STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interviews, for two (2) of 42 sampled residents, facility staff failed to implement its policy as evidenced by: 1) not having documented evidence they conducted a background check or that an employee received abuse education and 2) not removing the alleged perpetrator (facility staff) from the facility to protect the alleged victim (resident) from further abuse pending an investigation. Residents' #70 and #31. The findings included: Review of the facility policy Abuse Prevention Program revised on 12/01/22 documented: - As part of the resident abuse prevention, the administration will conduct employee background checks - Require staff training/orientation programs that include such topics as abuse preventions, identification, and reporting abuse 1. Facility staff failed to implement its policy by not having documented evidence they conducted a background check or that an employee received abuse education. Resident #70 was admitted to the facility on [DATE] with multiple diagnoses that included: Quadriplegia, Spinal Stenosis and Muscle Weakness. An Admission Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A Facility Reported Incident (FRI), DC~11412, submitted to the State Agency on 12/27/22 documented: - [Resident #70] reported to the nursing supervisor that the assigned RN (Registered Nurse/Employee #20) screamed at him because he refused to be turned. During an onsite investigation and review of the facility's investigation documents on 01/22/24 at approximately 9:30 AM, the surveyor asked to see the human resources (HR)/administrave record for Employee #20, Employee #1 (Administrator) and Employee #3 (Director of Human Resources) stated that they both looked but there is no file for that employee and would keep looking. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/25/2024

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 01/22/24 at 1:20 PM, Employee #3 stated, She (Employee #20) is an agency nurse. We don't have a file or any documentation for her. [RN/alleged perpetrator] worked at the facility from January 2021 to December 2022. I am not sure if there are any previous allegations of abuse made against this employee or any disciplinary actions. It appears that she was terminated in December 2022 after the alleged incident with [Resident #70]. Since I started working here in March 2023, I have made sure that all employees, agency or not, have a file with HR that includes all the required information. The evidence showed that facility staff failed to have documented evidence of a background check or that Employee #20received training/orientation that included such topics as abuse preventions, identification, and reporting abuse. 45104 2. Facility staff failed to remove the alleged perpetrator (facility staff) from the facility to protect the alleged victim (resident) from further abuse pending an investigation. A review of the facility' policy entitled, Abuse Investigation and Reporting, revised on 04/14/23 documented: Policy Interpretation and Implementation, Role of the Administrator .4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation . A review of the facility's policy entitled, Abuse Policy: Prevention/Recognizing Signs of Abuse and Neglect, revised on 04/23/24 documented, .Protection 1. Once an allegation of abuse is made the alleged abuser will be escorted from the premises by the supervisor to ensure the protection and safety of the resident. Resident #31 was admitted to the facility on [DATE] 19 with diagnoses that included the following: Hemiplegia, Chronic Respiratory Failure, Muscle Wasting, Major Depressive Disorder, Generalized Anxiety Disorder, Dysphasia, Paranoid Personality Disorder and Vascular Dementia. A Quarterly Minimum Data Set assessment dated [DATE] documented that facility staff coded the Resident as having a Brief Interview for Mental Status Summary (BIMS) score of 15 indicating intact cognition, being totally dependent for all ADL (assisted daily living) skills including eating and receiving anti-anxiety antidepressant and anti-psychotic medications for seven (7) days of the assessment. A Facility Reported Incident (FRI), DC~12366, submitted to the State Agency on 10/12/2023 documented: On 10/12/2023, [Resident #31] reported that on 10/09/2023, Employee #14, the day shift CNA assigned to her, allegedly said to her, You are pathetic, This is an initial report, investigation is on-going. DC police department was informed. CNA was removed from the unit. MD (Medical Director) was notified, [Name of Resident's] daughter] was notified, RP (Representative) is aware. During initial tour of the facility on 01/11/24 at 10:37 AM, Resident #31 was observed in bed watching TV. During an interview at the same time as the observation, the Resident stated that the incident occurred during the daytime shift. The CNA assigned to me was very combative --- every little thing I'd say she had to get the last word in. I can't remember exactly what she was assisting me with at the time, but she told me I was pathetic. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff initiated an investigation of the incident between Resident #31 and Employee #14 on 10/12/23. A review of the facility's investigative documents for the incident revealed the following: A Resident Concern/Complaint Form dated 10/12/23 documented that facility staff received Resident #31's complaint that on 10/09/23, Employee #14 (Resident's assigned CNA) called the Resident pathetic. A review of a care plan initiated on 10/12/2023 documented: Focus: Allegation of verbal abuse on 10/9/2023 reported by a resident on 10/12/2023, Goal: [Name of Resident #31] will feel safe through the review date with the target date of 03/14/2024. Interventions: Employees will continue to communicate with [Name of Resident #31] respectfully and treat her with dignity; [Name of Physician] was notified 10/12/2023. Rep (representative)/daughter were notified on 10/12/2023. Investigation is ongoing; Initial DOH (Department of Health) self-report done 10/12/2023; DC Police Department was notified 10/12/2023 . A written statement dated 10/12/23 from Employee #14 documented, (Every time) I enter Resident # 31's room she verbally abuses me. I simply say ' Hi, I am your aide. This is the task I'm here for. She then proceeds with rude comments which I simply ignore and go tell the RN (Registered Nurse). Had to notify Employee #15 (Registered Nurse assigned to Resident #31) and Employee #16 (Licensed Practical Nurse) that this happens every day. A written statement dated 10/12/23 from Employee #15 documented, On 10/09/23 assigned CNA working with Resident #31 complained that the resident was shouting at her while giving ADL care. Writer went to resident's room and educated not to shout while CNA giving care and resident verbalized understanding and would not do it anymore. A typed telephone statement from Employee #14 documented on 10/16/23: What was your interaction with Resident #1 when you provided care for her? Response: When I went into Resident #31's room. I introduced myself as her CNA today. Resident #31 replied I don't have time for your [expletive] today. I immediately left the room and reported the incident to Employee #15. I and Employee #15 returned to Resident #31's room, Employee #15 then explained to Resident #31 that I was there to take care of [pronoun] and assist with meals and that [pronoun] should be nice to me. Resident #31 agreed for me to take care of her. Resident #31 has always been rude to me. I will always ignore her comments and just do my job. During a telephone interview conducted on 01/19/24 at 12:16 PM, Employee #14 stated, I told management that Resident #31 was always nasty towards me. The Resident would cuss at me every day and I would tell the nurse. This occurred every single day for four months. The day of the incident she was verbally abusive to me. She said I don't want you to feed me [expletive]. I told the Nurse and Management, but they never switched my team. I told the Administrator about this. He asked Employee #15 if I ever complained about the Resident. She stated, Yes, I had. He then asked why would you keep her assigned to the Resident if you knew there were problems. She stated she went to speak with the Resident who then agreed that I could feed her, so the assignment was not changed. The Employee also stated, I continued to work with the Resident the rest of her shift and over the next 2-3 days and when she returned to the facility after the investigation was over, she was assigned to the 5th floor. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Employee #14's timecard showed that the Employee continued to work at the facility from 10/12/23 through 10/14/23. She returned to work on 10/18/23 and worked until 10/20/23. During a telephone interview conducted on 01/24/24 at 12:00 PM, Employee #15 stated, When there is a big concern or when an allegation of resident abuse involving staff occurs, the staff should be removed from assisting the Resident. The day of the incident I remember going with the CNA to the resident's room. I asked the Resident to allow the CNA to assist with feeding and the Resident agreed. I should have re-assigned the CNA since there was an allegation of abuse. The evidence showed that the facility staff failed to remove or suspend Employee #14 (alleged perpetrator) from the schedule from 10/12/23 to 10/14/23 to ensure the protection and safety of Resident #31 (alleged victim), during an investigation of abuse per the facility's policies.

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F 0625

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45104

Based on record review and staff interview for three (3) out of 42 sampled residents, the facility staff failed to provide written information to the resident or resident representative that stated the duration of the State Agency's bed-hold policy before the facility transferred the Resident to the hospital. Residents' #2, #310, and #34.

The findings included:

1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy, Apraxia, Contracture of the Left Hand, Presence of an Artificial Eye, and Obsessive Compulsive Disorder.

A review of Resident #2's medical record revealed:

Resident #2's face sheet indicated that her primary Payor was Medicaid.

A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the facility staff coded the Resident in the following manner: Brief Interview for Mental Status (BIMS) score of, 02, indicating severely impaired cognition.

An SBAR (Situation, Background, Assessment and Recommendation/Request) Communication Form and Progress Note dated 07/03/23 at 8:45 PM, documented: Situation: Charge nurse found resident on the floor, 911 was called and resident was transferred to the hospital . The charge nurse assessed the resident, [pronoun] was alert and oriented x 2, B/P (Blood Pressure) 130/98, Heart rate 118, Respiration 20, Oxygen 98% on room air, Temperature 98.0. Resident sustain(ed) injury to the right eye. The injury was clean and a 4 x 4 dressing applied. EMS (Emergency Medical System) transferred Resident to [Name of local hospital].

A review of a Department of Health (DOH) Complaint/Incident Report Form dated 07/04/23 at 2:26 AM documented: On July 3, 2023, at approximately 8.30 PM, Charge nurse was making rounds to [Resident#2 's Room] and met patient on the floor faced down. patient sustained injury to the right upper eye, no change in mental status compared to [pronoun] baseline. [Physician's Name] was called, order given to transfer resident to the nearest hospital via 911, Patient was picked up by 911 crew at approximately 9.07 pm to [Name of Local Hospital] Family member [Name of Resident's representative] was notified, Investigation is in progress.

A review of a DOH Notice of Discharge Transfer or Relocation Form dated 07/05/23 at 9:35 AM documented; .(1)The proposed action is: a) Transfer- Hospital/Rehab facility /Nursing home; Transfer type: Hospital; (2) Must list specific reason for this action: Transferred to hospital .(3) You are scheduled to be discharged , transferred or relocated on or by date: July 03, 2023 . Of note the facility staff submitted the Notice of Discharge Transfer or Relocation Form on 07/05/23, two days after the resident ' s discharge to the hospital.

(continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical record lacked documented evidence that the facility staff provided Resident #2's representative with written notice of the resident's bed hold days before the resident transferred to the hospital on 07/03/23. During a face-to-face interview on 01/23/24 at 1:51 PM Employee #17 (Social Worker) stated I filled out the notice of transfer form when I first came (to the facility). The Resident had bed hold days left and was allowed to come back to the facility, to the same room. I should have completed the form the same day as the Resident's transfer, and I should have included the number of the Resident's bed hold days. Cross Reference 22B DCMR Sec. 3270.1 47555 2. Resident #310 was admitted to facility on 01/21/23 with multiple diagnoses that included: Atrial Fibrillation, Heart Failure, Hypertension, End Stage Renal Disease, Arthritis and Other Fracture. An Admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. A review of Resident #310's face sheet documented that the resident was his own representative. A Physician note dated 02/15/23 at 19:27 (7:27 PM) documented, Resident is alert and oriented x 4 able to make needs known. At 17:30 pm (5:30 pm) resident was observed lying on the floor in his room close to his bed, face down. When asked, resident stated that, he was coming back from the bathroom when he felt dizzy and loss his balance and fell . He was observed with a deep cut underneath his chin and a cut on the lower lip. Further review of the progress note dated 02/15/23 showed, [Doctor's name] made aware at 5.40 pm. Order given to transfer resident to the ER for further evaluation. Resident left the facility to [Hospital's name] via stretcher at 18:40 pm (6:40 pm). A Physician order dated 02/15/23 documented, Transfer resident to the nearest ER due to bleeding from the chin as a result Fall. During a face-to-face interview conducted on 01/18/24 at 3:26 PM Employee #8 (Social Worker) stated, We do the 6-108's if the 6-108 is not in the electronic record, we have a book that we keep it in. I'll go see if I can find it. Employee #8 returned with a book labeled 6-108 and the document was not found for the resident's transfer to the hospital on 02/15/23. During a face-to-face interview conducted on 01/19/24 at 2:53 PM Employee #4 (Director of Social Services) stated, We have a book for the 6-108, .I know you had requested documents from prior dates, and we didn't have it [the 6-108]. Cross Reference 22B DCMR Sec. 3270.1 43776 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #34 was admitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Disorder, Urinary Incontinence and Muscle Wasting and Atrophy. Review of Resident #34's medical record revealed the following: A face sheet that showed that the resident is her own representative. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: clear speech, makes self understood and able understand others; a Brief interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A physician's order dated 12/30/23 that directed, Transfer resident to nearest hospital via 911 due c/o (complaint of) chest pain A Progress Note dated 12/30/23 at 8:40 AM: - Around 4:15 AM, resident called 911 that she was feeling shortness of breath - Emergency team arrived and took her to [Hospital name] A Progress Note dated 01/05/24 at 6:26 AM: - Resident was readmitted alert and responsive from [Hospital name] A Social Services Progress Note dated 01/05/24 at 7:35 AM documented: 6-108 form was completed and faxed to the ombudsman office for the transfer to the hospital that occurred on 12-3-23 [12/30/23]. Review of the Notice of Discharge, Transfer or Relocation Form dated 01/05/24 showed facility staff documented: - This proposed action is a transfer - Type- hospital - You are scheduled to be transferred on 12/30/23 - Your available number of bed hold days - 18 The evidence showed that facility staff failed to provide Resident #34 with written information that specified the duration of the state bed-hold days before or within 24 hours of transfer to the hospital. The evidence further showed that this notice was provided upon being readmitted back to the facility on [DATE]. During a face-to-face interview on 01/22/24 at 9:39 AM, Employee #4 (Director of Social Services) stated, Notice of transfer forms should be done as soon as possible or within a day (24 hours) after the resident goes to the hospital. This one (Resident #34's) was done late. I don't know what happened; it was around the New Year's holiday. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross Reference 22B DCMR Sec. 3270.1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27513 Based on record review, and staff interview for one (1) of 42 sampled residents, the facility staff failed to develop a resident's person-centered comprehensive care plan with goals and approaches for the use of an indwelling Foley catheter. Resident #54. The findings included: Resident #54 was admitted to the facility on [DATE]. The resident had a history of Cerebral Palsy, Asthma, Seizure, Anemia, Atrial Fibrillation, and Sepsis. A review of a physician's order dated 11/27/23 at 1900 [7:00 PM] directed: Foley catheter care q shift every shift. A review of an Admission Minimum Data Set (MDS) assessment dated [DATE] revealed that facility staff coded Resident #54 had a severe cognitive impairment. The resident was dependent on staff for bed mobility, transfers, toilet use and the resident had an indwelling catheter. A review of Resident #54's comprehensive care plans lacked documented evidence that the facility staff developed a care plan with goals and approaches for his use of an indwelling urinary catheter. During a face-to-face interview on 01/24/24 at approximately 1:00 PM, Employee #2 (Director of Nursing) reviewed Resident #54's care plan and stated that she did not see a care plan to address the resident's use of an indwelling urinary catheter.

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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 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 27513

Based on record review, and staff interviews, for one (1) of 42 sampled residents, the facility's staff failed to ensure Resident #362 was provided appropriate care to prevent the resident's suprapubic catheter from becoming dislodged during care. Resident #362.

The findings included:

41645

Resident #362 was admitted to the facility on [DATE] with multiple diagnoses including Functional Quadriplegia, Neuromuscular Dysfunctional Bladder, Urogenital Implants, and Calculus Ureter. It should be noted the resident was discharged home on 02/03/23.

A review of a care plan dated 08/29/22 documented the following but not limited to:

Focus Area - [Resident's name] has an indwelling suprapubic catheter (Neurogenic bladder).

Goal - [Resident's name] will be free from catheter-related trauma through review date.

Interventions

-Catheter: [Resident's name] has 24fr indwelling suprapubic Catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door.

-Check tubing for kinks each shift.

-Monitor and document intake and output as per facility policy.

A review of a physician order dated 12/07/22 instructed, Suprapubic cateter r/t (related to) neurogenic bladder every shift.

A Situation, Background, Assessment, Request Form dated 12/21/22 at 5:30 AM documented, Writer was called to room [ROOM NUMBER] by resident 'sitter regarding resident suprapubic catheter at 0515 (5:15 AM). Upon assessing resident, his suprapubic catheter was noted dislodged out of his bladder and intact with small bleeding at stoma site. Resident sitter stated that pt's (patient's) suprapubic catheter got dislodged while care was being rendered by assigned CNA (Certified Nurse's Aide). Resident denied pain upon assessment, new suprapubic catheter 24fr (French)/10cc (millimeters) available was inserted aseptically per facility guideline, procedure well tolerated and suprapubic catheter draining expectedly.

A Root Cause Analysis and Action Plan dated 12/21/22 at 5:45 AM documented the following but not limited to, Root Cause Analysis findings as possible improper handling of the catheter.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a State Survey Agency Intake Form (DC~11405) dated 12/28/23 documented, Suprapubic catheter dislodge at 0515 (5:15 AM) during morning (sic) care. Upon assessing resident, suprapubic catheter noted out of his bladder and intact with small bleeding at stoma site. Resident 'sitter stated that pt's suprapubic catheter got dislodged while care was being rendered by assigned CNA. Resident denied pain upon assessment, new suprapubic catheter 24fr/10cc available was inserted aseptically per facility guideline, procedure well tolerated and suprapubic catheter draining expectedly. Mother called and informed at 0645 (6:45 AM). MD called and gave order for urology consult. During a face-to-face interview on 01/16/24 at 1:39 PM, the Director of Nursing (DON) stated that the resident's catheter should not have been dislodged during care. Additionally, the employee said that the Certified Nursing Assistant involved was re-inserviced on handling durable medical equipment gently when providing care at the time of the incident. In addition, the employee stated that staff are always instructed to handle durable medical equipment gently.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review, resident and staff interview, for one (1) of 42 sampled residents, Employee #5 (Licensed Practical Nurse/LPN), failed to ensure that Resident #46 received effective pain management in accordance with the physician's orders and the comprehensive care plan. The findings included: Resident #46 was admitted to the facility on [DATE] with diagnoses that included: Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD) and Retention of Urine. A physician's order dated 11/02/23 that directed, Acetaminophen (pain reliever) Tablet 325 MG (milligrams), give 2 tablets by mouth every 6 hours as needed for pain, do not exceed 3-4gm (grams) in 24 hours. A care plan focus area: [Resident #46] has acute pain r/t (related to) medical procedure abdominal surgical site. Date Initiated: 11/02/2023. Interventions included: - Administer analgesia medication as per orders - Give 1/2 (half) hour before treatments or care - Anticipate the resident's need for pain relief and respond immediately to any complaint of pain A physician's order dated 11/06/23 that directed, Vital signs every shift An Admission Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; received PRN pain medications; experienced pain almost constantly; and that pain almost constantly interfered with therapy and day-to-day activities. Resident #46's vital signs and Medication Administration Record (MAR) showed the following: - 01/01/24 at 12:33 PM, staff documented pain level 9 on the numerical scale - 01/01/24 at 4:35 PM, staff documented pain level 9 on the numerical scale However, the MAR and progress notes lacked documented evidence that the resident was medicated for pain for the previously mentioned dates and times. It should be noted that the resident's next documented pain assessment was 0 on 01/01/24 at 6:23 PM. Resident #46's vital signs and Medication Administration Record (MAR) on 01/08/24 showed the following: (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 01/08/24 at 12:22 PM, staff documented pain level 10 on the numerical scale - 01/08/24 at 3:24 PM, staff documented pain level 10 on the numerical scale - 01/08/24 at 6:20 PM, staff documented pain level 9 on the numerical scale However, the MAR and progress notes lacked documented evidence that the resident was medicated for pain for the previously mentioned dates and times. It should be noted that the resident's next documented pain assessment was 0 at 11:23 PM on 01/08/24. Review of the progress notes dated on 01/01/24 and 01/08/24 showed no documented refusal of Acetaminophen by Resident #46. Review of the 5th floor nursing assignment sheet showed that Employee #5 (Licensed Practical Nurse/LPN), was the nurse assigned to Resident #46 on the dates 01/01/24 and 01/08/24, day shift (7:00 AM - 7:00 PM). During a face-to-face interview on 01/16/24 at 9:45 AM, Employee #5 stated, When a resident reports pain, I have to assess where the pain is and use the 1 to 10 scale to get the level. Then, whatever PRN (as needed) or regular medication they can get at that time, I would give it to them and then reassess half an hour later. If a resident refuses medications, I would let the doctor know and document it in PCC (Point Click Care, facility's electronic health record system). The employee was shown Resident #46's vital signs record, MAR and progress notes for January 2024 and asked where was the documented evidence that the resident either received or was offered and refused pain medications on 01/01/24 and 01/08/24 when he reported numerical pain levels of 9 and 10. The employee replied, I did give him [Resident #46] the PRN medication. I don't know why it didn't show up on the MAR. The evidence showed that on 01/01/24 and 01/08/24 during the day shift, 7:00 AM - 7:00 PM, Employee #5 failed to provide Resident #46 with effective pain management that was consistent with the physician's orders and the comprehensive care plan. Cross Reference 22B DCMR Sec. 3211.1

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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.

43776

Based on one (1) of five (5) observations and staff interview, facility staff failed to demonstrate competency to provide appropriate nursing services to assure resident safety.

The findings included:

According to the National Library of Medicine- National Center for Biotechnology Information,

- If multiple medications must be administered enterally, they should be administered separately, ideally after flushing the feeding tube with 5-10 mL of water, due to the unpredictable stability and compatibility of crushed drug mixtures and the potential for serious drug-drug interactions

- Guidance documents from CMS (Centers for Medicare and Medicaid Services) state that the crushed medications should not be combined and given all at once via feeding tube

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10511598/

According to the Long-Term Care Nursing: Medication Pass,

- Do not, under any circumstances, try to pre-pour medications to save time

- Pre-pouring medications are against regulations

- In addition, it increases the risk of making mistakes

https://ceufast.com/course/long-term-care-nursing-medication-pass#:~:text=More%20specifically%2C%20do%20NOT%2C%20under,the%20risk%20of%20making%20mistakes.

During an observation on 01/10/24 at 9:25 AM of Medication Cart C on the 4th floor with Employee #5 (Licensed Practical Nurse/LPN), the surveyor noted plastic cups with a substance that appeared to be crushed medications in water in the medication compartments for residents in rooms #4146, #4153, #4156, #4155 and #4150 (5 in total). When asked about the cups, Employee #5 stated that those were resident medications in the cups. I checked the medications against the [physician] orders first but I have not signed them off. I will sign them off once I give the resident their medications. I did that to let the medications soak so the G-tube (gastrostomy) tubes don't get clogged. When asked is that the standard of practice for medication administration, Employee #5 stated No.

During a face-to-face interview on 01/10/24 at 9:34 AM, Employee #6 (4th floor Unit Manager) stated that medications are not to be crushed or pre-poured ahead of time. We are supposed to go to each resident, administer the medications as ordered and then sign off.

The evidence showed that Employee #5 failed to demonstrate competency to provide appropriate nursing services to assure resident safety.

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	095027	A. Building B. Wing	01/25/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross Reference 22B DCMR Sec. 3226.4

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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 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. 43776 Based on one (1) of five (5) observations, record review and staff interviews, facility staff failed to ensure that the system to account for the reconciliation of controlled medications was followed. The findings included: During an observation on 01/11/24 at 8:44 AM of Medication Cart B on the 5th Floor with Employee #7 (Licensed Practical Nurse/LPN) the following was noted on the January 2024 Controlled Medication Shift Change Log: - 01/01/24 - 7:00 AM count correct- left blank; signature off-going nurse- left blank; signature on-coming nurse- left blank - 01/01/24 - 7:00 PM count correct- left blank; signature off-going nurse- left blank; - 01/02/24 - 7:00 AM count correct- left blank; signature off-going nurse- left blank; - 01/06/24 - 7:00 AM - 7:00 PM count correct- left blank - No entry for 01/06/24 7:00 PM - 7:00 AM - 01/07/24 - 7:00 AM - 7:00 PM count correct- left blank - 01/07/24 - 7:00 PM - 7:00 AM count correct- left blank - 01/08/24 - 7:00 AM - 7:00 PM count correct- left blank; signature on-coming nurse- left blank - 01/08/24 - 7:00 PM - 7:00 AM count correct- left blank; signature off-going nurse- left blank; - 01/09/24 - 7:00 AM - 7:00 PM count correct- left blank; signature on-coming nurse- left blank - 01/09/24 - 7:00 PM - 7:00 AM count correct- left blank; signature off-going nurse- left blank; signature on-coming nurse- left blank - 01/10/24 - 7:00 AM - 7:00 PM count correct- left blank; signature off-going nurse- left blank; signature on-coming nurse- left blank - 01/10/24 - 7:00 PM - 7:00 AM count correct- left blank; signature on-coming nurse- left blank; - 01/11/24 - 7:00 AM - 7:00 PM count correct- left blank; signature off-going nurse- left blank. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked about the narcotic count from this morning (01/11/24 at 7:00 AM - 7:00 PM) where there was no documentation of if the reconciliation was count was correct and was missing the signature of the off-going nurse, Employee #7 stated, I did [narcotic] count with the off-going nurse and it was correct, I forgot to circle 'yes' on the sheet. I'm not sure why she (off-going nurse) did not sign out. During a face-to-face interview on 01/11/24 at 9:12 AM, Employee #2 (Director of Nursing/DON) was shown the 5th floor January 2024 Controlled Medication Shift Change Log. The employee acknowledged the findings and stated, Out-going and in-coming nurses are supposed to do [narcotic] count and make sure it is correct by circling yes or no and signing their name, that is the process. The evidence showed that facility staff failed to ensure that the system to account for the reconciliation of controlled medications was followed. Cross Reference 22B DCMR Sec. 3224.3 (d)

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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. 41645 Based on observations and staff interview, the facility failed to serve cold food (pineapples and pears) at or below 41 degrees Fahrenheit for two (2) of 2 opportunities. The findings included: On 01/11/24 at 1:19 PM, a test tray on the 4th floor revealed a cup of pineapples that had a temperature of 51 degrees Fahrenheit. During a face-to-face interview on 01/11/24 at 1:20 PM, Employee #18 (Chef) acknowledged the findings. On 01/12/24 at 12:59PM, a test tray on the 4th floor revealed a cup of pears that had a temperature of 53 degrees Fahrenheit. During a face-to-face interview on 01/12/24 at 1:00 PM, Employee #18 acknowledged the findings. During a face-to-face interview on 01/12/24 at 1:30 PM, Employee #19 (Food Service Director) stated that moving forward they will order cooling bowls with lids to serve cold food.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 Based on record review and staff interview, for one (1) of 42 sampled residents, facility staff failed to operate and provide services in compliance with applicable State regulations regarding professionals providing services in the facility. Resident #70. The findings included: According to 22B DCMR sec. 3203.7, Each administrative record shall be retained for at least five (5) years from the date of creation. Resident #70 was admitted to the facility on [DATE] with multiple diagnoses that included: Quadriplegia, Spinal Stenosis and Muscle Weakness. An Admission Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A Facility Reported Incident (FRI), DC~11412, submitted to the State Agency on 12/27/22 documented: [Resident #70] reported to the nursing supervisor that the assigned RN (Registered Nurse) screamed at him because he refused to be turned. During an onsite investigation and review of the facility's investigation documents on 01/22/24 at approximately 9:30 AM, the surveyor asked to see the human resources (HR)/administrave record for the RN/alleged perpetrator, Employee #1 (Administrator) and Employee #3 (Director of Human Resources) stated that they both looked but there is no file for that employee and would keep looking. During a face-to-face interview on 01/22/24 at 1:20 PM, Employee #3 stated, She (Employee #20) is an agency nurse. We don't have a file or any documentation for her. [RN/alleged perpetrator] worked at the facility from January 2021 to December 2022. I am not sure if there are any previous allegations of abuse made against this employee or any disciplinary actions. It appears that she was terminated in December 2022 after the alleged incident with [Resident #70]. Since I started working here in March 2023, I have made sure that all employees, agency or not, have a file with HR that includes all the required information. This showed that facility staff failed to have documented evidence that an administrative record was created or retained for at least five (5) years for Employee #20, who was providing services in the facility. Cross Reference 22B DCMR sec. 3203.7