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	03/26/2025

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 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** Based on record review and staff interview for one (1) of 21 sampled residents, the facility's staff failed to immediately inform the administrative staff or resident's physician that the resident accidentally spilled hot coffee on her chest and developed a blister on her chest several hours later. (Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including Osteoporosis, Arthritis, Dementia, Muscle weakness, and CVA with left side weakness. A care plan with a revision date of 08/20/23 documented in part, Focus- [Resident #1] had an activity of daily living self-care performance deficit related to impaired balance [and] limited mobility .Intervention [Resident #1] requires set up with meals . A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status summary score of 9 indicating that the resident had a moderately impaired cognitive status. Additionally, the resident was coded for needing set-up with eating. An incident note dated 04/20/24 at 11:40 AM documented, At around 11:15am, resident requested for coffee then spilled it on herself in an attempt to drink the coffee. A weekly skin assessment note dated 04/30/24 at 11:40 AM documented in part, Skin condition is new, location-chest, type-blister, length- 3 centimeters (cm), width - 3 (cm), depth -0 (cm) .no pain mediation [medication] required .MD notified at 04/30/24 at 5 PM, no new orders received .[legal guardian] made aware of new skin condition on 04/30/24 at 5PM . A review of the facility's investigation related to the incident revealed a document titled Investigation Report dated 05/02/24 that documented in part, Nurse did not notify the supervisor, Director of Nursing, Assistant Director of Nursing, physician immediately after the incident. During a telephone interview on 03/03/25 at 11:30 AM, Employee #7 (assigned RN) stated that she worked for an agency and was working a double (day and evening shift) on 04/30/24. During the dayshift (7am-3PM) the resident accidentally spilled a cup of coffee on her chest. She did not report the incident until evening shift when she saw a blister on the resident's chest. Additionally, the employee said, Time just got away from me, and I didn't immediately tell anyone about the incident. And because I informed everyone later, the facility will not allow to work there anymore. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 03/03/25 at 3:28 PM, Employee #8 (Evening Shift Supervisor/RN) stated that Employee #7 informed him at 7 PM on 04/30/24 that the resident accidentally spilled coffee on her chest at 11 AM and developed a blister on her chest on the evening shift. Employee #7 told him that she didn't notify the DON or the ADON who were here in the facility at the time of incident because the resident did not have any injuries. Additionally, Employee #8 said the employee should have informed administrative staff immediately after the incident happened. During a face-to-face interview on 03/03/25 at 4:00 PM, Employee #3 (ADON) stated that she worked on 04/30/24 and Employee #7 did not inform her of the incident. She indicated Employee #7 should have reported the incident when it happened. Also, the employee said that Employee #7 attended an in-service on Abuse, Neglect Policies and Investigation of Resident Injuries on 01/23/24, where timely reporting incidents was covered. It should be noted that review of in-service documents showed that Employee #7 attended the training.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of 21 sampled residents, facility staff failed to report the results of an investigation of a resident elopement to the State Survey Agency within five (5) working days. (Resident #24) The findings included: An undated facility policy titled 'Wandering and Elopements' documented, The community will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Resident #24 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Syncope, Anxiety, Breast Cancer and Right Foot Fracture. An Elopement Evaluation dated 08/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 9.0, indicating the resident was moderately at risk of eloping and it documented the following: 3. Does the resident have a history of elopement or attempted leaving the facility without informing staff? a. Yes. A Care Plan dated 08/28/24 documented, Focus: [Resident #24] is an elopement risk/wanderer (exit seeking) r/t (related to) History of attempts to leave facility unattended. Goal: [Resident #24] safety will be maintained through the review date. Interventions: Distract [Resident #24] from wandering by offering pleasant diversions; structured activities, food, conversation, television, book; Identify pattern of wandering . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. A Care Plan dated 08/28/24 documented, Focus: Impaired Cognitive Functioning r/t (related to): Dementia (Risk for Wandering / Elopement). Goal: [Resident #24] will not leave the faculty [sic] [facility] unattended. Interventions: Clearly identify resident's room & (and) bathroom, Engage resident in purposeful activity, Identify if there are triggers for wandering / eloping, Identify if there is a certain time of day wandering / elopement attempts occur, Identify if there is a pattern and purpose of wandering, Identify wandering / elopement de-escalation behaviors. A Physician's note dated 10/01/24 documented, She walks around throughout the hallway, some staff had noticed that she wanders of[f] from her floor, she was found on the west side of the third floor. Discussed with the staff to monitor her presence on the floor. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 10, indicating the resident was moderately impaired. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Elopement Evaluation dated 11/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 8.0, indicating the resident was still moderately at risk of eloping and it documented the following: 3. Does the resident have a history of elopement or attempted leaving the facility without informing staff? a. Yes. A PsychoGeriatric Services note dated 12/06/24 documented, Patient seen to assess for adjustment disorder post admission to SNF (Skilled Nursing Facility). Patient is alert and oriented x 1. Patient is a poor historian, noted with disorganized thought process in the setting of dementia. Patient was anxious and sundowning. Received reports of behavioral disturbance such as wandering around, exit seeking, packing belonging[s] and want[ing] to go home. A PsychoGeriatric Services note dated 01/17/25 documented, Patient seen for consultation for worsening sundowning, increased confusion and restlessness as requested by facility. Patient received in hall way [hallway] pacing on the unit; patient was restless and irritated. Patient noted with confused and disorganized thought process. Staff reported worsening sundowning and going to other patient[s'] room[s], especially in the evening. Staff [are] unable to redirect patient most [of the] time. An updated Care Plan dated 01/28/25 documented, Focus: 01/27/25: [Resident's name] had an actual episode of elopement; 01/28/25: [Resident's name] had a wanderguard placed to her right ankle with safety monitoring every 15 minutes. A state reportable was submitted. Goal: [Resident's name] will not have any episode of elopement through the review date and [Resident's name] will wear her wanderguard at all times to maintain safety. Interventions: Evaluate placement of wanderguard on right ankle in accordance with the 15-minute checks/as ordered. Check for comfort every shift. [Resident's name] triggers for wandering/eloping are anxiety and agitations. The resident's behaviors is de-escalated by reassuring and engaging in activities of her choice. Observe for exit seeking behaviors and redirect. Report to the nurse and MD (Medical Doctor)/NP (Nurse Practitioner). Wander guard-check functioning daily on the evening shift, to include placement and reviewing on surrounding skins. A review of the facility's investigative packet dated 01/28/25 revealed written Witness Statement forms from all staff who worked on 01/27/25, the day Resident #24 eloped from the facility, staffing assignments for units Three (3) East and Three (3) West, Elopement education and QAPI (Quality Assurance and Performance Improvement) meeting minutes of the facility's action plan. It should be noted that there was no documented evidence in the investigative packet that included the facility's full investigation into the resident's elopement, and knowledge of, or results of how the resident eloped from her assigned unit on Three (3) East to outside walking along a busy intersection, approximately 1,000 feet at the back of the facility. The Department of Health (DC Health) received the following incident report [Intake Number: DC00013409] on 01/31/25 at 8:44 PM that documented in part, A full investigation was conducted. Staff were interviewed . and Dining Services employee confirmed that on Monday, January 27, 2025, she had observed [Resident #24's name] outside the community waling along [Street name] . and a head-to-toe assessment was conducted . In-services were conducted regarding [Facility's name] Elopement Policy . Wander Guard was applied to [Resident's name] right ankle .Staff are conducting checks every 15 minutes to monitor her whereabouts. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 03/03/25 at 2:40 PM, Employee #2 (Director of Nursing) acknowledged the findings of the facility's follow-up investigation that was submitted to the State Agency, and stated, We were trying to get the follow-up submitted, at the time we didn't know how she (Resident #24) got out.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to report the results of all investigations to the State Survey Agency, within 5 working days of the incident for three (3) of 21 sampled investigations. (Residents' #1, #18, and #24) The findings included: 1. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including Dementia, CVA with left sided weakness, Osteoporosis, Arthritis, and Muscle weakness. A Situation, Background, Assessment, and Recommendation form dated 04/06/24 at 2:40 PM documented in part, Resident observed with swollen left hand, elbow and forearm. Presented with pain and withdraw affected areas to touch, medicated with scheduled Acetaminophen with slight effect. Collaborated with [physician's name] who made an assessment and x-ray ordered to left hand, forearm and left elbow due to pain and swelling . A nursing note dated 04/07/24 at 11:18 AM documented in part, patient alert and verbally responsive, able to make needs known, nurse noted abnormal x-ray results finding acute mildly displaced fracture of distal shaft of ulna. Writer called MD to notified pt c/o left wrist pain (6/10) with movement, pain med Tylenol 325mg 2 tablet PRN for pain given to patient to reduce pain .MD gave new order to send patient to ER around 10:26am transfer by EMS around 11:50am .alert with no change in mental status . A nursing note dated 04/07/24 at 8:21 pm documented in part, patient return from [hospital's name] around 8:20pm alert and verbally responsive, with final diagnosis of Displaced oblique fracture of shaft of left ulna, initial encounter for closed fracture. cast on left arm noted. patient denied pain or discomfort, numbness, tingling sensation . [vital signs] 137/65, 75, 98.3, R18 . A facility reported incident (DC~12808) dated 04/08/24 documented in part, [Resident #1] was observed with swollen left hand, elbow and forearm and expression of pain on 04/06/24. MD made aware. X-ray ordered to left hand, forearm and elbow . Result received 04/07/24. Left forearm and hand with impression acute mildly displaced fracture of the distal shaft of the ulna. 5mm well corticated fragment anterior to ulna styloid which may represent old avulsion fracture. Mild degree of osteopenia. Mild degree of osteoarthritis Left elbow x-ray result No radiographic evidence of acute fracture or dislocation .Resident interviewed prior transfer she denied any prior or recent incidents or falls . An Investigation Report form dated 04/12/24 documented that the resident had a history of cerebral vascular disease with left side weakness, osteoarthritis, and osteopenia. And the existing diagnoses can easily lead to fracture. Resident #1's medical record and the facility's investigative files lacked documented evidence that the facility provided the State Agency with results of their investigation related to Resident #1's acute mildly displaced fracture of the distal shaft of the ulna that occurred on 04/07/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple observations from 02/25/25 to 03/03/25 from 9 AM to 4 PM showed Resident #1 not wearing a cast or splint. Her left arm did not appear swollen or disfigured. And she was able to independently move upper extremities. During a face-to-face interview on 03/04/25 at approximately 2 PM, Employee #4 (Medical Director) stated that Resident #1's ulna fracture was a pathological fracture. During a face-to-face interview on 03/05/25 at approximately 10 AM, Employee #3 (ADON) stated that the investigation was conducted by the previous DON and she could not find documentation that the DON sent the results of the investigation to the State Agency. 2. Resident #86 was admitted on [DATE] with multiple diagnoses including Dementia, Pacemaker, and Muscle Weakness. A nursing note dated 08/01/24 21:46 [9:46 PM] documented in part, Stated that she was trying to transfer herself from the wheelchair to the toilet when she fell. She did not call for help. During an assessment, she could not move her right hand and right leg, screaming in pain and for the nurse to call an ambulance. Complained of severe right shoulder and right hip pain and refused to take pain medication when offered. MD was made aware and given an order to transfer to the nearest ER for evaluation . A facility reported incident dated 08/01/24 at 5:30pm documented in part, [Resident #86] observed lying on her right side in the bathroom floor in her room. During assessment, resident stated, I was trying to transfer myself from the wheelchair to the toilet when I fell. She did not call for help at this time, while the call light was within reach. Her assigned CNA had changed her brief earlier while she was in bed. On further assessment, the resident is unable to move her right hand and leg . An Investigation Report form dated 08/01/24 documented in part, [Resident #86] was high risk for fall. She had a history of unsteady gait .atrial fibrillation, history of cystitis .which have contributed her fall transferring herself without assistance was unusual for the resident. A nursing progress note dated 08/09/24 at 2301 [11:01 PM] documented in part, [Resident #86] was re-admitted to the facility on [DATE] at 21:30 [9:30 PM] from [hospital's name]. Chief Complaint: Mechanical fall. Fracture of the right pelvis, right acetabular fracture, and right Pubic ramus fracture with no surgical intervention. Pain management with Tylenol 500mg PRN for pain . Head-to-toe assessment done, no apparent distress, AOX2 .noted with multiple bruises on both upper and lower extremities. Redness on upper and lower lips . The resident's medical record and the facility's investigative files lacked documented evidence that the facility provided the State Agency with results of the investigation related to Resident #86's fall with major injury [fracture of the right pelvis, right acetabular and right pubic ramus] that occurred on 08/01/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 03/05/25 at 3:33PM, Employee #8 (Evening supervisor/RN) stated that around 5:30 PM staff heard the resident yelling from her room. When he went into the room, he observed the resident lying on the floor in her bathroom. The resident could not move her left side. The resident said she fell when she was trying to transfer herself from her wheelchair to the toilet. The resident did not call staff for help. The resident was transferred to the hospital. During a face-to-face interview on 03/05/25 at approximately 3 PM, Employee #3 (ADON) stated that the investigation was conducted by the previous DON and she could not find documentation that the DON sent the results of the investigation to the State Agency. 3. Resident #24 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Syncope, Anxiety, Breast Cancer and Right Foot Fracture. An undated facility policy titled 'Wandering and Elopements' documented, The community will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. An Elopement Evaluation dated 08/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 9.0, indicating the resident was moderately at risk of eloping and it documented the following: 3. Does the resident have a history of elopement or attempted leaving the facility without informing staff? a. Yes. A Care Plan dated 08/28/24 documented, Focus: [Resident #24's name] is an elopement risk/wanderer (exit seeking) r/t (related to) History of attempts to leave facility unattended. Goal: [Resident #24's name] safety will be maintained through the review date. Interventions: Distract [Resident's name] from wandering by offering pleasant diversions; structured activities, food, conversation, television, book; Identify pattern of wandering . Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. A Care Plan dated 08/28/24 documented, Focus: Impaired Cognitive Functioning r/t (related to): Dementia (Risk for Wandering / Elopement). Goal: [Resident #24's name] will not leave the faculty [sic] [facility] unattended. Interventions: Clearly identify resident's room & (and) bathroom, Engage resident in purposeful activity, Identify if there are triggers for wandering / eloping, Identify if there is a certain time of day wandering / elopement attempts occur, Identify if there is a pattern and purpose of wandering, Identify wandering / elopement de-escalation behaviors. A Physician's note dated 10/01/24 documented, She walks around throughout the hallway, some staff had noticed that she wanders of[f] from her floor, she was found on the west side of the third floor. Discussed with the staff to monitor her presence on the floor. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 10, indicating the resident was moderately impaired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Elopement Evaluation dated 11/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 8.0, indicating the resident was still moderately at risk of eloping and it documented the following: 3. Does the resident have a history of elopement or attempted leaving the facility without informing staff? a. Yes. A PsychoGeriatric Services note dated 12/06/24 documented, Patient seen to assess for adjustment disorder post admission to SNF (Skilled Nursing Facility). Patient is alert and oriented x 1. Patient is a poor historian, noted with disorganized thought process in the setting of dementia. Patient was anxious and sundowning. Received reports of behavioral disturbance such as wandering around, exit seeking, packing belonging[s] and want[ing] to go home. A PsychoGeriatric Services note dated 01/17/25 documented, Patient seen for consultation for worsening sundowning, increased confusion and restlessness as requested by facility. Patient received in hall way [hallway] pacing on the unit; patient was restless and irritated. Patient noted with confused and disorganized thought process. Staff reported worsening sundowning and going to other patient[s'] room[s], especially in the evening. Staff [are] unable to redirect patient most [of the] time. An updated Care Plan dated 01/28/25 documented, Focus: 01/27/25: [Resident's name] had an actual episode of elopement; 01/28/25: [Resident's name] had a wanderguard placed to her right ankle with safety monitoring every 15 minutes. A state reportable was submitted. Goal: [Resident's name] will not have any episode of elopement through the review date and [Resident's name] will wear her wanderguard at all times to maintain safety. Interventions: Evaluate placement of wanderguard on right ankle in accordance with the 15-minute checks/as ordered. Check for comfort every shift. [Resident's name] triggers for wandering/eloping are anxiety and agitations. The resident's behaviors is de-escalated by reassuring and engaging in activities of her choice. Observe for exit seeking behaviors and redirect. Report to the nurse and MD (Medical Doctor)/NP (Nurse Practitioner). Wander guard-check functioning daily on the evening shift, to include placement and reviewing on surrounding skins. A review of the facility's investigative packet dated 01/28/25 revealed written Witness Statement forms from all staff who worked on 01/27/25, the day Resident #24 eloped from the facility, staffing assignments for units Three (3) East and Three (3) West, Elopement education and QAPI (Quality Assurance and Performance Improvement) meeting minutes of the facility's action plan. It should be noted that facility staff did not initiate an investigation into the resident's elopement until approximately 24 hours after she was found wandering outside of the facility by a Dining Services employee, then escorted back into the building. It should also be noted that there was no documented evidence in the investigative packet that the facility completed a thorough investigation and maintained documentation into the resident's elopement, including results of how the resident eloped from her assigned unit on Three (3) East to outside walking along a busy intersection, approximately 1,000 feet at the back of the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Department of Health (DC Health) received the following incident report [Intake Number: DC00013409] on 01/28/25 that documented, On January 28, 2025, the Director of Nursing (DON), [Director of Nursing's name], was notified by [Certified Nursing Assistant's name], CNA, that a Dining Services employee, [Dining Services employee's name], had informed her that she had observed [Resident #24's name] outside the facility walking along the sidewalk on [Street name] the previous day (01/27/25) and a follow-up report submitted to the State Agency on 01/31/25 at 8:44PM that documented in part, A full investigation was conducted. Staff were interviewed . and Dining Services employee confirmed that on Monday, January 27, 2025, she had observed [Resident #24's name] outside the community walking along [Street name] . and a head-to-toe assessment was conducted . In-services were conducted regarding [Facility's name] Elopement Policy . Wander Guard was applied to [Resident's name] right ankle . Staff are conducting checks every 15 minutes to monitor her whereabouts. During a face-to-face interview conducted on 03/03/25 at 2:40PM, Employee #2 (Director of Nursing) acknowledged the findings of the facility's initial and follow-up investigations that were submitted to the State Agency.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) of 21 sampled residents, facility staff failed to complete a Level I PASARR (Preadmission Screening and Resident Review) to determine if the resident had or may have had an MD (mental disability), ID (intellectual disability), or related condition for a resident that remained in the facility as a long-term care resident for longer than 30 days. Resident #15. The findings included: A review of a Level I Pre-admission Screen/Resident Review form dated 05/23/22 revealed that 'Section A' of the form documented that the resident's requirement for nursing facility services and length of stay would be less than 30 days and the remaining sections were incomplete, including Section E: Dementia which was left blank. Resident #15 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Bipolar Disorder, Major Depressive Disorder and Anxiety. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '01,' indicating the resident was severely impaired. It should be noted that Resident #15 had remained as a long-term care resident within the facility for over 30 days. During a face-to-face interview conducted on 02/26/25 at 1:19 PM, Employee #18 (Social Worker) acknowledged the findings and stated, It does say she would be here less than 30 days, but she needs an updated Level I [Pre-admission Screening and Resident Review] because she's been here longer. I will do an updated one. [Crossover: 22B DCMR Sec. 3231.12(e)]

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for two (2) of 21 sampled residents, the facility staff failed to develop and implement a person-centered care plan, and develop a discharge plan, for two residents. (Residents #8, #35.) The findings included: 1. The facility staff failed to develop a care plan for Resident #8's dysphagia which was documented in the medical record. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Dementia Unspecified Severity with Agitation, Age Related Osteoporosis, Personal History of Urinary Tract Infection and Altered Mental Status. A review of a Facility Reported Incident (FRI) DC~12784, submitted to the State Agency on 04/01/24 revealed the following: At around 2.10am on 3-31-24 when the assigned charge nurse was making rounds, found patient on the floor beside her bed lying on her side, patient appear to be in no acute distress but complained of both knee and both ankle pain, suddenly 911 just arrived on the floor that patient called 911 that she fell . Patient actually confirmed that she called 911 due to pain in her ankle and knees. patient was picked up by 911 and taken [Hospital Name] Review of Resident #8's medical record revealed the following: A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the facility staff coded the resident as having moderate cognitive impairment, and signs and symptoms of possible swallowing disorder Coughing or choking during meals or when swallowing medications. A review of a document titled Speech Therapy SLP (speech language pathology) Evaluation and Plan of Treatment dated and signed on 11/14/24 documented the following Diagnoses Dysphagia , oral phase onset 11/13/24 Treatment Approaches May Include Oral function therapy Evaluate swallowing Frequency 2 times (s)/week duration 30 days intensity daily Cert (sp) (certification) period 11/13/24 -12/12/24 Initial Assessment /Current Level of Function & Underlying Impairments Assessment Summary, Reason for Therapy Clinical impressions Reasons for Skilled Services: Patient presents with mild oral dysphagia which necessitates skilled SLP services for dysphagia to reduce aspiration with training in postural maneuvers, instruct family/staff in compensation techniques, develop and instruct in compensatory strategies and design and implement strategies in order to improve ability to minimize aspiration , consume intake without fear/anxiety, use facilitative techniques that associated functional deficits without skilled intervention, the patient is at risk for: aspiration and compromised general health. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a document titled Rehab Training Form Swallowing dated 01/03/25 revealed that staff made hand written checks to the following areas for Resident #8: Nursing, Diet Consistency Mechanical soft liquid consistency, Regular (w/straw only), Program: Position resident as upright as possible, Resident to remain upright after meal for: 30 min (sp) (minute), Resident to be out of bed for meals, Low stimulus environment for meals, Cue resident to eat slowly, chew completely / no talking during chewing/swallowing, Cue resident to alternate bites and sips intermittently during meals, Resident to remain upright after meal for 30-45 minutes. It is noted that the document titled Rehab Training Form Swallowing is signed at the bottom by 2 direct care staff and the speech pathologist. A review of the medical record lacked documented evidence of a care plan for the residents' dysphagia. During a face-to-face interview conducted on 03/03/25 at 3:02 PM Employee #3 (Assistant Director Of Nursing) acknowledged the findings and stated that she is responsible for the care plan and that she would get the Rehab employee's to discuss the resident's care with the surveyors. During a face-to-face interview conducted on 03/03/25 at 3:19 PM Employee #5 (Director of Rehab) stated that the resident was seen by the speech pathologist and that he participates in the interdisciplinary team meetings, but he does not discuss the speech pathology during the interdisciplinary team meetings. During a face-to-face interview conducted on 03/04/25 at 10:00 AM Employee #19 (Speech Pathologist) stated that she had Resident #8 from 11/13/24 until 1/30/25. The resident was observed coughing when consuming food and liquids. Employee #19 went on to explain that she provides rehab training forms to the direct care staff on the unit which provides strategies to follow to minimize the risk of choking. 2. The facility staff failed to develop a discharge care plan for Resident #35. Resident #35 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Malignant Neoplasm of Lower Lobe Right Bronchus or Lung, Unspecified Glaucoma, and Muscle Weakness. A review of Resident #35's medical record revealed the following: A review of a Social Services Progress note dated 12/23/24 at 3:41 PM, documented: SW (social worker) went to resident's room to complete social service assessment. Resident informed this SW (social worker) this was not a good time. Social services will continue to follow for discharge planning. A review of a physician order dated 01/03/25 documented Plan for patient to be readmitted to hospital on [DATE] for next cycle of chemo (chemotherapy) A review of a Discharge Summary Progress Note dated 01/06/25 at 7:18 PM Discharge Summary Resident discharged from facility at 6.51 via EMS (emergency medical services) accompanied by partner [Name] to [Hospital Name]. No complains of pain or any distress. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #35's care plan showed that there was no documented evidence of a discharge care plan. During a face-to-face interview conducted on 03/05/25 at 10:55 AM, Employee #3 (Assistant Director of Nursing) acknowledged the findings and stated that the resident was discharged to the hospital for further treatments and the resident was from out of state and had plans to return to his home state. During a face-to-face interview conducted on 03/05/25 at 12:50 PM, Employee #18 (Social Worker) stated that the Resident and the resident's family did not want to participate in discharge planning and the discharge care plan is not there because it was not done.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review staff interviews and resident interviews, for seven (7) of 21 sampled residents, the facility staff failed to have documented evidence that the Interdisciplinary Team (IDT) reviewed or revised care plans or conducted care plan conferences after each Minimum Data Set (MDS) assessments. (Residents' #1, #7 #8, #13 #15, #18, and, #20). The findings included: 1. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including Osteoporosis, Arthritis, Dementia, Muscle weakness, and CVA with left side weakness. Resident #1's medical record showed the facility's staff completed the following MDS assessments: a quarterly on 08/31/24 and 12/01/24. However, further review of the record lacked documented evidence that the IDT reviewed Resident #1's care plan or conducted a care plan conference after the two (2) previously mentioned assessments. A review of the resident's face sheet revealed she had a legal guardian listed as her responsible party. An observation on 03/06/24 at approximately 9 AM showed the resident in her room laying in bed, alert and oriented to name only. Additionally, the staff was assisting the resident with breakfast. 2. Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including Morbidy Obesity, Heart Disease and Breast Cancer. A review of Resident #7's medical record showed the facility's staff completed the following MDS assessments: a quarterly on 3/24/24, a comprehensive (annual) on 06/22/24 and a quarterly on 12/23/24. However, further review of the record lacked documented evidence that the IDT reviewed Resident #7's care plan or conducted a care plan conference after the three (3) previously mentioned assessments. A review of quarterly MDS assessment dated [DATE] documented that Resident #7 had a (BIMs) summary score of 14 indicating the resident had an intact cognitive status. A review of the resident's face-sheet revealed that the resident was her own responsible party. An observation on 03/06/25 at 11:00 AM showed the resident lying in bed well groomed. Additionally, the alert and oriented to name, time, place and situation. At the time of the observation, the resident stated, They don't conduct care plan conferences quarterly like are supposed too. 3. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including Dementia, Muscle Weakness, and Major Depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #18's medical record showed the facility's staff completed the following MDS quarterly assessments on 01/24/24, 04/25/24, 08/20/24, and 01/20/25. However, further review of the record lacked documented evidence that the IDT reviewed Resident #18's care plan or conducted a care plan conference after the four (4) previously mentioned assessments. A review of the resident's face-sheet revealed the resident had a health care power-of-attorney as her responsible party. An observation on 03/06/25 at 9 AM showed the resident out-of-bed in a wheelchair sitting in a common area watching tv. Additionally, the resident was awake and oriented to name only and well groomed. During a face-to-face interview on 03/06/25 starting at 11:12 AM, Employee #3 (Assistant Director of Nursing) stated that the IDT reviews resident care plans and conduct care plan conferences after each quarterly and comprehensive (annual) assessment. At the time of the interview, the employee reviewed Resident #1, #7, and #18's medical records and said that she did not see documentation that the IDT reviewed the residents' care plan or when care plan conferences were conducted after each comprehensive or quarterly MDS assessment. 7. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Dementia Unspecified Severity with Agitation, Age Related Osteoporosis, Personal History of Urinary Tract Infection and Altered Mental Status. A review of a Facility Reported Incident (FRI) DC# 00012784, submitted to the State Agency on 04/01/24 revealed the following: At around 2.10am on 3-31-24 when the assigned charge nurse was making rounds, found patient on the floor beside her bed lying on her side, patient appear to be in no acute distress but complained of both knee and both ankle pain, suddenly 911 just arrived on the floor that patient called 911 that she fell . Patient actually confirmed that she called 911 due to pain in her ankle and knees. patient was picked up by 911 and taken [Hospital Name] Review of Resident #8's medical record revealed the following: A review of the admission Minimum Data Set (MDS) assessment dated [DATE] showed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) Summary score of 13 indicating intact cognition, no impairment of the upper and lower extremities and no fall any time in the last month or prior to admission. A review of a [Progress Note] dated 03/31/24 at 4:03 AM, documented the following: Writer was rounding in the unit and observed Security Officer talking to resident at her bed side in (room number), while resident was laying on her right side on the floor by her bed, resident could not remember what had happened, but she had called 911 Emergency line. The Security Officer suddenly came to [Room Number] and stated that 911 had called him, apparently resident had called 911. Bed was in low position, resident's call light and bedside telephone were within reach, upon assessment resident stated that she was having pain in her ankles and knees, unable to rate her level of pain resident transferred to [Hospital Name] at 02:50AM, will continue with the plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document titled After Visit Summary (hospital name) dated 03/31/24 documented the following: Start taking Cephalexin (Keflex) (Antibiotic) Reason for visit Fall Diagnosis Fall, initial encounter, Urinary tract Infection with hematuria site unspecified, Contusion of left knee initial encounter A review of Resident #8's care plan lacked any documented evidence of care plan interventions for the resident's urinary tract infection or contusion to the left knee that occurred after the residents unwitnessed fall. During a face-to-face interview conducted on 03/03/25 at 3:00 PM, Employee #3 (Assistant Director of Nursing) stated that she is the person responsible for updating the care plans and acknowledged the findings. Cross Reference 22B DCMR Sec. 3210.4 (c) 4. Resident #13 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Anxiety, Depression and Cerebral Atherosclerosis. A Face Sheet revealed Resident #13's daughter was her Responsible Party. An Annual Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '04,' indicating the resident was severely impaired. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly MDS assessment dated [DATE]. A review of Resident #13's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly MDS assessment dated [DATE]. A review of Resident #13's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly MDS assessment dated [DATE]. A review of Resident #13's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. A Social Services note dated 10/29/24 at 17:33 (5:33PM) documented, IDT (Interdisciplinary Team) care plan meeting held today for [Resident #13's name]. A review of Resident #13's medical record revealed facility staff completed an Annual Minimum Data Set (MDS) assessment dated [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Annual MDS assessment dated [DATE]. It should also be noted that Resident #13 had only one (1) care plan meeting conducted by facility staff between 01/27/24 and 03/03/25. During a face-to-face interview conducted on 03/03/25 at 2:30PM, Employees' #2 (Director of Nursing), Employee #3 (Assistant Director of Nursing) and Employee #18 (Social Worker) acknowledged the findings and stated, The comprehensive care plan is done seven (7) days after the resident assessment by each department: nursing, dietary, physical therapy, etc. The documentation for the care planning meetings will be found in the 'Progress Notes' tab under 'Social Services' for the IDT Meetings. Social Services will put in a note for the IDT (Interdisciplinary Team) meetings that were completed. 5. Resident #15 was admitted to the facility on [DATE] with multiple diagnoses that included: Cognitive Communication Deficit, Bipolar Disorder, Anxiety and Mitral Valve Prolapse. A Face Sheet revealed Resident #15 had a Responsible Party/Temporary Guardian. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '06,' indicating the resident was severely impaired. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly MDS assessment dated [DATE]. A review of Resident #15's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. A Social Services note dated 04/04/24 at 14:53 (2:53PM) documented, Resident had a care plan meeting with RP (Responsible Party)/POA (Power of Attorney) [name] and IDT (Interdisciplinary Team) in attendance. A review of Resident #15's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE] and a Significant change MDS dated [DATE]. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly or Significant Change MDS Assessments dated 07/01/24 and 07/29/24. A review of Resident #15's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. A Social Services noted dated 10/29/24 at 17:36 (5:36 PM) documented, IDT Care Plan meeting held for [Resident #15's name]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a face-to-face interview conducted on 03/03/25 at 2:30PM, Employees #2 (Director of Nursing, DON), Employee #3 (Assistant Director of Nursing, ADON) and Employee #18 (Social Worker, acknowledged the findings and stated, The comprehensive care plan is done seven (7) days after the resident assessment by each department: nursing, dietary, physical therapy, etc. The documentation for the care planning meetings will be found in the 'Progress Notes' tab under 'Social Services' for the IDT Meetings. Social Services will put in a note for the IDT (Interdisciplinary Team) meetings that were completed. 6. Resident #20 was admitted to the facility on [DATE] with multiple diagnoses that included: Hypothyroidism, Venous Insufficiency, Chronic Kidney Disease and Lymphedema. A Face Sheet revealed Resident #20 was her own Responsible Party and had a Power of Attorney (POA). An admission Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '09,' indicating the resident was moderately impaired. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the admission MDS assessment dated [DATE]. A review of Resident #20's medical record revealed facility staff completed a Quarterly Minimum Data Set (MDS) assessment dated [DATE]. It should be noted that there was no documented evidence that facility staff conducted a care plan meeting following the Quarterly MDS assessment dated [DATE]. During a face-to-face interview conducted on 03/03/25 at 2:30PM, Employees' #2 (Director of Nursing, DON), Employee #3 (Assistant Director of Nursing) and Employee #18 (Social Worker) acknowledged the findings and stated, The comprehensive care plan is done seven (7) days after the resident assessment by each department: nursing, dietary, physical therapy, etc. The documentation for the care planning meetings will be found in the 'Progress Notes' tab under 'Social Services' for the IDT Meetings. Social Services will put in a note for the IDT (Interdisciplinary Team) meetings that were completed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews for one (1) of 21 sampled residents, the facility staff failed to adequately monitor a resident with a history of Dementia and prior exit-seeking behaviors. Subsequently, the resident eloped from the third-floor unit located in Building One and was found wandering outside of the facility near a busy intersection. (Resident #24) Due to these failures, an Immediate Jeopardy (IJ) was identified on March 26, 2025, at 1:09 PM. The facility provided a plan of action to address the immediacy on March 26, 2025, at 6:43 PM and it was accepted. Review of the facility's plan determined that the immediate jeopardy was Past Non-Compliance due to corrections being completed prior to the start of the recertification date. The facility immediate jeoparyd existed until Janury 29, 2025. The findings included: According to CMS (Center for Medicaid and Medicare Services), an elopement score refers to a score used in elopement risk assessments and defines elopement as a resident leaving the premises or a safe area without authorization and/or any necessary supervision https://www.cms.gov. An undated facility policy titled, 'Wandering and Elopements' documented, The community will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Resident #24 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Syncope, Anxiety, Breast Cancer and Right Foot Fracture. A Physician's order dated 08/01/24 documented, Appraise and observe patient for changes in physical/mental condition every shift. An Elopement Evaluation dated 08/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 9.0, indicating the resident was moderately at risk of eloping from the facility. A Care Plan dated 08/28/24 documented: -Focus: [Resident #24] is an elopement risk/wanderer (exit seeking) r/t (related to) History of attempts to leave facility unattended . Interventions: Distract [Resident #24] from wandering by offering pleasant diversions; structured activities, food, conversation, television, book; Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is [the] resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate; Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: Impaired Cognitive Functioning r/t (related to): Dementia (Risk for Wandering / Elopement). Goal: [Resident #24] will not leave the faculty unattended. Interventions: Clearly identify resident's room & (and) bathroom, Engage resident in purposeful activity, Identify if there are triggers for wandering / eloping, Identify if there is a certain time of day wandering / elopement attempts occur, Identify if there is a pattern and purpose of wandering, Identify wandering / elopement de-escalation behaviors, Implement a scheduled toileting program, Implement scheduled hydration, if not contraindicated, Provide care in a calm and reassuring manner, Provide clear, simple instructions, Provide reorientation to surroundings, environment, Schedule time for regular walks / appropriate activity. A Health Status Note dated 10/01/24 documented, Resident wanders and she was redirected to her room and TV (television) area several times during this shift. A Physician's note dated 10/01/24 documented, She walks around throughout the hallway, some staff had noticed that she wanders of[f] from her floor, she was found on the west side of the third floor. Discussed with the staff to monitor her presence on the floor. A Health Status Note dated 10/08/24 documented, periods of confusion and Noted wandering on unit asking where the restroom is. She was redirected to her room as needed. An updated Anxiety care plan goal and intervention with an initiation date of 10/28/24 documented, Goal: [Resident #24] will show decreased episodes of anxiety through the review date. Intervention: Monitor/record occurrence of for [sic] target behavior symptoms (pacing, wandering, inappropriate response to verbal communication, etc.) and document per facility protocol. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 10, indicating the resident was moderately impaired. An Elopement Evaluation dated 11/28/24 revealed that the facility coded the resident with an Elopement Risk Score of 8.0, indicating the resident was moderately at risk of eloping from the facility. A PsychoGeriatric Services note dated 12/06/24 documented, Patient seen to assess for adjustment disorder post admission to SNF (Skilled Nursing Facility). Patient is alert and oriented x 1. Patient is a poor historian, noted with disorganized thought process in the setting of dementia. Patient was anxious and sundowning. Received reports of behavioral disturbance such as wandering around, exit seeking, packing belonging[s] and want[ing] to go home. A Physician's order dated 12/24/24 documented, Xanax Oral Tablet 0.5 MG (milligram) (Alprazolam) Give 1 tablet by mouth in the evening for anxiety/restless for 30 days. A PsychoGeriatric Services note dated 01/17/25 documented, Patient seen for consultation for worsening sundowning, increased confusion and restlessness as requested by facility. Patient received in hall way [hallway] pacing on the unit; patient was restless and irritated. Patient noted with confused and disorganized thought process. Staff reported worsening sundowning and going to other patient[s'] room[s], especially in the evening. Staff [are] unable to redirect patient most [of the] time. I review[ed] patient medication and start patient on Risperdal 0.5mg (milligram) at bedtime and Xanax 0.5mg daily. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Physician's order dated 01/17/25 documented, Valproic Acid level one time only for Dementia behavior with behavior disturbances. A review of the facility's staffing on 01/27/25 revealed that the census for 3-East was 16 and there was a total of nine (9) clinical staff who included RN's (Registered Nurses), LPN's (Licensed Practical Nurses) and CNA's (Certified Nursing Assistants). It should be noted that the weather forecasted on 01/27/25 was a High of 51 degrees Fahrenheit and a Low of 27 degrees Fahrenheit, with an average temperature of 41 degrees Fahrenheit between 3:15PM and 5:15PM. https://www.weatherspark.com. The Department of Health (DC Health) received the following incident report [Intake Number: DC~13409] on 01/28/25 which documented, On January 28, 2025, the Director of Nursing (DON), [Director of Nursing's name], was notified by [Certified Nursing Assistant's name], CNA, that a Dining Services employee, [Dining Services employee's name], had informed her that she had observed [Resident #24's] outside the facility walking along the sidewalk on [Street name] the previous day (01/27/25). A full investigation is underway. A review of the facility's investigative packet dated 01/28/25 revealed written Witness Statement forms from all staff who worked on 01/27/25, the day Resident #24 eloped from the facility. During a face-to-face interview conducted on 02/25/25 at 11:32 AM, Resident #24 was asked if she had left the facility unattended and without facility staff being aware and she stated, No. It should be noted that during an observation conducted while interviewing the resident, there was a Wander Guard device attached to her right ankle. During a face-to-face interview conducted on 02/28/25 at 11:35 AM, Employee #13 (RN, Registered Nurse) confirmed what she documented in her written statement during the facility's investigation, stating that she was not aware that the resident left the facility until the next day and added that, Resident #24 had showed wandering and exit-seeking behavior in the past at least one or two times a week prior to the elopement. She further stated that, She [would] always come to this door (door that leads from the resident's assigned unit on three 3-East to get to the hallway that leads to the locked door to get to the elevator exit and also to the entry onto three 3-West) trying to leave and she goes to the other unit because she knows to just wave her hand [over the entry panel] and the doors will open; and the staff from the other side would have to bring her back. I heard that she went out through the service elevator, but you have to use a staff key fob, so she must've went [sic] [gone] out behind a staff person. Now we do every 15-minute checks, we have a book that documents it [her location] and it's kept with the CNA who is assigned. Whoever sees her has to sit with her wherever she is and now she has a Wander Guard. There's an order to check the wander guard to see if it's working on the 3 to 11 (3:00PM to 11:30PM) shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a face-to-face interview conducted on 02/28/25 at 1:23PM, Employee #4 (Associate Executive Director) stated, It wasn't brought to my attention until January 28th, the DON (Director of Nursing) informed me that she (Resident #24) was observed outside of the building the day before around 4PM, but we had not been informed for 24 hours. We have security footage that she exited [the building] around 4:24PM on January 27th, then on video coming back [into the building] around 4:41PM escorted back by an employee who found her outside on the sidewalk on [street name]. The employee recognized her and was able to bring her back inside. She was out of the building approximately 20 minutes total. The employee was outside taking her break. She (Resident #24) exited the back door which is fob-protected now. A dining service employee was coming through with a cart, an agency staff (contracted employee) and did not know the resident, so the resident walked past her. She (the contracted dining service employee) didn't know the resident, so she didn't say anything to the resident. At the time neither elevator was fob-protected. We educated everybody on the full elopement protocol, what you do when you notice a resident missing and what to do when they return. There should be documents in the investigation of the education that was provided to the staff. During a face-to-face interview conducted on 02/28/25 at 1:40PM, Employee #2 (Director of Nursing, DON) stated, I became aware the day after on January 28th [2025] in the evening around 3[PM] or 4[PM]. It was CNA, [Employee #9's name], she said that there were rumors going around that [Resident's name] eloped yesterday. I asked why didn't anybody report it yesterday, and she said it was a rumor. I told her [she was] to act immediately, so I acted immediately and contacted [Employee #4's name] and we started our investigation. She got a head-to-toe assessment to make sure she had no injuries. During a face-to-face interview conducted on 02/28/25 at 2:09PM, Employee #16 (Director of Property Management) stated, We got the video footage at 2PM, February 1st, and I sent them the video footage when I got it at 7PM. A review of the facility's surveillance footage on 02/28/25 at 2:10PM revealed that Resident #24 was standing at a locked entry/exit door on her assigned unit of the third floor (3 East). It then showed an unidentified Dining Service employee accessing the locked door from the other side, after exiting the service elevator in the hallway, and entering the unit. The employee was pushing a cart that was approximately waist high and appeared to contain some food and drink items. As the Dining Service employee entered through the opened door, Resident #24 exited through the same doorway and proceeded to the hallway and approached the elevator. The Dining Service employee looked back toward the resident as she walked through the door, however, the employee continued to push the food cart onto the unit. The resident was then seen pushing a button on the Service Elevator door and entered once the elevator door opened. Further review of the facility's surveillance revealed that Resident #24 exited from the service elevator onto the first-floor garage level to gain access outside of the facility. It should be noted that the resident was found walking along [Street Name], approximately 1,000 feet from the facility by Employee #11 who escorted the resident back inside the building. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a face-to-face interview conducted on 03/03/25 at 9:56AM, Employee #11 (Dining Services Employee who found resident) confirmed what she documented in her written statement during the facility's investigation and added that, I went out on my break at the back of the building alongside [Street name], saw a familiar face walking toward me, and [I] noticed it was [Resident #24'sname]. She seemed sought of confused, but she seemed happy that someone knew her. I took her back inside the building and I saw one of the Nurse Supervisors [Employee #14's name] and Employees' #9 and #12's names] (CNA's) and I mentioned to all of them that I saw [Resident's name] outside and I used to see her wander to the next unit (3 West) and into other resident's rooms about three (3) to four (4) times a week. Pretty much everyone who worked on 3 East knew that she would wander around and try to leave the building. During a telephone interview conducted on 03/03/25 at 9:29AM, Employee #9 (Assigned CNA) confirmed what she documented in her written statement during the facility's investigation that she did not have any knowledge that the resident exit[ed] the building and added that, I would sometimes see her wander in another resident's room on the evening shift and other staff said they would see her do that too. [Resident's name] move around all the time trying to leave, they all know, I have to follow her around and bring her back, you can see it on the camera. She would pack her clothes trying to leave. All of them knew she did that. I told them if you open[ed] the [surveillance] camera you would see how much she did that and I had to bring her back. When Employee #9 was asked whom she was referring to as all staff, she stated the DON, ADON (Assistant Director of Nursing), all of the CNA's (Certified Nursing Assistants) and all of the Nurses knew [Resident's name] would always pack her things and try to leave. She knows to go to the exit [doors] and wait for the door to open. If she was a one-to-one (24-hour monitoring with facility staff at all times), I could watch her, but she was not so I decided to resign. During a face-to-face interview conducted on 03/05/25 at 9:40AM, Employee #14 (Nurse Supervisor) confirmed what she documented in her written statement during the facility's investigation and added that, I didn't know she left the facility. I knew the next day (01/28/25) and I heard, maybe two (2) days after that, that the dietary person brought her back into the building and handed her over to the CNA that was working with her (the resident). It was [Employee #9's name] that was assigned to her and I do know she has memory issues. During a face-to-face interview conducted on 3/05/25 at 2:20PM with Employees' #2 (Director of Nursing, DON) and #3 (Assistant Director of Nursing, ADON), they were asked about Resident #24's prior wandering and exit-seeking behaviors, in which they acknowledged the findings and stated, For nursing it's me (Employee #2), [Employee #3's name] and the Charge Nurse on the floor that's responsible for observing and identifying the resident's behaviors, then resolve it. The identified behavior is documented on the MAR (Medication Administration Record). Employee #2 further stated, It was brought up in the clinical meetings in 2024, not sure of exact dates, more so about her wandering. I was aware that she would wander to the door, but she was easily re-directed. On 03/24/25 at 4:16PM, the State Surveyor asked Employee #4 (Associate Executive Director) in writing, what was done on 02/25/25, and Employee #4's replied via email stating, The fob reader device was installed on both elevators on February 25, 2025. An email dated 03/25/25 at 12:29PM received from Employee #4 documented, Our date of compliance for the plan of correction for the identified elopement was February 25, 2025, at 8:01AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up email dated 03/25/25 at 4:36PM from Employee #4 documented, The below email is from the technician who installed and activated the fob readers on both elevators. Upon review of the referenced email, it revealed the technician's name and email address that documented, The Fob access readers for elevators in building 1 floor 3 were installed and activated on Tuesday, February 25th at 8:00am. During a face-to-face interview conducted on 03/26/25 at approximately 1:30PM, Employees' #1 (Administrator), #2 (DON), #3 (ADON) and #4 (Associate Executive Director) were directed to provide a copy of the facility's documentation to the company requesting installation of the key fob reader for the main elevator and service elevator located on the Third Floor of Building one (1). At approximately 4:02PM on 3/26/25, Employee #1 (Administrator) was asked to provide a work order that documented the facility's request to have a key fob reader installed to both elevators on the Third Floor, Building one (1), as well as the company's work order that documented the completed installation and activation of the key fob readers. Employee #1 stated, We don't have a work order, we would've completed an invoice with the amount paid. It may not have a date and time on it. At approximately 5:30PM on 3/26/25, Employee #1 was asked to provide the invoice that documented the request for the key fob reader and the documentation the facility received back from the company that showed the date and time the request was completed and he stated, I'll see what I can find, but the documentation we have from the company we already sent that to you. Employee #1 was asked if he was referring to the email from the technician that was forwarded by Employee #4 that documented, The Fob access readers for elevators in building 1 floor 3 were installed and activated on Tuesday, February 25th at 8:00am, Employee #1 stated, Yes. It should be noted that the facility staff could not provide documented evidence of the invoice with date and time of the facility's request and completion of the installation and activation of the key fob readers for the main elevator and service elevator located in Building one (1) on the Third Floor when requested by the State Surveyor. Based on these findings, an Immediate Jeopardy (IJ)-J situation was identified on March 26, 2025, at 1:09PM. The facility staff provided their removal plan to the State Survey Team that was accepted on March 26, 2025, at 6:43PM. The plan included the following Interventions: - Medical Director notification on January 28th; - Resident's family notification (via phone) on January 28th; - Physical assessment of residents conducted on January 28th; - Ad hoc QAPI Meeting was conducted on January 28th; - BIMS assessment completed on January 28th; -Elopement assessment completed on January 28th ; - Education was conducted on all shifts for all staff members on IRC's Wandering and Elopement Policy on January 28th and 29th; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Elopement Drill was conducted on January 30th; -Meeting with resident's family conducted on January 28th; -Care plan meeting was conducted with resident's family on January; -A Psychiatric evaluation was conducted on January 31st; -As an additional precaution to the existing secure exit doors, a secondary measure of security was implemented with restricted fob access at each elevator that was initiated on January 30th and fully installed on February 25th at 8:00am.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record reviews and staff interviews, for one (1) of 21 sampled residents, the physician failed to review a resident's total program of care, including medications and treatments, after five physician visits. Subsequently, a resident's blood pressure medication order was not clarified and corrected from 11/04/24 to 02/05/25. Resident #4 The findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Convulsions, Hypertension, Affective Mood Disorder, Anxiety Disorder, Difficulty in Walking, and Generalized Muscle Weakness. A review of Resident #4's medical record showed: A physician's order dated 08/23/24 at 9:00 AM that documented: Metoprolol Succinate Extended Release (ER)[Beta Blocker Antihypertensive] Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A physician's order dated 08/23/2024 at 9:00 that documented: Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 50 mg. Give 1 tablet by mouth one time a day. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A physician's visit note dated 08/29/24 and signed by Employee #6 (Medical Director), that documented: Thank you for referring [Name of Resident #4] number to me for evaluation. Below are my notes for the consultation for a Geriatrics House call intake visit .This patient is homebound due to multiple medical diagnoses as listed below. This patient has a history of: uncontrolled hypertension, seizures, progressive dementia, gait imbalance, and bed-bound status .Current outpatient medications on file before visit: . Metoprolol Tartrate (Lopressor) 25 milligram tablet. Take one tablet, 25 milligrams by mouth two times daily . There was no documented evidence that the physician reviewed the Metoprolol Succinate orders and reconciled them with the Resident's current medications and treatments at this visit. A written physician's order sheet dated 11/04/24 at 11:39 AM in Resident #4's paper chart that documented: 1.D/C (discontinue) previous Metoprolol order 2. Give Metoprolol Succinate ER 50 mg po (by mouth) BID (twice daily). Hold if SBP (systolic blood pressure) is less than 110 and pulse is less than 60 for HTN (Hypertension). The physician orders were checked and signed off by Employee #6 (Physician/Medical Director) and Employee #20 (Charge Nurse). (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #4's electronic health record (EHR) showed a new physician's order dated 11/04/24 at 9:00 PM that directed: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg (Metoprolol Succinate). Give 1 tablet by mouth two times a day for hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75mg daily. Of note the special instructions Please administer with Metoprolol 25 mg tablet for total of Metoprolol 75 mg daily, were still included in this order. The directions to: Give 1 tablet (Metoprolol 50 mg) by mouth two times (100 mg), exceeded the total dose of Metoprolol provided in the special instructions (75 mg daily). There was no documented evidence that new physician orders were initiated to clarify the total daily dose of the Resident's Metoprolol. This order was discontinued on 12/19/24. A review of Resident #4's November 2024, medication administration sheet (MAR) documented that facility staff administered Metoprolol in the following manner: 1. On 11/04/24 at 9:00 AM, Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension .Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/04/24 at 6:05 PM. 2. Per the new physician's order starting on 11/04/24 at 9:00 PM, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and HR less than 60. Of note the special instructions that directed, Please administer with Metoprolol 25 mg tablet for total of Metoprolol 75mg daily, were included as part of this order - -This order had a discontinuation date of 12/19/2024. 3. Facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60 during November 2024. A physician's visit note dated 11/05/24 documented: .Current Medications on file prior to visit .Metoprolol tartrate (Lopressor) 25 mg tablet - Take 1 tablet 25 mg by mouth two 2) times daily . No current facility-administered medications on file prior to visit. Accurate medication list in PCC [Name of electronic health record program] . Assessment/ Plan .Hypertension (HTN), benign .Increase metoprolol . No additional instructions were documented in the physician's note for this visit. In addition, the current medications on file did not include the new physician orders for the Resident's Metoprolol that were initiated on 11/04/24. A review of a pharmacy delivery sheet dated 11/05/24 showed that 60 tablets of Metoprolol Succinate ER 50 mg were delivered to the facility for Resident #4. A Health Status Pharmacy Consult Note on 11/14/24 documented: Pharmacy Consult: MRR Completed. See Pharmacist Report for recommendations. The facility staff provided no documented evidence of the pharmacist's report for recommendations or the physician's response to the recommendations for this date. A Health Status Pharmacy Consult Note on 12/13/24 documented: Pharmacy Consult: MRR Completed. See Pharmacist Report for recommendations. The facility staff provided no documented evidence of the pharmacist's report for recommendations or the physician's response to the recommendations for this date. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 12/19/24 at 2:28 PM that directed: Metoprolol Succinate ER 50 mg Oral Tablet Extended Release 24 Hour. Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily, This order had a discontinuation date of 02/05/25. A physician visit note dated 12/20/24 and 12/30/24 and signed by Employee #6 (Medical Director that documented: .I have reviewed and reconciled the medication list with the patient today .Current Medications . Metoprolol succinate XL(Toprol-XL) 100 mg Oral Daily, Do not crush or chew .Assessment/Plan . Hypertension (HTN), benign, Improving with treatment above goal: Elevated BP (blood pressure), asymptomatic; .Increase metoprolol .There was no documented evidence that the physician reviewed the current medication changes made to the Resident's Metoprolol despite the discrepancy between the active physician's orders in the resident's electronic health record as of 12/19/24 and the physician's visit notes for 12/20/24 or 12/30/24. The active physician's orders in Resident #4's EHR directed, Metoprolol Succinate ER 50 mg Oral Tablet Extended Release 24 Hour. Give 2 tablet(s) by mouth one time a day (total daily dose would equal 100 mg). In addition, the special instructions to, Please administer 25 mg Metoprolol with 50 mg Metoprolol for a total daily dose of 75 mg, remained in the active order in the Resident's EHR. There was no documented evidence that the physician reviewed changes made to the frequency and total daily dose of the medication. A review of Resident #4's MAR for December 20-31, 2024, showed that facility staff documented that they administered Metoprolol at 9:00 AM daily per the following order: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for total of Metoprolol 75 mg daily. In addition, facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60. A physician visit note dated 01/02/25 and signed by Employee #6 (Medical Director) that documented: .I have reviewed and reconciled the medication list with the patient today .Current Medications .Metoprolol succinate XL(Toprol-XL) 100 mg Oral Daily. Do not crush or chew . There was no documented evidence that the physician reviewed or reconciled the discrepancies between the list of current medications in the physician visit note and the active order for the Metoprolol in the Resident's EHR. The special instructions to administer 25 mg Metoprolol with 50 mg Metoprolol for a total daily dose of 75 mg remained in the active order in the Resident's EHR. In addition, the current medication list for this visit did clarify the current dose and frequency of medication during the 01/02/25 physician visit. A pharmacist recommendation to physician, dated 01/14/25 documented: Resident has the following order Metoprolol (Succinate) ER 50 mg give one tablet by mouth two times a day for hypertension, hold for B/P less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. Please clarify the dosage/directions for the above order. Resident does not have an order for Metoprolol 25 milligrams. Please clarify if the dosage changed and if so, please update directions. A physician visit note dated 01/16/25 and signed by Employee #6 (Medical Director) that documented: I have reviewed and reconciled the medication list with the patient today .Current Medications .Metoprolol Succinate XL(Toprol-XL) 50 mg 24 hr (hour) tablet. Take 2 tablets (100 mg) by mouth daily. Of note, as of 01/16/25, the active orders for Metoprolol Succinate 50 mg still included special instructions to Please administer with metoprolol 25 mg tablet for a total of metoprolol 75 mg daily. (continued on next page)

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	095028	A. Building B. Wing	03/26/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 02/05/25 at 10:38 AM that directed: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg. Give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and HR less than 60. A physician's order dated 02/05/25 at 9:04 PM that directed: Metoprolol Tartrate Oral Tablet 50 mg. Give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and HR less than 60. A review of Resident #4's MARs for January 1- February 1-5, 2025, showed that facility staff documented that they administered Metoprolol at 9:00 AM daily under the following order: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. In addition, facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60. A review of the physician's response to the pharmacist recommendations for the MMR 01/14/25 that documented: Agree. Clarify order for Metoprolol: Patient's on 50 mg po (by mouth) BID (twice daily). The physician's response was signed and dated by Employee #6 (Medical Director) on 02/07/25. A review of Resident #4's medical record showed no documented evidence that Employee #6 (Medical Director) reviewed the Resident's total program of care, including medications and treatments during physician visits made on 08/29/24, 11/05/24, 12/20/24, 12/30/24, 01/02/25, and 01/16/25, as evidenced by: 1) Not documenting a review of the new medication orders for the resident's Metoprolol initiated on 08/23/24 at the physician visit on 08/29/24. The note contained only the list of the Resident's medication prior to the visit. 2) Not documenting a review of the new orders for the resident's Metoprolol initiated on 11/04/24 at the physician visit on 11/05/24. 3) Not documenting a review of the new orders for the resident's Metoprolol initiated on 12/19/24 at the physician visits on 12/20/24 and 12/30/24. 4) Not reconciling instructions on the current medication list to match the orders for Metoprolol during the 01/02/25 and the 01/16/25 physician visits. 5) Not documenting a physician's response to the pharmacist's recommendations for MMR 01/14/25 until 02/07/25 (22 days after the pharmacist's recommendation. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 03/04/25 at 3:06 PM Employee #22(Consultant Pharmacist), stated that she recommended that the physician clarify Resident #4's Metoprolol dose 3 times before the physician responded. She stated that she documented that she had recommendations for Resident # 4 medication in the Health Status Pharmacy Consult Notes on 11/24/24, 12/13/24, and 01/14/25 and each time she faxed her recommendation to clarify the resident's Metoprolol dose on Pharmacist Recommendation to the Physician Report to the physician. She added that usually after she sends her recommendations to the physician, he or she will either respond to the form and fax it back to her, or they will update the medication order in the resident's electronic health record. She concluded the interview by stating that the physician never responded to her recommendation to clarify the resident's Metoprolol dose until 01/14/25. Of note, the facility did not provide documented evidence of the Pharmacist's Recommendation to the Physician Report, or the physician's response for 11/24/24 or 12/13/24. During a face-to-face interview on 03/05/25 at 3:27 PM, Employee #6 (Medical Director) acknowledged the finding and stated that when she conducts her physician visits with the residents, she is responsible for reviewing all medications and treatments for the Residents. She acknowledged that she changed Resident #4's Metoprolol dose several times to get the Resident's blood pressure under better control. She provided no further explanation for the lack of clarification of the Resident's Metoprolol orders after each dose change during the physician visits.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of 21 sampled residents, the facility staff failed to ensure that all licensed nurses had the specific competencies, and skill sets necessary to care for residents' needs. Resident #4. The findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Convulsions, Hypertension, Affective Mood Disorder, Anxiety Disorder, Difficulty in Walking, and Generalized Muscle Weakness. A review of Resident #4's medical record showed: A physician's order dated 08/23/24 at 9:00 AM that documented: Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A physician's order dated 08/23/2024 at 9:00 that documented: Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 50 mg. Give 1 tablet by mouth one time a day. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A written physician's order sheet dated 11/04/24 at 11:39 AM in Resident #4's paper chart that documented: 1.D/C (discontinue) previous Metoprolol order 2. Give Metoprolol Succinate ER 50 mg po (by mouth) BID (twice daily). Hold if SBP (systolic blood pressure) is less than 110 and pulse is less than 60 for HTN (Hypertension). The physician orders were checked and signed off by Employee #4 (Medical Director) and Employee #20 (Charge Nurse). A review of Resident #4's electronic health record (EHR) showed a physician's order dated 11/04/24 at 9:00 PM that directed: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg (Metoprolol Succinate). Give 1 tablet by mouth two times a day for hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75mg daily. Of note, the special instructions to administer Metorporl 50 mg and Metoprolol 25 mg together for a total daily dose of Metoprolol 75 mg, were erroneously transcribed and included in this order. A review of Resident #4's November 2024, medication administration sheet (MAR) documented that facility staff administered Metoprolol in the following manner: 1. On 11/04/24 at 9:00 AM, Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension .Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/04/24 at 6:05 PM. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per the new physician's order starting on 11/04/24 at 9:00 PM, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and HR less than 60. Of note the special instructions that directed, Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75mg daily, were included as part of this order - -This order had a discontinuation date of 12/19/2024. 3. Facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60 during November 2024. A physician's order dated 12/19/24 at 2:28 PM that directed: Metoprolol Succinate ER 50 mg Oral Tablet Extended Release 24 Hour. Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. A review of Resident #4's medication administration records (MARs) for December 20-31, 2024, January 1-31, 2025, and February 1-5, 2025, showed that facility staff documented that they administered Metoprolol at 9:00 AM daily per the following order: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. In addition, facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60 From December 2024 to February 5, 2025. A review of the physician orders for Resident #4's Metoprolol in the electronic health record showed: 1. On 08/23/24, the Resident had physician orders for Metoprolol Succinate ER 50 mg and Metoprolol Succinate ER 25 mg, that directed facility staff to administer both doses together for a total daily dose of 75 mg Metoprolol. 2. On 11/04/24 the order for Metoprolol Succinate 25 mg was discontinued. 3. The physician order for Metoprolol Succinate ER 50 mg on 11/04/24 showed that the order was inaccurately transcribed by Employee # /Registered Nurse, and included in the special instructions to administer with Metoprolol 25 mg tablet for total of Metoprolol 75 mg daily. 4. The physician order for Metoprolol Succinate ER 50 mg on 12/19/24 showed that the order was inaccurately transcribed by Employee # /Registered Nurse, and included in the special instructions to administer with Metoprolol 25 mg tablet for total of Metoprolol 75 mg daily. This order was not discontinued until 02/05/25. 5. The medication administration records from 11/04/24 to 02/05/25 included orders for Metoprolol Succinate ER 50 mg that directed, Please administer with Metoprolol 25 mg tablet for total of Metoprolol 75 mg daily. Facility staff continued to document that they administered Metoprolol Succinate ER 50 mg with Metoprolol Succinate 25 mg for a total dose of 75 mg from 11/04/24 to 02/05/25 due to a medication transcription error made by Employee #20 (Charge Nurse). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview on 03/06/25 at 9:07 AM, Employee #20 (Charge Nurse), stated that she transcribed Resident # 4's Metoprolol orders on 11/04/24 and 12/19/24. She explained that when transcribing new medication orders, she either hits the update button and types in the new medication order, or she hits the new order button and types in the new medication order. She then reviewed the orders that she transcribed on 11/04/24 and 12/19/24 and acknowledged that both orders contained special instructions to: Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily, even though the Metoprolol 25 mg order was discontinued on 11/04/24 at 9:00 AM. The Employee acknowledged the finding and stated that she had received education and training on prescribing medication orders when she first became employed by the facility, but she was not made aware that clicking the update button transcribed special instructions from the prior medication orders into the new medication order and onto the medication administration records. During a face-to-face interview on 03/06/25 at 10:55 AM, Employee #3 (Assistant Director of Nursing/ADON)stated when the physician writes a new medication order on the Physician's Order Sheet in the resident's paper chart, the charge nurse for that Resident and the prescribing physician check the order and sign off on the orders with signature, date and time. The charge nurse then electronically transcribes the order into the Resident's electronic health record. She further explained that the charge nurse should discontinue the old orders for the medication first before entering a new order for the same medication. If the charge nurse clicks update medication order instead of clicking the new medication order, any special instructions that were included in the old medication order are automatically transcribed as special instructions into the new medication order. For this reason, we encourage the transcribing nurses not to use the update button to avoid errors. The Employee further stated that the medication administration records reflect the medication orders exactly as they were transcribed into the electronic health record. However, before administering medications the nurses should review the MAR to determine if there are any special instructions. If there is a discrepancy with any medication order on the MAR, then the nurse should call the pharmacy and/or call the physician before administering the medication. She then stated that she was immediately going to re-educate the Employee #20 (Charge Nurse).

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the attending physician failed to document in the resident's medical record a response, if applicable, to address the pharmacist identified irregularities for five (5) of 21 sampled residents. Residents' #18, #2, #8, #4 and #15. The findings included: An undated policy titled, Medication Regimen Review documented in part: - Policy Statement: The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. - The attending physician documents in the medical record that the irregularities has been reviewed and what (if any) action was taken to address it. - The goal of the MRR (Medication Regimen Review) is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication[s]. - The Consultant Pharmacist provides the Director of Nursing Services and Medical Director with a written, signed and dated copy of all medication regimen reports. - Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. 1. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including Osteoporosis. A physician order dated 10/29/24 instructed, Diclofenac Sodium External Gel 1 % 1GM (Topical) apply to both shoulders two times a day for shoulder pain. This order was discontinued on 02/07/24. Monthly Medication Reviews (MMR) dated 11/24/24, 12/13/24, and 01/14/25 documented, Diclofenac gel comes with a dosing care to measure the amount applied, in grams with each administration. Please clarify dosage amount, in grams, and update Point Click Care/Medication Administration Record appropriately. The resident's medical record lacked documented evidence of the physician response to address the pharmacist concerns related to clarifying the dose of Diclofenac gel noted by the pharmacist on 11/24/24 and 12/13/24. A physician order dated 02/07/25 instructed Diclofenac Sodium External Gel 1 % apply one (1) gram topically to both shoulders two times a day for shoulder pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a face-to-face interview on 03/05/25 at approximately 1:00 PM, Employee #6 (Attending Physician/Medical Director) stated that it was an oversight that she did not document her response for the pharmacist irregularities in the resident's record. She did, however, change the Diclofenac order on 02/07/25. 2. The facility staff failed to show documented evidence in the Resident #2's medical record of the pharmacist's recommendations and the physician's responses to those recommendations. Resident #2 was admitted to the facility 05/05/20 with multiple diagnoses that included the following: Malignant Neoplasm of Prostate, Aphasia, Adjustment disorder with Mixed Anxiety and Depressed Mood, and Major Depressive Disorder. A review of Resident #2's medical record revealed the following: A review of a Health Status Note dated 09/15/24 at 2:23 PM, documented Pharmacy Consult: MRR (Medication regimen review) See pharmacist report for recommendations. A review of a Health Status Note dated 05/20/24 at 8:37 PM documented Pharmacy Consult: MRR (Medication regimen review) See pharmacist report for recommendations. It is noted that the medical record lacked documented evidence of the pharmacist recommendations and of the physician's review or response to the recommendations. 3. The facility staff failed to show documented evidence in the medical record of the pharmacist recommendations and the physician's responses to the recommendations for Resident #8. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Dementia Unspecified Severity with Agitation, Age Related Osteoporosis, Personal History of Urinary Tract Infection and Altered Mental Status. A Review of Resident #8's medical record revealed the following: A review of a Health Status Note dated 03/17/24 at 6:25 PM, documented Pharmacy Consult: aMRR (Medication regimen review) See pharmacist report for recommendations. A review of a Health Status Note dated 10/07/24 at 5:36 PM, documented Pharmacy Consult: MRR (Medication regimen review) See pharmacist report for recommendations. A review of a Health Status Note dated 02/09/25 at 1:30PM, documented Pharmacy Consult: MRR (Medication regimen review) See pharmacist report for recommendations. During a face-to-face interview conducted on 03/03/25 at 2:02 PM, Employee #3 (Assistant Director of Nursing) stated that the pharmacist recommendations are kept in a binder in the nursing office and that the physician reviews them every week at the risk meeting. During a face-to-face interview conducted on 03/03/25 at approximately 2:15 PM, Employee #3 and Employee #2 (Director of Nursing) both acknowledged the pharmacist recommendations and the physician's responses were not in the resident's medical records. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview conducted on 03/04/25 at 3:18 PM, Employee #22 (Consultant Pharmacist) stated that she sends the recommendations via email to the medical director, director of nursing, assistant director of nursing and the administrator. Employee #22 stated she was not sure if she has access to the entire medical record and she does not come on site to review the paper chart that the facility keeps for each resident. 4. Resident #4 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Convulsions, Hypertension, Affective Mood Disorder, Anxiety Disorder, Difficulty in Walking, and Generalized Muscle Weakness. A review of Resident #4's medical record showed: A physician's order dated 08/23/24 at 9:00 AM that documented: Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A physician's order dated 08/23/2024 at 9:00 that documented: Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 50 mg. Give 1 tablet by mouth one time a day. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. This order was discontinued on 11/4/2024. A written physician's order sheet dated 11/04/24 at 11:39 AM in Resident #4 's paper chart that documented: 1.D/C (discontinue) previous Metoprolol order 2. Give Metoprolol Succinate ER 50 mg po (by mouth) BID (twice daily). Hold if SBP (systolic blood pressure) is less than 110 and pulse is less than 60 for HTN (Hypertension). The physician orders were checked and signed off by Employees #6 (Medical Director) and Employee #20 (Charge Nurse). A review of Resident #4's electronic health record (EHR) showed a new physician's order initiated on 11/04/24 at 9:00 PM that directed: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 mg (Metoprolol Succinate). Give 1 tablet by mouth two times a day for hypertension. Hold for systolic blood pressure (SBP) less than 110 or heart rate (HR) less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75mg daily. Of note, the special instructions Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily, were transcribed in this order. The order was discontinued on 12/19/24. A review of Resident #4's November 2024, medication administration sheet (MAR) documented that facility staff administered Metoprolol in the following manner: -On 11/04/24 at 9:00 AM, Metoprolol Succinate Extended Release (ER) Oral Tablet 24 Hour 25 milligram (mg). Give 1 tablet by mouth one time a day for Hypertension .Administer with Metoprolol 50 mg tablet for total Metoprolol 75 mg daily. This order was discontinued on 11/04/24 at 6:05 PM. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Per the new physician's order starting on 11/04/24 at 9:00 PM, Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 110 and HR less than 60. Of note the special instructions that directed, Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75mg daily, were included as part of this order - -This order had a discontinuation date of 12/19/2024. - Facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60 during November 2024. A Health Status Pharmacy Consult Note on 11/14/24 documented: Pharmacy Consult: MRR Completed. See Pharmacist Report for recommendations. The facility staff provided no documented evidence of the pharmacist's report for recommendations or the physician's response to the recommendations for this date. A Health Status Pharmacy Consult Note on 12/13/24 documented: Pharmacy Consult: MRR Completed. See Pharmacist Report for recommendations. The facility staff provided no documented evidence of the pharmacist's report for recommendations or the physician's response to the recommendations for this date. A physician's order dated 12/19/24 at 2:28 PM that directed: Metoprolol Succinate ER 50 mg Oral Tablet Extended Release 24 Hour. Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily, This order had a discontinuation date of 02/05/25. A review of Resident #4's MAR for December 20-31, 2024, showed that facility staff documented that they administered Metoprolol at 9:00 AM daily per the following order: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. In addition, facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60. A pharmacist recommendation to the physician, dated 01/14/25 documented: Resident has the following order Metoprolol (Succinate) ER 50 mg give one tablet by mouth two times a day for hypertension, hold for B/P less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. Please clarify the dosage/directions for the above order. Resident does not have an order for Metoprolol 25 milligrams. Please clarify if the dosage changed and if so, please update directions. A review of Resident #4's MARs for January 1- February 1-5, 2025, showed that facility staff documented that they administered Metoprolol at 9:00 AM daily under the following order: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 2 tablet(s) by mouth one time a day for hypertension. Hold for SBP less than 110 and HR less than 60. Please administer with Metoprolol 25 mg tablet for a total of Metoprolol 75 mg daily. In addition, facility staff documented that the Resident had no systolic blood pressure below 110 or heart rate below 60. (continued on next page)

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	095028	A. Building B. Wing	03/26/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/25 a signed and dated physician's response dated to the pharmacist recommendations for the MMR 01/14/25 documented: Agree. Clarify order for Metoprolol: Patient's on 50 mg po (by mouth) BID (twice daily). This response was made 22 days after the pharmacist's recommendations on the 01/14/25 MMR. The facility provided no documented evidence of the physician's response to the pharmacist recommendations made on 11/14/24 or 12/13/24 in the resident's medical record. During a face-to-face interview on 03/03/25 at 2:21 PM, Employee #3 (Assistant Director of Nursing/ADON) stated the pharmacist MMR recommendations and physician responses for residents are kept in a binder, not in the resident's medical records. She added that the pharmacist documents her MMR recommendations on the Pharmacy Recommendation to the Prescriber Report, for each Resident and emails them to the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Medical Director. The DON and ADON place the pharmacist's recommendations in a binder in the administrative office. The pharmacist's recommendations are then discussed during weekly risk management meetings with the physician. The physician then reviews, responds to, and signs the recommendations made by the pharmacist on the Pharmacy Recommendation to the Prescriber Report, and the reports are then placed back in the binder. A review of the binder showed no documented evidence of the physician's response to the pharmacist recommendations made on 11/14/24 or 12/13/24. The Employee acknowledged the finding and provided no further explanation for the missing pharmacist recommendations made on 11/14/24 or 12/13/24, or the physician's response, During a telephone interview on 03/04/25 at 3:06 PM, Employee #22 (Consultant Pharmacist) stated that she recommended that the physician clarify Resident #4's Metoprolol dose 3 times before the physician responded. She stated that she documented that she had recommendations for Resident # 4 medication in the Health Status Pharmacy Consult Notes on 11/24/24, 12/13/24, and 01/14/25 and each time sent a Pharmacist Recommendation to the Physician Report, with the recommendation to clarify the Resident#4'ss Metoprolol dose She added that usually after she sends the Pharmacist Recommendation to the Physician Report, to the physician, the physician either documents a response on the form and faxes it back to the pharmacist, or the physician will update the medication order in the resident's electronic health record. She concluded the interview by stating that she did not receive a response to her recommendation (on 01/14/25), to clarify Resident #4's Metoprolol dose from Employee #6 (Medical Director) until 02/07/25. 5. Resident #15 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Bipolar Disorder, Major Depressive Disorder and Anxiety. A Physician's order dated 05/22/22 documented, Buspirone HCl (Hydrochloride) Tablet 5 MG (milligram) Give 1 tablet by mouth two times a day for Anxiety and Sertraline HCl Tablet 50 MG Give 1 tablet by mouth one time a day for Depression/Anxiety. A Care Plan dated 06/24/24 documented: Focus - [Resident #15's name] is at risk for adverse reaction r/t (related to) PolyPharmacy .Interventions - Request physician to review and evaluate medications; Review [Resident's name] medications with MD (Medical Director)/Consulting pharmacist for: duplicate medications or prescriptions, proper dosing, timing and frequency of administration, adverse reactions, supporting diagnosis; Review Pharmacy consult recommendations, and follow up as indicated. A Health Status Note dated 11/21/24 at 07:04 (7:04AM) and e-signed (electronically signed) by the facility's Pharmacy Consultant documented, MRR Completed. See Pharmacist Report for recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that there was no documented evidence of the Pharmacist's report or recommendation, nor the Physician's response to the report/recommendations in the resident's record. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '01,' indicating the resident was severely impaired. During a face-to-face interview conducted on 02/27/25 at 9:00AM, Employee #2 (Assistant Director of Nursing) acknowledged the findings and stated, I looked everywhere and I cannot find it (the pharmacist's recommendations and the physician's response). Cross Reference 22B DCMR Sec. 3231.9

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview for one (1) of 21 sampled residents, facility staff failed to ensure that a resident's medication was properly labeled, as evidenced by an opened multi-dose bottle of a liquid supplement that was undated inside the resident's medication drawer. (Resident #4) The findings included: A facility policy titled 'Medication Storage in the Facility' with a revised date of August 2014 documented: Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier and D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and new date of expiration (Note: the best stickers to affix contain both a date opened and expiration notation line). Resident #4 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Seizures, Dilated Cardiomyopathy and Hypertension. A Physician's order dated 12/24/24 documented, Prosource/Active Liquid two times a day for wound healing Give 30ml (milliliter). A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'Severely Impaired.' A Medication Administration Record (MAR) dated 2/1/25 - 2/28/25 documented that facility staff signed off on the MAR that the resident was being administered 'Prosource/Active Liquid' at 9:00AM and 5:00PM every day. During a medication storage observation on unit Three (3) [NAME] that was conducted on 02/25/25 at 2:29PM, it revealed that Resident #4's medication drawer contained a 887ml bottle of 'ProSource' with a pharmacy label that documented the resident's name, room number and physician's order for administration. It should be noted that the bottle of 'ProSource' was nearly empty and there was no date opened sticker on the opened bottle of liquid medication to indicate the date it was initially opened by the facility staff. During a face-to-face interview conducted on 02/25/25 at 2:30PM, Employee #21 (Registered Nurse) acknowledged the findings and stated, I will throw that out.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, facility staff failed to prepare, and distribute foods under sanitary condition, as evidenced by one (1) of one (1) open, and expired eyewash solution in the east-wing kitchen, one (1) of one (1) dishwashing machine in the east-wing kitchen that was leaking, one (1) of one (1) empty paper towel dispenser in the east-wing kitchen, one (1) of one (1) broken paper towel dispenser in the west-wing kitchen, one (1) of one (1) expired eyewash solution in the west-wing kitchen, no handwashing soap for one (1) of one (1) handwashing sink in the west-wing kitchen, dust and/or foreign substance accumulation in one (1) of one (1) walk-in refrigerator, and four (4) of four (4) ready-to-eat food packages that were inappropriately stored in the walk-in refrigerator. The findings included: During observations in dietary services on February 26, 2025, at approximately 9:00 AM, the following was observed: 1. A bottle of eyewash solution located in the east-wing kitchen was open and expired as of 09/2024. 2. One (1) of one (1) dishwashing machine in the east-wing kitchen leaked on both sides of the machine during the wash and rinse cycles. 3. There were no disposable paper towels provided at the hand washing sink located on the east-wing kitchen of the facility. 4. The paper towel dispenser mounted on the wall above the hand washing sink at the service kitchen located in the west-wing kitchen was broken. 5. A bottle of eyewash solution located in the west-wing kitchen expired as of 09/2024. 6. There was no handwashing soap available for use in one (1) of one (1) handwashing sink located in the west-wing kitchen. 7. Dust and/or foreign substance build-up was observed on wire guards for the air condenser fans and ceiling inside the walk-in refrigerator, and on a grate cover of the drop ceiling above hot food holding and cook line (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	areas in the main kitchen located on the fourth floor. 8. One (1) of one package of ready-to-eat chopped celery, one (1) of one package of diced onions, one (1) of one package of diced carrots, and one (1) of one package of diced onions that were stored in the walk-in refrigerator at the main kitchen on the fourth floor showed signs of spoilage, such as discoloration, and texture change to touch. It was also observed that liquid matter accumulating inside those food packages was leaking out of the packaging materials and accumulating inside a holding pan where these food items were stored. During a face-to-face interview on March 3, 2025, at approximately 10:00 AM, Employee #17 acknowledged the findings.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on a review of the facility's records and a staff interview, the facility failed to comply with the State Regulation (22B DCMR section 3211.5) for daily staffing ratios, as evidenced by not providing the minimum daily average of at least six tenths (0.6) hours of resident care per resident by a Registered Nurse for seven (7) of 43 sampled days. The findings included: A review of the facility's daily staffing sheets revealed the following: On 03/30/24 the facility's resident census was 27. In addition, residents received 0.5 hours of direct nursing care being provided by a Registered Nurse. On 03/31/24 the facility's resident census was 27. In addition, residents received 0.2 hours of direct nursing care being provided by a Registered Nurse. On 04/30/24 the facility's resident census was 27. In addition, residents received 0.2 hours of direct nursing care being provided by a Registered Nurse. On 12/25/24 the facility's resident census was 29. In addition, residents received 0.5 hours of direct nursing care being provided by a Registered Nurse. On 12/31/24 the facility's resident census was 30. In addition, residents received 0.5 hours of direct nursing care being provided by a Registered Nurse. On 01/08/25 the facility's resident census was 29. In addition, residents received 0.5 hours of direct nursing care being provided by a Registered Nurse. On 02/11/25 the facility's resident census was 30. In addition, residents received 0.5 hours of direct nursing care being provided by a Registered Nurse. During a face-to-face interview conducted on 03/05/25 at 12:05PM, Employee #2 (Director of Nursing) was made aware of the concerns with staffing not being met. She acknowledged the findings. [Crossover: 22B DCMR Sec. 3211.5]

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interview, facility staff failed to maintain essential kitchen equipment in good working condition as evidenced by one (1) of one (1) dishwashing machine in the east-wing kitchen that squirted a water solution on both sides of the machine during the wash and rinse cycles. The findings included: During a walkthrough of the east wing kitchen at approximately 9:00 AM, on February 26, 2025, one (1) of one (1) dishwashing machine repeatedly spurted a water solution on both sides of the machine during the wash and rinse cycles. During a face-to-face interview on March 3, 2025, at approximately 10:00 AM, Employee #17 acknowledged the findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations and staff interview, facility staff failed to maintain an effective pest control program as evidenced by flying insects that were observed around one (1) of one (1) handwashing sink in the east-wing kitchen. The findings included: During observation on 2/26/2025 at approximately 9:00 am, flying insects were observed around one (1) of one (1) handwashing sink in the east-wing kitchen of the facility. During a face-to-face interview on 2/26/2025 at approximately 9:00 AM, Employee #17 stated that the facility receives pest extermination services from a professional company regularly and as needed. He added he will call the exterminator as soon as possible to address the problem. During a face-to-face interview on March 3, 2025, at approximately 10:00 AM, Employee #17 acknowledged the findings.