a. Resident #80 was admitted on [DATE] with multiple diagnoses including Chronic Respiratory Failure, Muscle Weakness, and Difficulty Walking. A quarterly Minimum Data Set assessment dated [DATE] documented in part, Brief Interview for Mental Status summary score of 15 indicating that the resident had an intact cognitive status. The resident was coded for having impaired bilateral lower extremities and requiring partial to maximum assistance from staff with activities of daily living. A review of a list of residents in the facility who smoke on 04/15/25 at approximately 3:45 PM, revealed Resident #10 and Resident #92 were identified by staff as smokers. At the time of review, Employee #1 (Administrator) and Employee #2 (DON) stated that they were a Non-Smoking Facility. Staff do not provide residents with assistance with smoking. The facility does not have a designated area for smoking. And all residents who smoke go outside and up the street away from the building when they smoke. On 04/15/25 starting at approximately 3PM, the State Survey Team conducted a tour of the facility that included observations, resident interviews, and staff interviews. The tour revealed that the facility had two additional residents who smoke (Residents #46 and #80). An observation on 04/15/25 at 3:45 PM revealed a designed smoking area sign posted on the wall to the left of the facility's main entrance door. At the time of the observation, Employee #1 (Administrator) stated the sign was an old sign, and that the area was not a designated smoking area. During an observation on 04/15/25 at approximately 4:45 PM, Resident #80 was lying in bed, alert and orientated to name, time, place, and situation. At the time of the observation, the resident stated that he started smoking again a few weeks ago. He said that he smokes daily outside of the building near the wheelchair ramp that's close to the entry door. Additionally, the resident said, I would never smoke in the building. It is a hospital, and everyone knows you don't smoke in a hospital. When asked if he had access to cigarettes and matches, the resident showed the surveyors an opened pack of cigarettes and a green butane lighter. Also, the resident said he was not provided with information about the facility's smoking policy. A review of Resident #80's medical record on 04/15/25 at approximately lacked documented evidence of a care plan addressing the resident smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #80 was identified by staff as a smoker. The facility's protocol is that all residents who smoke have a care plan in place to address the resident smoking. The employee then said she reviewed Resident #80's medical record and did not see a smoking care plan. Additionally, the employee said that a smoking assessment would not be done unless the resident triggers for new behavior of smoking. During a face-to-face interview on 04/17/25 at approximately 9 AM, Employee #11 (assigned CNA) stated that she was not aware that Resident #80 was a smoker. Additionally, the employee said she did not know if residents were allowed to keep cigarettes and lighters in their person or in their rooms. And that she was not aware of the facility's smoking policy. During a face-to-face interview on 04/17/25 at approximately 9:15 AM, Employee #12 (assigned LPN) stated that Resident #80 is a smoker. The resident lets staff know when he is going out to smoke. Staff do not assist him with smoking. And she was not aware of the facility's policy with residents keeping their cigarettes, matches, or lighter on their person or in their room. She believed that Resident #80 is allowed to keep his cigarettes and lighter with him. 2b. Resident #46 was admitted on [DATE] with multiple diagnoses to include Chronic Obstructive Pulmonary Disease, History of Falls, Generalized Muscle Weakness, Schizophrenia, Bipolar and Anxiety. A Smoke-Safety Screen dated 12/04/23 documented in part, Resident had cognitive loss, visual deficits and dexterity problems. The resident smokes 2-2.5 cigarettes daily .has received cigarettes from other residents, possible new behavior .safe to smoke with supervision .unsafe for resident to smoke related to impaired decision making and limited mobility . Please note review of the resident medical record to include assessments and progress notes from 01/01/25 to 04/14/25 lacked documented evidence that the facility's staff monitored the resident for receiving cigarettes from other residents. A review of an annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status summary score of 12 indicating that the resident had a moderately intact cognitive status. Additionally, the resident was not coded for using tobacco products. A care plan with a revision date of 01/16/25 documented in part, Focus- [Resident #46] has a history of smoking related to lifestyle .Interventions - [Resident #46] was educated about the facility policy on smoking. The facility non-smoking facility and she verbalized understanding. Notify charge nurse immediately if it suspected that resident has violated facility smoking policy. Smoking cessation was offered. A quarterly MDS assessment dated [DATE] documented in part that the resident had a Brief Interview for Mental Status summary score of 11 indicating the resident had a moderately impaired cognitive status. Also, the resident was coded for requiring supervision to maximum assistance from staff with activities of daily living and independently using a manual wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a face-to-face interview on 04/15/25 at approximately 4:50 PM, Resident #46 stated that she smokes outside the building near the wheelchair ramp. She also keeps her cigarettes or black and mild (cigar) on her person. She will ask residents who are outside smoking with her for a lighter or match. The resident stated that, I'm grown. I don't need no one to supervise me while I'm smoking. The resident also stated that when she goes outside, she does not announce that she is going out to smoke. During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #46 was identified by staff as a smoker. Additionally, the employee stated that she had reviewed the resident record it did not see that the resident was being monitored for the behavior of asking other residents for cigarettes, as indicated on the smoking evaluation dated 12/04/23. During a face-to-face interview on 04/17/25 at approximately 9:30 AM, Employee #11 (assigned CNA) stated that Resident #46 was a smoker. She informs the nurses when the resident wants to smoke. She pushes the resident in her wheelchair outside (in front of the building) to smoke. Additionally, the employee said that she does not assist the resident with lighting light her cigarettes. And she does not know where the resident keeps her cigarettes, lighters or matches. Additionally, the employee said that she was not aware of the facility's smoking policy. During a face-to-face interview on 04/17/25 at approximately 9:40 AM, Employee #12 (assigned LPN) stated that Resident #46 is a smoker. The CNA accompanies her while she smokes. Also, the CNA is responsible for lighting the resident's #46's cigarette because the resident was not safe to do that task. 2c. Resident #92 was admitted on [DATE] with multiple diagnoses including Paraplegia, Muscle Weakness, Depression, Bipolar, and Anxiety. A review of the resident's medical record lacked documented evidence of a smoking care plan. A quarterly Minimum Data Set assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status summary score of 15 indicating the resident had an intact cognitive status. The resident was also coded for impairment of upper extremities (both sides), impairment of lower extremities (both sides), requiring partial to maximum staff assistance with activities of daily living, and independently using a motorize wheelchair for mobility. During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #80 was identified by staff as a smoker. The facility's protocol is that all residents who smoke should have a smoking care plan in their medical record. The employee then said she reviewed Resident #92's medical record and did not see a smoking care plan. Additionally, the employee said that the resident would not have a smoking assessment unless they trigger for a new behavior of smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a face-to-face interview on 04/17/25 at approximately 10 AM, Resident #92 stated that he was a smoker and goes outside and to the street to the corner to smoke. The resident was asked if he had any smoking paraphernalia such as cigarettes and a lighter on his person and the resident stated, No, I don't have nothing [anything] on me, and my lighter is broke. When asked how he would light his cigarettes if he didn't have a lighter, the resident stated, I would just get a light from somebody else that's outside smoking. During a face-to-face interview on 04/17/25 at 10:20 AM, Employee #33 (CNA) stated that she was not aware of any residents that smoke. The employee also said that she was not aware where residents store their smoking paraphernalia. 2d. Resident #10 was admitted on [DATE] with multiple diagnoses including Nicotine Dependence, Paraplegia, Epilepsy, Lack of Coordination, Muscle Weakness, and Bipolar. A review of a care dated 01/04/24 documented in part, Focus - [Resident #10] is a cigarette smoker and does not wish to stop during the hospital stay .Interventions: Explore smoking apron, Educated about the facility policy on smoking. The Facility Non-smoking Facility and he verbalized understanding, Offer a nicotine patch. Offer smoking cessation classes. Resident able to smoke unsupervised per the smoking assessment. Resident smokes off [the] Facility premises. An annual Minimum Data Set (MDS) assessment dated [DATE] documented that the Brief Interview for Mental Status (BIMS) summary score of 15 Brief Interview for Mental Status (BIMS) summary score of 15 indicating that the resident had an intact cognitive status. Additionally, the resident was coded for having an impairment of the upper extremity (one-side), impairment of lower extremities (both sides), requiring set-up to partial staff assistance from staff with activities of daily living, independent with using his motorized wheelchair, and using tobacco products . A quarterly Smoking Safety Screen assessment dated [DATE] documented that the resident had a score of 1. 0 indicating that the resident was safe to smoke without supervision. The assessment also documented in part, Smokes 5- 10 cigarettes per day, Can light his own cigarettes, Does not need the facility to store lighters and cigarettes, Adaptative equipment needed - cigarette holder, Safe to smoke independently . A quarterly Smoking Safety Screen assessment dated [DATE] documented that the resident had a score of 1. 0 indicating that the resident was safe to smoke without supervision. The assessment also documented in part, Smokes 5- 10 cigarettes per day, Can light his own cigarettes, Does not need the facility to store lighters and cigarettes, Adaptative equipment needed - smoking apron and cigarette holder, Safe to smoke without supervision. A quarterly MDS assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) summary score of 15 indicating that the resident had an intact cognitive status. Additionally, the resident was coded for having an impairment of the upper extremity (one-side), bilateral impairment of lower extremities, requiring set-up to partial staff assistance with activities of daily living, and independent with using motorized wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a face-to-face interview on 04/17/25 at 9:50 AM, Resident #10 stated, I go smoke my cigarettes around the corner. I never got no smoking apron or cigarette holder. I would like to have a smoking apron. When asked where he stores his smoking paraphernalia (cigarettes and lighter), the resident stated, I get it from someone I know outside. When asked about the facility's smoking policy or smoking contract, Resident #10 stated, I don't know nothing about a policy or contract, they just tell us don't smoke. During a face-to-face interview on 04/17/25 at 11:33AM, Employee #31 (assigned LPN) stated that she did not know Resident #10 was a smoker. I have never seen cigarettes on him. I know the resident goes downstairs but I don't know what he does there. When asked about the facility's smoking policy the employee stated, I don't know the specifics. I know that the residents are not allowed to smoke. During a face-to-face interview on 04/17/25 at 11:35 AM, Employee #32 (assigned CNA) stated, I am not aware if [Resident #10] is a smoker. I have never found or seen any smoking materials in his possession. When asked about the facility's smoking policy, the employee stated that she was not aware of one. During a face-to-face interview on 04/17/25 at approximately 12:00 PM, Employee #2 (DON) acknowledged that Resident #10 is a known cigarette smoker and that facility staff failed to ensure that he was smoking safely as evidenced by not providing the resident with the required adaptative equipment needed (smoking apron and cigarette holder). These findings resulted in an Immediate Jeopardy being called on 04/17/25 at 3:36 PM. On 04/17/25 at 8:28 PM, the facility's Administrator provided the State Agency Survey Team with an acceptable Plan of Removal that addressed the immediate concerns with residents' smoking. The plan included the following interventions: Resident-Specific Interventions - Resident #10: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 - Resident #46: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 - Resident #80: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 - Resident #92: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Resident #48: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 Facility-Wide Interventions - We will conduct a facility-wide audit of all residents to identify active smokers starting 4/18/25. Smoking Policy will be revised as of 4/18/25. - We will complete the Smoking Safety Assessment on all identified smokers starting 4/18/25. We will update and individualize the care plans for each smoker to reflect supervision needs, location, and supplies needed to assure safe smoking based on their assessment findings starting 4/18/25. If smoking paraphernalia is found, we will immediately attempt to confiscate all smoking paraphernalia. If unable to confiscate the smoking materials, social services, recreation services, ombudsman and/or the police will be involved. All items confiscated will be labeled and logged. - We will reinforce the prohibition of smoking materials in resident rooms or on persons with residents and staff. This will be started 4/18/25. - Residents identified as smokers will be educated starting 4/18/25 on the updated smoking policy, smoking process and a smoking contract. Staff Education and Competency Validation - 70 percent of current staff (clinical, non-clinical, and agency staff) will receive in-service training on the smoking policy, safe smoking practices, resident supervision, and emergency response protocols starting 4/18/25. The goal will be 100% of staff to receive training. - Training will include the revised smoking policy and procedure. Nursing staff or designee will be assigned to monitor known smokers in the designated smoking area - Smoking binders will be placed on all floors and the security desk to help identify residents who smoke. Implementation of Systems and Monitoring Processes - We will develop a daily room audit tool that includes permission to inspect for smoking paraphernalia (lighter, cigarettes, etc.). This will be completed by nurse aide or designee. - We will establish and enforce a smoking materials storage protocol; only designated staff will have access. - We will create a resident smoking log and supervision documentation tool that includes time in/out, safe smoking supplies offered/accepted or declined. - We will assign a designated Smoking Safety Supervisor per shift. - We will complete monthly audits added to the QAPI Committee agenda for compliance tracking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Designated Smoking Area Protocols - We will enforce the use of a designated smoking area (outside to the left of the main entrance on the ground level)- Smoking area will include a fire extinguisher (in close proximity), fire blanket, will post no-smoking signage, and will have locked cart for smoking materials at the security desk). - All residents who smoke will have to sign in/out and will be supervised by a nursing assistant or other clinical staff. - Smoking aprons will be offered and documented on the smoking log. Return of smoking materials will also be documented on the log. - Residents will only be able to access smoking materials during scheduled supervised times. (10am,1 pm, 4pm, 7pm and 10pm). Completion date for Immediate Jeopardy Compliance - 4/21/25 After the plan was verified, the IJ was removed on April 24, 2025, at 1:50 PM while the survey team was onsite. Based on observations, record reviews and staff interviews, for six (6) of 49 sampled residents, facility staff failed to ensure that resident environments were free of accident hazards as evidenced by: (1) Four portable space heaters observed in Residents' #10, #48, #87, and 92 rooms; and (2) Inadequate supervision and unsafe smoking practices for Residents' #10, #46, #80, and #92 who were identified by staff as smokers. An Immediate Jeopardy, related to space heaters in resident rooms, was identified on 04/13/25 at 1:34 PM. The facility provided a plan of action to address the immediacy on 04/13/25 at 5:04 PM that was accepted. After the plan was verified, the IJ related to space heaters was removed on 04/22/25 at 9:34 AM, while the survey team was onsite. After the removal of immediacy, the deficient practice remained at a scope and severity of E. An Immediate Jeopardy, related to inadequate supervision and unsafe smoking practices were identified on 04/17/25 at 3:36 PM, The facility provided an acceptable Plan of Removal to address the immediate concerns on 04/17/25 at 8:28 PM. While on site the State Survey Team, verified that the facility's Plan of Removal interventions for inadequate supervision and unsafe smoking practices were implemented. The IJ was then removed on 04/24/25 at 1:50 PM. After removal of the immediate concerns, the deficient practice remained at a scope and severity of D. The findings included: 1. Review of the facility's Electrical Appliances policy dated 05/24/24 documented: Portable space heaters are not allowed in resident areas. 1a. Resident #87 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Respiratory Failure with Hypoxia and Hypercapnia, Asthma, and Muscle Weakness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE] which showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 11, indicating mild cognitive impairment. There was no functional impairment in range of motion and in upper extremities that was noted. During a unit tour of the 5th floor on 04/13/25 at 6:50 AM, a portable space heater was observed in use and blowing hot air on Resident #87. The space heater was noted to be approximately less than one foot away from the resident's bed, on top of a gray, plastic wash basin, that was sitting on top of the bedside drawer. During a face-to-face interview at the time of the observation, Employee #5 (assigned Licensed Practical Nurse/LPN) was asked why there was a space heater in the resident's room. The employee responded, [Resident #87] was transferred to this room with the space heater about three (3) days ago. She gets cold. I think her family bought it for her. When asked if she was aware that space heaters were not permitted in resident care areas, the employee did not respond. During subsequent observations of all resident rooms, on all floors, portable space heaters were noted plugged in for use on the fourth and fifth floors respectively for the following residents: #92, #10, and #48. 1b. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses that included: Muscle Weakness, Paraplegia, and Nicotine Dependence. Review of the resident's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated [DATE] that showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition and had functional limitation impairment in range of motion on one side for upper extremities. 1c. Resident #92 was admitted to the facility on [DATE] with multiple diagnoses that included: Paraplegia, Polyneuropathy, Generalized Muscle Weakness, and Need for Assistance with Personal Care. Review of the resident's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated [DATE] that showed facility staff coded: a BIMS summary score of 15, and functional limitation impairment in range of motion on both upper extremities. 1d. Resident #48 was admitted to the facility on [DATE] with diagnoses that included Quadriplegic C5-C7 and Vascular Myelopathy. Review of Resident #48's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated [DATE] that showed facility staff coded a BIMS summary score of, 15, and impairments in functional limitations in range of motion impairment on both sides for upper and lower extremities. It should be noted that Residents' #87, #48, #84, #10 were non-ambulatory. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A face-to-face interview was conducted on 04/13/25 at 10:22 AM with Employees #3 (Registered Nurse/RN Supervisor) and Employee #4 (Plant Operations Supervisor). Employee #3 stated that she was not aware that space heaters were not allowed in resident rooms. Employee #4 acknowledged the findings and stated that space heaters are not allowed in resident rooms. These findings resulted in determination of Immediate Jeopardy on 04/13/25 at 1:34 PM. The facility's Administrator provided a plan of action to address the immediacy on 04/13/25 at 5:04 PM that was accepted and included: 1. Immediate Removal of Hazard Facility staff will be sent to each unit simultaneously to the rooms identified by surveyors to remove the portable space heaters within 15 minutes of notification of the Immediate Jeopardy. All other resident rooms will be checked and any portable space heaters found will be removed immediately on 04/13/25. 2. Environmental Sweep A facility-wide sweep will be conducted by the Maintenance Director and Administrator within 1 hour to identify any other unauthorized electrical appliances or hazards. Documentation of the sweep, including date, time, and rooms assessed, will be completed and placed in the IJ response binder on 04/13/25. Any additional hazards found will be removed immediately, and residents will be educated as needed. 3. Policy Enforcement The facility's Electrical Appliances policy will be reviewed and updated to explicitly prohibit portable space heaters in all patient care areas on 04/13/2025. 4. Resident and Family Education All residents and their responsible parties will be provided with written and/or verbal education on prohibited appliances, including portable space heaters, starting on 4/13/2025. A robo call will be sent to every family member/POA on 04/13/25 regarding the prohibition of portable space heaters. 5. Staff Education All staff present here today on 04/13/25 including housekeeping, maintenance, dietary, nursing, and respiratory therapy will be educated on identifying and reporting unsafe resident practices and prohibited electrical appliances as of 4/13/2025. All other staff will be educated upon arrival before the start of their next shift on prohibited electrical appliances to include portable space heaters starting on 04/13/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	We will complete at least 80% compliance by Wednesday, April 16, 2025, with a goal of 100%. 6. Date of Compliance April 16, 2025 The Survey Team verified that the plan of action to address the immediacy was in place. The Immediate Jeopardy related to space heaters in resident rooms was lifted on 04/22/25 at 9:34 AM while the survey team was onsite.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility staff failed to provide a resident with water flushes via Percutaneous Endoscopic Gastrostomy (PEG) tube as prescribed for one (1) of 49 sampled residents. (Resident #38) The findings included: Resident #38 was admitted on [DATE] with multiple medical diagnoses that included Dysphagia following Cerebral Infarction and Gastrostomy Tube. A care plan with a review date of 09/13/24 documented in part, Focus - [Reside#38] requires tube feeding related to Dysphagia .Interventions -The resident is dependent with [gastrostomy] tube feeding and water flushes . A physician order dated 02/12/25 instructed, hydration water flushes 300 milliliters every four (4) hours via gastrostomy tube. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in part that the resident had a Brief Interview for Mental Status (BIMS) summary score of 01, indicating that the resident cognitive status was severely impaired. The resident was also coded for using a feeding tube. During an observation on 04/18/25 at approximately 11:00 AM, Resident #38 was lying in bed, alert and oriented to name. The resident was receiving enteral water flush hydration via gastrostomy tube. The resident's feeding pump for water flushes was set at 300 milliliters every six (6) hours. During a face-to-face interview with on 4/18/25 at approximately 11:00 am, Employee #14 (assigned LPN) stated that the feeding pump's water flush frequency setting of every six hours was incorrect. The resident has a order for water flushes every (4) hours. The employee immediateley changes the setting to every four (4) hours. When asked, did he check the tube feeding setting when he started his shift, the employee stated, No.

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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 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** Based on observations, record reviews and staff interviews, for two (2) of 49 residents sampled, facility staff failed to ensure that the residents received care and services, consistent with professional standards of practice, for their central intravenous (IV) lines. Residents' #91 and #53. The findings included: Review of the facility's Central Venous Catheter Dressing Changes dated 05/24/24 documented: - The purpose of this procedure is to prevent catheter-related infections - After the original insertion of CVAD (central venous access device), change transparent semi-permeable membrane (TSM) dressings at least every 5-7 days and PRN (as needed). According to the National Institute of Health (NIH): - Per Centers for Disease Control (CDC) guidelines and nursing standards of practice, central line dressings should be changed at a minimum of every seven (7) days and as needed. - Label the dressing with the date, time, and your initials, as well as the date the dressing should be changed again. - Labeling is a quality measure to promote ongoing adherence to agency policies and recommendations. https://www.ncbi.nlm.nih.gov/books/NBK594495/ 1. Resident #91 was admitted to the facility on [DATE] with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure. Review of the resident's medical record revealed the following: An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. Physician's orders dated 02/10/15 directed, Established [central] line - Change dressing Q (every) 7 days, every night shift every Monday for IV-line Care; Change dressing as needed if not intact or soiled as needed for IV care; Observe insertion site every shift for redness, warmth, swelling, drainage, coldness or irritation, every shift for IV care. Review of the April 2025 Treatment Administration Record (TAR) showed that on 04/07/25, facility staff documented a check mark and their initials to indicate that the resident's central IV-line dressing was changed during the night shift. During an observation on 04/13/25 at 2:28 PM, Resident #91 was noted with a left upper arm peripheral inserted central catheter (type of CVAD) with a dressing that was dated 04/03/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview at the time of the observation, Employee #16 (Registered Nurse/RN) acknowledged that the central line dressing had not been changed in over seven days, and that the facility's policy is to change the dressing at least every seven days. The evidence showed that facility staff failed to ensure that Resident #91 received care and services, consistent with professional standards of practice for her left upper arm peripheral inserted central catheter IV site. 2. Resident #53 was admitted to the facility on [DATE] with multiple diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Anoxic Brain Injury. Review of the resident's medical record revealed: A Quarterly MDS assessment dated [DATE] showed that facility staff coded that the resident had an IV access. A physician's order dated 04/15/25 directed, Established [central] line, change dressing every 7 days, every night shift, every Sunday for midline dressing change. Review of the TAR for April 2025 showed that facility staff documented a check mark and their initials to indicate that the resident's midline central IV site dressing was completed on 04/26/25. During an observation on 04/28/25 at 10:00 AM, Resident #53 was observed lying in bed, the dressing on his midline IV site was noted with a transparent dressing that had no date on it to show when the central line catheter dressing was last changed. During a face-to-face interview at the time of the observation, the Employee #6 (6th Floor Unit Manager) acknowledged the finding and stated, There's no date visible to say when the dressing was changed so it will get changed today.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 49 residents sampled, facility staff failed to ensure that Resident #53's attending physician evaluated his total program of care as evidenced by failing to have documented evidence that the physician reviewed the pharmacist recommendations for four (4) months. The findings included: Review of the facility's Medication Regimen Review policy dated 06/21/17 documented: - The pharmacist must report any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing (DON), and these reports must be acted upon in a manner that meets the needs of the residents. - For non-urgent recommendations, the facility, and attending physician must address the recommendation(s) in a timely manner, no later than their next routine visit. Resident #53 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Pain, Schizophrenia, Anxiety Disorder, and Anoxic Brain Injury. Review of the resident's medical record revealed the following: Physician's orders dated 10/29/24 that directed, Lidocaine External Patch (topical pain reliever) 4% (Lidocaine), apply to left lower leg topically one time a day for leg pain; Olanzapine (Antipsychotic medication) oral tablet 2.5 MG (milligrams), give 2.5 mg via G (gastrostomy) -tube two times a day; Quetiapine Fumarate (Antipsychotic medication) oral tablet 150 MG, give 150 mg via G-tube every 12 hours; and Acetaminophen (pain reliever) oral tablet, give 650 mg via G-tube every 6 hours as needed (PRN) for Pain. A physician's order dated 11/20/24 that directed, Oxycodone (narcotic pain reliever) HCl (hydrochloride) oral tablet 5 MG, give 1 tablet enterally every 4 hours as needed for Pain. It should be noted that this medication was discontinued (d/c) on 01/30/25. 11/21/24 at 5:50 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review (MRR) report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Olanzapine 2.5 mg, give via G-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via G-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS (Centers for Medicare and Medicaid) with antipsychotic drug utilization, recommend review and clarify indication. - Lidocaine Patch 4%, apply to left lower leg topically one time a day for leg pain at 9:00 AM. Patch can be applied for up to 12 hours. There shall be a drug-free period of 12 hours. To avoid medication administration errors, clarify directions with prescriber to include 12 hours on and 12 hours off. Kindly update PointClickCare (PCC/facility's electronic) and document lidocaine patch removal at 9:00 PM on the Medication Administration Record (MAR). Review of the MRR for November 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 12/19/24 at 1:41 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G (gastrostomy) - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). Review of the MRR for December 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 01/22/25 at 3:45 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. A physician's order dated 01/30/25 that directed, Oxycodone HCl oral tablet 5 MG, give 1 tablet enterally every 6 hours as needed for Pain. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MRR for January 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 02/16/2025 at 7:15 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. Review of the MRR for February 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 03/12/25 at 11:05 AM Care Conference Note: - [Resident #53] had a care conference held on 03/11/25 with the interdisciplinary team (IDT) team and niece to discuss the plan of care. - The plan of care was reviewed and will continue. A care plan focus area, reviewed on 03/11/25, documented, [Resident #53] is at risk for adverse reaction r/t (related to) polypharmacy with interventions that included, Request physician to review and evaluate medications; review pharmacy consult recommendations, and follow up as indicated. Review of Resident #53's physician's orders showed that on 03/25/25 is when the resident's primary care doctor reviewed and acted upon the consultant pharmacist's recommendations and identified irregularities from November 2024, December 2024, January 2025 and February 2025. The evidence showed no documented evidence that from November 2024 through February 2025, four (4) months, the physician reviewed Resident #53's total program of care, to include medication management, as evidenced by the consultant pharmacist's identified irregularities and recommendations not being acted upon. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 04/28/25 at 2:55 PM, Employee #2 (DON) was asked why Resident #53's medication regimen reviews were not reviewed or acted upon from November 2024 - February 2025. Employee #2 stated, [Resident #53's] primary doctor was also the medical director, who left abruptly, without notice on 01/27/25. Her residents were then picked up by [Physician's name], who also became the Medical Director. Once reviewed and acted upon, the forms are given back to the clinical team to file. I am not sure why the doctors did not review the MRRs for [Resident #53] for those months. Cross Reference 22B DCMR Sec. 3207.10

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, for two (2) of 49 residents, sampled, facility staff failed to demonstrate appropriate competencies and skills sets to provide safe nursing services. Residents #73 and #209. The findings included: Review of the facility's Change in a Resident's Condition or Status policy dated 05/24/24 documented: - The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; need to transfer the resident to a hospital/treatment center. - Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR Communication Form. 1. Resident #73 was admitted to the facility on [DATE] with multiple diagnoses that included: Encounter for Attention Gastrostomy, Anoxic Brain Injury, and Adult Failure to Thrive. Review of the resident's medical record revealed the following: A physician's order dated 03/05/25 directed, Enteral feed order every shift for dysphagia, Glucerna 1.5 at 46 ml (milliliters)/hr(hour) X 24 hours via PEG (Percutaneous Endoscopic Gastrostomy). An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded that the resident received nutrition via a feeding tube. During an observation on 04/13/25 at 8:50 AM, Resident #73 was observed lying in bed. The machine with the resident's tube feeding was alarming with the following error message, Flow error. Clog in line down stream of pump. The surveyor pushed the resident's call light in order to alert the staff. At 9:19 AM, Employee #8 (Certified Nurse Aide/CNA) entered the room. The employee performed hand hygiene, donned gloves, and proceeded to push the restart button on the machine. When asked if he's been trained in the care of gastrostomy tubes, the employee stated, No. CNAs are not trained to troubleshoot G (gastrostomy)-tubes. During a face-to-face interview on 04/13/25 at approximately 9:30 AM, Employee #2 (Director of Nursing/DON) was made aware of the observation and stated, If the G-tube is alarming, the CNA should've made the nurse aware, they are not to restart it themselves. 2. Resident #209 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Injury, and Metabolic Encephalopathy. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical record revealed the following: A Situation Background Assessment and Request (SBAR) Communication Form completed by Employee #34 (assigned Registered Nurse/RN) 04/21/25 at 5:59 PM documented: - Situation - Tachycardia with a pulse of 135 and an oxygen saturation of 85%. - This started on: 04/21/25 at 9:00 AM. - Most Recent Vital signs: blood pressure: 108/73 - date: 04/21/25 at 1:36 AM; respiration: 18.0 (Breaths/min) date - 04/21/25 at 1:36 AM; temperature: 98.3 (°F) date - 04/21/25 at 1:36 AM, route: axillary. - Comments: In the morning the resident had a pulse of 135 and his oxygen saturation was 85%, I informed Nurse Practitioner (NP), and she said to call 9-1-1, the resident was transferred via Emergency Medical Services to [Hospital name]. Review of the SBAR form and the progress notes showed that the nurse failed to gather all relevant and pertinent information for the provider prompted by the SBAR Communication Form as evidenced by the lack of documentation that Resident #209's blood pressure, respirations or temperature were assessed at the time of his change in condition. A face-to-face interview was conducted on 04/23/25 at 4:15 PM, with Employee #34 and Employee #2 (DON). Employee #34 stated, There was a lot going on at the time. I saw that he [Resident #209] was tachycardic and his saturations were low, so I called the doctor, who said to transfer the resident to the hospital. He left the facility around 9:00 AM. Employee #2 stated, The protocol is to do a complete assessment, including all vital signs, when there is a change in condition and document them in the SBAR form to relay to the doctor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility's staff failed to ensure a resident's medication recently received from pharmacy was available for administration for one (1) of 49 sampled residents. (Resident #75) The findings included: Resident #75 was admitted on [DATE] with multiple diagnoses including Epilepsy, Spastic Quadriplegia, Ventilator Dependent and Gastrostomy Tube. A policy titled, Medication Ordering and Receipt with a review date of 01/03/25 instructed, The nurse .will sign the packing slip .indicating the correct medication has been delivered to the correct medication cart . A physician's order dated 03/31/25 instructed, Levetiriacetam (anti-epileptic drug) 100 milligrams/milliters solution administer 10 millitiers (1000 milligrams) via gastrostomy tube every 12 hours to prevent seizures. A pharmacy request form dated 04/11/25 revealed that the facility reordered Resident #75's Levetiracetam 100mg/ml solution on 04/11/25 and it was delivered to the facility on that same day. A medication observation on 04/18/25 at approximately 9:30 AM, Employee #16 (RN) was unable to locate Resident #75's Levetiracetam after looking on all three (3) medication carts and the medication room. When the employee attempted to use another resident's Keppra (10 milliters) to administer to Resident # 75, the surveyor intervened. During a face-to-face interview on 04/18/25 at approximately 9:40 PM, Employee #16 stated that she was using another resident's Levetiracetam because she could not find Resident #75's medication. When asked, is it the facility's policy to use another resident's medication? The employee said, No and then said she would make the nurse practitioner aware, so she could an order to administer the tablet (crush) form that they had on hand as stock medication. During a face-to-face interview on 04/18/25 at approximately 10 AM, Employee #6 (RN/Unit Manager) stated that an employee signed a pharmacy slip indicating that Resident #75's Levetiracetam was delivered on 04/11/25. The employee said that facility's protocol is that when the nurse signs for the medication they then put on the correct medication cart. Additionally, the employee said she could not explain why the medication was not available. Also, the employee stated that Employee #16 should not have used another resident's Levetiracetam for Resident #75.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 49 residents sampled, facility staff failed to have documented evidence that the attending physician reviewed and acted upon identified irregularities noted by the pharmacist. Resident #53. The findings included: Review of the facility's Medication Regimen Review policy dated 06/21/17 documented: - The pharmacist must report any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing (DON), and these reports must be acted upon in a manner that meets the needs of the residents. - For non-urgent recommendations, the facility, and attending physician must address the recommendation(s) in a timely manner, no later than their next routine visit. Resident #53 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Pain, Schizophrenia, Anxiety Disorder, and Anoxic Brain Injury. Review of the resident's medical record revealed the following: Physician's orders dated 10/29/24 that directed, Lidocaine External Patch (topical pain reliever) 4% (Lidocaine), apply to left lower leg topically one time a day for leg pain; Olanzapine (Antipsychotic medication) oral tablet 2.5 MG (milligrams), give 2.5 mg via G (gastrostomy)-tube two times a day; Quetiapine Fumarate (Antipsychotic medication) oral tablet 150 MG, give 150 mg via G-Tube every 12 hours; and Acetaminophen (pain reliever) oral tablet, give 650 mg via G-Tube every 6 hours as needed (PRN) for Pain. A physician's order dated 11/20/24 that directed, Oxycodone (narcotic pain reliever) HCl (hydrochloride) oral tablet 5 MG, give 1 tablet enterally every 4 hours as needed for Pain. It should be noted that this medication was discontinued (d/c) on 01/30/25. 11/21/24 at 5:50 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review (MRR) report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Olanzapine 2.5 mg, give via G-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via G-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS (Centers for Medicare and Medicaid) with antipsychotic drug utilization, recommend review and clarify indication. - Lidocaine Patch 4%, apply to left lower leg topically one time a day for leg pain at 9:00 AM. Patch can be applied for up to 12 hours. There shall be a drug-free period of 12 hours. To avoid medication administration errors, clarify directions with prescriber to include 12 hours on and 12 hours off. Kindly update PointClickCare (PCC/facility's electronic) and document lidocaine patch removal at 9:00 PM on the Medication Administration Record (MAR). Review of the MRR for November 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 12/19/24 at 1:41 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G (gastrostomy) - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). Review of the MRR for December 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 01/22/25 at 3:45 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. A physician's order dated 01/30/25 that directed, Oxycodone HCl oral tablet 5 MG, give 1 tablet enterally every 6 hours as needed for Pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MRR for January 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 02/16/2025 at 7:15 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. Review of the MRR for February 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 03/12/25 at 11:05 AM Care Conference Note: - [Resident #53] had a care conference held on 03/11/25 with the interdisciplinary team (IDT) team and niece to discuss the plan of care. - The plan of care was reviewed and will continue. A care plan focus area, reviewed on 03/11/25, documented, [Resident #53] is at risk for adverse reaction r/t (related to) polypharmacy with interventions that included, Request physician to review and evaluate medications; review pharmacy consult recommendations, and follow up as indicated. Review of Resident #53's physician's orders showed that on 03/25/25 is when the resident's primary care doctor reviewed and acted upon the consultant pharmacist's recommendations and identified irregularities from November 2024, December 2024, January 2025 and February 2025. The evidence showed that from November 2024 through February 2025, four (4) months, identified irregularities for Resident #53 were not reviewed or acted upon by the resident's attending physician. During a face-to-face interview on 04/28/25 at 2:55 PM, Employee #2 (DON) was asked why Resident #53's medication regimen reviews were not reviewed or acted upon from November 2024 - February 2025. Employee #2 stated, [Resident #53's] primary doctor was also the medical director, who left abruptly, without notice on 01/27/25. Her residents were then picked up by [Physician's name], who also became the Medical Director. Once reviewed and acted upon, the forms are given back to the clinical team to file. I am not sure why the doctors did not review the MRRs for those months.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations and staff interview, facility staff failed to ensure that the medication error rate was 5% or less. Subsequently, the facility had a 16% medication error rate. The findings included: During eight (8) medication administration observations conducted from 04/15/25 through 04/25/25 showed (4) errors out 25 opportunities. The medication error rate was 16%. During a face-to-face interview on 04/25/25 at approximately 3PM, Employee #2 stated that staff are provided with education on medication administration and medication management. She will ensure they receive additional education. Cross Reference F554, F684, F755, F761, and F880

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, facility staff failed to ensure safe and secure storage of residents' medications as evidenced by storing: three (3) opened and undated vials of insulin for three residents in the medication refrigerator, two, opened, expired insulin vials for two (2) residents in the medication refrigerator, and by failing to remove one Resident's insulin pen from the medication refrigerator after the Resident was discharged from the facility. Residents #9, # 64, #77, #209, and #259. The findings included: 1.On 04/23/25 at 12:03 PM, during an observation of the 5th Floor Medication Storage Room, one opened, expired vial of Humalog Mix 75/25 insulin for Resident #9 was observed in the medication room refrigerator. A handwritten date was observed in the box that the vial of insulin came in, indicating that the insulin vial had been opened on 03/20/25. Per manufacturers' ([NAME] Lilly) the guidelines for Humalog Mix 75/25 (https://uspl.lilly.com/humalog7525.html#ug), stated, Opened Humalog mix 75/25 vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin. this applies whether the vial is stored in the refrigerator or at room temperature. A review of Resident #9's medication record revealed the following: Resident #9 was admitted to the facility on [DATE] with diagnoses that included: Diabetes Mellitus, Atrial Fibrillation; Heart Failure; Hypothyroidism; and Gastroesophageal Reflux Disease (GERD). A physician's order dated 04/09/25 that directed: Humalog Mix 75/25 Suspension (75-25) 100 units/ml, (units per milliliter) (Insulin Lispro Protamine and Lispro) Inject 20 units subcutaneously in the morning for diabetes AC (before a meal) Breakfast. An April 2025 medication administration record (MAR) which documented that facility staff administered expired Humalog Mix 75/25 insulin to the Resident from 04/21/25 to 04/22/25. A review of Resident #9's blood sugar readings from 04/21/25 to 04/23/25 showed: 4/24/2025 08:47 88.0 mg/dL (milligram per deciliter) 4/23/2025 23:33 133.0 mg/dL 4/23/2025 16:52 127.0 mg/dL 4/23/2025 14:23 126.0 mg/dL 4/23/2025 14:18 89.0 mg/dL (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/23/2025 04:12 120.0 mg/dL 4/22/2025 15:43 83.0 mg/dL 4/22/2025 11:33 99.0 mg/dL 4/22/2025 08:30 94.0 mg/dL 4/21/2025 22:57 135.0 mg/dL 4/21/2025 15:19 198.0 mg/dL 4/21/2025 12:28 200.0 mg/dL 4/21/2025 10:14 245.0 mg/dL During a face-to-face interview on 04/09/25 with Employee # 45, a Licensed Practical Nurse assigned to Resident #9, he stated that he had not noticed that Resident #9's insulin expired. He further said that he had not removed the insulin from the refrigerator and did not administer insulin to the Resident on 04/24/25 because his blood sugar before breakfast was 88 mg/dl. During a face-to-face interview with Employee #3/5th floor Unit Manager/Registered Nurse, she stated, I take the responsibility for checking the refrigerator for expired medications. She then acknowledged the finding and said that she would discard the expired Humalog Mix 75/25 insulin from the refrigerator and order a new vial of insulin for Resident #9. 2. On 04/24/25 at 12:48 PM during an observation of the 6th Floor Medication Storage Room, in the medication refrigerator, the following was observed: one(1) vial of Aspart (Novolog) insulin opened on 03/17/25 with no expiration date for Resident #64; one opened vial of Lantus insulin with no date for Resident #209; one opened vial of Lantus insulin with no date for Resident #77, and one opened Lantus insulin pen that showed approximately 20 units had been used with no date on it for Resident #259, who was discharged from the facility on 02/28/25. A. Resident #64 was re-admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus; End-Stage Renal Disease; Seizures, and Encounter for Gastostomy. A review of Resident #64's medication record showed the following: A physician's order dated 02/10/25 that directed: Check Blood Sugar one time a day *Use Per Sliding Scale and Inject Subq (subcutaneously) * 1-150=0 units; 151-200=1 units; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; Call Physician (for) Blood Sugar greater than 400 for Diabetes Mellitus. The order was discontinued on 02/17/25. A physician's order dated 02/18/25 that directed: Insulin Aspart Injection Solution (Insulin Aspart) Inject as per sliding scale: if 1 - 150 = 0 unit; 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units BS>400, Call MD (Physician), subcutaneously one time a day for diabetes, The order was discontinued on 02/18/25 and was never renewed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per manufacturers' (Novo Nordisk) guidelines for Novolog (insulin Aspart injection), (https://www.novolog.com/taking-novolog.html), opened vials of Novolog should be disposed after 28 days, even if there is insulin left in the pen or vial. A review of Resident #64's February 2025 medication administration records showed that facility staff had not administered Aspart to Resident #64 after 02/18/25. B. Resident #209 was admitted to the facility on [DATE] with diagnoses that included: Anoxic Brain Damage, Not Elsewhere Classified Metabolic Encephalopathy. Epilepsy and Type 2 Diabetes Mellitus Without Complications. A review of Resident #209's medical record showed: A physician's order dated 04/15/25 that documented: Insulin Glargine Solution 100/ml. Inject 40 units subcutaneously two times a day for hyperglycemia. The physician discontinued the order on 04/22/24 and did not renew it. On 04/24/25, the Resident was discharged to the hospital and did not return to the facility. Two days later, the insulin was observed in the medication refrigerator. Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, In-use (opened) Lantus vials or pens can be used for 28 days whether stored in the refrigerator or at room temperature. A review of Resident#209's April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 04/15/25 to 04/22/25. Of note, the Resident's vial of Lantus insulin had no date indicating when it was opened or expired during this period. C. Resident #77 was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus Without Complications; Obstructive Hydrocephalus and Chronic Respiratory Failure. A review of Resident #77's medical record showed: A physician's order dated 03/23/25 that documented: Lantus 100 unit/ml Solution. Inject 20 units subcutaneously two times a Day for Diabetes Mellitus. Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, In-use (opened) Lantus vials can be used for 28 days whether stored in the refrigerator or at room temperature. A review of Resident #77's March and April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 03/23/25 to 04/24/25. Resident #77's vial of Lantus insulin was observed on 04/24/25 stored in the medication refrigerator with no date indicating when facility staff opened it or when it expired. D. Resident #259 was admitted to the facility on [DATE] with diagnoses that included: Quadraplegia; Type 2 Diabetes Mellitus Without Complication; Chronic Respiratory Failure; Anemia, Dysphagia, and Depression. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #259's medical record showed: A physician's order dated 02/10/25 that documented: Lantus SoloStar 100 UNIT/ML Solution pen-injector Inject 15 units subcutaneously one time a day at bedtime for Diabetes Mellitus Type 2, Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, In-use (opened) Lantus Solostar pens should be used for 28 days, even if there is still insulin left in the pen. On 02/28/25, the Resident was transferred to the hospital and did not return to the facility. Approximately 57 days later, on 04/24/25, the Resident's insulin was observed in the medication refrigerator. During a face-to-face interview on 04/24/25 at 1:55 PM, Employee #6, 6th Floor Unit Manager was made aware of the open, undated, and expired insulin stored in the medication refrigerator in the Medication Storage Room. The Employee commented that each nurse is responsible for ensuring that all medications are in date before removing them from the medication refrigerator and certainly before administering the medication to the Resident. She added that the nurses are also responsible for ensuring that all medications for residents who have been discharged from the facility are removed from the medication refrigerator and sent back to the pharmacy immediately. She further commented that if the nurse observes no date on an opened insulin vial or pen, the nurse is responsible for discarding the insulin and ordering a new vial or pen. The Employee then acknowledged the findings and stated that they would have an in-service meeting with the nurses on the unit about medication storage immediately after the interview. Cross reference 22B DCMR Sec 3227.12

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and staff interviews, the facility staff failed to ensure that food was prepared in a form designed to meet the individual needs for one (1) of six (6) sampled residents who was prescribed a mechanically altered diet. Subsequently, Resident #38 was served roast beef that was not mechanically altered to bite size as prescribed. (Resident #38) The findings included: Resident #38 was admitted on [DATE] with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Oropharyngeal Disease, Gastrostomy Tube, Gastro-Espohgeal Reflux, and Loss of Teeth. A physician's order dated 02/12/25 instructed Pleasure diet -soft and bite sized texture .upright 90-degree positioning, assist feed, small bites/sips, slow rate . Please note: This is a pleasure diet, the resident received gastrostomy tube feeding daily to meet nutritional needs, per physician order. A quarterly Minimum Data Set, dated [DATE] documented in part that the resident had a Brief Interview for Mental Status summary score was blank indicating the resident did not answer the test questions. Also, the resident was coded for impairment of bilateral upper extremities, required maximum assistance with eating, required assistance with oral hygiene, received enteral bolus tube feedings for nutrition and hydration, and received an altered diet. A speech therapy evaluation and plan of treatment dated 03/31/25 - 04/29/25 documented in part, Treatment of swallowing dysfunction .evaluation of oral and pharyngeal swallowing function . Goal-Patient will consume soft/bite sized solids .Risk Factors-due to physical impairment and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for aspiration . During an observation on 04/22/25 at approximately 1:30 PM, Resident #38 was observed awake, sitting in bed with head of bed elevated at a 90-degree angle. A bedside table with a lunch tray was positioned directly in front of the resident. The lunch tray consisted of a small bowl of roast beef chunks in gravy and one cup of juice. At the time of the observation, Employee # 11 (assigned CNA) was standing to the left of the resident's bed stating that she was getting ready to feed the resident. When asked, was the roast beef the appropriate diet for the resident, the employee failed to answer. The surveyor asked the employee not to feed the resident until Employee #15 (Speech Pathologist) could view the tray. Also noted during the observation was Feeding Protocol that was posted on the left wall of the resident's bed. The Feeding Proctol documented in part, Soft and bite-sized pleasure diet .maintain upright posture (90-degree angle) during po (by mouth) intake . During a face-to-face interview conducted outside in the resident's room [ROOM NUMBER]/22/25 at approximately 1:35 PM, Employee #15 (Speech Pathologist) viewed the lunch tray and stated that the roast beef appeared to be larger than bite sized. The employee then stated, This is unsafe for the resident. Bite sized is no larger than 1.5 centimeters. I will go down and talk to dietary. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 04/22/25 at approximately 1:40 PM, Employee #17 (Dietician) stated that she was not sure if the roast beef was bite sized. She would talk with dietary staff to find out. During a face-to-face interview on 04/23/25 at approximately 9 AM, Employee #37 (Director of Food and Nutrition) stated that her staff made an error with the resident's lunch tray on 04/22/25. The employee then said, They sent the resident a regular diet instead of bite sized.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview, during a tour of the kitchen on April 13, 2025, at approximately 6:30 AM, facility staff failed to store and distribute food under sanitary condition as evidenced by one (1) of one (1) open bag of shredded carrots that was stored in the walk-in freezer undated, two (2) of five (5) torn air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, six (6) of six (6) ceiling lights above the three-compartment sink that were soiled with dust, one (1) of two (2) open eyewash solution bottle that was stored by the tray line for use, one (1) of two (2) garbage disposals that was inoperative , two (2) of two steamers with an 'out of service since May 8, 2023' sign, one (1) of two food warmers that has been inoperative since June 1, 2023. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 celling lights were missing a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced. The findings included: 1. An open bag of shredded carrots was stored in one (1) of one (1) refrigerator/freezer unit with no label to indicate when it was opened. 2. Two (2) of five (5) air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, were torn. 3. Six (6) of six (6) ceiling light covers above the three-compartment sink were soiled with dust. 4. One (1) of two (2) bottles of eyewash solution stored for use near the tray line, was stored open, with a broken sterility seal, and needed to be discarded. 5. One (1) of two (2) garbage disposal units was inoperative. 6. Two (2) of two (2) steamers have been out of service since May 8, 2023. 7. One (1) of two (2) food warmers has been out of service since June 1, 2023. 8. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 celling lights did not have a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced. Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.

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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. Based on a review of the facility's records and a staff interview, the facility failed to comply with the State Regulation (22B DCMR sect. 3211.5) for daily staffing ratios, as evidenced by not providing the minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, with at least six tenths (0.6) hours being provided by a registered nurse for seven (7) of 35 sampled days. The findings included: A review of the facility's daily staffing sheets revealed the following: On 10/19/24 the facility's resident census was 110. In addition, residents received 3.9 hours of direct nursing care. On 11/24/24 the facility's resident census was 105. In addition, residents received 3.8 hours of direct nursing care. On 12/21/24 the facility's resident census was 110. In addition, residents received 3.3 hours of direct nursing care with 0.50 of those hours being provided by a registered nurse. On 12/22/24 the facility's resident census was 110. In addition, residents received 3.6 hours of direct nursing care. On 12/29/24 the facility's resident census was 109. In addition, residents received 4.0 hours of direct nursing care. On 04/18/25 the facility's resident census was 106. In addition, residents received 3.9 hours of direct nursing care. On 04/26/25 the facility's resident census was 104. In addition, residents received 4.0 hours of direct nursing care. During a face-to-face interview on 05/05/25 at approximately 10:00 AM, Employee #22 (Staffing Coordinator) stated that they were short of staff on the previously mentioned days because they were in the process of hiring additional staff. Additionally, the employee said that she was not aware of the staffing requirements.

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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** Based on record review and staff interview for one (1) of 49 residents sampled, facility staff failed to have accurate documentation in Resident #209's medical record. The findings included: Resident #209 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Injury, and Metabolic Encephalopathy. Review of the resident's medical record revealed the following: 04/21/25 at 5:59 PM Situation Background Assessment and Request (SBAR): - Situation - Tachycardia with a pulse of 135 and an oxygen saturation of 85% - Comments: In the morning the resident had a pulse of 135 and his oxygen saturation was 85%, I informed Nurse Practitioner (NP), and she said to call 9-1-1, the resident was transferred via Emergency Medical Services to [Hospital name]. A physician's order dated 04/21/25 directed, Transfer to hospital. Review of the Medication and Treatment Administration Record for April 2025 showed that on 04/21/25, night shift (7:00 PM - 7:00 AM), the nurse documented a check mark and their initials to indicate that they took vital signs (including a blood glucose level), administered medications and treatments to Resident #209, who was no longer in the facility. During a face-to-face interview on 04/23/25 at 4:15 PM, with Employee #34 (assigned RN on 04/21/25) stated that Resident #209 left the facility around 9:00 AM on 04/21/25. The evidence showed that facility staff failed to have accurate documentation in Resident #209's medical record. During a face-to-face interview on 04/23/25 at 4:20 PM, Employee #2 (DON) reviewed Resident 209's medical record and acknowledged the findings. Cross Reference 22B DCMR Sec. 3231.11

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, for one (1) of two (2) sampled residents that were administered insulin, the facility's staff failed to follow acceptable Infection Control practices. As a result Employee #47 (RN) failed to perform hand hygiene after administering insulin. (Resident #38) Resident #38 was admitted on [DATE] with multiple diagnoses including Type 2 Diabetes Mellitus. A policy titled, Subcutaneous Injections with a review dated of 05/24/24 instructed on part, Put on gloves . Select appropriate injection site . slowly inject medications .with drawn needle quickly .discard equipment . remove gloves .perform hand antiseptic [hand hygiene] . A physician order dated 02/12/25 instructed, Humalog 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 150 = 2unit; 151 - 200 = 4unit; 201 - 250 = 6unit; 251 - 300 = 8unit; 301 - 350 = 10unit; 351 - 400 = 12unit Call Md If Blood sugar is less than 60mg/dl (milligram per deciliter) or more than 400mg/dl, subcutaneously every 6 hours for Type 2 Diabetes Mellitus. During a medication administration observation on 04/22/24 starting at 6:30 AM, showed Employee #47 performing a fingerstick glucose test for the resident. The resident's blood sugar level was 194 mg/dl. Additionally, Employee #47 administered the resident Humalog Insulin 4 units subcutaneously, per sliding scale. After administering insulin, the employee removed and discarded her gloves in the trash can, walked out of the resident's room, and started documenting on the electronic health record. During a face-to-face interview on 04/22/25 at approximately 6:40 AM, Employee #47 stated that she should have performed hand hygiene after removing her glove. The employee said that she was nervous and forgot. Based on observation, record reviews and staff interviews, for three (3) of 49 sampled residents the facility staff failed to: (1) provide a safe, sanitary and comfortable environment; (2) follow acceptable standards of precautions of Resident #78's Enhanced Barrier Precautions; and (3) follow acceptable standards of precautions for Resident #38's Enhanced Barrier Precautions and failed to follow acceptable Infection Control practices by not performing hand hygiene after administering Resident #38's insulin. (Residents #20, #78, and #38) The findings included: 1) Resident #20 was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy; Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side; Dysphagia; Chronic Obstructive Pulmonary Disease, Unspecified and Colostomy Status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an initial tour on 04/13/25 at 6:49 AM, an Enhanced Barrier Precaution sign was observed, posted on the wall to the left of Resident #20 room door. The sign directed all visitors to wash/sanitize their hands before entering and exiting the resident's room and directed providers and staff to put on new gloves and a new gown when performing high-contact Resident care activities (i.e. personal hygiene, changing briefs or assisting with toileting, device care use: central line, urinary catheter feeding tube, tracheostomy, wound care, etc.) for the Resident. The Resident was observed resting in bed lying on his back. On the left side of the resident's bedrail was an ileostomy drainage container. Employee #43 Registered Nurse assigned to the Resident entered the Resident room and stated, I was just about to empty his (ileostomy) container. It gets emptied every 4-8 hours. The Employee then went to the sink in the resident's room, washed her hands, applied a new pair of gloves, and but failed to put on a gown before emptying the resident's ileostomy container. The Employee emptied the bag, removed her gloves, and washed her hands in the sink before exiting the room. During a face-to-face interview immediately after the observation, when asked what Enhanced Barrier Precautions means, She stated that you wash your hands, apply gloves and a gown if you are within close contact to the Resident. When asked what stopped her from putting a gown on, the Employee replied I don't know. I was just trying to empty the Resident's ileostomy container. The Employee then acknowledged that a gown should have been worn when she changed the resident's colostomy and made no further comment. 2) Resident #78 was admitted to the facility on [DATE] with diagnoses that included: Intraspinal Abscess and Granuloma; Metabolic Encephalopathy; Resistance to Multiple Antimicrobial Drugs; Chronic Respiratory Failure, Functional Quadriplegia, and Dependence on Respirator [Ventilator] Status. During an initial tour on 04/13/25 at 07:05 AM an Enhanced Barrier Precaution sign was observed, posted on the wall to the left of Resident #78's room door. The sign directed all visitors to wash/sanitize their hands before entering and exiting the resident's room, and directed providers and staff to put on new gloves and a new gown when performing high -contact Resident care activities (i.e. personal hygiene, changing briefs or assisting with toileting, device care use: central line, urinary catheter feeding tube, tracheostomy, wound care, etc.) for the Resident. The Resident was observed asleep, lying in bed on his back. On the right side of the resident's bedrail was a urinary catheter drainage container. Employee #44 Certified Nurse Aide/CNA assigned to the Resident#78 entered the Resident's room, washed her hands., and applied a new pair of gloves. The Employee did not put on a gown before emptying the resident's urinary catheter container. The Employee emptied the urinary container, removed her gloves, and washed her hands in the sink before exiting the room. During a face-to-face interview immediately after the observation, when asked what Enhanced Barrier Precautions means, She stated that it means you wash your hands, apply gloves and a gown. When asked what stopped her from putting a gown on, the Employee replied I don't know. I always put on a gown I forgot this time. The Employee then acknowledged the finding. 2. Resident #38 was admitted on [DATE] with multiple medical diagnoses that included Gastrostomy tube. A physician order dated 2/12/25 instructed Glucerna 1.5 bolus 220 milliliters every 4 hours via gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in part that the resident had a Brief Interview for Mental Status (BIMS) summary score of 01, indicating that the resident cognitive status was severely impaired. The resident was also coded for using a feeding tube. During observation of Unit 4 on 04/21/25 at approximately 2:45 PM showed a Enhanced Barrier Precautions (EBP) sign posted on Resident #38's door. The signage included the following directives: STOP - ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, before entering and when leaving the room . At the time of the observation, Employee #14, (Licensed Practical Nurse/LPN), was observed entering Resident #38's room and troubleshot a sounding error alarm on display panel for the feeding tube pump alarm. The employee did this task without performing proper hand hygiene before entering and after exiting the resident's room. During a face-to-face interview on 04/21/25 at 2:45 PM, Employee #14 (LPN) stated that because the resident was on EBP, he should have performed hand hygiene before entering and exiting the Resident #38's room . However, the employee stated, I forgot.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, and interview, facility staff failed to ensure that the environment remains free of pest as evidenced by three (3) of three (3) mouse traps that were observed around the cook line, one (1) of one (1)mouse trap and mouse droppings in the dishwashing machine room, and flying pest in the three-compartment sink area. The findings included: 1. Three (3) of three (3) mouse traps were observed around the cook line, behind one (1) of one (1) grill and one (1) of one (1) gas stove, and one (1) of one (1) mouse trap and mouse droppings were seen in a corner area of the dishwashing machine room. 2. Flying insects that appear to be gnats were observed in the area where the three-compartment sink is located, and sporadically throughout the kitchen. Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on record reviews and staff interviews, facility staff failed to ensure that staff members were educated on the resident's rights and the facility's responsibilities to properly care for its residents, as set forth at §483.10, respectively. The findings included: A review of the Facility's Assessment updated 12/03/24, that documented: .Section 3.4 Staff Training/Education and Competencies. We only hire individuals that are eligible to work in The District of Columbia, currently using temporary nursing assistant(s). Department and job specific competencies are completed during orientation and reviewed annually. Competencies follow a pattern of requirements for certification and licensure renewal and trends of events within the facility and industry as a whole .List of competencies include- tracheostomy, ventilator, Enteral Tube feeding, ostomy, IVs (intravenous), TPN, (total parenteral nutrition) vital signs, weight taking, height measuring, oxygen, suctioning, systems assessment, turning and repositioning, SBAR (Situation, Background, Assessment, Request) Communication Forms, Care plan, change in condition communications, computer documentation and changes in condition and reporting, complaint management, drains, referrals, appointment making, assistance with ADLs (activities of daily living skills), wound care, IDT (interdisciplinary team) assessments and isolation. A review of the facility's policy entitled, Resident Rights, (revised 05/24/24) documented .Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our residents' rights. On 05/05/25, the facility's education and training records for Residents' Rights were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, 2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including Resident Rights and Facility Responsibilities. In the column next to Residents Rights were the comments, Review and packet and HealthStream. Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence that showed what the HealthStream education/training for Residents Rights consisted of and there was no documented evidence to show that the educator provided a review and packet for Resident Rights to facility staff as part of their education and training. In addition, there was no documented evidence that staff who were not present for the September 19-20, 2024, skills fair, received the training. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/Regional Director of Operation stated, All staff receive education and training on Residents Rights that they during orientation before they are assigned to the floor and as part of the staff skills fair training annually. Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets. She commented further that she could not substantiate what specific information the staff educator provided for review or in the education packet for Resident Rights. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator, The staff is not getting the education to the extent needed; the Director of Nursing and myself (Administrator) provide some of the education PRN (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it. Cross reference 22B DCMR Sec 3214.4

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on record reviews and staff interviews, facility staff failed to provide training that outlined and informed staff of the elements and goals of the facility's QAPI program. The findings included: On 05/05/25, the facility's education and training records were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, 2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including QAPI (Quality Assurance and Performance Improvement Plan and Participation. In the column next to QAPI were the comments, Review and packet. Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence to show that the educator provided a review or a packet for QAPI to facility staff as part of their education and training. In addition, there was no documentation to show that staff who were not present for the September 19-20, 2024, skills fair, received QAPI training. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records for staff. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/Regional Director of Operations, stated that, All staff are required to receive QAPI training. QAPI training is usually completed during staff orientation and as part of the staff skills fair training that the facility has annually. Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets for QAPI training. She commented further that she could not substantiate that the staff educator provided training that outlined and informed staff of the elements and goals of the facility's QAPI program, or how to facility staff could communicate concerns, problems or opportunities for improvement to the facility's QAA (Quality Assessment and Assurance Committee). During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator, stated: The staff is not getting the education to the extent needed. The Director of Nursing (DON) and myself [Administrator] provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute and Rehab Capitol Hill	223 7th Street NE Washington, DC 20002

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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. Based on record reviews and staff interviews, facility staff failed to provide a training program or another practical manner to effectively communicate the standards, policies, and procedures of the compliance and ethics program to its entire staff. The findings included: On 05/05/25, the facility's education and training records for its Compliance and Ethics program were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, 2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including Compliance and Ethics. In the column next to Compliance and Ethics, were the comments, Review and packet. Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence to show that the educator provided a training program or another practical manner to effectively communicate the standards, policies, and procedures of the compliance and ethics program to its entire staff. In addition, there was no documentation to show that staff who were not present for the September 19-20, 2024, skills fair, received education and training for the facility's Compliance and Ethics program. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee#48/ Regional Director of Operations stated that The Compliance and Ethics training is usually completed during staff orientation and as part of the staff skills fair training that the facility has annually. Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets for Compliance and Ethics training. She commented further that she could not substantiate that the staff educator provided training on the facility's Compliance and Ethics program. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator stated, The staff is not getting the education to the extent needed; The Director of Nursing (DON)and myself [Administrator] provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/05/2025

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Bridgepoint Subacute and Rehab Capitol Hill	223 7th Street NE Washington, DC 20002

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record reviews and staff interviews, facility staff failed to show documented evidence of its Required In-Service Training for Nurse Aides. The findings included: A review of the Facility's Assessment updated 12/03/24, that documented: .Section 3.4 Staff Training/Education and Competencies. We only hire individuals that are eligible to work in The District of Columbia, currently using temporary nursing assistant(s). Department and job specific competencies are completed during orientation and reviewed annually . On 05/05/25, the facility's education and training records for the required in-service training for Nurse Aides were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. The binder contained the following education and training provided by the educator for the facility's Certified Nurse Aides (CNAs) in 2024: 1)Documentation news article and monthly test; No staff sign-in sheet was attached: (June); 2) Reporting to the Nurse, news article and monthly test; No staff sign-in sheet was attached (July); and, 3) Skin and Wound Observation news article and monthly test; No staff sign-in sheet was attached (August). Of note, the facility's education and training binder showed documented evidence of its required in-service training for Nurse Aides for only three (3) months out of 12. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee# 48/Regional Director of Operations stated, The the CNAs receive the required in-service training during staff orientation before they are assigned to the floor and annually at the SNF Specific Skills Fair. Employee #48 then reviewed the staff education and training binder, and the facility's administrative records, and stated that all she could find was the training that the educator provided for June, July and August, 2024. She commented further that she could not substantiate that the staff educator provided all of the required in-service training for the CNAs. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1 stated, The staff is not getting the education to the extent needed; The Director of Nursing and the Administrator provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/05/2025

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on record reviews and staff interviews, facility staff failed to show documented evidence of an effective training program for all staff, which includes, at a minimum, training on behavioral health care and services for its residents. The findings included: On 05/05/25, the facility's education and training records for were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. The binder showed no documented evidence of an effective training program for all staff, which included, at a minimum, training on behavioral health care and services for its residents. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/ Regional Director of Operations, stated that the behavioral health care and services for residents is usually completed during staff orientation and as part of the staff skills fair training that the facility has annually. Employee #48, then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that she did not see where the behavioral health care and services for residents was included as part of the annual SNF Specific Skills Fair. She commented further that she could not substantiate the staff educator provided education and training on the behavioral health care and services for its residents. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1 stated: The staff is not getting the education to the extent needed; The Director of Nursing and the Administrator provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it.