STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095031	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspire Rehabilitation and Health Center LLC	2131 O Street NW Washington, DC 20037

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, for one (1) of 12 sampled residents, facility staff failed to develop a comprehensive care plan with goals and interventions to address one resident's use of a Foley Catheter. Resident #9. The findings included: Resident #9 was admitted to the facility on [DATE] with multiple diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Gastrostomy Status, and Aphasia. Review of the resident's medical record showed the following: 04/10/25 at 10:43 PM admission Note: - The resident arrived from [hospital name] around 9:00 PM on a stretcher accompanied by 2 paramedic staff. - Resident has Foley Catheter draining yellow urine. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded that the resident had an indwelling catheter. A Physician's orders dated 05/29/25 directed, Foley Catheter due to Obstructive Uropathy. During an observation on 06/23/25 at 10:33 AM, Resident #9 was observed in bed with a Foley Catheter to bedside drainage. Further review of the resident's medical record showed no documented evidence that a comprehensive care plan with goals and interventions was developed to address her use of a Foley Catheter. During a face-to-face interview on 06/25/25 at 1:50 PM, Employee #2 (Director of Nursing/DON) stated, The resident's last care plan meeting was 04/11/25 and acknowledged that facility staff failed to develop a comprehensive care plan with goals and interventions to address Resident #9's use of a Foley Catheter. Cross Reference 22B DCMR Sec. 3210.4

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

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of 12 sampled residents, facility staff failed to ensure that one resident was free of a significant medication error as evidenced by ordering. transcribing and dispensing a medication that included an incorrect route for the Resident's medication. Resident #4 The findings included: Resident # 4 was admitted to the facility on [DATE] with diagnoses that included: Seizure Disorder, Adrenal Insufficiency, resolved COVID-19, Bowel dysfunction, Diabetes Mellitus DM, Intellectual Delay, Ogilvie syndrome, Gastrostomy Status, Dependence on Supplemental Oxygen, Aspiration Pneumonia. A review of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) defines a medication error as Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is under the control of a healthcare professional, patient, or consumer.Medication errors occur at any stage of the medication management process, not just administration. This includes prescribing, transcribing, dispensing, and administering. The potential for harm exists even if an error was caught before administration. The incorrect order and transcription created a risk for the resident .Long-term care facilities have a responsibility to prevent medication errors. This includes ensuring accurate prescribing, transcribing, and administration of medications. Any deviation from established protocols or physician's orders can be considered a medication error and could have serious consequences for residents (https://www.nccmerp.org). A review of the facility's Medication Transcription policy (reviewed 01/2025) documented: 1. Medication Transcription: All medication orders, including new, changed, or discontinued prescriptions, must be transcribed promptly and accurately into the MAR by licensed nursing staff. All transcriptions must match the prescriber's written or electronic order .4. Medications from external sources: Medications may be ordered or provided by other healthcare facilities (hospitals or external specialty pharmacies) and must be reviewed for accurate dosage, must be packaged and approved by the resident's physician before administration. A review of Resident #4's medical record revealed the following: An admission minimum data set (MDS) assessment dated [DATE] that showed that the resident was severely cognitively impaired, had a gastrostomy tube and was in hospice. A physician's order dated 03/19/24 at 9:45 PM that directed: Lorazepam Oral Concentrate 2 mg/ml (milligrams per milliliter) (Lorazepam) Give 0.5 ml by mouth every 15 minutes as needed for seizure until 04/16/2024. A physician's order dated 03/19/24 at 10:00 PM, Morphine Sulfate (Concentrate) oral solution 20 mg/ml (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain until 04/02/2024. Of note, Resident #4 had a gastrostomy tube that was clogged and was not functioning properly, and the resident could not take medications orally due to his diagnoses. A physician's order dated 03/19/24 at 10:00 PM that directed: Lorazepam Oral Concentrate 2 mg/ml (Lorazepam) Give 0.5 ml sublingually every 15 minutes as needed for seizure until 04/16/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Progress Note dated 03/19/24 at 11:35 PM that documented: Resident .admitted to the facility from [Name of Local Hospital]. He is non-verbal with visual and hearing impairment. His admitting diagnoses are resolved COVID-19, Bowel dysfunction, Diabetes Mellitus (DM,) imbalanced nutrition, intellectual delay and Seizure disorder. Lungs are clear on auscultation. Abdomen is soft and non-distended and positive bowel sounds in all 4 quadrants. He has G-Tube in place which is not used for feeding due to him being on comfort care . A physician's order dated 03/20/24 that documented: NPO (nothing by mouth) Diet NPO Texture, at risk for malnutrition/comfort care measure only- no GT (gastrostomy tube) related to Unspecified Adrenocortical Insufficiency; Severe Intellectual Disabilities. A Physician History and Physical dated 03/20/24 at 1:04 PM that documented: .Assessment and Plan: The resident had an advanced intellectual disability, bilateral flexion, and malfunctioning G-tube. Per transfer summary, there was massive distention of the [abdomen] with the use of the G-tube. The summary stated the stomach had collapsed. The resident was transferred to palliative care. P (Plan): refer to current orders and plan of care. The patient will be placed on comfort care pending further social evaluation. An SBAR (Situation, Background, Assessment (Registered Nurse/RN) or Appearance (Licensed Practical Nurse/LPN) and Request) - Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 03/26/24 at 4: 18 AM, that documented: Situation: Unresponsiveness; Background: Adrenocortical Insufficiency; Assessment: . Resident was unresponsive .PN (Progress Note): At the beginning of shift, Resident was received in bed sleeping, chest moving up and down, ADL (activities of daily living) care provided, at 3:25 am, Resident was observed unresponsive in bed, no pulse, nor respiration, Resident is DNR, (Do Not Resuscitate), DNI (Do Not Incubate), [Name of Medical Director] notified, pronounced Resident dead. A medication administration record (MAR) for March 2024 showed that from 03/19/24 to 03/26/24, the facility staff did not administer Morphine Sulfate (Concentrate) oral solution 20 mg/ml (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain. The order on the Resident's MAR had an incorrect route for the medication (morphine). Of note, the Resident per physician's order could not receive anything by mouth. An Interim Medication Regimen Review (MMR) report from the consultant pharmacist dated 03/20/24 at 10:27 PM documented: Based on the information for this review. I have no recommendations at this time .Should there be any questions regarding the resident's medication regimen, please contact the consulting pharmacist of record. Of note, the consultant pharmacist was not available for interview. In addition, the dispensing pharmacist, Medical Director, and the nurse who transcribed Resident #4's medication order when the Resident was admitted to the facility, were not available during the survey for interview. A review of Resident#4's medical record showed that although facility staff never administered the Resident's Morphine, there was no documented evidence to show that the dispensing pharmacist, Medical Director, transcription nurse, or the consultant pharmacist corrected the medication order by changing the route from oral to another route, the Resident's medication. During a face-to-face interview on 06/27/25 at 10:34 AM, Employee #2 (Director of Nursing/DON) stated, When a resident is admitted from the hospital, the nurse assigned to the resident (admitting nurse), reviews the medication lists from the hospital discharge summary. The nurse then calls the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician, and the nurse and physician review the resident's medication orders. Once the physician approves the orders, the admitting nurse then transcribes (enters) the orders in the resident's electronic health record. After the admitting nurse enters the orders in the computer in the resident's electronic health record, the unit manager completes a 24-hour chart check to ensure that transcribed orders for the residents were entered into the Resident's electronic medical record accurately. In addition, when asked if there was any documentation from the dispensing pharmacy to show that the order for the resident's morphine was incorrect, she stated that she could not provide documentation. Of note, the dispensing pharmacist, the Medical Director, and the nurse who transcribed Resident #4's medication order when the Resident was admitted to the facility, were not available during the survey for interview. During a face-to-face interview on 06/27/25 at 11:14 AM, , Employee #4 (Licensed Practical Nurse/1st Floor Resident Clinical Coordinator), stated: When Resident #4 was admitted to the facility, I completed a 24-hour chart check. I printed the medication orders that the transcription nurse entered and reviewed them for accuracy. I then documented that the 24-hour chart check was completed in the reports section of the Resident's electronic health record. When I reviewed Resident #4's medication orders, I didn't consider the route for morphine, because it was such a small dose. The medication could have been given by another route besides orally. The medication was never given, but I understand it was a near miss and was an error and the Employee acknowledged the finding.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, for two (2) of 12 sampled residents, facility staff failed to follow infection control policies and procedures for residents on Enhanced Barrier Precautions (EBP). Residents' #9 and #12The findings included:A facility policy Infection Prevention and Control Policy dated January 2025 documented:- Standard and transmission-based precautions are to be followed to prevent the spread of infections.1. Resident #9 was admitted to the facility on [DATE] with multiple diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Gastrostomy Status, and Aphasia. Review of the resident's medical record showed the following:A care plan focus area: [Resident #9] is on Enhance Barrier Precautions (EBP) last reviewed on 04/11/25 that had interventions that included, use Enhanced Barrier Precautions: use of gown and gloves only for high-contact resident care activities due to G (gastrostomy) tube, Foley [Catheter] and wounds.A physician's order dated 05/29/25 directed, Use Enhanced Barrier Precautions: Use of gown and gloves only for high-contact resident care activities due to G (gastrostomy) tube, Foley [Catheter] and wounds, every day shift.During an observation on 06/23/25 at 10:33 AM, there was a Enhanced Barrier Precautions sign posted at the door of Resident #9's room that documented, Providers and staff must wear, gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use - urinary catheter, feeding tube . Upon entering the resident's room, Employee #8 (Certified Nursing Assistant/CNA) was observed bathing the resident and not wearing a gown. It should be noted the employee was wearing a face mask and gloves. When asked if she was aware that Resident #9 is on Enhanced Barrier Precautions, she stated, Yes. When asked why she is not wearing a gown while bathing Resident #9, she stated, I forgot.The evidence showed that Employee #8 failed to follow infection control policies and procedures for Resident #9 who was on Enhanced Barrier Precautions.During a face-to-face interview on 06/25/25 at 1:50 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated that education will be provided. 2. Resident #12 was admitted to the facility on [DATE] with diagnoses that included: Bilateral above the knee amputations, Chronic Obstructive Pulmonary Disease COPD, Gout, Osteoarthritis, Hypertension, Benign Prostatic Hyperplasia (BPH), Urinary retention, and Dysphagia.During an initial tour on 06/23/25 at 10:25 AM, on the outside of Resident #12 room beside the door entrance was a sign that read: Enhanced Barrier Precautions Everyone must: Clean their hands; including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following high-contact resident care activities: dressing; bathing/showering, transferring; changing linens, providing hygiene, changing briefs or assisting with toileting . Inside of the room Employee # 5 (Certified Nurse's Aide/CNA) was observed at Resident #12's bedside. The Resident was laying supine with the bed raised. Beside the bed on the bedside table was a basin of soapy water with a washcloth. Employee #5 was wearing gloves and was drying Resident#12 with a towel. The Employee then put a clean gown on the Resident. She then poured out the dirty water in the Resident's sink, removed her gloves, washed her hands, placed the dirty towel and wash cloth in a dirty linen bag that was in the resident's room. The Employee then exited the Resident's room carrying the dirty linen bag and placed the bag in the soiled linen room. From 06/16/25 to 06/25/25, the facility was in a COVID-19 outbreak status and all staff and visitors were instructed to wear face masks in residential care areas during this time period.A review of Resident #12's medical record showed:A significant change minimal data (MDS) set assessment dated [DATE] that documented that the Resident had upper and lower extremity impairments on both sides, was dependent on staff for bathing and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal hygiene and had one Stage IV pressure ulcer that was present upon admission.During a face-to-face interview on 06/23/25 at 10:53 AM, Employee #5 (Certified Nurse Assistant/CNA) when asked what the proper PPE was for bathing a resident on enhanced barrier precautions (EBP), responded that staff should wear a gown and gloves. When asked when she had been educated on proper PPE for staff caring for residents on EBP the Employee responded that she could not remember and provided no explanation for not wearing a gown when bathing Resident #12. During a face-to-face interview on 06/23/25 at 10:31 AM, Employee #4 (Licensed Practical Nurse/1st Floor Resident Clinical Coordinator), stated that all the CNAs had been educated during orientation and at least annually via the Shared Nursing Leadership (a computer -based education/ training program). She then acknowledged that Employee #5 should have been wearing gloves, a gown while bathing Resident #12 and stated that she would immediately provide a reminder/in-service for all staff to wear proper PPE for all residents on any type of precaution on the unit.Cross Reference 22B DCMR Sec. 3217.6