STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside at Rock Creek	3050 Military Road NW Washington, DC 20015

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27513 Based on record review and staff interviews for two (2) of three (3) sampled residents, facility staff failed to notify Medicaid residents when the amount in their account reached $200 of the SSI (supplemental security income) resource limit for both resident's accounting of funds. Residents' #6 and #7. The findings included: According to District of Columbia Department of Health Care Finance, .You may be eligible for Medicaid coverage of Long Term Care (LTC) services, if you: .Have resources up to $4,000 (asset limits) for one person . https://dhcf.dc.gov/service/long-term-care-ltc 1. Resident #6 was admitted to the facility on [DATE]. A review of the facility Trial Balance record dated 11/03/23, showed a current balance of $4,296.15 for Resident #6. 2. Resident #7 was admitted to the facility on [DATE]. A review of the facility Trial Balance record dated 11/03/23, showed a current balance of $4,497.67 for Resident #7. A face-to-face interview was conducted on 12/06/23 at 1:00PM with Employee#2, [Director of Nursing] to determine if a letter was sent and received by the residents and/or their Power of Attorney notifying them that the resident(s) reached within $200 of the SSI resource limit and they may lose eligibility for Medicaid for both residents' personal accounting funds. She stated, I will look for it.' A blank copy of the notification letter was made available to the surveyor. During a face-to-face interview on 12/07/23, at approximately 1:00 PM with Employee #2. She acknowledged the findings when a copy/receipt of the letter of notification to the resident/POAs was not presented to be reviewed by the surveyor. (continued on next page)

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

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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff failed to notify Residents' #6, #7, and/or their Power of Attorney(s) when the amount of funds in their account reached within $200 of the SSI resource limit and they may lose eligibility for Medicaid for both residents' personal accounting funds.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure the security of all personal funds of residents deposited with the facility. 27513 Based on record review and staff interview, the facility staff failed to provide adequate surety bond coverage to assure the security of all residents' personal funds deposited with the facility. The Resident census on the first day of the survey was 30. The findings included: A review of the Surety Bond dated the effective date of 05/06/23, and expiration date of 05/06/24, shall be continued until canceled by the Surety Provider .or the Oblige (the Facility) in the amount of $100,000.00. A review of the Resident Funds Trust Account RMFS (Resident Fund Management Service) statements for 08/01/23, to 10/03/23, revealed the following bank account balance: Totaled for statements dated: August 2023 = $123,976.18 September 2023 = $124,237.60 October 2023 = $124,359.08 There was no evidence that the facility staff maintained a surety bond to cover the amount of funds in the resident funds account for August 2023 - October 2023. During a face-to-face interview on 12/07/23, at approximately 12:20 PM with Employee #2. She acknowledged the findings.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45102 Based on record reviews, resident representative, and staff interviews, for one (1) of 22 sampled residents, the facility staff failed to show documented evidence of notifying Resident #2's responsible party of a change in the resident's medical status on 12/01/22 and of the residents unwitnessed fall that occurred on 01/29/23. The findings included: A review of the facility policy titled Change in a Resident's Condition or Status with a revision date of 02/2021, instructs staff to do the following: .Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; .Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status . Resident #2 was admitted to the facility on [DATE], with multiple diagnoses that included Dementia, Primary Generalized Osteoarthritis, and Muscle Weakness. A review of Resident #2's medical record revealed the following: A review of Resident #2's face sheet revealed that the resident has a Responsible party who is also listed as the financial-power of attorney and the care guardian- power of attorney. The resident also has four contacts with the relationship identified as friends and emergency contacts; and a nephew listed as an emergency. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], shows that the facility staff coded the resident as having severe cognitive impairment. [E-Interact Change in Condition Evaluation] 12/01/22 at 12:55 PM .Was called to the resident's room by nurse assistant .Observed that the resident has open and discoloration on sacral area. MD (Medical Doctor) and family made aware . It was noted during a review of the following documentation: [E Interact Change in Condition Evaluation] 12/01/22 at 12:55PM in the section titled Resident Representative Notification facility staff documented notifying the residents relative (name or relationship not documented); however, there is no documented evidence that the resident's Guardian/Power of Attorney was notified. [E-Interact Change in Condition Evaluation] 01/29/23 at 4:15 AM .Staff nurse called to room .by PCT (Patient Care Technician) while rounding on unit and resident was observed sitting on the floor and leaning on the side of the bed, when questioned, resident responded saying; she was following instructions, resident alert and forgetful, denies pain . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was noted during a review of the following documentation: [E Interact Change in Condition Evaluation] 01/29/23 at 4:15 AM, in the section titled Resident Representative Notification facility staff documented notifying the residents relative and there is no documented evidence that the resident's Guardian/Power of Attorney was notified. During a telephone interview conducted on 11/29/23, at approximately 10:00 AM, with the Power of Attorney for Medical Care and Guardian for Resident #2, stated that the facility has not communicated when there has been a change in condition with Resident #2. During a face-to-face interview conducted on 12/07/23 at approximately 10:00 AM, Employee #2 (Director of Nursing) stated that the charge nurse should contact the residents Power of Attorney or Responsible party and it was not documented in the resident's notes.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45102 Based on record reviews and staff interviews for one (1) of 22 sampled residents, the facility staff failed to implement its written policies and procedures for allegations of potential abuse neglect as evidenced by the facility staff failing to show documented evidence of conducting a thorough investigation into a residents fall. (Residents #135) The findings included: A review of the facility's policy titled Accident and Incident Report with a revision date of 10/2019, documented All accidents or incidents involving residents will be documented on the Accident/ Incident Report Form .The Nurse Supervisor or Charge Nurse shall initiate and complete an Accident/incident form at the time of the incident. The following data will be documented on the incident form .brief description of incident -facts only, no assumptions should be made. Document only what is observed A review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating with a revision date of 4/2023, documented .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must first be reported to the supervisor, the supervisor to Licensed Nursing Home Administrator, and to other officials according to state law The Licensed Nursing Home Administrator or designee reports the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the community; The local/state ombudsman; The resident's representative All allegations are thoroughly investigated . Within five (5) business days of the incident, the administrator will provide a follow-up investigation report . The facility staff failed to implement its policies and procedures to conduct a thorough investigation into Resident #135's unwitnessed fall that occurred on 10/12/22. Resident #135 was admitted to the facility on [DATE], with multiple diagnoses that included Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Repeated Falls, Syncope and Collapse. A review of a Facility Reported Incident (FRI) DC#00011029, submitted by the facility to the State Agency on 10/13/22, documented .At about 9.10 pm, resident was observed lying on the floor in her room (on her back side) with face up. Head to toe assessment done. No injury or skin issues noted. Resident complain of pain and medicated with PRN (as needed) pain medication . A review of Resident #135's medical record revealed the following: [Health Status Note] 10/12/22 at 10:37 PM, documents .At about 9.10pm. Resident was observed on the floor in her room, lying on her back. Resident states she don't know what happen, and can't remember is (if) (Sp) she hits her head on the floor. Supervisor on duty notified. MD (medical doctor) gave an order to transfer resident to hospital for further evaluation . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Physician Order] 10/12/22 Transfer resident to nearest ER (emergency room) for further evaluation secondary to unwitnessed fall . A review of the facility's incident investigation showed that it consisted of the intake that the facility submitted to the State Agency and a document titled Incident investigation. It was noted that the incident investigation documented one staff's encounter with the resident after the resident fell on [DATE]. The facility was unable to provide documented evidence that a thorough investigation was conducted into Resident #135's unwitnessed fall that occurred on 10/12/22. During a face-to-face interview conducted on 12/07/23 at 3:33 PM, Employee # 16 (Registered Nurse Supervisor) stated that nobody witnessed what happened and the family agreed to send the resident to the hospital. During a face-to-face interview conducted on 12/07/23 at approximately 3:45 PM, Employee #2 (Director of Nursing) stated that the investigation was not complete and acknowledged the findings.

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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** 45102 Based on record reviews and staff interviews for one (1) of 22 sampled residents, the facility staff failed to show documented evidence of conducting a thorough investigation into a residents fall. (Resident #135) The findings included: A review of the facility's policy titled Accident and Incident Report with a revision date of 10/2019, documented All accidents or incidents involving residents will be documented on the Accident/ Incident Report Form .The Nurse Supervisor or Charge Nurse shall initiate and complete an Accident/incident form at the time of the incident. The following data will be documented on the incident form .brief description of incident -facts only, no assumptions should be made. Document only what is observed A review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating with a revision date of 4/2023, documented .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must first be reported to the supervisor, the supervisor to Licensed Nursing Home Administrator, and to other officials according to state law The Licensed Nursing Home Administrator or designee reports the allegation immediately reports his or her suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the community; The local/state ombudsman; The resident's representative . All allegations are thoroughly investigated . Within five (5) business days of the incident, the administrator will provide a follow-up investigation report . 1) The facility staff failed to conduct a thorough investigation into Resident #135's unwitnessed fall that occurred on 10/12/22. Resident #135 was admitted to the facility on [DATE], with multiple diagnoses that included Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Repeated Falls, Syncope and Collapse. A review of a Facility Reported Incident (FRI) DC#00011029, submitted by the facility to the State Agency on 10/13/22, documented .At about 9.10pm, resident was observed lying on the floor in her room (on her Back side) with face up. Head to toe assessment done. No injury or skin issues noted. Resident complain of pain and medicated with PRN (as needed) pain medication . A review of Resident #135's medical record revealed the following: [Health Status Note] 10/12/22 at 10:37 PM, documents .At about 9.10pm. Resident was observed on the floor in her room, lying on her back. Resident states she don't know what happen, and can't remember is(if) (Sp) she hits her head on the floor. Supervisor on duty notified. MD (medical doctor) gave an order to transfer resident to hospital for further evaluation . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Physician Order] 10/12/22 Transfer resident to nearest ER (emergency room) for further evaluation secondary to unwitnessed fall . A review of the facility's incident investigation showed that it consisted of the intake that the facility submitted to the State Agency and a document titled Incident investigation. It was noted that the incident investigation documented one staff's encounter with the resident after the resident fell on [DATE]. The facility was unable to provide documented evidence that a thorough investigation was conducted into Resident #135's unwitnessed fall that occurred on 10/12/22. During a face-to-face interview conducted on 12/07/23 at 3:33 PM, Employee #16 (Registered Nurse Supervisor) stated that nobody witnessed what happened and the family agreed to send the resident to the hospital. During a face-to-face interview conducted on 12/07/23 at approximately 3:45 PM, Employee #2 (Director of Nursing) stated that the investigation was not complete and acknowledged the findings. Cross Reference 22B DCMR Sec. 3232.2

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45102 Based on record reviews and staff interviews for one (1) of 22 sampled residents, the facility staff failed to provide written notice of the bed hold policy to include the number of bed hold days to the resident or their responsible party upon transfer to the emergency room . (Resident #135) The findings Included: Resident #135 was admitted to the facility on [DATE], with multiple diagnoses that included Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Repeated Falls, Syncope and Collapse. A review of a Facility Reported Incident (FRI) DC#00011029, submitted by the facility to the State Agency on 10/13/22, documented .At about 9.10 pm, resident was observed lying on the floor in her room (on her Back side) with face up. Head to toe assessment done. No injury or skin issues noted. Resident complain of pain and medicated with PRN (as needed) pain medication . A review of Resident #135's medical record revealed the following: [Health Status Note] 10/12/22 at 10:37 PM, documents .At about 9:10pm. Resident was observed on the floor in her room, lying on her back. Resident states she don't know what happen, and can't remember is (if) (Sp) she hits her head on the floor. Supervisor on duty notified. MD (medical doctor) gave an order to transfer resident to hospital for further evaluation . [Physician Order] 10/12/22 Transfer resident to nearest ER (emergency room) for further evaluation secondary to unwitnessed fall . Skilled nursing noted dated 10/13/2022 at 07:12 AM A follow up call was made to [hospital] at 05:00 am and according to (ER Nurse) resident will be admitted . Now further information received. Further review of Resident #135's medical record showed no documented evidence that facility staff provided the resident, or their responsible party written notice upon transfer to specify the proposed action, ie transfer to the hosptial; the reaseon for this action; the date of transfer; the resident's destination, the person responsibe for supervising the transfer etc . and the bed hold policy when the resident was transferred to the emergency roiagnom on [DATE]. During a face-to-face interview conducted on 12/07/23 at approximately 3:15 PM, Employee #2 (Director of Nursing) acknowledged the findings. Cross Reference - 22 B DCMR Sec. 3270.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45104 Based on record review and staff interviews for one (1) of 22 sampled residents facility staff failed to accurately code a resident for hospice on a quarterly Minimum Data Set (MDS) assessment. Resident #21. The findings included: Resident #21 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Non-traumatic Brain Disorder, Bipolar Disorder, Anxiety, Weakness, Heart Disease, Fracture of Left Femur, and Unspecified Fall of Subsequent Encounter. A review of Resident #21's medical record revealed the following: An informed consent form dated 06/24/22 and signed by the Resident's representative for the resident to start hospice services. A physician's order dated 06/25/22 at 4:07 PM that documented: Admit to [Name of Hospice] for hospice services. Diagnosis: Cerebral Arthrosclerosis. Please call [Name of Hospice] at [Hospice Phone Number]. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status Summary score of 03 indicating the resident had severely impaired cognition, required extensive assistance for all ADL (assisted daily living) care, and was not receiving hospice services. A review of Resident #21's medical record lacked documented evidence that hospice services ever stopped for the resident. During a telephone interview on 12/07/23 at 4:23 PM, Employee #18 stated that if hospice was not checked on the MDS assessment, it should have been since the Resident was receiving hospice services at the time of the assessment. Cross Refrence 22B DCMR sect 3212.1

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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** 27513 Based on record review and staff interviews for one (1) of 22 sampled residents facility staff failed to update and revise the care plan with resident-centered goals for one (1) resident's use of bilateral hand palm protecters. (Residents' #1). The findings included: Resident #1 was admitted to the facility on [DATE], with multiple diagnoses that included: Osteoarthritis, Right-Hand Contracture, and Left-Hand Contracture. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as having a Brief Interview for Mental Status Summary score of 00 indicating the resident had severely impaired cognition, required extensive assistance for all ADL (assisted daily living) care, and had upper extremity impairment on both sides. A review of a [Physician's Order] dated 11/28/23 at 3:00 PM documented: Patient to wear left and right palm protectors for 4-5 hours a day. On 11/28/23 at 3:13 PM Resident #1 was observed by the Surveyor awake and lying-in bed with the bed linen pulled up to the resident's waist. The surveyor observed that the resident's right and left hands were contracted. Next to the Resident's bed was a nightstand. On top of the resident's nightstand were two palm protector braces-one for the left hand and one for the right. On 11/29/23 at 9:43 AM Resident #1 was observed awake, lying down, in bed. The surveyor observed that facility staff had applied a palm protector to the Resident's left and right hands. A review of the Treatment Administration Records (TAR) from 11/28/23 to 12/08/23 documented that that Resident #1 was wearing left and right palm protectors for 4-6 hours a day. A review of the [Care Plan] initiated on 09/24/21 documented: Focus: [Resident #1] has limited physical mobility r/t (related to) contractures, weakness; Goal: [Resident #1] will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, . Bil (bilateral) foam rolls to hands as tolerated for contracture .Provide supportive care, and assistance with mobility as needed. Document assistance as needed . A review of Resident #1's medical record lacked documented evidence that the facility staff revised and updated the Resident's care plan to include the resident's use of palm protectors for bilateral hands. During a face-to-face interview on 12/07/23 at 10:26 AM, Employee #3 (Assistant Director of Nursing), Employee #3 acknowledged that facility staff had not updated Resident #1's care plan to include the resident's use of palm protectors to bilateral hands. Cross Reference DCMR 3210.4(c) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45104 47555

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47555 Based on observation, record review, and staff interviews for two (2) of 22 sampled residents, facility staff failed to provide adequate supervision consistent with a resident's needs, goals, and care plan to reduce the risk of an accident, subsequently, a resident had an unwitnessed fall; facility staff failed to ensure a resident who was identified as having a high fall risk on admission received adequate supervision to prevent injury of unknown origin. Subsequently, the resident was observed with discoloration on her right eyelid and a raised area around her eyebrow; and the facility failed to provide an environment free from accident hazards as evidenced by three (3) of 51 oxygen tanks that were unsafely stored in the oxygen storage room on the [NAME] side of the facility. (Residents' #11 and #22.) The findings included: 1.Facility staff failed to provide adequate supervision consistent with Resident #11's needs, goals, and care plan to reduce the risk of an accident, subsequently, the resident had an unwitnessed fall on 11/27/23. A facility policy titled 'Fall Risk Evaluation' documented, The nursing staff, in conjunction with the Interdisciplinary Team Members will seek to identify and document resident risk factors for falls and establish a resident-centered falls management plan based on relevant evaluation information. A facility policy titled 'Assessing Falls and Their Root Cause' documented, Definition-Root Cause Analysis (RCA) is a process to find out what happened, why it happened and to determine what can be done to reduce the risk of it happening again and Review the resident's care plan to assess for any special needs of the resident and Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly and Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. A hospital Admission History and Physical dated 11/04/23 documented, Resident #11's name 89yo (year old) M (male) with Alzheimer's Dementia, Paroxysmal Atrial Fibrillation, and Anxiety who was [NAME] in via EMS (emergency medical service) after being found down in his room at his nursing home [Assisted Living Facility]. Patient states that he fell down stairs, patient's son who was at bedside says this is doubtful and believes that the fall was from standing. Per patient's son, patient has fallen many times in the past, most recently 1mo (month) ago, but has never broken a bone 2/2 (secondary to) falling prior to this presentation and Patient is unable to provide a reliable history. A Hospital Discharge Summary - Hospital Course dated 11/07/23 documented, 89M with Alzheimer's dementia, paroxysmal atrial fibrillation, and anxiety who presented after fall in nursing home and was found to have L (left) hip fracture. Left intertrochanteric femur fracture: S/p (status post) unwitnessed fall at nursing home. Patient with recurrent falls, no prior broken bones. XR (Xray) with L intertrochanteric fracture. Ortho consulted, s/p ORIF (Open Reduction Internal Fixation) 11/5/23. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside at Rock Creek	3050 Military Road NW Washington, DC 20015

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was admitted to facility on 11/07/23 with multiple diagnoses that included: Alzheimer's Dementia, Repeated Falls, Hip Fractures and other Multiple Trauma, Muscle Weakness, Atrial Fibrillation, Anemia, Anxiety and Depression. A Clinical Admission Evaluation dated 11/07/23 documented, Wanders at night - Yes and Sleep - Sleeps intermittently and Resident #11's name is an [AGE] year old male transfer from [hospital name], on assessment is alert and oriented to self with confusion observed. A Fall assessment dated [DATE] documented, Type: Re-Admission; Score: 55.0; Category: High Risk for Falling; What type of gait does the resident exhibit?-Weak; Mental Status - Overestimates or forgets limits. A care plan dated 11/08/23 documented, Special instructions: HIGH FALL RISK! DO NOT LEAVE HIM UNATTENDED. A Physician History and Physical dated 11/09/23 documented, s/p (status post) fall in Assisted Living transferred to the hospital and [AGE] year old male resides in Assisted Living, previously had private aide services, ceased and sustained a fall. Work up revealed Left hip fracture. Patient is a poor historian, history of Dementia and not on anticoagulation secondary to fall history and recurrence Dementia debility and lacks safety awareness and Does not follow commands and Rehab Potential: Poor, as per rehab team with safety awareness concerned about patient's ability to fully follow rehab recommendations and treatment. An Admission Minimum Data Set (MDS) assessment dated [DATE] showed the resdient had a Brief Interview for Mental Status (BIMS) summary score of '06,' indicating the resident had severely impaired cognition. The resdient was coded for functional limitation indicating of lower extremity impairment on one side, requiring assistive devices for mobility walker and wheelchair; and the resident needed assistance from staff with bathing, eating, dressing, toileting. Also, the resident was coded for having a history of falls with fracture within the last 2 to 6 months prior to admission to the facility. A care plan dated 11/19/23 documented the following: Focus area -[Resident #11's name] is at risk for falls r/t (related to) deconditioning, history of falls. Interventions: Please offer to take me to the toilet before and/or after my meals as well as before and/or after my activities and before bed. Focus area - [Resident #11's name] has a communication problem r/t (related to) Neurological symptoms. Intervention: Anticipate and meet needs. A review of the resident's record revealed CNA (Certified Nursing Assistant) documentation dated 11/26/23 at 04:24 AM documented, Sit to Stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's record revealed CNA (Certified Nursing Assistant) Documentation dated 11/26/23 at 10:25 PM documented, TRANSFER: SELF PERFORMANCE - How resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet) and TOTAL DEPENDENCE - Full staff performance The aforementioned entries were documented by facility staff in the resident's electronic record on the day and evening shifts prior to the unwitnessed fall that occurred on 11/27/23, indicating that the resident was totally dependent upon staff to assist with mobility and transferring from various positions while out of bed. A review of a facility witness statement dated 11/27/23 at 12:30 PM by Employee #13 (CNA) documented, About 12:30 pm while I [was] serving lunch I heard a shout for help. I went to the room and discovered the resident on the floor. I reported [it] to the Charge Nurse. A review of a facility witness statement dated 11/27/23 at 12:30 PM by Employee #14 (LPN) documented, [Employee #13's name] called and told me that she saw the resident on the floor on his back. Assessed and no injury noted. [Employee #13's name] and me helped resident onto a couch. A care plan focus area dated 11/27/23 documented, [Resident #11's name] had an actual fall r/t (related to) poor safety awareness, cognitive impairment, Unsteady gait, poor balance, s/p (status post) left hip replacement Fall 11/27/23, Fall 11/08/23 [on Memory Care Unit] s/p (status post) Left hip replacement. Intervention: Neuro Checks as per policy. PT/OT (physical therapy/occupational therapy) consult as needed, Bed locked and in lowest position, Reduce clutter in room, PT (physical therapy) consult for strength and mobility. Frequent rounding and anticipate resident needs. A physician progress note dated 11/27/2023 at 12:45 PM documented, e (electronic) INTERACT SBAR (Situation, Background, Appearance, Review and Notify) Summary for Providers, Situation: Falls, Nursing observations, evaluation, and recommendations are: [Employee #13's name], called and told me that she saw the resident on the floor on his back and Writer and [Employee #13's name] helped resident onto a couch. An Incident Note dated 11/27/2023 at 5:22 PM documented, Resident was observed on the floor by his bedside with his wheelchair beside him. Resident is able to verbalize situation, stated, I was trying to get into my bed. Resident is at baseline with cognitive impairment and poor safety awareness. A SBAR (Situation, Background, Appearance, Review and Notify) Communication Form dated 11/27/23 documented, Functional Status Evaluation: Falls (one or more). A physician order dated 11/28/2023 AT 10:57 PM documented, 2 view bilateral hip x ray. S/P (status post) fall one time only until 11/29/2023 schedule for tomorrow 11/29/23. A Facility Investigation Report dated 11/28/23 documented, CNA informed the nurse that she saw the resident on the floor. As per resident, he tried to transfer from wheelchair to bed and Morse Fall-50, indicating the resident is a high risk for falls and Nurse evaluated resident post fall. Resident was assisted to his wheelchair. X-ray ordered and Resident has Dementia; no safety awareness and Reminding staff to do frequent rounding. Do not leave Resident unattended and Resident is a high risk for falls especially now that he is getting stronger and is capable of wheeling himself. Staff needs to anticipate his needs and continue frequent rounding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 11/29/23 at 12:12 PM, the resident was observed being wheeled to the dining area where other residents were seated at various tables awaiting lunch. The resident was positioned by facility staff at a table alone, sitting in wheelchair awaiting lunch meal. When facility staff walked away, the resident was observed self-propelling in his wheelchair away from the dining area. The resident was then observed bending over from the wheelchair trying to adjust the footrest, but was unsuccessful as he appeared unsteady. Facility staff returned approximately seven minutes later and found that the resident was not where they had left him. The resident was assisted back to the table where he was seated and left alone again. A physician progress note dated 11/30/2023 at 3:32 PM documented, patient with left femur fracture secondary to fall. with cognitive impairment, lacks safety awareness and s/p (status post) slide to floor no acute pain issues patient underwent imaging study, no hip dislocation, no pathologic left femur fracture and deconditioned state cognitive impairment. A face-to-face interview was conducted on 12/07/23 at 1:34 pm with Employee #14 (Licensed Practical Nurse) who stated, I was with a resident giving meds and [Employee #13's name] called me and after I finished passing my meds [resident's medications] she told me he was on the floor. So, I went to [the resident's] room and he was lying on his back, and I asked him what happened. He said he tried to transfer from chair to bed and slid down to the floor and I was the charge nurse for only the west side that day. He was in the hospital because of a fall then admitted to the Memory Care Unit then he was transferred here to us on 3 West. We keep an eye on him by putting him around the dining area, sometimes when I'm documenting I'll keep him near me. We (the facility staff) share being with him, so everybody is monitoring him, like teamwork. When he was on the Memory Care Unit, the family had a private duty aide for him, but not since he's been on 3 West. The CNA was serving lunch trays when the resident fell in his room. He wheeled himself to the room and fell in the room where he was alone. Sometimes he is by himself. Employee #14 was asked if she knew his care plan had special instruction item that documented, HIGH FALL RISK! DO NOT LEAVE HIM UNATTENDED and she stated, No, not aware his care plan states he should not be left unattended. After I give meds [resident's medications], especially for residents that have falls risk I will check them often. A face-to-face interview was conducted on 12/07/23 at 2:59 PM with Employee #13 (Certified Nursing Assistant) who stated, I didn't have him, but I heard him calling for help so I went to see him and saw him on the floor. I called the nurses for help and then I wrote a report. He was on the floor in his room he was sitting on his butt, so I just told him I'll be right back, got the nurse and they all come and helped with him off the floor and This happened near lunch time, and they brought him to the table to eat lunch that's why I was in that area because I was getting trays ready for lunch. I've been assigned to work with him before sometimes early in the morning if he's restless and everybody watches him because he's always trying to go somewhere or running off in his wheelchair. A face-to-face interview was conducted on 12/07/23 at 3:20 PM with Employee #15 (Registered Nurse) who stated, because of his memory status and his adjustment process to the unit, we have always gone in his room, and I bring him here to the nurse's station, but sometimes he doesn't want to be here with me. He's getting used to the unit and requires less monitoring. We never leave him unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee #15 was asked where was the resident during our interview and she stated, He was with activities, but then he said he wanted to take a nap. I think he's in his room now. When asked what happens when he wakes up and he's alone in his room and the nurse stated, The new staff for the next shift is making rounds now. He is getting used to using the call bell and he calls us, and sometimes use his call bell. He's never out of our sight unless he's taking a nap. A face-to-face interview was conducted on 12/08/23 at 1:33 PM with Employee #2 (Director of Nursing) who stated, We actually almost went to the range of 1-to-1 monitoring, I pulled one of my supervisors to be with him and of course with hospitalization . and change in environment, he had no awareness and wanted to stand then eventually he fell down and we even asked his family to consider a private duty aid, but they declined because of the cost. We're doing our best and staff taking turns to be with him. Employee #2 was asked how the staff document the frequent rounding and monitoring and she stated, It's not documented anywhere, the staff just round (check on) often for the resident's safety. Employee #2 acknowledged the resident's care plan dated 11/08/23 that documented, do not leave unattended and stated, Since that fall [on 11/27/23] he has gotten better with his awareness of the unit. Cross Reference DCMR Chapter 32 of Title 22B Section 3211.1(d). 27513 2. The facility staff failed to ensure Resident #22 who was identified as having a high fall risk on admission received adequate supervision to prevent injury of unknown origin. Subsequently, the resident was observed with discoloration on her right eyelid and a raised area around her eyebrow. Resident #22 was admitted to the facility on [DATE], with diagnoses that included Acute Respiratory Failure, Alzheimer's Disease, Dementia, Hypertension, and Encephalopathy. A review of a health status note dated 12/1/22 at 1:12 PM documented, Writer attention was call to resident's room. Resident was observed with black eye on her right eye. Resident's stated that there wasn't such as of yesterday before he left the unit. Resident is in stable condition, and care provided tolerated well. [doctor name] made aware of incident and response pending. No acute distress/observed. Respiratory effort normal on room air and able to move all extremities within her normal limit. A review of a Health status note dated 12/01/22 at 3:02 PM documented, [Physician Name] responded and order to transfer resident to ER [emergency room]. 911 called @[at] this hour. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a discharge summary dated 12/02/22 at 4:19 PM documented, Discharge diagnosis Accidental fall, fall on anticoagulation . Hospital course . PMHX [pass medical history] of dementia and CVA[cerebrovascular accident], BIB [brought in by] EMS [emergency services], presents to ED [emergency department] with c/o [complain of] right eye pain onset . Pt's husband says he noticed a contusion and swelling on her right eye around 10:00 this morning. He says he last saw around 1200 yesterday and the contusion was not there. He notes that the color and swelling has improved throughout the day. EMS says pt had nasal bleeding from both nostrils upon their arrival. Pt's [patient] husband says she is on anticoagulants. Denies fever, chills, n/v/d, chest pain, cough, or rash. No other acute complaints or symptoms. Primary and secondary trauma surveys were done on the patient which were significant for periorbital contusion. OMFS [oral and maxillofacial Surgery] was consulted and their recommendations were appreciated. Appropriate imaging was obtained which was negative for any acute pathology at discharge, patient was medically stable and at baseline. Patient was discharged back to nursing home. Discharge instructions: Intermittent ice to the area 10-20 minutes on and off TID (three times a day) or more, Follow up with OMFS in OMFS clinic in a week 12/8/22 at 10 AM . A review of a State Survey Agency Facility Reported Incident Form DC-00011304 submitted to the state agency on 12/2/22 at 5:41 PM shows Resident was observed with discoloration on her right eyelid and a raised area around her eyebrow. She denies feeling pain. MD [medical doctor] was made aware and ordered to send resident to the ER [emergency room] for further evaluation due to resident being on anticoagulant. Resident was picked up by ambulance to [hospital name]. Resident spouse was in the unit. A review of Resident #22's admission Minimum Data Set [MDS] assessment dated [DATE], showed that the resident had severe cognitive impairment, needed extensive assistance with one (1) person physical assist for bed mobility, transfer, locomotion on the unit, and extensive assistance with two (2) person physical assist for toilet use, and personal hygiene, range of motion with no impairment and the resident had a fall in the last month prior to her admission to the facility. Review Investigation notes dated 12/9/2022 signed by DON [director of nursing] showed that the seven (7) staff interviewed statement documentation stated they did not observe when Resident #22's injury occurred. The investigation summary conclusion stated that the etiology of the trauma is uncertain, conclusively, it can be ascertained that it is an injury of unknown origin. As a way of preventing such occurrences in the future, the resident's name has been placed on the list .for safety, and monitoring for fall . A face-to-face interview was conducted on 12/7/23 at 1:55 PM with Employee #8 [LPN] who stated, The resident had a sitter with her when she was first admitted to the unit in September of 2022. It was around the time of the incident that the private duty aide was discontinued. The staff took turns monitoring the resident by constantly visiting her, and knowing she was safe. I did not witness when her injury occurred. During a face-to-face interview with Employee #2 [Director of Nursing] on 12/7/22, at 2:44 PM, she acknowledged the findings and stated, It was an injury of unknown origin. Cross Reference DCMR Chapter 32 of Title 22B Section 3211.1(d). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.The facility failed to provide an environment free from accident hazards as evidenced by three (3) of 51 oxygen tanks that were unsafely stored in the oxygen storage room on the [NAME] side of the facility. During an environmental walkthrough on the [NAME] side of the facility on December 1, 2023, at approximately 8:45 AM, three (3) of 51 oxygen tanks were loosely stored upright, on the floor of the oxygen storage room, and presented an accident hazard. Employee #3 who was present at the time of observation, acknowledged the above findings during a face-to-face interview on December 1, 2023, at approximately 9:00 AM.

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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** 45102 Based on record reviews and staff interviews for one (1) of 22 sampled residents, the facility staff failed to show documented evidence of reconciling Resident #27's prescribed controlled substance medication with the Pharmacy delivery staff on multiple occasions; and failed to record when controlled substance medication (Fentanyl patches) were received on the narcotic medication reconciliation log for the resident. The findings included: A review of the facility's policy titled Controlled Substances with a revision date of 5/2023, instructs staff to do the following: .Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record .an individual resident controlled substance record is made for each resident who will be receiving a controlled substance .the record contains: quantity received; date and time received signature of person receiving medication .Controlled substance inventory is monitored and reconciled to identify loss or potential diversion . Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including Fracture of Unspecified Part of Neck of Left Femur. 1)Facility staff failed to ensure that a nurse representing the facility and the delivery person from the pharmacy signed that controlled substances were delivered from the pharmacy and received by the facility for Resident #27. A review of Resident #27's medical record revealed the following: A review of the physician's order dated 09/20/23 instructed, Fentanyl (synthetic opioid analgesic) Transdermal Patch 72-hour 12 MCG (microgram)/HR (hour) (Fentanyl) Apply 1 patch transdermally every 72 hours for pain and remove per schedule . A review of Pharmacy Delivery Sheets from 09/20/2023 to 12/02/2023 revealed the following: 09/20/2023 - Fentanyl 12 MCG/HR Patch QTY (Quantity) =5 10/20/2023 - Fentanyl 12 MCG/HR Patch QTY =10 10/31/2023 - Fentanyl 12 MCG/HR Patch QTY=12 12/02/2023 - Fentanyl 12 MCG/HR Patch QTY= 10 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was noted that only one nurse employed with the facility signed each delivery sheet which acknowledged that the Fentanyl patches were received from the pharmacy. However, there was no signature from the person delivering the medication from the pharmacy indicating that the control substances received and counted by both parties. 2) Facility staff failed to record when controlled substance medication (Fentanyl patches) were received on the narcotic medication reconciliation log for the resident. A review of facility's binder titled, Controlled Substance Book contained multiple forms with no titles. During an interview with Employee #2 (Director of Nursing) on 12/05/2023 at 1:28 PM, she stated that facility staff use the previously mentioned forms as the resident's narcotic medication reconciliation log (used to track the resident's medication delivered from pharmacy). Upon further review of the medication reconciliation form showed that when the pharmacy delivered the Fentanyl patches, facility staff failed to record the actual amount of patches delivered in the specified section of the form titled, RCD (Received) from Pharm (Pharmacy). As evidenced below: 09/20/2023 - a handwritten line was drawn in the section titled RCD from Pharm. 10/02/2023 the section titled RCD from Pharm was left blank; 10/31/2023, the section titled, quality on hand was listed as 14; in the section titled, RCD from Pharm a handwritten line drawn; 12/02/2023 a handwritten line was drawn in section titled RCD from Pharm. During a face-to-face interview conducted on 12/05/23 at approximately 4:00 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated that education will be provided to the staff. There was no documented evidence that the facility staff reconciled narcotics as evidenced by Failure to have the pharmacy delivery personnel sign the delivery sheet and nursing staff failed to document when the pharmacy delivered Fentanyl 12 MCG/HR patches in Resident #27's narcotic medication reconciliation logs. 3) Review of one (1) of two (2) nursing units, the facility staff failed to account for the receipt, usage, disposition, and reconciliation of controlled medications. A review of the Medication Storage in the Facility- Controlled Substance Storage, policy revised in August 2018 documented: At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented (See Documentation Examples, Form 8: Shift Verification Of Controlled Substances Count) . A review of the Shift count Narcotic records on Unit 3 East was completed on November 29, 2023, at approximately 9:10 AM, and it showed the following activity in the Narcotic reconciliation record for the following dates: 11/19/23 3-11 shift the same nurse signed coming on and going off duty. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/22/23 3-11 shift the same nurse signed coming on duty and going off duty. The review of the above-mentioned dates showed the same nurse signed the Shift Narcotic Count Sheet as the nurse coming on duty and the nurse going off duty. A review of the Medication Storage in the Facility- Controlled Substance Storage, policy states, At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented (See Documentation Examples, Form 8: Shift Verification of Controlled Substances Count) The evidence showed that licensed nursing staff failed to adhere to an acceptable standard of practice to reconcile the verification of controlled substances on the aforementioned dates and shifts. During a face-to-face interview on 12/08/23 at approximately 11:00 AM Employee # 17 (Licensed Practical Nurse) stated that on 11/19/23 and 11/22/23, she worked through the next shift, and she signed as the nurse coming on duty and the nurse going off. The Employee then acknowledged the findings.

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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** 27513 Based on record review and staff interview for two (2) of 22 sampled residents, facility staff failed to acknowledge and/or respond to the pharmacist medication regimen review recommendation. Residents' #6 and #25. The findings included: 1. Facility staff failed to acknowledge and/or respond to the pharmacist's medication regimen review recommendations for Resident #6. Resident #6 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus, Anxiety Disorder, and Major Depressive Disorder. According to the Medication Administration Record Resident #6 nurse staff signed that the resident received the following medications: Vibryd 20mg [milligram], Tamsulosin HCL [Hydrochloride] 0.4mg capsule, Pradaxa 150mg capsule, Bevespi Aerosphere inhaler 2 puffs, Metoprolol Tarte 25mg, Furosemide 20mg, and Novolog 100unit/ml [milliliters] per sliding scale. On the following dates 2/18/23, 5/16/23, and 11/21/23 the monthly Health Status progress note completed by the Pharmacy consultant showed, MRR (Medication Regimen Review) completed. See Pharmacist note for recommendations. There were no recommendation notes found on the record. A review of Resident #6's medical record on 12/04/23 showed there were no pharmacy recommendations with the rationale of action taken by facility staff for the following dates: 02/18/23, 05/16/23, and 11/21/23. During a face-to-face interview on 12/04/23 at 11:00 AM with Employee #2 (Director of Nursing) she was asked to locate the pharmacy recommendations for the medication regimen review dates of: 02/18/23, 05/16/23, and 11/21/23. She stated she would look for them. During another face-to-face interview on 12/ 06/ 23 at approximately 1:00 PM, Employee #2, she stated, I am unable to find the Medication Regimen Review information you requested. The evidence showed that facility staff failed to acknowledge and/or respond to the pharmacy consultants, Medication Regimen Review recommendation(s) for Resident #6. 45104 2. Facility staff failed to acknowledge and/or respond to the pharmacist's medication regimen review recommendations for Resident #25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was admitted to the facility on [DATE] with the following diagnoses: Encounter for Palliative Care, Urinary Tract Infection, Acute Embolism and Thrombosis, Dementia, Osteoporosis, Pulmonary Edema, Anxiety and Depression. A review of Resident #25's medical record revealed: The following physician's orders dated 07/17/23: Apixaban Oral Tablet 5 mg (milligram). Give 1 tablet by mouth two times a day for DVT (Deep vein thrombosis) prophylaxis. Discontinued. Risperidone Oral Tablet 0.5 mg. Give 1 tablet by mouth one time a day for Anxiety. Discontinued. Escitalopram Oxalate Tablet 5 mg. Give 1 tablet by mouth one time a day for Anxiety/Depression. Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 100 mg. Give 1 tablet by mouth one time a day for HTN (hypertension). Hold for SBP (systolic blood pressure) < 100 or HR (heart rate) <55. Mirtazapine Oral 15 mg. Give 1 tablet by mouth at bedtime for Major Depressive Disorder. Rivastigmine Transdermal Patch 24 Hour 9.5 mg/hr (hour). Apply 1 patch transdermally one time a day for Dementia. Rotate sites of patch application and remove per schedule. Telmisartan Oral Tablet 40 mg. Give 1 tablet by mouth one time a day for HTN. Hold for SBP < 110. A Health Status Progress Note dated 07/18/23 at 5:59 PM documented: Pharmacy Consult: MMR Completed. See Pharmacist Report for Recommendations. A Health Status Progress Note dated 08/10/23 at 8: 37 PM documented: Pharmacy Consult: MMR Completed. See Pharmacist Report for Recommendations. On 12/06/23 at 4:08 PM and 12/07/23 at approximately 2:40 PM, the surveyor requested documentation of the physician's review and response to the pharmacist's monthly medication review and recommendations for Resident #25 on 07/17/23 and 08/10/23. The facility staff provided no documented evidence that the physician responded to or reviewed the pharmacist's recommendations for Resident #25 on 07/17/23 and 08/10/23. During a face-to-face interview on 12/07/23 at 2:45 PM Employee #2 (Director of Nursing) stated that she had requested a copy of the pharmacist's recommendations and the physician's response for Resident #25 on 07/17/23 and 08/10/23 from the pharmacy, but she had not received them. She then acknowledged that there was no documented evidence that the physician responded or reviewed the pharmacist's recommendations for Resident #25 in the resident's medical record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45102 Based on record review, staff and resident representative interviews for one (1) of 22 sampled residents, the facility staff failed to ensure that Resident #27 was free from a significant medication error as evidenced by the resident being observed with three (3) Fentanyl patches on at once by the facility's staff and the residents relative. The findings included: A review of the facility's policy titled Administration Procedures for All Medications with an effective date of 8/2018, instructs staff to do the following: .Prior to removing the medication package/container from the cart/drawer. Check MAR (medication administration record)/TAR (treatment administration record) for order . A review of the facility's policy titled Medication Administration-General Guidelines with an effective date of 8/2018, documents the following: .Medications are administered in accordance with written orders of the prescriber. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses that included Fracture of Unspecified Part of Neck of Left Femur, and Unspecified Dementia Severe Without Behavioral Disturbance. A review of a Facility Reported Incident (FRI) submitted to the State Agency on 12/04/23, documented the following .Suspected medication error. Residents' daughter noted her mother to be hard to be awakened when she visited today 12/4/2023 at around noontime. Daughter informed the ADON (Assistant Director of Nursing) of the condition, went to the residents room and evaluated the resident . A review of Resident #27's medical record revealed the following: A review of the physician order dated 09/20/23 at 10:30 PM, instructed, Fentanyl (synthetic opioid analgesic) Transdermal Patch 72-hour 12 MCG (microgram)/HR (hour) (Fentanyl) Apply 1 patch transdermally every 72 hours for pain and remove per schedule . Review of the medication administration record from the dates of 11/20/23 to 12/4/23 documents that staff administered Fentanyl Transdermal Patch 72-hour 12 MCG/HR and removed the previously placed patch. Review of a handwritten witness statement dated 12/4/23, located in the facility's incident investigation binder revealed the following statement written by Employee #11, .I noticed 3 fentanyl patches on her chest 2 on the upper chest and 1 on the R (Right) breast area. I took off 2 patches located on the chest and left the one on the R (right) breast area. During a face-to-face interview conducted on 12/05/23 at 11:45 AM, Resident #27's Relative stated that she came in the previous day and Resident #27 was unrousable and she had 3 patches on her chest with no date or time written on the patches. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 12/05/23 at 2:27 PM, Employee #11 (Registered Nurse) stated that she observed 3 fentanyl patches on the resident on the previous day and she removed 2 of the patches. During a face-to-face interview conducted on 12/08/23 at 10:40 AM, Employee #2 (Director of Nursing) stated that the Fentanyl patch was not removed on 11/25/23 based on the facility's investigation and education is being provided to the nursing staff. Cross Reference - 22 B DCMR Sec. 3227.18

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27689 Based on observations and interview, facility staff failed to store and distribute food under sanitary condition as evidenced by expired food items such as 12 of 14, V8 vegetable drinks that were in the kitchen on the East and [NAME] side of the facility. The findings included: During a walkthrough of dietary services on [DATE], at approximately 12:00 PM, the following observations were made: 1. Six (6) of six (6) 5.5 fluid ounces of V8 vegetable drinks stored in the kitchen on the East side of the facility were expired as of [DATE]. 2. Six (6) of eight (8) 5.5 fluid ounces of V8 vegetable drinks stored in the kitchen on the [NAME] side of the facility were expired as of [DATE]. Employee #6 acknowledged the findings during a face-to-face interview on [DATE], at approximately 12:15 PM.

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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** 47555 Based on observation, record review and staff interviews for one (1) of 22 sampled residents, facility staff failed to show documented evidence that a skin assessment was completed on admission, documented as ordered by the physician and weekly per the facility policy that accurately reflected a resident's change in skin condition. Resident #18. The findings included: Resident #18 was admitted to facility on 02/23/22 with multiple diagnoses that included: Dementia, Muscle Weakness, Difficulty Walking, Multiple Falls, Hypertension, Kidney Disease, Thyroid Disease and Anemia. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '12,' indicating the resident had moderately impaired cognition; and coded the resident's functional status as 2-person physical assistance with toilet use and 1-person physical assistance with bed mobility, transfers, locomotion on/off unit, dressing, eating and personal hygiene. 1A) Facility staff failed to show documented evidence that skin assessments were completed on admission and weekly per the facility policy and physician's order that accurately reflected a resident's change in skin condition. The facility policy titled 'Pressure Injury Risk Assessment' documented, The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed and Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition and Conduct a comprehensive skin assessment with every risk assessment. If a new skin alteration is noted initiate a (pressure or non-pressure) form related to the type of alteration in skin. A review of Resident #18's medical record revealed: A Physician's order dated 02/24/22 documented, Complete second day admission skin evaluation and document findings in notes. A Physician's order dated 07/22/22 documented, Body Audit Complete an assessment of residents' skin and document as below: 0= No new skin alteration 1= Existing skin alteration; treatment in place 2= New skin alteration- Please complete a NEW weekly assessment for Skin Integrity Review every day shift every Fri (Friday). There was no documented evidence that facility staff completed skin assessments as ordered by the physician. 1B) Facility staff failed to record on the Documentation Survey Report that Resident #18 had a bluish discoloration to her left shin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled 'Charting and Documentation' documented, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record and Policy Interpretation and Implementation: The following information is to be documented in the resident medical record: Objective observations; Changes in the resident's condition; Events, incidents or accidents involving the resident and Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. A Skilled Nursing Note dated 02/12/2023 at 12:46 PM documented, Resident is alert and oriented x 3 tolerated medication and meals this shift. Resident was observed with a skin discoloration to left shin while providing personal care. Resident states she bruises easily, can't explained what happened. However resident says it was not caused by staff. Resident denies pain. No limitation with ROM (range of motion), ambulates without difficulty. MD (medical doctor) and [daughter's name] notified. Will continue with plan of care. A Weekly Skin Assessment Note dated 02/12/23 at 13:21 (1:21 PM) documented, Skin Condition Location: Left Lower Leg Front; Skin Condition Type: Bruising; Length (cm): 2 Width (cm): 2 Depth (cm): 0.00; Wound Edge is: Distinct, outline clearly visible, attached, even with wound base; Surrounding Skin is: Pink or normal for ethnic group. A Skilled Nursing Note dated 02/12/23 at 13:25 (1:25 PM) documented, Resident's daughter states she saw the bruised area on the shin, and resident states is from X-ray machine. Resident had x-ray of the left 4th finger done on 2/9/23. Resident later confirmed it was caused by x-ray machine. MD (medical doctor) updated. A review of Resident #18's medical record revealed a document titled 'Documentation Survey Report dated 02/12/23 that documented, 5 for day shift at 2:39 PM, evening shift at 4:57 PM and night shift at 05:49 AM that indicated None of the above observed on the day it was reported that Resident #18 was noted to have a bruise on her left shin. A document titled 'SBAR (Situation, Background, Appearance, Review and Notify)' Communication Form documented, Change in skin color or condition; This started on 02/12/2023, Skin Evaluation: Discoloration. A Physician order dated 02/12/23 documented, Monitor bruised area to left shin every shift, notify MD (medical doctor) of abnormal changes. A Facility Reported Incident received by the State Agency on 02/13/23 documented, Resident was observed with bluish discoloration on her left shin. ROM (range of motion), WNL (within normal limits). Denied pain on assessment. Resident able to ambulate without difficulty. Resident is alert and oriented times three. Questioned about circumstance related to discoloration, resident initially stated that she does not know how incident occurred and strongly expressed discoloration was not caused by staff. Resident later alleged at this time of reporting that discoloration was accidentally caused by the x-ray machine on 2/8/2023 when she had x-ray of her left hand done. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan Focus Area dated 02/12/23 documented, [Resident's name] has alteration in skin integrity AEB (as evidenced by) bluish discoloration on left shin. Interventions: Monitor left shin discoloration daily and report abnormalities; Monitor/document location, size of discoloration. Report abnormalities. A Skin/Wound Note dated 02/13/23 at 12:16 PM documented, Chief Complaint: Comprehensive skin and wound evaluation for Wound team asked to consult on bruises to the patient's left shin and Dermatologic - Patient has thin / fragile skin. Patient has generalized dry skin. Wounds - There are no open wounds on today's comprehensive skin examination. Bruise to right shin and PLAN - Wound plan of care: No open areas noted upon assessment today. Small, raised bruise noted to left shin. Continue to monitor site. Patient does not require wound care services at this time. A review of Resident #18's record showed no documented evidence of weekly skin assessments until 02/12/23, when a bruise was observed on the resident's left shin, which was one year after the resident was admitted to the facility. Further review of the record showed that there were no additional weekly skin assessments after 02/12/23 through 10/06/23. During a face-to-face interview conducted on 12/01/23 at 1:36 PM Employee #3 (ADON) stated, Yes, we have a Skin Assessment Policy. The weekly skin assessments are for everybody whether you have a wound or not. No order for a weekly skin assessment is needed, we do them as soon as admitted . For the admissions, we do them on the day they come in, then day 2 of admission to make sure we didn't miss anything, then again on the 3rd day to check again, then it's ongoing weekly until discharge. Employee #3 was asked if there would be a reason why the Weekly Skin Assessments are not done for any of the residents and she stated, Oh no, there should not be a reason that the weekly assessment isn't done, everyone should get it done weekly. If the resident refuses, then we should try again, but there should be a note in the chart if the resident refuses or why the weekly skin assessment wasn't done. The nurses are responsible for doing the weekly skin assessments. Once the admission assessment is done then it triggers the weekly skin assessment for each resident. If it's not done on admission, then it will not automatically trigger to do the assessments, but it should always be done for each resident. Employee #3 was then asked about documentation when residents have an alteration in their skin and she stated, If they put a '5' that means it was nothing new observed on the skin. The Surveyor showed Employee #3 the reference guide that documented, '5' - None of the above observed, '2' - Discoloration, 'N' - Not a new skin condition and showed her the resident's record that revealed that facility staff had documented '5,' indicating 'None of the above observed' for day, evening and night shifts on the same day it was reported that the resident had a bruise to her left shin. Employee #3 acknowledged the findings and stated, we need better education on how to document the skin assessments. During a face-to-face interview conducted on 12/01/23 at 3:30 PM Employee #2 (DON) stated, The policy is there, sometimes our policies overlap. That's the Weekly Skin Assessment Policy (referring to the document titled 'Pressure Injury Risk Assessment').

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27513 Based on record reviews and staff interviews for five (5) of 22 sampled residents, the facility staff failed to ensure that residents had collaborative hospice care plans between the hospice agency and the facility that included a description of the care, services, and frequency of visits to be provided by the contracted hospice provider. (Residents' #13, #17, #16, #21, #27) The findings included: 1. Resident #13 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Atrial Fibrillation, Hypothyroidism, and Anemia. A review of a [Physician's order] dated 06/09/21 documented, admitted to [Hospice provider name] for dx [diagnoses] of Cerebral Atherosclerosis. A review of the facility care plan showed [Resident #13 name] is on [hospice provider] care. Last revised 8/20/23. Goal: receives hospice treatment, she will be kept comfortable for quality of life. Interventions: Continue to receive services from [Hospice agency name] as it relates to comfort care and ensuring all medical equipment needs are being met, has received a new high back wheelchair and a Geri chair to encourage social engagement, and receives hospice treatment measures through [hospice provider]. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded severely impaired cognitive skills for daily decision-making and that hospice care was being received while a resident. A Hospice (Agency) Plan of Care dated 11/01/23 documented, [Resident #13] has a terminal prognosis and admitted to [Hospice provider] diagnoses of Cerebral Atherosclerosis last revised on 11/29/23 had interventions of Periodic confusion, reorient to place, time, and day. Edema: continue to monitor. Breathing on RA [room air]: PRN [as needed] oxygen in place. Incontinent of bladder: educate facility staff to provide timely care. Generalized weakness, bed-bound: safety precautions reinforced. Stage 11 pressure ulcer on sacral area: dressing down with Calcium Alginate. Pain: PRN Morphine in place. Social Worker: continues to provide emotional support. Chaplin: not visiting at this time, DNR [do not resuscitate]: Family very involved in care. The evidence showed that facility staff failed to have a person-centered hospice care plan for Resident #13 that included a description of the care, services, and the frequency of visits to be provided by the contracted hospice provider and failed to have the most recent hospice plan of care in Resident #13's medical record. During a face-to-face interview conducted on 12/07/23 at approximately 12:05 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, We will make sure that the (facility's) hospice care plan is more detailed, and that the most recent hospice plan of care is in the chart and that it aligns with our plan of care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #17 was admitted to the facility on [DATE] with multiple diagnoses that included: Cerebral Infarction, Parkinson's Disease, Hyperlipidemia, Seizure, General Muscle Weakness, and Major Depressive Disorder. A review of a [Physician Order] dated 11/21/23 documented, admitted to [hospice provider], Dx: Parkinson's Disease. A Hospice (Agency) Plan of Care dated 11/23/23 documented [Resident #17] has a terminal prognosis and admitted to [Hospice provider] diagnoses of Parkinson's Disease initiated 11/23/23, had interventions of Oxygen increase activity: administer oxygen and medication as ordered, rest period during ADLS [Activity of daily living] and ambulation, monitor effectiveness of oxygen and meds and report changes to MD [medical doctor]. Safe environment/cluster free: ensure environment cluster free, educate staff to lower bed lock wheel when transferring resident, educate staff to make rounds on the patient every 2 hours, educate facility staff to provide timely incontinent care to prevent pt from trying to get out of bed. Skin integrity: Assess skin each visit, reinforce work on skin breakdown wound care, reinforce, and provide an ongoing demonstration on how to provide wound care, monitor for s/s of infection, and evaluate the effectiveness of the plan of care. Medication: administer pain medication as ordered, assess for pain and report to MD, monitor for number of PRN [as needed] doses from MD, monitor the effectiveness of pain medication and report to MD. A review of the facility's care plan documented [Resident#17] is Hospice care [name of company] (11/21/23) for supportive and comfort care r/t [related to] Parkinson's Disease. Last revised 12/1/23. Goal: My caregiver team will keep me as comfortable as possible. Interventions: limit my lab tests/diagnostics as possible, collaborate with hospice to provide the best possible care, assess for signs and symptoms of pain and discomfort, treat according to the pain management prescribed, administer oxygen as needed for comfort, follow hospice care directives, and notify/consult hospice about the residents need. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as having severely impaired cognitive skills. During a face-to-face interview conducted on 12/06/23 at 11:25 AM, Employee #9 (Hospice Agency Admission Nurse) stated, A Hospice caregiver comes on days assigned and stays for 4 hours. They can change, turn, and feed the resident and report any findings. The Hospice caregiver should be doing only the care I have documented to be done. I assess the Hospice resident and prepare a plan of care which includes medication orders from the Hospice doctor. After the doctor reviews and approves the plan of care this information is given to the facility nurse for follow-up care. The evidence showed that both the facility and the contracted Hospice staff failed to have a person-centered hospice care plan for Resident #17 that included a description of the care, services, and the frequency of visits to be provided by the contracted hospice provider in the hospice plan of care in Resident #17's medical record. During a face-to-face interview conducted on 12/06/23 at approximately 12:00 PM, Employee #2 (Director of Nursing) acknowledged the findings with Employee #2 stating, We will make sure that the hospice and facility care plan is in collaboration describing, and that the most recent hospice plan of care is in the chart and that it collaborates with our plan of care. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) The facility staff failed to ensure that Resident #27 had a current written hospice care plan that included the most recent hospice plan of care in the residents' medical record. Resident #27 was admitted to the on 09/08/23, with multiple diagnoses that included Fracture of Unspecified Part of Neck of Left Femur, and Unspecified Dementia Severe Without Behavioral Disturbance. [Physicians Orders] dated 09/10/23 Admit to [Hospice name] Hospice. [Physicians Orders] dated 09/11/2023 Admit to hospice with diagnosis of ES Dementia/hip fracture . The medical record lacked documented evidence of a hospice care plan and of any collaboration between the facility staff and the hospice staff. During a face-to-face interview conducted on 12/08/23 at approximately 1045 AM, Employee #2 (Director of Nursing) acknowledged the findings. 4. Resident #21 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Non-traumatic Brain Disorder, Bipolar Disorder, Anxiety, Weakness, Heart Disease, Fracture of Left Femur, and Unspecified Fall of Subsequent Encounter. A review of a [Physician's order] dated 06/25/22 at 4:07 PM documented: Admit to [Name of Hospice] for hospice services. Diagnosis: Cerebral Arthrosclerosis. Please call [Name of Hospice] at [Hospice Phone Number]. A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status Summary score of 03 indicating the resident had severely impaired cognition, required extensive assistance for all ADL (assisted daily living) care, and was not receiving hospice services. A care plan dated 03/05/23 documented: Focus: Hospice, Goal: Ensure [Resident #21] remains comfortable in all areas of medical treatment; Interventions: [Resident #21] is currently a hospice resident under [Name of Hospice Agency]' [Resident #21] will receive comfort treatment through supervision of the assigned hospice. R.N. (Registered Nurse) Hospice will be adjusted as needed and reviewed quarterly with POA (Power of Attorney). Further review of Resident #21's medical record lacked documented evidence that the Resident's hospice plan of care included the frequency of hospice visits provided by the hospice agency. In addition, there was no documented evidence that the facility staff updated the Resident's comprehensive person-centered care plan to include a description of the collaboration of care and services provided by the hospice agency and the care and services provided by the facility. During a face-to-face interview on 12/07/23 at 10: 26 AM, with Employee #2 (Director of Nursing/DON) and Employee #3 (Assistant Director of Nursing/ADON), Employee #3 acknowledged that there were no collaborative interventions or goals on Resident #21's care plan. In addition, Employee #2 acknowledged that the Resident's Hospice Plan of Care lacked documented evidence of the frequency of hospice visits for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside at Rock Creek	3050 Military Road NW Washington, DC 20015

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The facility staff failed to ensure that Resident #16 had a current written hospice care plan that included the most recent hospice plan of care in the residents' medical record Resident #16 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Non-traumatic Brain Disorder, Bipolar Disorder, Anxiety, Weakness, Heart Disease, Fracture of Left Femur, and Unspecified Fall of Subsequent Encounter. A review of a [Physician's order] dated 01/19/23 documented: Admit the patient to [Name of Hospice] for hospice services. Kindly call [Hospice phone number] for any change in the patient's condition. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status Summary score of 04 indicating the resident had severely impaired cognition, required extensive assistance for all ADL (assisted daily living) care by one staff member and had received hospice care in the facility within the past 14 days. A care plan dated 01/26/23 documented: Focus: [Resident #16] was admitted to [Name of Hospice Agency] and is under [Name of Hospice Agency]; Goal: [Resident #16]will be comfortable and receive palliative care for quality of life; Interventions: [Resident #16] Monitor for pain and medicate as necessary; [Resident #16] to be kept comfortable at all times; [Resident #16] to be out of bed as tolerated daily; Resident to receive Hospice care from [Name of Hospice] and aide per [Name of Hospice] protocol.is currently a hospice resident under [Name of Hospice Agency]; [Resident #16]. Further review of Resident #16's medical record lacked documented evidence that the Resident's hospice plan of care included the frequency of hospice visits provided by the hospice agency. In addition, there was no documented evidence that the facility staff updated the Resident's comprehensive person-centered care plan to include a description of the collaboration of care by discipline and services provided by the hospice agency and the care and services provided by the facility. During a face-to-face interview on 12/07/23 at 09:58 AM, Employee # 10 (Hospice CNA/Aide) stated he comes to see Resident #16 approximately twice a week depending on his schedule. He added that he does not have a specific day or time. When asked about the gap in hospice visits between 10/20/23 and 10/30/23, he stated that he signs the Resident's Hospice log when he has the opportunity, but the sign-in sheets are not always there. He added when that happens, he lets the Resident's nurse know that he is there, and he sees the resident without signing the book. During a face-to-face interview on 12/07/23 at 10: 26 AM, with Employee #2 (Director of Nursing/DON) and Employee #3 (Assistant Director of Nursing/ADON), Employee #3 acknowledged that there were no collaborative interventions or goals on Resident #16's care plan. In addition, Employee #2 acknowledged that the Resident's Hospice Plan of Care lacked documented evidence of the frequency of hospice visits for the resident. 45102 45104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095028	A. Building B. Wing	12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside at Rock Creek	3050 Military Road NW Washington, DC 20015

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 27689 Based on observations and interview, facility staff failed to provide a safe environment to residents and staff, as evidenced by three (3) of 51 oxygen tanks that were unsafely stored in the oxygen storage room on the [NAME] side of the facility. The findings include: During an environmental walkthrough on the [NAME] side of the facility on December 1, 2023, at approximately 8:45 AM, three (3) of 51 oxygen tanks were loosely stored upright, on the floor of the oxygen storage room, and presented an unsafe environment. Employee #3 who was present at the time of observation, acknowledged the above findings during a face-to-face interview on December 1, 2023, at approximately 9:00 AM.