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	03/12/2026

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Number of residents sampled: Number of residents cited: Based on observations and staff interviews, for 49 of 49 sampled residents/and or their representatives, the facility staff failed to: 1) post the results of its most recent survey in a place readily accessible to residents, family members, and resident representatives and 2) have reports from the three preceding years, including certification surveys, complaint investigations, and any plan of correction in effect with respect to the facility available upon request for any individual to review. The findings included: During an observation and interview on 03/09/26, at approximately 10:10 AM with Employee #3 (Front Desk Receptionist), the surveyor observed the Employee behind the front desk of the facility's front entrance. When asked where the facility kept the most recent State Agency survey results, the employee responded, while looking around on top of her desk and on top of the black cabinets behind her chair, she stated, I am not sure where they keep them, but I can call the Administrator to find out. During a second observation on 03/09/26 at 10:19 AM, the surveyor observed a binder placed in a plastic binder holder attached to a wall across from the front entrance reception desk. On the outside of the binder was a sign on the Facility's letterhead that read, Entrance Survey Results Book. Please Do Not Remove. The binder had four subject tabs labeled for four surveys. Under the first tab was the survey results and a page that read, CMS 2567 & State Form Recertification, and Annual Licensure Survey Conducted 08/05/22. Under the second tab labeled, State, were the survey results for the licensure survey conducted on 08/05/22. Under the third tab labeled Emergency Preparedness and Life Safety Code Survey, were the emergency preparedness and life safety survey results conducted on 08/09/22, and under the fourth tab labeled Federal Comparative Life Safety Code Survey, were the results of the comparative federal life safety code survey conducted on 09/27/22. There were no recent state or federal surveys in the binder. During a face-to-face interview on 03/09/25 at 10:35 AM, Employee #1 (Administrator) stated that all current survey reports should be kept in a binder across from the front desk. At approximately 11:00 AM, Employee #1 returned and acknowledged that the facility did not have the most recent survey reports available in the binder at the front desk but stated that the binder would be updated as soon as possible.During a Resident Council meeting on 03/09/25 at 2:00 PM, when asked whether the results of the State inspections were available to read without having to ask, the Residents did not know that they were available or where to find them. During the time of the observations and resident and staff interviews, there was no evidence that the facility had posted the results of its most recent survey in a place readily accessible to residents, family members, and resident representatives. In addition, the facility failed to have available, upon request, its survey reports, including certification surveys, complaint investigations, and any plan of correction in effect for the three preceding years, for review by any individual, and failed to have the reports in areas easily accessible to the public. On 03/10/25 at approximately 1:30 PM, Employee #1 stated that the binder had been updated to include the most recent surveys and all surveys conducted in the prior three years.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, facility staff failed to maintain a safe environment for the residents.The findings included:During the initial kitchen walkthrough on 03/02/ 2026 approximately at 11:15 AM, a damaged dry wall and missing base board were observed in the dry storage room.During a face-to-face interview on 03/02/2026, approximately at 11:15 AM, the above observation was acknowledged by Employee #14, Food Service Manager.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility staff failed to develop effective discharge planning for one (1) of 49 sampled residents whose record showed discharge upon hospitalization. (Resident #188) Resident#188 was admitted on [DATE] 22:28 with diagnosis of fluid overload, hypertension, Skin ulcer of right heel and with Necrosis of muscles, Dementia, Heart failure with reduced ejection fraction, and iron deficiency Anemia. A review of her medical record on 3/6/2026 showed the following progress notes: Date: 01/23/2026 07:24 Type: Nurses Notes: Resident received in bed awake with hypotensive, high fever, altered mental status, lethargy but alert, no SOB or distress noted, V/S- 90/58, HR-102, RR-18, Temp- 101.5, SPO2-97%RA. MD made aware new order given, Transfer to nearest ER [emergency room] for further evaluation. 911 called and resident RP [name] notified of the situation and the plan of care. Further review of progress notes dated 01/23/2026 16:18 showed Hospitalization listing the hospital as the resident's discharge location. A review of Care plan on 03/10/2026 showed Resident #188's care plan was closed on 02/10/2026, the reason listed read discharged . It should be noted there was no documented evidence of discharge planning in the resident's medical record and no additional information related to discharge planning subsequent to the resident's hospitalization. A face-to-face interview conducted on 03/11/2026 with Employee#2 [Director of Nursing] stated that the patient was discharged . The findings were acknowledged when there was no documented discharged reason with location for the resident discharge.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of 49 sampled residents, the facility staff failed to initiate discharge planning for one resident expressed a desire to return to the community. Resident #30. The findings included . Resident #30 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection, Epididymitis, Hydronephrosis, Muscle Weakness, Calculus in Ureter, Retention of Urine, Dysphagia Oral Phase, Abnormalities of Gait, Obstructive and Reflux Uropathy, Hypertension, Hyperlipidemia, and Adjustment Disorder with Mixed Anxiety and Depressed Mood.Review of the Minimum Data Set (MDS) dated [DATE] indicated the resident had a BIMS score of 12, indicating the resident has some level of cognition impairment.The MDS also documented the resident's overall goal was discharge to the community.Review of the medical record lacked documented evidence of discharge planning outlining the resident's anticipated discharge destination, services needed after discharge, or coordination with community providers.During a face-to-face interview on 3/5/2026 at approximately 2:20 PM, Resident #30 stated, I want to get the hell out of here; I want them to remove this thing [referring to the indwelling catheter he had on] and get the hell out here.During a face-to-face interview on 3/5/2026 at approximately 3:00 PM, Employee #6, Social Services Director, stated that discharge plans are typically documented in the progress notes and discussed during the Interdisciplinary Team (IDT) meeting, usually initiated within 7-10 days after admission. Employee #5 added that discharge planning includes determining equipment needs, anticipated discharge date , and contacting community agencies.Employee #6 further stated that Resident #30 does not have a place to go after discharge and that an application had been submitted to the Department of Aging for assisted living placement. However, Employee #6 acknowledged that communication with the resident regarding the discharge planning process had not been documented in the medical record, stating, I communicated with the resident, but it is not documented.Review of the Social Services progress notes dated 2/16/2026 documented: IDT meeting was conducted with resident. Resident was alert and oriented. Resident was in a bad mood and didn't have any questions or concerns. , but no discharge plan, anticipated discharge location, or post-discharge services were documented.During a face-to-face interview on 3/12/2026 at approximately 11:05 AM, Employee #2, Director of Nursing (DON) stated that discharge planning begins at admission and is followed-up during IDT meetings, and that discharge planning information should be documented in the electronic medical record (PointClickCare) under social services progress notes.Despite these statements, review of the medical record revealed no documented discharge plan for Resident #30, including anticipated discharge destination, post-discharge services, or documented communication with the resident regarding discharge planning, despite the resident's stated goal to discharge to the community and his expressed desire to leave the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interview for one (1) of 49 sampled residents, the facility staff failed to accurately code a Resident as receiving opioids on a quarterly MDS assessment. Resident #185The findings included:Resident #185 was admitted to the facility on [DATE] with diagnoses that included: Hypertension, Cerebral Vascular Accident with Left- sided Residual Deficit, Atrial defibrillation, Parainfluenza, Epilepsy, Type 2 Diabetes Mellitus, Vascular Dementia, and Schizophrenia. A review of Resident #185's medical record revealed the following: A physician's order dated 11/17/25 at 2:00 PM that directed: Tramadol HCl Oral Tablet 50 mg (milligrams) (Tramadol HCl). Give 1 tablet by mouth every 8 hours for pain. The physician's order was discontinued on 01/29/26.A physician's order dated 01/30/26 at 12:00 AM, that directed Tramadol HCl Oral Tablet 50 mg (milligrams) (Tramadol HCl). Give 1 tablet by mouth every 8 hours for pain. The physician's order was discontinued on 03/10/26.A physician's order dated 03/11/26 at 9:00 AM that directed: Tramadol HCl Oral Tablet 50 mg (milligrams) (Tramadol HCl). Give 1 tablet by mouth every 8 hours for pain.A quarterly minimum data set (MDS) dated [DATE] MDS showed that Resident #185 was taking the following medications: an antidepressant, an anticoagulant, a hypoglycemic, and an anticonvulsant. Of note, the MDS assessment did not show that the resident was taking opioids for pain.A review of Resident #185's medication administration (MAR) records from November 17, 2025, to March 10, 2026, showed that facility staff administered Tramadol HCl Oral Tablet 50 mg one tablet by mouth every 8 hours for low back pain.During a face-to-face interview on 03/04/26 at 2:42 PM, Employee #5, MDS Coordinator, acknowledged the finding and stated, It was overlooked. I will correct it now.

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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, observations, and staff interviews, the facility failed to ensure a PASARR Level II evaluation was completed for one (1), who had a diagnosis of Bipolar Disorder, of 49 sampled residents. (Resident #50)Findings Include:Resident #50 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Neurosyphilis, Hypothyroidism, Displaced Intertrochanteric Fracture of the Right Femur, Muscle Weakness, Cognitive Communication Deficit, Anemia, Essential Hypertension, Osteoarthritis, and Tobacco Use.A review of the Minimum Data Set (MDS) Quarterly assessment dated [DATE] indicated: BIMS score: 15, indicating the resident was cognitively intact and able to participate in care planning. The resident was assessed for mood symptoms, include: little interest or pleasure in doing things, feeling down, depressed, or hopeless, feeling tired or having little energy. The resident had impairment of both lower extremities and used a wheelchair for mobility.Self-care performance was coded as: Eating and Oral Hygiene - setup or clean-up assistance; Upper Body Dressing - supervision or touching assistance; Toileting Hygiene, Shower/Bathe Self, Lower Body Dressing, Putting On/Taking Off Footwear, Personal Hygiene - dependentThe resident was coded as always incontinent with bladder and bowel.A review of the resident's medical diagnosis list confirmed Bipolar Disorder was documented at the time of admission.A review of the care plan initiated 04/14/2025 documented: Focus: [Resident #50] has diagnosis of Bipolar Disorder, Goal: Resident will demonstrate more mood stability with fewer episodes of mania/depression, Intervention: Staff will encourage the resident to maintain treatment and medication compliance to establish stable and consistent mood.On 03/02/2026 at approximately 2:30 PM, Resident #50 was observed lying in bed with no acute signs of distress but stated, I am too young to be like this, to be a resident here.On 03/11/2026 at approximately 1:05 PM, the resident was observed lying in bed watching television after finishing lunch with no acute distress. The resident stated, It is very boring here. I have watched more TV in here than my entire past life. The resident expressed unhappiness about staying in the facility.A review of the PASARR Level I screening dated 04/14/2025 documented in part: .beneficiary has negative screen for ID or related conditions, and no further action is necessary.However, a review of ePASARR submissions dated 05/21/2025 and 03/11/2026 documented in part: .beneficiary has a positive screen for serious mental. and indicated a possible positive screen for serious mental illness that was submitted to the Department of Health Care Facilities (DHCF).There was no evidence in the resident's medical record that a PASARR Level II evaluation was completed despite the documented diagnosis of Bipolar Disorder.During a face-to-face interview on 03/12/2026 at approximately 1:30 PM, Employee #6 (Social Services Director) stated that he does not complete PASARR screenings and that Employee #9 (Business Office Manager) handles the process. He further stated that a psychiatric company evaluates residents and based on that evaluation he believed the PASARR process is completed. Employee #6 also stated that Resident #50 often expresses anger about life.During a face-to-face interview on 03/12/2026 at approximately 2:05 PM, Employee #10 (Business Office Manager) explained that when a resident is admitted , a psychiatric doctor evaluates the resident within 30 days, and Employee #10 reviews the psychiatric note for mental illness diagnoses. If a mental illness diagnosis is present, Employee #9 then files an ePASARR with Teligent (psych. evaluation company name) for further screening. Employee #10 stated further that Teligen determines whether the resident requires a PASARR Level II evaluation. She added she received training from the Department of Behavioral Health on filing ePASARR.

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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 record review, observation, and staff interviews, the facility failed to develop and/or implement a comprehensive care plan interventions to address one resident's documented allergies and the application of dentures for another resident in two (2) of 49 sampled residents. (Resident #49 and #199).Findings include: Resident #49 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection, Convulsions, Todd's Paralysis (Postepileptic), Dysphagia, Hypertension, Acute Kidney Failure, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side, Acute Embolism and Thrombosis of Deep Veins of Lower Extremity, Muscle Weakness, Altered Mental Status, Morbid Obesity, and Age Related Nuclear Cataract. A review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #49 had a BIMS score of 14, indicating the resident was cognitively able to participate in the care decisions. A review of the Physician History and Physical dated 02/25/2026 revealed Resident #49 had documented allergies to Motrin and Tuna. A review of the resident's comprehensive care plan revealed there was no care plan developed to address the resident's allergies (Tuna and Motrin). During an observation on 03/02/2026 at approximately 11:25 AM, Resident #49 was observed lying in bed and stated she was allergic to Tuna. Resident #49 stated she believed the facility was providing her food that had tuna in it and because of that she was experiencing some allergic reaction on her face, a rash on her face. The resident showed no signs of distress at the time of observation. During a face-to-face interview on 03/10/2026 at 11:55 AM, Employee #7 (RN, 1st Floor Unit Manager) stated she believed that the Tuna allergy for Resident #49 was listed on the resident's meal ticket, but she needed to verify this information with the food operation department. During a face-to-face interview on 03/10/2026 at approximately 2:50 PM, Employee #8 (Dietician) stated that residents' food preferences are entered into the facility's dining manager electronic system, which generates information that appears on residents' meal tickets. Employee #8 further stated that food preferences are obtained during the initial assessment and baseline care plan development and are reviewed every three (3) months and revised as needed based on health conditions, physician orders, and resident preferences, with documentation in care plan and dietician progress notes. During a face-to-face interview on 03/09/2026 at approximately 3:10 PM, Employee #9 (RN Charge Nurse, 1st Floor) stated she had never heard Resident #49 complain about food allergies, but she knew the resident was allergic to Tuna because she completed the admission assessment. Employee #8 also stated that the resident's granddaughter visited the day prior, and when asked if there were any unmet needs for her grandmother, she did not express any concerns. During a face-to-face interview on 03/09/2026 at approximately 3:30 PM, Employee #2 (Director of Nursing) stated that medication and food allergies should be assessed and documented in the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's record during admission. Employee #2 further stated she was not aware of any complaint from Resident #49 related to allergies. During a face-to-face interview on 03/10/2026 at 3:00 PM, Employee #2 stated that the resident should have a care plan addressing her allergies. Employee #2 further stated that the care plan for allergies was developed and added to the resident's comprehensive care plan on the same day (03/10/2026). The facility failed to ensure Resident #49's documented allergies were addressed in the comprehensive care plan until after the surveyor inquiry. 2. Resident #199 was admitted to the facility on [DATE] with diagnoses that included: Dysphagia Following Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Autonomic (Poly)Neuropathy, Heart Failure, Primary Open-Angle Glaucoma, Major Depressive Disorder, Morbid (Severe) Obesity and Generalized Muscle Weakness. During an initial tour observation and face-to-face interview on 03/03/26 at 11:00 AM, Resident #199 was observed awake, lying in her bed, watching television. Next to the head of the bed on the right side was a night table with the Resident's belongings and a denture cup. When asked if the Resident required staff assistance during oral care, the Resident stated, Yes, they help me rinse my mouth and put my dentures in, but I have not been wearing them lately. They don't fit right, and when I try to wear them, they hurt. I need to get new ones. When asked if the facility was aware, the Resident stated, Yes, I just saw the dentist a few months ago and got these dentures because I lost my old ones, but they don't fit right. Resident #199 was admitted to the facility on [DATE] with diagnoses that included: Dysphagia Following Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Autonomic (Poly)Neuropathy, Heart Failure, Primary Open-Angle Glaucoma, Major Depressive Disorder, Morbid (Severe) Obesity, and Generalized Muscle Weakness. During an initial tour observation and face-to-face interview on 03/03/26 at 11:00 AM, Resident #199 was observed awake, lying in her bed, watching television. Next to the head of the bed on the right side was a night table that had the Resident's belongings and a denture cup sitting on top of it. When asked if the Resident required staff assistance during oral care, the Resident stated, Yes the help me rinse my mouth, and help me put my dentures, but I have not been wearing them lately. They don't fit right, and when I try to wear them, they hurt. I want to get new dentures so I can eat other foods. When asked if the facility was aware of the Resident's concern with the dentures, the Resident stated, Yes, I just saw the dentist a few months ago and got these new dentures. I lost my old ones, but these new dentures don't fit right. During an observation on 03/05/26 at 3:22 PM Resident #199 was observed awake, lying in her bed watching television. The resident was not wearing dentures. When asked if any staff had assisted her with her dentures, she said, No, as I said before they hurt.During an observation on 03/11/26 at 9:46 AM, Resident #199 was observed awake, lying in her bed, watching television. The resident was not wearing dentures. When asked if any of the nursing staff offered to schedule an appointment with the dentist to get the dentures fixed, the Resident stated, No. A review of Resident #199's medical record revealed the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 12/17/19 at 6:39 PM that directed: Consults: Dental consult and treat as needed. A physician's order dated 11/09/20 at 4:33 PM that directed: Schedule resident for General Dental for dentures [Name of Local Hospital] after teeth extraction. A physician's order dated 12/11/23 10:45 AM that directed: Dentures -Every day shift for dentures rinse and apply every morning and every evening shift for denture, remove denture, rinse and place in denture cup.Three (3) physician's order dated 11/11/24 at 3:00 PM that directed: Dentures- Assist/encourage resident to place full upper& lower dentures on during AM care 7-3 shift and off during PM care 3-11 shift, Check dentures for fitness while the resident is awake, and Check linens, waste basket, meal trays, and dishes for dentures before discarding if missing.A physician's order dated 11/11/24 at 8:00 PM that directed: Assist/encourage resident to wash dentures and place in denture and place in denture tablet at bedtime. A care plan initiated on 09/17/24 that documented: [Name of Resident #199] has impaired dentition r/t (related to) using denture(s). Goal: [Name of Resident #199] has clean teeth, healthy gums, and a mouth until the next review date. Interventions: Assess and document resident's ability to perform dental care, assist if needed; Dental consult per facility policy and prn; Modify diet for ease/comfort of oral intake prn (as needed), Monitor oral intake; Assist/encourage resident to place full upper and lower dentures on during AM care 7-3 shift and off during PM care 3-11 shift;. Assist/encourage resident to wash dentures and place in denture tablet at bedtime; Check dentures for fitness while resident is awake; Check linens, wastebasket, meal trays, and dishes for dentures before discarding if missing. A quarterly Minimum Data Set (MDS) assessment dated 12/22//25 which documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resident had intact cognition, hand upper extremity impairments on both sides, and required substantial maximal assistance with oral hygiene which included the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. A review of Resident #199's Treatment Administration Records (TAR) from 03/01/26 to 03/11/26, showed that facility staff documented that per physician orders, they were: assisting/encouraging the resident to place full upper and lower dentures on during AM care [7-3 shift]; assisting the Resident to remove during PM care [3-11 shift]; checking dentures for fitness while resident was awake, and assisting/encouraging the Resident to wash the dentures and place them the denture cup at bedtime. Of note on: 03/03/26 at 11:00 AM, 03/05/26 at 3:22 PM, and 03/11/26 at 9:46 AM, Resident #199 was observed not wearing her dentures. During a face-to-face interview on 03/10/26 at 3:31 PM, Employee #20 /Evening shift Certified Nurse Assistant, when asked if she had ever assisted Resident #199 with removing and rinsing her dentures, she stated, That might be something the nurses or day shift CNA does, because I didn't even know she had dentures. I have never seen her wearing dentures. Based on observations, record reviews, and interviews, the facility staff showed no evidence that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they implemented Resident #199's dental care plan interventions. During a face-to-face interview on 03/11/26 at 1:58 PM, Employee #19 (Registered Nurse/Unit Manager), stated that Resident #199 had a dental care plan with interventions that included assisting the Resident with her dentures. When asked if she was aware of any issues or concerns that Resident ##199 had with her dentures fitting properly, the Employee stated, No. Employee #19 then went to Resident#199's room and observed the Resident with no dentures in her mouth. Employee #19 asked Resident#199 why she was not wearing her dentures. The Resident replied that they did not fit right and hurt, so she had not been wearing them for a few months.Employee #19 commented further that no one, including the Resident, made her aware that the Resident's dentures were not fitting properly. When asked if the nursing staff had: assisted/encouraged the Resident to place full upper and lower dentures on during AM care [7-3 shift]; assisted the Resident to remove during PM care [3-11 shift]; checked the Resident's dentures for fitness while the Resident was awake, and assisted/encouraged the Resident to wash the dentures and place them in the denture cup at bedtime, or helped the Resident to obtain a dental consult per the Resident's dental care plan interventions, Employee #19 stated, I will put in for a dental consultation now. The Employee then acknowledged the findings and made no further comment.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff and resident interviews, the facility staff failed to implement and document individualized one-to-one (1:1) activity sessions for a bed-bound resident in accordance with the resident's care plan and assessed needs for one (1) of 49 sampled residents. (Resident #34). Findings include:Resident #34 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Osteomyelitis of Vertebra Sacral and Sacrococcygeal Region, Stage 4 Sacral Pressure Ulcer, Generalized Muscle Weakness, Oropharyngeal Dysphagia, Moderate Protein-Calorie Malnutrition, Cognitive Communication Deficit, and Monoclonal Gammopathy.Review of the Minimum Data Set (MDS) dated [DATE] indicated the resident had minimal hearing difficulty with hearing aid use, BIMS score of 14 indicated the resident was cognitively intact, was dependent on staff for toileting hygiene, shower/bathe self, upper body and lower body dressing and putting on/taking off footwear, used wheelchair for mobility, and reported little interest or pleasure in doing things, indwelling catheter and frequently incontinent bowel.Review of the care plan, revised on 03/05/2025, documented in part:Focus: The resident is dependent on staff for activities, cognitive stimulation, and social interaction related to physical limitations.Goal: The resident will attend or participate in activities of her choice weekly by the next review date.Interventions: Invite the resident to scheduled activities. Provide 1:1 bedside or in-room activities if unable to attend group activities. Provide an activities calendar and notify the resident of any changes. Staff to converse with the resident during care and encourage engagement in activities.During an observation on 03/04/2026 approximately at 1:00 PM, Resident #34 was observed lying in bed with no signs of distress. The activities calendar was posted on the wall behind the head of the resident's bed.During an observation on 03/09/2026 approximately at 10:55 AM, Resident #34 was observed sitting in her wheelchair while being wheeled out of her room by the unit manager for a doctor's appointment. No signs of distress were noted.Review of the activities task documentation from 02/05/2026 through 03/05/2026 revealed that the resident received only two documented 1:1 activity sessions, on 02/19/2026 and 03/02/2026, despite the care plan indicating weekly participation.Review of progress notes from 02/02/2026 through 03/06/2026 revealed limited documentation from activities department and did not demonstrate consistent provision of 1:1 activity session. Documentation included:02/25/2026 at 12:32 PM: Resident was greeted for social daily visits.02/20/2026 at 10:39 AM: Resident had mail dropped off and daily morning social visit.02/19/2026 at 11:03 AM: Resident brother paid her a visit.These entries did not reflect provision of structured 1:1 activity sessions as included in the resident's care plan and assessed needs.During a face-to-face interview on 03/04/2026 at 1:00 PM, Resident #34 stated she was not aware the activities calendar was posted in the room. Additionally, the resident said, I really don't know the activities process. I am bedridden. For example, I didn't know about the Thanksgiving party until a Certified Nursing Aide (CNA) told me.During a face-to-face interview on 03/06/2026 at 10:00 AM, Employee #18 (Activities Director) stated that residents with physical limitations who cannot attend group activities receive 1:1 activities, such as painting or watching movies. The Activities Director stated that 1:1 activities should be conducted weekly for residents with physical limitations and that documentation of activities had not been consistently done prior to their starting work at the facility two months ago, but that they now document activities in progress notes.During a face-to-face interview on 03/06/2026 at 11:10 AM, Employee #2 (Director of Nursing) stated residents are provided with an activities calendar and nursing staff remind residents about activities as part of the morning routine. The DON further stated that residents unable to attend group activities should receive bedside activities such as coloring or other engagement from staff and activities personnel.Despite these statements, the facility failed to consistently provide and document weekly 1:1 activity sessions for Resident #34 in accordance with the resident's care plan and assessed needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews for two (2) of 49 sampled residents, it was determined that the facility staff failed to follow physician orders for splint placement for one resident with a contracture and failed to consistently assist one resident with the application of dentures. (Residents #5 and #199) The findings included: Resident #5 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia with Psychotic Disturbance, Seizure Disorder and Colostomy. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'Modified Independence,' had a history of Dementia and had impairment on both sides to upper and lower extremities. A physician's order dated 12/31/25 documented, in part: FMP (functional maintenance program); Splint; Patient will wear the left elbow extension splint in LUE (left upper extremity) for 3 hours. A care plan dated 01/16/26 documented, in part: Focus: [Resident #5's name] Requires to wear the left elbow extension splint in LUE (left upper extremity) for 3 . INTERVENTIONS: check extremities with splints/prosthesis/brace every shift to ensure adequate circulation. report abnormalities to MD (medical doctor); Check skin beneath and adjacent to splint for pressure or irritation q (every) day. During an initial observation conducted on 03/02/26 at approximately 9:30 AM, the resident was noted to be lying in bed with a splint in place to his left arm. During a follow-up observation conducted on 03/02/26 at approximately 3:20 PM, the resident was noted with the left arm splint still in place. During a face-to-face interview conducted on 03/12/26 at 11:54 AM with Employee #4 (Restorative Aide/Certified Nursing Assistant) she stated that, We remove it [the splint] but it's not documented that we remov[ed] it. We put [the splint] on between 7 to 8 (7:00 AM and 8:00 am) then go back to remove it between 1-2pm (1:00 PM and 2:00 PM) every day except Sundays. We get the order from Rehab, with the order of how long to wear it. Rehab put the splint on first then we follow the order. It should be noted that Employee #4 was unaware of the length of time that splint for Resident #5 should be in place as ordered by the physician. 2. Resident #199 was admitted to the facility on [DATE] with diagnoses that included: Dysphagia Following Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Autonomic (Poly)Neuropathy, Heart Failure, Primary Open-Angle Glaucoma, Major Depressive Disorder, Morbid (Severe) Obesity, and Generalized Muscle Weakness. During an initial tour observation and face-to-face interview on 03/03/26 at 11:00 AM Resident #199 was observed awake, lying in her bed watching television. Next to the head of the bed on the right side was a night table that had the Resident's belongings and a denture cup sitting on top of it. When asked if the Resident required staff assistance during oral care, the Resident stated, Yes, they help me rinse my mouth, and help me put my dentures, but I have not been wearing them lately. They don't (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fit right, and when I try to wear them, they hurt. I want to get new dentures so I can eat other foods. When asked if the facility was aware of the Resident's concern with the dentures, the Resident stated, Yes, I just saw the dentist a few months ago and got these new dentures. I lost my old ones, but these new dentures don't fit right. During an observation on 03/05/26 at 3:22 PM Resident #199 was observed awake, lying in her bed watching television. The resident was not wearing dentures. When asked if any staff had assisted her with her dentures, she said, No, as I said before they hurt. During an observation at 03/11/26 at 9:46 AM, Resident #199 was observed awake, lying in her bed watching television. The resident was not wearing dentures. When asked whether any of the nursing staff offered to schedule an appointment with the dentist to get the dentures fixed, the Resident stated, No. A review of Resident #199's medical record revealed the following: Three (3) physician's order dated 11/11/24 at 3:00 PM that directed: Dentures- Assist/encourage resident to place full upper& lower dentures on during AM care 7-3 shift and off during PM care 3-11 shift, Check dentures for fitness while the resident is awake, and Check linens, waste basket, meal trays, and dishes for dentures before discarding if missing. A physician's order dated 11/11/24 at 8:00 PM that directed: Assist/encourage resident to wash dentures and place in denture and place in denture tablet at bedtime. A care plan initiated on 09/17/24 that documented: [Name of Resident #199] has impaired dentition r/t (related to) using denture(s). Goal: [Name of Resident #199] has clean teeth, healthy gums, and mouth until the next review date. Interventions: Assess and document resident's ability to perform dental care, assist if needed; Dental consult per facility policy and prn; Modify diet for ease/comfort of oral intake prn (as needed), Monitor oral intake; Assist/encourage resident to place full upper and lower dentures on during AM care 7-3 shift and off during PM care 3-11 shift;. Assist/encourage resident to wash dentures; place dentures in denture tablet at bedtime; check dentures for fit while resident is awake; check linens, wastebasket, meal trays, and dishes for dentures before discarding if missing. A quarterly Minimum Data Set (MDS) assessment dated 12/22//25 which documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of 15, indicating that the resident had intact cognition, hand upper extremity impairments on both sides, and required substantial maximal assistance with oral hygiene which included the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. A review of Resident #199's Treatment Administration Records (TAR) from 03/01/26 to 03/11/26, showed that facility staff documented that per physician orders, they were: assisting/encouraging the resident to place full upper and lower dentures on during AM care [7-3 shift]; assisting the Resident to remove during PM care [3-11 shift]; checking dentures for fitness while resident was awake, and assisting/encouraging the Resident to wash the dentures and place them the denture cup (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at bedtime. Of note on: 03/03/26 at 11:00 AM, 03/05/26 at 3:22 PM, and 03/11/26 at 9:46 AM, Resident #199 was observed not wearing her dentures. During a face-to-face interview on 03/10/26 at 3:31 PM Employee #20 /Evening shift Certified Nurse Assistant, when asked if she had ever assisted Resident #199 with removing and rinsing her dentures, she stated, That might be something the nurses or day shift CNA does, because I didn't even know she had dentures. I have never seen her with dentures. Observations of Resident #199 and resident and staff interviews, showed no evidence that nursing staff implemented Resident #199's care plan, which included assisting the Resident with applying and removing her dentures. During a face-to-face interview on 03/11/26 at 1:58 PM, Employee #19 (Registered Nurse/Unit Manager), stated there were physician orders for the Resident #199's dentures and a dental care plan with interventions for the Resident's dentures. When asked if she was aware of any of issues or concerns that Resident #199 had with wearing her dentures, the Employee replied, No. Employee #19 then went to Resident#199's room. Employee #19 observed Resident #199 awake, lying in bed, watching her television. The resident was not wearing dentures. Employee #19 asked the Resident why she was not wearing her dentures. The Resident replied that they did not fit right and hurt, so she had not been wearing them for a few months. Employee #199 stated that no other nursing staff reported that Resident #199's dentures were not fitting properly. When asked how that was possible if the nurses had been following the physician's orders and the Resident's dental care plan interventions, The Employee then acknowledged the findings and made no further comment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that irregularities identified during the consultant pharmacist's Medication Regimen Review (MRR) were reported, acted upon, and/or implemented in a timely manner for four (4) of 49 sampled residents. (Residents #4, #5, #19 and #7) Resident #4 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease, Hypertension, Diabetes Mellitus, Hyperlipidemia, Osteoarthritis, Dementia with psychotic disturbance, Paranoia Schizophrenia, Depression, and Anxiety. A review of the Physician Medication orders showed Resident #4 is currently taking the following medication. Clonazepam 0.5mg for Anxiety Mirtazapine 15 mg for Depression Olanzapine 20mg for Paranoid Schizophrenia Amlodipine 10mg for HTN Donepezil 10mg for Dementia Metoprolol 25mg for HTN Hydralazine 100mg for HTN Gabapentin 300mg for Neuroleptic pain Eliquis 5mg for Chronic embolism and Thrombolysis in right leg Ezetimibe 10mg for Hyperlipidemia Toujeo Solostar 300-unit pen injector for DM Voltaren Arthritis topical Gel for pain A review of the Pharmacist drug regimen review (DRR) documentation in e-chart showed reviews were conducted on the following dates [1/26/26, 1/25/26, 3/14/26, 3/9/26, 9/3/25, 6/25/25 2/5/25, 2/4/25, 2/1/25]. the pharmacist recorded three (3) irregularities, dated [9/3/25 ,1/25/2026, and 3/4/2026] and the physician/advanced practice nurse response was recorded as I agree, however the response did not include what action was to be taken for the irregularities. Additionally, there was no documented evidence that the Pharmacist drug regimen review was conducted monthly. A face-to-face interview conducted on 03/11/2026 with Employee# 2 [Director of Nursing] reviewed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's records and acknowledged the lack of monthly reviews and complete responses to the DRR. 2. Resident #5 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia with Psychotic Disturbance, Seizure Disorder and Colostomy. A physician's order dated 6/10/25 documented, Memantine HCl (Hydrochloride) Oral Tablet 10 MG (milligram) (Memantine HCl) Give 1 [one] tablet by mouth two times a day for Dementia. A physician's order dated 6/10/25 documented, QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for Agitation. A physician's order dated 6/26/25 documented, Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 capsule[s] by mouth three times a day for Dementia w/(with) behavioral disturbances give with food. A care plan dated 06/25/25 documented, in part: Focus: [Resident #5's name] uses psychotropic medications r/t (related to) Disease process (DEMENTIA WITH PSYCHOTIC DISTURBANCE) . Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Discuss with MD, family re[[NAME]] ongoing need for use of medication. Educate his family about risks, benefits and the side effects and/or toxic symptoms of psychoactive medication drugs being given. Monitor/record/report to MD (medical doctor) prn (as needed) side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'Modified Independence,' the resident had a history of Dementia and was prescribed antipsychotic medications. A review of Resident #5's medical record conducted on 03/11/26 at approximately 9:30 AM revealed that there was no documented evidence of monthly drug regimen reviews conducted for the following months: March 2025, April 2025, May 2025, August2025 and September 2025. 3. Resident #19 was admitted to the facility on [DATE] with multiple diagnoses that included: Schizophrenia with Psychotic Disorder. A physician's order dated 11/25/25 documented, Abilify Oral Tablet 2 MG (Aripiprazole) Give 1 tablet by mouth one time a day for schizophrenia. A care plan dated 11/26/25 documented, in part: Focus: [Resident #19's name] uses psychotropic medications r/t (related to) schizophrenia . Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of (psychotropic medication drugs being given). Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. A care plan dated 12/16/25 documented, in part: Focus: [Resident #19's name] is at risk for adverse reaction r/t POLYPHARMACY . Interventions: Discuss with resident and family the number and type of medications resident is taking and the potential for drug interactions and side effects from over-medication. Monitor for possible signs and symptoms of adverse drug reaction: falls, weight loss, fatigue, incontinence, agitation, lethargy, confusion, agitation, depression, poor appetite, constipation, gastric upset. Request physician to review and evaluate medications. Review Pharmacy consult recommendations, and follow up as indicated. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '13,' indicating the resident was cognitively intact, had a history of Schizophrenia with psychotic disturbance and was prescribed antipsychotic medications. A review of Resident #19's medical record conducted on 03/11/26 at approximately 9:30 AM revealed that there was no documented evidence of monthly drug regimen reviews conducted for the following months: August 2025 and September 2025. During a face-to-face interview conducted on 03/11/26 at approximately 10:20 AM with Employee #2 (Director of Nursing) she acknowledged the findings and stated, in part that If it's medication changes, then it's the Unit Managers and the Charge Nurse who updates the order if the provider agrees and then the reviewed pharmacy recommendation is placed back into the binder to be uploaded in the miscellaneous tab under pharmacy recommendation within one week. The Unit Managers don't keep hard copies because they're all uploaded. 4. Resident #7 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Type 2 Diabetes Mellitus, Protein Energy Malnutrition, Major Depressive Disorder, Atrial Fibrillation, Hydronephrosis, Urinary Retention, and Urinary Calculus. A review of the Minimum Data Set (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicated the resident had some level of impaired cognition. The resident utilized a wheelchair for mobility and had an indwelling urinary catheter. A review of the resident's care plan, initiated 04/07/2025, indicated the resident had actual skin impairments including a left great toe diabetic wound, and included interventions to follow wound care orders as directed. A review of the Consultant Pharmacist Medication Regimen Review (MRR) dated 12/23/2025 documented in part: The resident has an order for DICLOFENAC (Voltaren) gel. Please provide a dose. Please note the suggested dosing: For upper extremities: Apply 2 grams every 6 hours – not to exceed 8 grams/day to any single joint. For lower extremities: Apply 4 grams every 6 hours – not to exceed 16 grams/day to any single (continued on next page)

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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

joint.

Please also consider updating the order to include 'Maximum total body dose (all joints combined) is 32 grams/day,' if applicable.

The pharmacist recommendation was signed by the consultant pharmacist and also signed and dated by Employee #7, RN, 1st Floor Unit Manager.

Further review of a Consultant Pharmacist MRR dated 02/27/2026 documented the same recommendation requesting that the Voltaren gel order include a defined dose and dosing limits. This document was signed by the consultant pharmacist and Employee #7, RN, 1st Floor Unit Manager.

A review of the Medication Administration Record (MAR) dated 02/01/2026 through 02/28/2026 revealed Resident #7 received Voltaren Arthritis Pain External Gel 1% (Diclofenac Sodium topical) twice daily at 0900 hours (9:00 AM) and 1700 hours (5:00 PM). The MAR did not reflect the dosing parameters recommended by the consultant pharmacist.

A review of the physician order dated 03/02/2026, ordered by Employee #11, documented:

Voltaren Arthritis Pain External Gel 1% (Diclofenac Sodium topical) – Apply to left hand topically two times a day for left hand pain.

This order did not include the dosing parameters recommended in the pharmacist's DRRs dated 12/23/2025 and 02/27/2026.

Further review revealed a subsequent physician order dated 03/06/2026, ordered by Employee #13, Medical Director, documented:

Voltaren Arthritis Pain External Gel 1% (Diclofenac Sodium topical). Apply to bilateral knee topically four times a day for bilateral knee pain. Apply 4 grams every 6 hours – not to exceed 16 grams/day to any single joint.

This order reflected the dosing guidance previously recommended by the consultant pharmacist.

During a face-to-face interview on 03/11/2026 at approximately 11:30 AM, Employee #2 (Director of Nursing) stated that the DON, ADON, and QA/IP staff receive Medication Regimen Review reports through the SCCG portal, and these reports are distributed to unit managers for physician review and implementation. The DON further stated that once providers agree with recommendations, they should be implemented and uploaded to the resident's PointClickCare electronic medical record within approximately one week.

The DON acknowledged that the pharmacy recommendations referenced above were not uploaded into the PointClickCare system at the time of the interview, and stated they would be uploaded as soon as possible.

During a phone interview on 03/11/2026 at approximately 11:50 AM, Employee #11, Nurse Practitioner, stated that it is his responsibility to review medications and consider pharmacy recommendations when prescribing medications. He stated he inadvertently missed the pharmacist's recommendations dated 12/23/2025 and 02/27/2026 to include dosing parameters for Diclofenac
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Voltaren) gel when prescribing the medication on 03/02/2026. Based on the above findings, the facility failed to ensure that pharmacist-identified medication regimen irregularities were acted upon and implemented in a timely manner for Resident #7.

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations and staff interviews, facility staff failed to employ staff with the appropriate competencies. The findings include:During the initial kitchen survey on 03/02/2026 approximately at 11:15 AM, it was observed that the kitchen food service manager has not obtained a valid certified food protection manager identification card issued by the DC Department of Health.During a face-to-face interview on 03/02/2026, approximately at 11:15 AM, the above observation was acknowledged by Employee #14, Food Service Manager and Employe #15, Nutritionist.

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

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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 interviews, facility staff failed to prepare and distribute food under sanitary conditions, and store food at the appropriate temperatures as evidenced by the following observations. The findings include:During an initial kitchen survey in the kitchen on 03/02/2026 approximately at 11:15 AM, the following observations were made: Interior surfaces of the ice making machines were not cleaned.There was no hand-washing soap provided in the dispenser mounted on wall above hand washing sink at the food preparation area in the kitchen.Food service manager, Employee #13 and Employee #14, Nutritionist, were immediately made aware of these findings and proceeded to implement measures to address these issues.During a face-to-face interview on 03/02/2026, approximately at 11:45 AM, the above observations were acknowledged by Employee #13, Food Service Manager and Employee #14, Nutritionist.During follow-up kitchen survey on 03/11/2026 approximately at 12:50 PM, the following observations were made: Cooked chicken was not held at proper hot holding temperature on the steam table. Employee #13 (Kitchen Manager) used digital probe thermometer to check the cooked chicken temperature and observed it was held at 122 degrees F.Melted commercially packaged chocolate ice cream in small cup in bin with ice observed melted.The automatic dish washing machine was supplied with sodium hypochlorite (commonly known as bleach) sanitizing chemical. However, there was no proper test strips provided to measure the appropriate concentration of the sodium hypochlorite (bleach) solution.Employee belongings such jackets, backpacks, etc were placed haphazardly on top of cases of bottled water stored for emergency purposes. During a face-to-face interview on 3/11/2026, approximately at 12:50 PM, the above observations were acknowledged by Employee #13, Food Service Manager and Employee #15, Maintenance Staff.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record reviews and interviews, for three (4) of 49 sampled residents, the facility staff failed to ensure that residents and or their representatives understood the binding arbitration agreements made between the residents and /or their representatives and the facility. Residents #125, ##27, #33, and #127.The findings included:A review of the facility's most recent admission packet included the following binding arbitration agreement for residents and the facility that documented: Resident-Facility Binding Arbitration Agreement[Name of Facility] and [Resident's Name](Resident, or :Resident Legally Authorized Representative (hereinafter, collectively, Resident) understand and agree that any dispute, disagreement, controversy, demand or claim, including but not limited to, legal claims, arising between them regarding any service or health care provided to the Resident by the Facility, even if such dispute arises after the Resident's stay at the Facility has ended, shall be submitted to binding arbitration and exclusively resolved by arbitration, except as otherwise set forth below. This Agreement does not apply to (a) collection actions instituted by the Facility, (b) the Resident's due process rights before state or federal regulatory or administrative agencies.The parties understand and agree that by signing this arbitration agreement, they are giving up and waiving their statutory and constitutional rights to have any claim, including malpractice and wrongful death claims, decided in a court of law before a judge and jury.The parties acknowledge that this Agreement binds the Facility, the Facility's Agents, the Facility's Employees, the Resident, the Resident's legally authorized appointed representative (including without limitation a Guardian, Attorney in Fact, or holder of Power of Attorney), the Resident's spouse, children, and heirs(once determined), the Resident's Estate (once extant), The Resident's Estate executor (upon naming), te Resident's successors and assigns, and all persons whose claim(s) derives through or on behalf of the Resident.The Resident understands that (1) the Resident should seek legal counsel concerning this Agreement, (2) the Resident does not have to sign this Agreement as a precondition to the Facility providing services to the Resident, and (3) this Agreement may be rescinded by written notice sent to the other party by Certified Mail, return receipt requested, within thirty (3) days of the date upon which it is signed.Rescission or waiver of this Agreement can only be affected in writing. 1.Resident was admitted to the facility on [DATE] with diagnoses that included: Multiple Sclerosis, Other Muscle Spasms, Vitamin D Deficiency, Contracture, Left Hand; Vitamin B-12 Deficiency Anemia, and Weakness.A review of Resident #125's medical record revealed:A face sheet which documented that Resident #125 represented himself and was his own responsible party.An admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.A binding arbitration agreement between Resident #125 and the facility dated 08/27/25 that was -e-signed (electronically signed) by Resident #125 as his own representative and by Employee # (Admissions Director) as the Facility's representative.During a face-to-face interview on 03/10/26, at 10:57AM, Resident #125 stated, I understand what arbitration is, and the process of arbitrating when an issue or concern arises, but I don't remember signing an arbitration agreement with the facility. If I signed the agreement, I was not clear on what I was signing. I may have signed it just to get through the admission packet. I don't recall the Admissions person clearly explaining to me that that I should seek legal counsel before signing the agreement, or that if signed the agreement, I was giving up certain legal rights, otherwise, I would never have signed it. 2.Resident #27 was admitted to the facility on [DATE] with diagnoses (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that included: Dysphagia; Hemiplegia and Hemiparesis following Cerebral Infarction; Encounter for Attention to Gastrostomy; Type 2 Diabetes Mellitus; Cognitive Communication; Muscle Weakness (Generalized) and Gout. A review of Resident #27's medical record revealed:A face sheet showing that Resident #27 had two family members documented as Emergency Contact #1 and Emergency Contact #2, respectively.A binding arbitration agreement between Resident #27 and the facility, dated 05/29/25, signed by Resident #27. Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE], which showed the Resident had a Brief Interview for Mental Status (BIMS) of 00, indicating that the Resident had severely impaired cognition.A quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.During a telephone interview on 03/10/26 at 10:27 AM, with Emergency Contact #1 and #2 for Resident #27, Emergency Contact #1 stated, We don't remember signing anything that would have prevented [Name of Resident #3] or our family from ever taking the facility to court. We currently have several concerns with the facility and will be filing grievances. The arbitration process nor the agreement with the facility were made clear with us, before signing because we would not have signed anything like that. 3.Resident #33 was admitted to the facility on [DATE] with diagnoses that included: Fracture of Rib, Left Side; Protein-calorie Malnutrition; Atrial Fibrillation; Systolic (Congestive) Heart Failure; Muscle Weakness (Generalized) and Cognitive Communication Deficit. A review of Resident #33's medical record revealed: A face sheet showing that Resident #33 was her own responsible party and that the Resident had four family members documented as Emergency Contact #1-#4, respectively.A binding arbitration agreement between Resident #33 and the facility dated 06/20/25 that was e-signed (electronically signed) by Resident #33's Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE], which showed the Resident had a Brief Interview for Mental Status (BIMS) of 15, indicating that the Resident had intact cognition.During a face-to-face interview on 03/11/26 at 9:08 AM, Resident #33 stated, I don't remember signing any legal papers like that. There were a lot of papers to sign when I first got here. [Emergency Contact #2] was with me when I first got here, and he wouldn't allow me to sign something like that. Call him. Of note Emergency Contacts #1 and #2 for Resident #33 could not be reached by phone and were unavailable for interview during the survey. 4.Resident #127 was admitted to the facility on [DATE] with diagnoses that included: Hemiplegia, Affecting Right Dominant Side; Displaced Fracture of Lateral End of Right Clavicle; Hematuria; Muscle Weakness (Generalized); Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, and Cognitive Communication Deficit.A review of Resident #127's medical record revealed:A face sheet which showed that Resident #127 had a Power of Attorney as her representative/responsible party.A binding arbitration agreement between Resident #127 and the facility dated 02/10/26 that was e-signed (electronically signed) by Resident #33's Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.During a telephone interview on 03/12/26 at 11:50 AM with Resident #127's representative/Power of Attorney, she stated, I did not understand what I was signing at that time at all. I am not even sure if I understand how arbitration works. Given the need to quickly find a long-term care facility for the Resident, I was more concerned with the Resident's current state of health and welfare. I do not remember the admissions staff suggesting that I seek legal counsel before signing the agreement, and the admission staff person did make it clear that by signing the document, I or the Resident would be giving up the right to ever seek legal action against the facility in court.Interviews with Residents, Resident representatives, and residents' emergency contacts who had signed binding arbitration agreements with the facility showed no evidence that facility staff (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained the agreements clearly to ensure that the Residents' representatives or residents' emergency contacts understood what they were signing. During a face-to-face interview on 03/12/26 at 3:23 PM, Employee #21, Director of Admissions, stated: The binding arbitration agreements are included in our admission packet. Before going over the binding arbitration agreements with the Resident, I always wait until the facility has determined the Resident's Brief Interview for Mental Status (BIMS) summary score. For residents with a BIMS score of 12 or higher, I schedule a meeting with the Resident and/or their representative or emergency contacts to review the admissions packet and the binding arbitration agreement. I also schedule meetings with the resident representative of residents who have a BIMS score of 12 or lower and want to sign an arbitration agreement. Before the Resident/representative or emergency contact signs the binding arbitration agreement, I ask whether they have ever heard of a binding arbitration agreement. If they haven't, I will explain what it is. I explain that by signing the agreement, they agree to use our arbitrator, rather than their own legal counsel, for any unresolved grievance, dispute, or legal matter between the Resident and the facility. I let them know that signing is voluntary and is not required for the Resident's admission to the facility. I then let the Resident, their representative, or emergency contact know that they have 30 days from the date that they signed the binding arbitration agreements to change their minds. When asked if that process for rescinding the binding arbitration agreement between the Resident, representative or emergency contact and the facility was outlined anywhere in the document itself, Employee started , No, I just let the Resident or representative know that can contact me by calling my office extension or come to my office and I let our regional office know so it can be rescinded.When asked how she determines that the Resident or representative understood all of the information she provided about the binding arbitration agreements, the Employee stated, I ask them if they understand.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record reviews and interviews, for three (4) of 49 sampled residents, the facility staff failed to ensure that binding arbitration agreements made between the facility and the resident and or their representative provided for the selection of a neutral arbitrator agreed upon by both parties; and provided for the selection of a venue that is convenient to both parties. Residents # 125, #27, #33, and #127.The findings included:A review of the facility's most recent admission packet included the following binding arbitration agreement for residents and the facility that documented: Resident-Facility Binding Arbitration Agreement [Name of Facility] and [Resident's Name](Resident, or :Resident Legally Authorized Representative (hereinafter, collectively, Resident) understand and agree that any dispute, disagreement, controversy, demand or claim, including but not limited to, legal claims, arising between them regarding any service or health care provided to the Resident by the Facility, even if such dispute arises after the Resident's stay at the Facility has ended, shall be submitted to binding arbitration and exclusively resolved by arbitration, except as otherwise set forth below. This Agreement does not apply to (a) collection actions instituted by the Facility, (b) Resident's due process rights before state or federal regulatory or administrative agencies.The parties understand and agree that by signing this arbitration agreement, they are giving up and waiving their statutory and constitutional rights to have any claim, including malpractice and wrongful death claims, decided in a court of law before a judge and jury.The parties acknowledge that this Agreement binds the Facility, the Facility's Agents, the Facility's Employees, the Resident, the Resident's legally authorized appointed representative (including without limitation a Guardian, Attorney in Fact, or holder of Power of Attorney), the Resident's spouse, children, and heirs(once determined), the Resident's Estate (once extant), The Resident's Estate executor (upon naming), the Resident's successors and assigns, and all persons whose claim(s) derives through or on behalf of the Resident. Of note, there was no language in the agreement stating that if the Resident and facility go to arbitration, a neutral arbitrator agreed upon by both parties will be selected, along with an arbitration venue convenient to both parties.1.Resident was admitted to the facility on [DATE] with diagnoses that included: Multiple Sclerosis, Other Muscle Spasms, Vitamin D Deficiency, Contracture, Left Hand; Vitamin B-12 Deficiency Anemia, and Weakness.A review of Resident #125's medical record revealed:A face sheet which documented that Resident #125 represented himself and was his own responsible party.An admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition.A binding arbitration agreement between Resident #125 and the facility dated 08/27/25 that was -e-signed (electronically signed) by Resident #125 as his own representative and by Employee #21 (Admissions Director) as the Facility's representative.During a face-to-face interview on 03/10/26, at 10:57AM, with Resident #125, when asked if Employee #21 explained that if the Resident and the facility go to arbitration a neutral arbitrator and a neutral location for the arbitration to take place would be selected by both parties, Resident #125 stated, No, I don't recall the Admissions person explaining that to me. 2.Resident #27 was admitted to the facility on [DATE] with diagnoses that included: Dysphagia; Hemiplegia and Hemiparesis following Cerebral Infarction; Encounter for Attention to Gastrostomy; Type 2 Diabetes Mellitus; Cognitive Communication; Muscle Weakness (Generalized) and Gout. A review of Resident #27's medical record revealed: A face sheet showing that Resident #27 had two family members documented as Emergency Contact #1 and Emergency Contact #2, respectively.A binding arbitration agreement between Resident #27 and the facility, dated (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/29/25, signed by Resident #27. Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition.A quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.During a telephone interview on 03/10/26 at 10:27 AM, with Emergency Contact #1 and #2 for Resident #27, Emergency Contact #1 stated, I don't remember the admission staff person ever explaining that we could select a neutral arbitrator and a neutral location for arbitration that was convenient for us and the facility. 3.Resident #33 was admitted to the facility on [DATE] with diagnoses that included: Fracture of Rib, Left Side; Protein calorie Malnutrition; Atrial Fibrillation; Systolic (Congestive) Heart Failure; Muscle Weakness (Generalized) and Cognitive Communication Deficit. A review of Resident #33's medical record revealed:A face sheet showing that Resident #33 was her own responsible party, and that the Resident had four family members documented as Emergency Contact #1-#4, respectively.A binding arbitration agreement between Resident #33 and the facility dated 06/20/25 that was e-signed (electronically signed) by Resident #33's Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE] showed the Resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.During a face-to-face interview on 03/11/26 at 9:08 AM, with Resident #33 when asked if the facility staff explained that if the Resident and the facility go to arbitration, both parties could choose a neutral arbitrator and a neutral location for the arbitration, the Resident stated, No. 4.Resident #127 was admitted to the facility on [DATE] with diagnoses that included: Hemiplegia, Affecting Right Dominant Side; Displaced Fracture of Lateral End of Right Clavicle; Hematuria; Muscle Weakness (Generalized); Adjustment Disorder with Mixed Disturbance of Emotions and Conduct and Cognitive Communication Deficit.A review of Resident #127's medical record revealed:A face sheet which showed that Resident #127 had a Power of Attorney as her representative/responsible party.A binding arbitration agreement between Resident #127 and the facility dated 02/10/26 that was e-signed (electronically signed) by Resident #33's Emergency Contact #1 as the Resident's representative and by Employee # (Admissions Director) as the Facility's representative.An admission Minimum Data Set (MDS) assessment dated [DATE], which showed the Resident had a Brief Interview for Mental Status (BIMS) of 14, indicating that the Resident had intact cognition.During a telephone interview on 03/12/26 at 11:50 AM with Resident #127's representative/Power of Attorney, when asked if facility staff explained that should the Resident and staff have to go to arbitration, a neutral arbitrator and a neutral location for the arbitration would be selected by both parties, she stated No , I don't recall anyone from Admissions explaining that to me.Interviews with Residents, Resident representatives, and residents' emergency contacts who had signed binding arbitration agreements with the facility showed no evidence that facility staff explained that if arbitration occurs between the Resident, the representative, or Emergency contact, a neutral arbitrator and a neutral location for the arbitration would be selected by both parties.During a face-to-face interview on 03/12/26 at 3:23 PM, Employee #21, Director of Admissions, stated that Language regarding the selection of the arbitrator and the location for arbitration is not included in the agreement. I believe Residents and their reps do have a say in the arbitrator. In cases of arbitration, I am accustomed to letting them know who their arbitrator is. I will have to check with my regional office to see if the arbitrator and the location can be selected by both parties.

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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 review and staff interviews for eight (8) of 49 sampled residents, it was determined that the facility staff failed to: (a.) implement appropriate infection control measures to manage the transmission of a Norovirus outbreak when five (5) residents-four (4) residents on one floor and one (1) resident on another floor-became ill within a five-day period with nausea and vomiting. Subsequently, during this period, one (1) of the five (5) residents became ill after he was allowed to cohort in the same room with his roommate who had exhibited symptoms of the Norovirus (b.) perform hand hygiene when providing services to three (3) residents during meal time; and (c.) conduct an annual review of two (2) infection control policies. Residents' #144, #194, #162, #130, #99, #180, #33, #12. The findings included: A facility policy titled ?Infection Prevention and Control Policy' with a review date of 1/2026 [January 2026] documented, in part: Purpose: The facility will maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and To provide an ongoing surveillance for infection control that is actively involved in detecting trends in facility infections, early detection of outbreaks, and to evaluate the efficacy of infection control practices. (a.) Facility staff failed to implement appropriate infection control measures to address the transmission of a Norovirus outbreak when five (5) residents-four (4) residents on one floor and one (1) resident on another floor-became ill within a five-day period with nausea and vomiting. Subsequently, during this period, one (1) of the five (5) residents became ill after he was allowed to cohort in the same room with his roommate who had exhibited symptoms of the Norovirus just one day earlier. 1. Resident #144 was admitted to the facility on [DATE] with multiple diagnoses that included: Heart Failure, Hypertension, Stroke, Peripheral Vascular Disease and Altered Mental Status. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '09,' that indicated the resident was moderately impaired. Functional goals and abilities that indicated the resident was dependent on staff for Activities of Daily Living (ADL) care and required substantial to maximal assistance from staff with meals. The facility's census dated 12/26/25 revealed that Resident #144 had a roommate. A Situation, Background, Assessment, Request (SBAR) Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 12/26/25 at 13:50 [1:50 PM] documented, in part: Vomiting. Resident vomited during his Lunch when the CNA (Certified Nursing Assistant) was feeding him. [Nurse Practitioner's name] was made notified with NNO (no new orders). Refused his Lunch after he vomited. 2. Resident #194 was admitted to the facility on [DATE] with multiple diagnoses that included: Acute Osteomyelitis of Right Ankle and Foot, Malignant Melanoma of Skin, Anemia and Dementia. An admission Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '05,' that indicated the resident was severely impaired. Functional goals and abilities that indicated the resident was dependent on staff for all ADL care. The facility's census dated 12/27/25 revealed that Resident #194 had a roommate. A Situation, Background, Assessment, Request (SBAR) Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 12/27/25 at 11:45 [AM]documented, in part: Vomiting x 2 [twice] . Gastrointestinal (vomiting) . New orders: Senna Oral Tablet 8.6 MG (Sennosides) 1 tablet PO (by mouth) Q (every) 12 hours for bowel regimen hold for loose stool . Vomited x 2 about 100cc of some food particles . MD (medical doctor) made aware, new order given. A physician's order dated 12/29/25 at 13:19 [1:19 PM] documented, Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth every 12 hours for bowel regimen old [sic] [hold] for loose stool. A review of Resident #194's Medication and Administration Record dated 12/1/2025 - 12/31/25 revealed that facility staff administered Senna oral tablet 8.6 MG every 12 hours as ordered by the physician. It should be noted that Resident #194 had a planned (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge to home with home health services on 01/30/26. 3. Resident #162 was admitted to the facility on [DATE] with multiple diagnoses that included: Stroke, Hemiplegia, Dementia, Anemia and Hypertension. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the facility coded a Brief Interview for Mental Status (BIMS) summary score of ?05,' indicating that the resident was severely impaired. Functional goals and abilities that indicated the resident required Supervision from staff with toileting and showers, tub/shower transfer, toilet transfer and to walk 10 feet; set-up only from staff with eating, oral hygiene, dressing, personal hygiene, sit-to-stand and chair/bed-to-chair transfers. The facility's census dated 12/28/25 revealed that Resident #162 had a roommate. His roommate was Resident #99. A Situation, Background, Assessment, Request (SBAR) Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 12/28/25 at 22:24 [10:24 PM] documented, in part: vomited x 1 [once] with undigested food particles.Around 10:15pm resident had one episode of vomiting with presence of food particles.Encouraged oral fluids. [Doctor's name] notified and order obtained Zofran 4 mg (milligram) q (every) 8 hours for nausea/vomiting. A physician's order dated 12/28/25 documented, Zofran Oral Tablet 4 MG (Ondansetron HCl (hydrochloride)) Give 1 tablet by mouth every 8 hours as needed for Nausea/vomiting. A nursing progress note dated 12/28/25 at 23:41 [11:41 PM] documented, in part: Zofran 4mg given for vomiting. 4. Resident #130 was admitted to the facility on [DATE] with multiple diagnoses that included: Stroke, Dementia, Depression and Hypertension. An Annual Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '04,' that indicated the resident was severely impaired. Functional goals and abilities that indicated the resident was dependent with toileting hygiene/shower-bath/dressing/personal hygiene/transfers/bed mobility; and required setup assistance with eating and oral hygiene. The facility's census dated 12/29/25 revealed that Resident #130 had a roommate.A Situation, Background, Assessment, Request (SBAR) Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 12/29/25 at 02:23 [10:24 PM] documented, in part: vomited x3 [three times] with undigested food particles . Resident was noted with vomit of undigested food particles at 11:15pm. After cleaning her up, she had another episode of vomiting and large BM (bowel movement) . [Doctor's name] made aware and order to administer PRN (as needed) Zofran 4mg q 8 hours for nausea/vomiting.At 5:30AM resident noted vomiting again, Doctor was called and gave the order to send the resident to the nearest ER (emergency room) for evaluation. A physician's order dated 12/29/25 documented, Ondansetron HCl Oral Tablet 4 MG (Ondansetron HCl) Give 1 tablet by mouth every 8 hours as needed for Nausea and vomiting. A review of Resident #130's Medication Administration Record dated 12/1/2025 - 12/31/25 documented that facility staff administered Ondansetron HCl Oral Tablet 4 mg for nausea and vomiting on 12/29/25 at 01:45 AM. A physician's order dated 12/29/25 at 05:31 [5:31 AM] documented, Transfer to the ER for evaluation and treatment. A nursing progress note dated 12/29/25 at 05:47 [5:47 AM] documented, Ondansetron HCl Oral Tablet 4 MG Give 1 tablet by mouth every 8 hours as needed for Nausea and vomiting PRN Administration was: Ineffective indicating the medication was ineffective in relieving her episodes nausea and vomiting. A nursing progress note dated 12/29/25 at 07:30 [7:30 AM] documented, in part: This writer was notified again by the unit nurse that resident continues to vomit food particles. Upon assessment resident appeared weak, had vomited multiples times .Foul smelling bowelmovement was noted. This nurse called and notified the physician again, new order to sendresident to the ER to evaluate and treat obtained. Resident initially declined going to the hospital when EMS (emergency medical services) arrived, but RP (responsible party) was contacted again who spoke with resident over the phone and resident agreed to go to the hospital. Resident left facility at about 6:40am to [hospital name]. A nursing progress noted dated 12/29/25 at 20:18 [8:18 PM] documented, in part: Writer called [hospital name] to f/u (follow up) with resident status, ER personnel who stated that resident is evaluated, and she is discharging. The ER personnel stated she is in stable condition, waiting for transportation. A nursing progress note dated 12/30/25 at 13:11 (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[1:11 PM] documented, in part: [Resident #130], a resident of this facility who is readmitted after a short stay hospitalization for nausea and vomiting. Resident returned via stretcher to [room number] . no N/V (nausea/vomiting) noted or voiced by the resident. It should be noted that Resident #130 returned to the same semi-private room prior to her hospitalization for nausea and vomiting and she had a roommate. A social work progress note dated 12/31/25 at 08:54 [8:54 AM] documented, in part: Resident transferred to [hospital name] emergency room related to multiple episode[s] of emesis, 6-108 (notice of discharge or relocation form), Bed Hold Policy, sent to resident's responsible party/LTC (long term care) Ombudsman. 5. Resident #99 was admitted to the facility on [DATE] with multiple diagnoses that included: Alzheimer's Disease, Renal Disease, Arthritis and Anemia. An Annual Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '04,' that indicated the resident was severely impaired. Functional goals and abilities that documented the resident required supervision with showers and bathing and was independent with all other activities of daily living care. The facility's census dated 12/29/25 revealed that Resident #99 had a roommate. Resident #162 was his roommate. A Situation, Background, Assessment, Request (SBAR) Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool dated 12/29/25 at 19:18 [7:18 PM] documented, in part: vomited x1 (one time) with undigested food particles . Around 18:00 [6:00 PM] Resident had one episode of vomiting with presence of food particles . Encouraged oral fluids . [Doctor's name] notified and order obtained Zofran 4 mgs (milligrams) PO (by mouth) Q (every) 8HRS (eight hours) prn (as needed) for vomiting. A physician's order dated 12/29/25 at 19:52 [7:52 PM] documented, Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 1 tablet by mouth every 8 hours as needed for vomiting. A review of Resident #99's Medication Administration Record dated 12/1/2025 - 12/31/25 documented that facility staff administered Zofran oral tablet 4 MG ON 12/29/25 at 8:12 PM as ordered by the physician. A nursing progress note dated 12/29/25 at 22:37 [10:37 PM] documented, in part: Resident verbalized feeling much better after PRN zofran [Zofran] administered for vomiting. He was encouraged and offred [offered] to take fluids. It should be noted that Resident #99 became ill while cohorting with his roommate, Resident #162, who first became ill with symptoms of nausea and vomiting. It should also be noted that there is no documented evidence that Residents' #144, #194, #162, #130 and #99 were moved to another room when they became ill with the symptoms of the Norovirus, or away from their roommates, who were initially unaffected, to prevent the spread of the virus. A review of the facility's daily census from 12/25/25 to 01/02/26 revealed that the facility had available beds and unoccupied resident rooms. During a face-to-face interview conducted on 03/4/26 at approximately 10:00 AM with Employee #12 (Infection Prevention and Control) he stated, We thought it was an isolated incident, so we didn't think that we needed to move affected residents to other rooms. During a face-to-face interview conducted on 03/06/26 at approximately 3:34 PM with Employee #2 (Director of Nursing) she acknowledged the findings. (b.) Facility staff failed to conduct hand hygiene in between providing services to three (3) residents while handling meal trays, offering set-up and feeding assistance as to prevent the spread of infections. A facility policy titled ?Hand Hygiene' with a review date of 01/2026 [January 2026] documented, in part: 1. All personnel are provided with hand hygiene training upon hire and annually thereafter. 2. All personnel are required to adhere to hand hygiene policies and practices. Staff adherence to hand hygiene is incorporated into infection prevention and control process surveillance and monitored by the infection preventionist as part of the facility infection prevention and control program. 1. Hand hygiene is indicated: a. before touching a resident; b. before preparing or handling food; f. after touching a resident; g. after touching a resident's environment or belongings (e.g., bedrails, etc.) . 1. Use an alcohol-based hand rub (ABHR) for most clinical situations. a. Unless hands are visibly soiled, ABHR is the preferred method of hand hygiene in clinical situations because it is more effective at killing germs, faster to use, and less irritating to the skin than soap and water. Resident #180 was admitted to the facility on [DATE] with multiple diagnoses that included: Stroke, Dementia, Hemiplegia, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seizure Disorder and Acquired Absence of Right Leg Above Knee. A care plan dated 04/05/19 documented, in part: Focus: [Resident's name] has Self Care performance Deficit. Interventions: Feed/assist resident during meals. A care plan dated 10/17/25 documented, in part: Focus: [Resident's name] has an ADL self-care performance deficit r/t Disease Process . Interventions: BED MOBILITY: The resident is totally dependent on (2) staff for repositioning and turning in bed. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '13,' that indicated the resident was cognitively intact. Functional goals and abilities that documented the resident required Substantial to Maximal assistance from staff with bed mobility and Partial to Moderate assistance from staff with eating meals. A physician's order dated 02/10/26 documented, Regular diet Mechanical Soft texture, Thin Liquids consistency. 2. Resident #33 was admitted to the facility on [DATE] with multiple diagnoses that included: Heart Failure, Hypertension, Stroke and Fracture of Left Side Rib. A care plan dated 06/16/25 documented, in part: [Resident's name] has ADL Self-care deficit related to generalized weakness and impaired mobility due to Right MCA Stroke . Interventions: Assist with daily hygiene, grooming, dressing, oral care and eating as needed. EATING: Ms. [NAME] can eat independently after tray setting up. A physician's order dated 08/21/25 documented, Regular diet, Mechanical Soft texture, Thin Liquids consistency. A care plan dated 02/16/26 documented, in part: Focus: [Resident's name] has an ADL self-care performance deficit r/t Disease Process . Interventions: EATING: The resident is set up meals by (1) staff for eating. EATING: The resident requires (setup assistance) by (1) staff to eat. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '12,' that indicated the resident was moderately impaired. Functional goals and abilities that documented the resident required Substantial to Maximal assistance from staff with bed mobility, lying to sitting, and transfers; and required Setup assistance with eating. A review of the facility's census on 03/04/26 revealed that Resident #33 had a roommate. Her roommate was Resident #12. 3. Resident #12 was admitted to the facility on [DATE] with multiple diagnoses that included: Aphasia, Dementia, Stroke and Hemiplegia. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that facility staff coded a Brief Interview for Mental Status (BIMS) summary score that indicated the resident was ?Severely Impaired.' Functional goals and abilities that documented the resident was Dependent with all Activities of Daily Living and required Substantial to Maximal assistance from staff with eating. A care plan dated 01/30/26 documented, in part: [Resident's name] has an ADL self-care performance deficit r/t (related to) Hemiplegia/Hemiparesis of cerebral infarction. Interventions: BED MOBILITY: The resident requires extensive assistance by (1) staff to turn and reposition in bed . EATING: The resident requires extensive assistance by (1) staff to eat. A care plan dated 01/30/26 documented, in part: The resident has limited physical mobility r/t right sided weakness . Interventions: Provide supportive care, dependent with ADL's: locomotion, bed mobility, transfer, bathing, personal hygiene, eating as needed. A physician's order dated 02/02/26 documented, NAS (no added salt)/LCS (low concentrated sweets) diet Mechanical Soft texture, Thin Liquids consistency. During a dining observation conducted on 03/04/26 at approximately 8:38 AM to 9:00 AM, a facility staff was observed passing breakfast trays to the residents. It was noted that Employee #22 (assigned Certified Nursing Assistant, CNA) removed a breakfast tray from the food cart and delivered the meal tray to Resident #180, placed the tray on the bedside table, raised the head of the bed, assisted the resident up in bed, removed the dome covering the hot plate, repositioned the bedside table in front of the resident, removed silverware and straw from the packaging, opened a carton of milk and placed the straw into the milk carton. After completing these tasks, Employee #22 left the resident's room. She then retrieved another meal tray from the food cart and delivered the tray to Resident #33 where she placed the tray on the bedside table, assisted the resident to a sitting position at the side of the bed, repositioned the bedside table in front of the resident, removed the dome covering the hot plate, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed the silverware and straw from the packaging, opened a carton of milk and placed the straw into the milk carton, and cut the resident's pancakes into small pieces. After she completed those tasks, she left the semi-private room and retrieved another meal tray. Employee #22 delivered that tray to Resident #12, Resident #33's roommate, then repositioned the bedside table in front of the resident, removed the dome covering the hot plate, removed the silverware and straw from the packaging, opened a carton of milk and placed the straw into the milk carton, then sat down next to the resident to provide feeding assistance. It should be noted that, while Employee #22 (CNA) was being observed, she did not perform any hand hygiene using an alcohol-based hand rub (ABHR), or soap and water, before and after touching a resident and the resident's environment (e.g., bed and bedside table) and before and after providing setup and feeding assistance to Residents' #180, #33, and #12. During a face-to-face interview conducted on 03/04/26 with Employee #22 (CNA) she stated, I must have forgot. During a face-to-face interview conducted on 03/04/26 at approximately 9:05 AM with Employees' #23 (Unit Manager) and Employee #2 (Director of Nursing), they both acknowledged the findings. (c.) Facility staff failed to conduct an annual review for two (2) of its infection control policies. A review of the facility's Infection Control policies revealed a policy titled ?Policy - COVID-19 Resident Vaccination Policy that documented, Revised 06/1/2022 and a policy titled ?Policy: COVID-19 PPE, source control for Healthcare personnel' that documented, Rev (revised) Date: 6/2023. During a face-to-face interview conducted on 03/12/26 at approximately 3:30 PM with Employee #12 he acknowledged the findings and stated, We wait to get the updates from our regional office. Cross reference: DCMR S 3206.3

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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 staff interviews, facility staff failed to maintain equipment in safe operating condition.The findings included:During the initial kitchen survey on 03/02/ 2026 approximately at 11:15 AM, it was observed that:1. The automatic dish washer pressure gauge was not functional2. The back flow preventer valve next to the pressure gauge at the automatic dishwashing machine was leaking water.3. Water was spraying out of the dishwashing machine when the dish mashing machine was operating. Plastic bags were put atop the machine in an effort to stop the water from spraying out of it.4. The spray hose was placed on the garbage scrap board, below the floor rim level and there wasn't a hook or a hanger provided to store it above flood rim level when it is not in use. 5. Condensate water drainpipe originating from air conditioning unit installed above ceiling was extended through the ceiling tile and drained into the garbage disposer sink. Employee # 14, Food Service Manager, and Employee #17, Maintenance Director, were immediately made aware of these findings and proceeded to implement measures to address the issues.During a face-to-face interview on 03/02/2026, approximately at 11:15 AM, the above observations were acknowledged by Employee #14, Food Service Manager and Employee #17, Maintenance Director.

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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, record reviews and staff interviews, facility staff failed to maintain an effective pest control program so that the facility is free of pests.The findings included:During the follow-up kitchen survey on 03/10/ 2026 approximately at 12:50 PM, it was observed a dead cockroach on floor in the dry storage room. Employee #14, Food service manager, and Employee #16, Maintenance Staff, were immediately made aware of these findings and proceeded to implement measures to address the issue.Record review of the pest control reports from Bay City pest management Co. Inc dated 2.28.2026 and 2.7.2026 documented in part that there was no cockroach activity noted in the kitchen.During a face-to-face interview on 03/10/2026, approximately at 12:50 PM, the above observations were acknowledged by Employee #14, Food Service Manager and Employee #16, Maintenance Staff.During a face-to-face interview on 03/10/2026 approximately at 1:10 PM, Employee #1, Administrator, stated the contracted professional pest exterminator services the facility biweekly and as needed.