

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>43776</p> <p>Based on observations, record review and staff interviews, for two (2) of 47 sampled residents, facility staff failed to provide a clean, homelike environment. Residents' #132 and #113.</p> <p>The findings included:</p> <p>1. A Complaint, DC~12341, received by the State Agency on 10/04/23 from Resident #132's representative documented that:</p> <ul style="list-style-type: none"> <li>- Residents are in unsanitary living conditions</li> <li>- The facility failed to provide daily clean and safe living environment</li> </ul> <p>During an observation of Resident #1332's room, 515 bed A, on 10/30/23 at 10:50 AM, the air conditioning/heating unit was noted with thick layers of gray dust-like material. The resident's over-bed table was sticky to the touch, wet, and had with dark colored stains.</p> <p>During a face-to-face interview on 10/30/23 at 10:55 AM, Employee #6 (Director of Housekeeping and Laundry) acknowledged the findings, stated that cleaning the resident overhead tables and the grills of the air conditioning/heating unit is part of the housekeeping duties and would get someone from housekeeping to come to Resident #132's room.</p> <p>2. A Complaint DC~12130 received by the State Agency on 07/26/23 from Resident #113's representative documented that:</p> <ul style="list-style-type: none"> <li>- The facility is unclean</li> <li>- I have to ask for the floor to be mopped</li> </ul> <p>During an observation on 10/30/23 at 11:28 AM of Resident #113's room, 510, upon entering the room, two large areas of chipping paint and a large hole were noted on the right wall.</p> <p>(continued on next page)</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a face-to-face interview on 10/30/23 at 12:01 PM Employee #12 (Director of Maintenance) acknowledged the findings and stated, Our maintenance guy made written note of this on Thursday (10/26/23) during his daily rounds but it was never entered into the electronic system as a request for me to see. We'll take care of it now.</p> <p>Cross Reference 22B DCMR Sec. 3256.1</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645</b></p> <p>Based on record review and staff interview the facility's staff failed to follow it's Abuse Policy by not thoroughly investigating: an allegation of staff-to-resident sexual abuse (inappropriate touch), an allegation of staff-to-resident verbal abuse,a fall incident, an allegation of a verbal altercation between residents and an unusual occurrence for five (5) of 47 sampled residents. (Residents #228, #229, #230, #331, and #332).</p> <p>A review of a policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation with a revision dated of ,d+[DATE] instructed, All allegations are thoroughly investigated.</p> <p>1.The facility's staff failed to thoroughly investigate Resident #228 allegation of staff-to-resident sexual abuse (inappropriate touch).</p> <p>Resident #228 was admitted to the facility on [DATE] with multiple diagnoses including Hemiplegia, Morbid Obesity, and Muscle Weakness.</p> <p>The staff assignment for the night shift on [DATE] revealed five (5) employees worked that shift. According to the facility's investigation packet, two (2) of the five (5) employees (the assigned nurse and assigned CNA) provided statements. There was no documented evidence that the facility interviewed the three other employees who may have had knowledge of the incident.</p> <p>A review of an Admission Minimum Data Set, dated dated [DATE] revealed the resident had a Brief Interview of Mental Status summary score of 10 indicating the resident cognitive function was moderately impaired. The resident was code for requiring extensive assistance for staff for toilet use and being frequently incontinent of urine and bowel.</p> <p>A nursing note dated [DATE] at 4:41 PM documented, Around 2:45 pm, unit manager received a call from [resident's daughter name] alleging that she got a phone call from her father saying he was inappropriately touched by [Employee #4, CNA] over the night Investigation started immediately. Head to toes assessment done, scrotal area observed with a scratch, Pain assessment-denies pain verbally and did not express pain nonverbally MD notification called to DC police staff suspended f pending investigation. Investigation initiated. Resident reassured.</p> <p>A psychiatric nursing note dated [DATE] at 10:10 PM documented the following but not limited to, [Resident's name] explored his accusation made about a male staff touching him inappropriately. He explained that the staff was rough, pulling on his sore arms when personal care was provided (washing him). He said that he and the staff [Employee #4] enjoyed joking with each other and the staff did not take his complaints about being treated roughly while being bath seriously. He reported that the male staff told him his testicles were large and squeezed them while he was washing that area. [Resident's name] said he did not view this behavior as sexual stimulation but a joke.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a State Survey Agency Facility Reported Incident Intake form #DC ~11597 dated [DATE] documented, Around 2.45 pm, unit manager received a call from [Resident's daughter] alleging that she got a phone call from her father saying he was inappropriately touched by a CNA over the night. Investigation started immediately. Head to toe assessment done, scrotal area observed with a scratch. Pain assessment was done with denies pain verbally and did not express pain non verbally MD notification called to DC police staff suspended pending investigation. Investigation initiated Resident reassured.</p> <p>During a face-to-face interview on [DATE] at 3:37 PM, Employee #2 (DON) stated that the facility obtains written statements or questionnaires from all staff who worked on the shift on which the allegation was made. The employee said that they had gotten statements from all five staff who worked on the nightshift of [DATE], but she could not explain why they were not in Resident #228's investigative packet.</p> <p>2. The facility staff failed to thoroughly investigate Resident #230's allegation of staff-to-resident verbal abuse.</p> <p>Resident #230 was admitted to the facility on [DATE] with multiple diagnoses including Chronic Pulmonary Disease.</p> <p>A review of a nursing note on [DATE] at 4:30 PM documented but not limited to, Note Text: At around 3:40 PM writer's attention was drawn to the presence of 911 in the lobby. Upon enquiry it was noted that resident had called 911. Writer and nursing supervisor went to resident about her reason of calling 911 and she said she just want to get out of here and not to come back. She refused assessment but allowed us to take vital signs which was ,d+[DATE] (blood pressure),80 (pulse),18 (respiration), 97% (oxygen saturation level), 97.4 (temperature). 911 crew also found resident to be stable but resident insist going so they call a private ambulance who came at 4:07[PM]. [Doctor's name] was notified and gave order to send patient to hospital per her request. Resident left the facility at 4:15 pm to [hospital's name].</p> <p>A nursing note dated [DATE] at 11:18 PM documented, It was reported [resident representative's name] via email that her mother [resident's name] was mistreated by a male staff wearing a green uniform yesterday being Sunday, Dec. 11th, 2022, before going to the Hospital. Police has (sp) been called and they will be on their way for further investigation. Report was given to the incoming supervisor to look up for the police.</p> <p>A nursing note dated [DATE] at 11:30 PM documented, The police came and talked to her they said it is not a police matter, that it is something the management will handle internally.</p> <p>A review of a 5-Day-Minimum Data Set, dated dated [DATE] documented the resident did not have a Brief Interview for Mental Status summary score indicating that the resident was not tested . Additionally, the resident was coded for verbal behavioral symptoms directed towards others including threatening others, screaming at others, and cursing at others. The resident was also coded for rejection of care.</p> <p>A State Agency Facility Reported Incident #DC~11357 date [DATE] documented, Per resident's daughter she stated, My mom, [resident's name] called at 4 pm to let me know a male dressed in all green uniform threatened her.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The staff assignment for the evening shift on [DATE] revealed six (6) employees worked that shift. According to the facility's investigation packet, three (3) of the six (6) employees provided statements. There was no documented evidence that the facility interviewed the three other employees who may have had knowledge of the incident.</p> <p>During a face-to-face interview on [DATE] at 3:35 PM, Employee #2 (DON), reviewed the resident's investigation packet and stated that she did not see a statement or questionnaire for three staff members who worked the time of the incident with Resident #230.</p> <p>3. The facility's staff failed to investigate Resident #229's fall incident that occurred on [DATE].</p> <p>Resident #229 was admitted to the facility on [DATE] with multiple diagnosis including Lung Cancer and Legal Blindness.</p> <p>An Admission Minimum Data Set, dated dated [DATE] documented the resident had a Brief Interview for Mental Status summary score of 15 indicating that the resident had an intact cognitive status. In addition, the resident was coded for being independent with indoor ambulation and receiving Physical, Occupational, and Speech Therapy services.</p> <p>A nursing note dated [DATE] at 11:30 PM showed, Resident was observed by medication nurse at 11:00 PM and she was sleeping. Around 11:15 PM resident was observed on floor, unresponsive Resident was transferred back to bed. CPR was initiated. 911 was called and arrived around 11:43. [Doctor's name] was called and ordered to be transferred to nearest hospital for evaluation and treatment via EMS (Emergency Medical Center). Responsible Party was called.</p> <p>A nursing note dated [DATE] at 2:10 AM documented, EMS (Emergency Medical Service) team pronounced resident dead at approximately 12:35 am, CPR terminated, Dr. [NAME] made aware and he stated that cause of death is Malignant Neoplasm of Lower Lobe of Left Bronchus or Lung. RP could not be reached on phone immediately, but a call back message was left. Resident was given postmortem care with dignity. Writer will continue to follow up with RP (responsible party).</p> <p>A State Survey Agency Facility Reported Incident Intake Form # DC~11434 dated [DATE] at 4:39 AM documented the following but not limited to: According to the charge nurse, resident was last seen lying on her bed with bed on lowest position and respiration un-labored at 11PM. By 11:15 pm, resident was observed on the floor unresponsive. Code called, resident was assisted back to the bed. MD was made aware and MD gave order to transfer resident to the nearest ER via 911 for treatment and further evaluation.</p> <p>A review of the facility's investigation documents lacked documented evidence that the facility's staff investigated Resident #229's fall that occurred on [DATE].</p> <p>During a face-to-face interview on [DATE] at 2:10 PM, Employee #3 (ADON) stated that the facility investigates all fall incidents to include gathering witness statements from staff who worked at the time of the resident's fall. However, Employee #3 could not explain why there was no documented evidence of the facility's investigation of Resident #229's fall incident that occurred on [DATE].</p> <p>45102</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. The facility staff failed to implement its policy to investigate Resident #331's allegation of a report of a verbal altercation with another resident.</p> <p>Resident #331 was admitted to the facility [DATE], with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit.</p> <p>A review of a complaint intake #DC00011545 submitted to the State Agency on [DATE] documented .There are several concerns: [DATE] -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted .In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection .</p> <p>A review of Resident #331's medical record revealed the following:</p> <p>[Social Work Progress Note] [DATE] at 11:19 AM, documents .Writer received a call from residents sister . because resident call her &amp; (and) shared that she had some type of verbal altercation with another resident .</p> <p>[Nursing Progress Note] [DATE] 1:57 PM, documents : In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated .</p> <p>[Physician Orders] [DATE] .In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization .</p> <p>Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note.</p> <p>During a face-to-face interview conducted on [DATE] at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.</p> <p>5A. The facility staff failed to implement its policy to investigate an allegation of abuse concerning Resident #332.</p> <p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia</p> <p>A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on [DATE] revealed the following: .Resident was transferred hospital on [DATE] due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time .On [DATE], resident called the Admission Director with the following concerns, Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice .</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of 01 indicating severe cognitive impairment.</p> <p>[Speech Therapy Treatment Encounter Notes] [DATE] at 10:21 AM, documents .Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware .</p> <p>The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.</p> <p>During a face-to-face interview conducted on [DATE] at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.</p> <p>During a face-to-face interview conducted on [DATE] at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated I don't remember that kind of report to me.</p> <p>During a telephone interview conducted on [DATE] at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them.</p> <p>5B. The facility staff failed to implement its policy to investigate an unusual occurrence concerning resident #332.</p> <p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.</p> <p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 01 indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Nursing Progress Note] [DATE] at 2:18 PM, documents, .At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) .with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied I'm trying to give my mom supplements, She is what I do even when she was in the hospital. On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her.</p> <p>The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on [DATE] in the nursing progress note.</p> <p>During a face-to-face interview conducted on [DATE] at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45102</p> <p>Based on record review and staff interviews for two (2) of 47 sampled residents, the facility staff failed to report allegations of abuse and an unusual incident to the State Agency. Resident #331 and #332.</p> <p>The findings included:</p> <p>A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating with a revision date of 06/2023 instructs the facility staff to do the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .</p> <p>1. If resident abuse, neglect, exploitation, misappropriation of resident property, unusual occurrences or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law.</p> <p>1. The facility staff failed to report an allegation of a verbal altercation involving resident #331 and another resident to the State Agency.</p> <p>Resident #331 was admitted to the facility 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit.</p> <p>A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented .There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted .In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection .</p> <p>A review of Resident #331's medical record revealed the following:</p> <p>[Social Work Progress Note] 01/09/23 at 11:19 AM, documents .Writer received a call from residents' sister .because resident call her &amp; (and) shared that she had some type of verbal altercation with another resident .</p> <p>[Nursing Progress Note] 01/09/23 1:57 PM, documents : In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated .</p> <p>[Physician Orders] 01/09/23 .In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization .</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note.</p> <p>During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.</p> <p>2A. The facility staff failed to report an allegation of abuse concerning Resident #332.</p> <p>A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: .Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time .On 10/27/2022, resident called the Admission Director with the following concerns, Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice .</p> <p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.</p> <p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental status (BIMS) summary score of 01 indicating severe cognitive impairment.</p> <p>[Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents .Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware .</p> <p>The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.</p> <p>During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility did not report this to the State Agency.</p> <p>During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated I don't remember that kind of report to me.</p> <p>During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them.</p> <p>2B. The facility staff failed to report an unusual occurrence concerning resident #332 to the State Agency.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.</p> <p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 01 indicating severe cognitive impairment.</p> <p>[Nursing Progress Note] 10/12/22 at 2:18 PM, documents, .At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) .with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied I'm trying to give my mom supplements, She is what I do even when she was in the hospital. On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her.</p> <p>The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22, in the nursing progress note.</p> <p>During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility did not report this to the State Agency.</p> <p>Cross Reference22B DCMR Sec.3232.4</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776</b></p> <p>Based on record review and staff interviews, for three (3) of 47 sampled residents, facility staff failed to have documented evidence that they took corrective actions to protect and prevent further potential abuse of Resident #103 by Employee #13 (Smoke Aide), the alleged perpetrator, after an allegation of physical abuse; failed to show documented evidence that investigations were conducted into Resident #331's report to a social worker of a verbal altercation with another resident; and Resident #332's abuse allegation and unusual incident. Residents #103, #331 and #332.</p> <p>The findings included:</p> <p>Review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy documented:</p> <ul style="list-style-type: none"> <li>- The Administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility.</li> <li>- If the investigation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to his/her/their former position and will be paid in full for the duration of the suspension.</li> <li>- The employee will obtain education for the incident prior to returning to work and will not be allowed to work with the suspected victim to prevent retaliation.</li> <li>- Corrective actions may include a full review of the incident(s) by the QAPI committee.</li> </ul> <p>1. Facility staff failed to to have documented evidence that they took corrective actions to protect and prevent further potential abuse of Resident #10 for six months after an alleged incident.</p> <p>Resident #103 was admitted to the facility on [DATE] with diagnoses that included: Schizophrenia and Depressive Disorder.</p> <p>Review of Resident #103's medical record revealed the following:</p> <p>A care plan focus area last revised in March 2022 documented, [Resident #103] wishes to smoke at the facility and is assessed as a Safe Smoker</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: clear speech; understood others and able to make self understood; and a Brief Interview for Mental Status (BIMS) Summary Score of 10, indicating moderate impaired cognition.</p> <p>A schedule for calendar for September 2022 documented that on 09/29/23 from 9:30 AM - 6:00 PM, Employee #13/alleged perpetrator was the assigned to the courtyard/smoking patio.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Situation Background Assessment Request (SBAR) Communication Tool dated 09/29/22 at 11:00 AM documented:</p> <ul style="list-style-type: none"> <li>- Situation - At 10:30AM Resident alleged smoke aide put his hands on his left shoulder, at the smoking area.</li> <li>- Resident denies pain; head to toe assessment shows no bruises or any skin issue. Staff suspended pending investigation.</li> <li>- Medical Doctor and representative made aware.</li> </ul> <p>A care plan focus area initiated on 10/04/22 documented,</p> <ul style="list-style-type: none"> <li>- [Resident #103] is at risk of feelings emptiness, anxiety, uneasiness, characterized by; ineffective coping, related to restricted physical activity (smoking) AEB (as evidenced by) reported that assigned smoke aide did not maintain his physical distance (finger on him shoulder) for redirection in the designated smoking area.</li> </ul> <p>Review of Employee #13's human resources (HR) file on 11/01/23 at approximately 9:00 AM, showed a Disciplinary Action Form dated 09/29/22 that documented:</p> <ul style="list-style-type: none"> <li>- It was alleged [Employee #13 tapped [Resident #103] on the shoulder with his finger and asked him to return inside.</li> <li>- Corrective Action Taken - [Employee #13] will be suspended pending investigation.</li> <li>- Employee #13 received abuse training and education on 10/05/22 and returned to work on 10/06/22.</li> </ul> <p>It should be noted that there was no documented evidence in Employee #13's HR file to show that the employee was no longer working as a Smoke Aide upon returning from suspension.</p> <p>Review of the facility's investigation documents on 11/01/23 at 9:30 AM showed a document dated 03/21/23 that documented:</p> <ul style="list-style-type: none"> <li>- Per the facility policy, you [Employee #13] are not to come in contact with this resident [Resident #103] at any time.</li> <li>- This means you will not provide direct care or services to this resident, or enter this resident's room for any reason (not even to provide care or services to their roommate).</li> </ul> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A conference was conducted on 11/01/23 at 10:30 AM with Employee #1 (Administrator), Employee #2 (Director of Nursing/DON), Employee #3 (Assistant Director of Nursing/ADON), and Employee #14 (Human Resources Manager/HRM). During the conference, the employees were asked to explain why did take until 03/21/23, approximately six months after the alleged incident, for the facility administration to have documented evidence of the corrective actions that were taken to protect and prevent further potential abuse of Resident #103 from Employee #13. Employee #2 stated, After the investigation and suspension, [Employee #13] was removed from that position (Smoke Aide) and worked as restorative aide. When asked to show/provide documented evidence of Employee #13's position change after allegation, Employee #14 reviewed Employee #13's HR file and acknowledged that there was no such documentation.</p> <p>On 11/02/23 at 12:00 PM, Employee #1 and Employee #2 came to the State Surveyor with documents and Employee #1 stated, We called the previous Administrator who was here at the time of this incident (09/29/22) and she directed us looked through some folders and we found these additional documents.</p> <p>The additional documents showed:</p> <ul style="list-style-type: none"> <li>- A Personnel Action Notice dated 03/21/23 with Employee #13's name; Job/Department Change; Current Job/Department: Smoking Aide; New Job/Department CNA (Certified Nurse Aide)/Restorative.</li> </ul> <p>Employee #1 stated, The board held a meeting in March [2023] and reviewed all incidents that involved allegations of abuse. For this particular case, they felt it was warranted to take the steps of removing [Employee #13] from the position of a smoke aide to restorative aide out of abundance of caution. When asked prior to this personnel action, where was the employee working, Employee #2 stated, [Employee #13] was working as the Smoke Aide and there were cameras out there that were being monitored at all times by the front desk staff.</p> <p>The evidence showed that from 10/06/22 to 03/21/23, approximately six months, facility staff failed to have documented evidence that they took any corrective actions to protect and prevent further potential abuse of Resident #103 by Employee #13. During a face-to-face interview on 11/02/23 at 12:08 PM, Employees #1 and #2 acknowledged the finding.</p> <p>Cross Reference 22B DCMR Sec. 3203.5</p> <p>45102</p> <p>2. The facility staff failed to investigate Resident #331's report of a verbal altercation with another resident.</p> <p>Resident #331 was admitted to the facility on [DATE], with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit.</p> <p>A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented .There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted .In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC (District of Columbia) really needs to do an inspection .</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #331's medical record revealed the following:</p> <p>[Social Work Progress Note] 01/09/23 at 11:19 AM, documents .Writer received a call from residents sister . because resident call her &amp; (and) shared that she had some type of verbal altercation with another resident .</p> <p>[Nursing Progress Note] 01/09/23 1:57 PM, documents : In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated .</p> <p>[Physician Orders] 01/09/23 .In-House transfer from room [ROOM NUMBER]D to room [ROOM NUMBER]A for comfort and socialization .</p> <p>Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note.</p> <p>During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated.</p> <p>3A. The facility staff failed to investigate an allegation of abuse concerning Resident #332.</p> <p>A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: .Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time .On 10/27/2022, resident called the Admission Director with the following concerns, Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice .</p> <p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.</p> <p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of 01 indicating severe cognitive impairment.</p> <p>[Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents .Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware .</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note.</p> <p>During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility does not have an investigation into this incident.</p> <p>During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated I don't remember that kind of report to me.</p> <p>During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them.</p> <p>3B. The facility staff failed to investigate an unusual occurrence concerning resident #332.</p> <p>Resident #332 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia.</p> <p>A review of Resident #332's medical record revealed the following:</p> <p>A review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 01 indicating severe cognitive impairment.</p> <p>[Nursing Progress Note] 10/12/22 at 2:18 PM, documents, .At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) .with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied I'm trying to give my mom supplements, She is what I do even when she was in the hospital. On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her.</p> <p>The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22 in the nursing progress note.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility does not have an investigation into this incident.</p> <p>Cross Reference 22B DCMR Sec. 3232.1</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776</b></p> <p>Based on record reviews and staff interviews, for two (2) of 47 sampled residents, facility staff failed to provide the residents or their representative with bed-hold notice upon transfer to the hospital. Residents' #87 and #278.</p> <p>The findings included:</p> <p>1. Resident #87 was admitted to the facility on [DATE] with diagnoses that included: Benign Prostatic Hyperplasia, Cerebellar Ataxia and Degenerative Diseases of Basal Ganglia.</p> <p>Review of Resident #87's medical record revealed the following:</p> <p>A Modified Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 15, indicating intact cognition.</p> <p>A physician's order on 08/30/23 directed, Transfer patient to nearest ER (emergency room ) for evaluation and treatment for worsening sacral stage 4 wound and possible infection.</p> <p>An Admission Note dated 09/13/23 at 11:45 PM documented that Resident #87 was readmitted from [Hospital name] at 8:30 PM.</p> <p>Review of a Notice of Discharge, Transfer or Relocation Form showed:</p> <ul style="list-style-type: none"> <li>- Submitted on 09/06/23 at 5:52 PM</li> <li>- Resident #87s name</li> <li>- Proposed action - transfer</li> <li>- Transfer type - hospital</li> <li>- You are scheduled to be transferred on 08/31/23</li> </ul> <p>The evidence showed that facility staff failed to must provide Resident #87 written notice which specifies the duration of the bed-hold policy upon transfer to the hospital on 08/30/23.</p> <p>During a face-to-face interview on 11/06/23 at 10:35 AM, Employee #16 (Social Worker) reviewed Resident #87's Notice of Discharge, Transfer or Relocation Form and stated, It was an oversight. When we caught it the following week, it was submitted.</p> <p>2. Resident #278 was admitted to the facility on [DATE] with diagnoses that included: Muscle Weakness, Adjustment Disorder with Disturbance of Conduct and Anemia.</p> <p>Review of Resident #278's medial record revealed the following:</p> <p>(continued on next page)</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A face sheet that documented the resident's daughter as the primary contact.</p> <p>A Quarterly MDS assessment dated [DATE] showed that facility staff coded: BIMS Summary Score of 01, indicating severely impaired cognitive function.</p> <p>A Situation Background Assessment Request dated 12/08/22 at 10:32 AM documented:</p> <ul style="list-style-type: none"> <li>- Situation: Observed with a bump size of a quarter left side of head</li> <li>- New orders: Transfer resident to the hospital for CT (computed tomography) Scan /evaluation and treatment</li> </ul> <p>A Facility Reported Incident (FRI), DC-11326 submitted to the State Agency on 12/08/22 at 12:03 PM documented:</p> <ul style="list-style-type: none"> <li>- Around 9:55 AM, assigned Certified Nursing Assistant (CNA) observed a bump on the left side of head the size of a quarter</li> <li>- Medical Doctor assessed the resident ad order given to transfer resident to the emergency department for CT scan and evaluation</li> </ul> <p>A Nurse's Note dated 12/08/22 at 11:03 PM documented, Writer placed a follow up call to [Hospital name] on the status of the resident, spoke with ER nurse, stated resident is admitted .</p> <p>An Admission Note dated 12/13/22 at 9:36 PM documented that the resident was readmitted from the hospital on that day to room [ROOM NUMBER] B.</p> <p>Review of a Notice of Discharge, Transfer and Relocation Form in Resident #278's medical record showed that the form was completed by Employee #16 (Social Worker) and it documented:</p> <ul style="list-style-type: none"> <li>- Submitted on 12/23/22 at 6:34 AM</li> <li>- Resident #278's representatives name</li> <li>- Proposed action - transfer</li> <li>- Transfer type - hospital</li> <li>- You are scheduled to be transferred on 12/08/22.</li> </ul> <p>The evidence showed that facility staff provided Resident #278's representative notice of transfer to the hospital on 12/23/22, 15 days after the resident was initially transferred to the hospital and 10 days after the resident had already been readmitted back to the facility.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a face-to-face interview on 11/03/23 at 1:27 PM, Employee #16 stated that Notice of Discharge, Transfer and Relocation are to be provided immediately to the resident or the representative in person or via email. When asked about Resident #278's Notice of Discharge, Transfer and Relocation Form, Employee #16 reviewed the document, acknowledged the findings and stated, I don't know why this one was delayed.</p> <p>Cross Reference 22B DCMR Sec. 3270.1</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45104</b></p> <p>Based on record reviews and staff interviews for two (2) of 47 sampled residents facility staff failed to accurately code Resident #379's Quarterly Minimum Data Set (MDS) assessments to accurately reflect the resident's history of falls and failed to accurately code Resident #174's Admission MDS to reflect the resident's surgical wound.</p> <p>The findings included:</p> <p>1. Resident #379 was admitted to the facility on [DATE] with diagnoses that included: Cognitive Communication Deficit, Muscle Weakness, Unspecified, Severe Protein-Calorie Malnutrition, Adult Failure to Thrive, History of Falls, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety.</p> <p>A review of Resident #379's medical record revealed the following:</p> <p>A physician's order dated 12/01/2 at 11:0 PM documented: Precautions: Fall every shift.</p> <p>A care plan initiated on 12/02/22 documented: Focus: [Resident #379] has Fall Prevention in place . Goal: [Resident Name] will have reduced incidents of falls through the next review period x 90 .</p> <p>An Admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of 08, indicating the Resident had moderately impaired cognition and had a history of falls that included a fall within 2-6 months of the admission assessment.</p> <p>A Post Fall Assessment done on 12/26/22 at 1:15 PM documented: Score 10.0 Moderate Risk for recent fall.</p> <p>SBAR Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool on 12/26/22 at 1:52 PM documented: . Reason: Fall .Additional Comments: .Writer was alerted by OT (Occupational Therapist) that patient was on the floor. Observed [the] patient sitting on the floor leaning against the wall outside her room. When asked what happen(ed)? Pt (patient) stated, I was going across the hall to my neighbor, and I fell . Pt was assessed head to toe, UL (upper and lower) ext (extremity) ROM (range of motion) within limits. Denies pain or discomfort. Pt (patient) was assisted up by [the] writer and therapist using [a] gait belt and rolling walker.</p> <p>A care plan initiated on 12/26/22 documented: Focus: [Resident# 374] had an actual fall with no injury due to unsteady gait The care plan was revised on 01/13/23 and documented: Focus: [Resident] was observed on the floor on 01/13/23 with an abrasion 0.3 x 0.3 cm x 0 at the back of her head .</p> <p>(continued on next page)</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>SBAR Physician/NP/PA Communication Tool on 01/13/23 at 4:50 PM documented: .Reason: Fall with an apparent head injury . Additional Comments: Resident was observed on the floor on her back .Upon assessment, a minor blood was noted at the back of her head, the area was cleaned with normal saline, an ice pack was applied to the area, no bleeding. Pressure dressing was applied to the site. Resident is alert. Resident was asked if she hurts anywhere, she said no . Resident was assisted back to the bed by three nursing staff. [Physician's Name] was notified, .gave an order to send Resident to the nearest ER (emergency room ) for evaluation and treatment .</p> <p>A Department of Health Complaint /Incident Report submitted on 01/13/23 at 8:18 PM that documented: Writer was informed that Resident was observed on the floor on her back at 4:50 PM. A nursing staff called the charge nurse to assess this Resident. Upon assessment, minor</p> <p>blood was noted at the back of her head .area was cleaned with normal saline, ice pack was applied to the area .Pressure dressing was applied to the site. Resident is alert, verbally responsive, but she could not recall how she got on the floor. Resident was asked if she hurts anywhere, she said no. She was able to move her extremities. The bed was on the lowest Position and the call bell was in the bed. Resident was assisted back to the bed by three nursing staff . [Name of Physician] was notified, she gave an order to send Resident to the nearest emergency room (ER) for evaluation and treatment .</p> <p>A review of Resident #379's medical record revealed that the Resident had two falls; one fall with no injury on 12/26/22 and another fall with injury on 01/13/23.</p> <p>A Quarterly MDS assessment dated [DATE] documented that Resident #379 had only one fall (with a minor injury) since the Resident's last assessment on 12/05/22, or since the resident's admission on 12/01/22.</p> <p>During a face-to-face interview on 11/06/23 at 11:30 AM, Employee #15 (MDS Coordinator), acknowledged that the fall with no injury (on 12/26/22) was missed, and she stated that she would correct the resident's MDS assessment to include the Resident's fall.</p> <p>[Cross-over DCMR 3231.2]</p> <p>43776</p> <p>2. Facility staff failed to accurately code Resident #174's An Admission MDS assessment.</p> <p>Resident #174 was admitted to the facility on [DATE] with diagnoses that included: Extradural and Subdural Abscess, Osteomyelitis of Vertebra, Lumbar Region and Urinary Tract Infection.</p> <p>Review of Resident #174's medical record showed the following:</p> <p>A Hospital Discharge Summary dated 10/11/23 at 2:45 PM documented that the resident had an L (lumbar) 4 - L5 laminectomy on 09/26/23.</p> <p>An Admission Note dated 10/11/23 at 9:12 PM documented:</p> <p>- Status post laminectomy and wound vac placement</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Skin/Wound Note dated 10/12/23 at 3:43 PM documented:</p> <ul style="list-style-type: none"> <li>- Wound Nurse assessed patient</li> <li>- Right lower posterior back, 4 (length) x 3.7 (width) x 5.7 (depth) cm (centimeter) with the PSAOS abscess (collection of pus in the iliopsoas muscle compartment)</li> <li>- Wound vac in place</li> </ul> <p>A Physician's Progress Note dated 10/15/23 at 10:08 AM documented:</p> <ul style="list-style-type: none"> <li>- Status post laminectomy, wound vac placement PSOAS abscess</li> </ul> <p>An Admission /Medicare - 5 Day MDS assessment dated [DATE] showed facility staff coded: a BIMS Summary Score of 15, indicating intact cognition and had no surgical wound(s).</p> <p>The evidence showed that facility staff failed to Resident #174's Admission MDS assessment to capture that he had a surgical wound on his right lower back.</p> <p>During a face-to-face interview on 11/06/23 at 2:39 PM, Employee #15 (MDS Coordinator), reviewed Resident #174's Admission MDS assessment, acknowledged the finding and stated, The MDS will have to be modified to capture the surgical wound.</p> <p>Cross Reference 22B DCMR Sec. 3231.12</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45104</p> <p>Based on observations, record review and staff interviews for one (1) of 47 sampled residents facility staff failed to implement a Resident's care plan for the use of carrot palm guards to bilateral hands to prevent skin integrity impairment and further immobility/contractures. Resident #25</p> <p>The findings included:</p> <p>Resident #25 was admitted to the facility on [DATE] with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia.</p> <p>A review of Resident #25's medical record revealed the following:</p> <p>A Quarterly MDS dated [DATE] showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of 06, indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care.</p> <p>A physician's order dated 12/04/19 read: Carrot palms to prevent further tightness on at 10:00 AM and off at 12:00 PM.</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has a risk for skin integrity impairment related to immobility, incontinence .Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of redness or skin breakdown . Interventions: Apply pressure relief cushions and devices per order.</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity .Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) .Interventions: .splint application as recommended to right and left ext (extremity) .</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands .Goal: [Resident #25] will not have an increase of contracture by the next review in 90 days (initiated 06/14/16) .Interventions: .Apply carrot palm guards as ordered .</p> <p>A physician's order dated 08/01/23 read: Splinting order: Resident to wear bilateral [NAME] guard for 6 hours as tolerated to maintain skin integrity.</p> <p>During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand.</p> <p>Based on three observations and a review of Resident #25's comprehensive care plan, the evidence showed that facility staff failed to implement the Resident's use of bilateral palm guards. In addition, the Resident's refusal for treatment (i.e. Resident #25's refusal to keep palmar guards on hands) was not included as part of the resident's comprehensive care plan.</p> <p>During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), when asked about the Resident's use of palm guards, stated that the resident takes them off and throws them down on the floor. When asked if she or any of the other facility staff made the physician aware that the resident was removing the palm guards, she stated that she had not, but would do so. The Employee then acknowledged that the Resident's refusal to keep the bilateral palm guards on should have been included as a focus of the resident's comprehensive care plan.</p> <p>Cross Refrence 22B DCMR sect. 3210.4 (c)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45104</p> <p>Based on observations, record review, and staff interviews for one (1) of 47 sampled residents facility staff failed to ensure that a resident with a limited range of motion received the appropriate treatment and services to increase the resident's range of motion or prevent further decrease in range of motion.</p> <p>The findings included:</p> <p>Resident #25 was admitted to the facility on [DATE] with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia.</p> <p>A review of Resident #25's medical record revealed the following:</p> <p>A Quarterly MDS dated [DATE] showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of 06, indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care.</p> <p>A physician's order dated 12/04/19 read: Carrot palms to prevent further tightness on at 10:00 AM and off at 12:00 PM.</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has [a] risk for skin integrity impairment related to immobility, incontinence .Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of redness or skin breakdown . Interventions: Apply pressure relief cushions and devices per order.</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity .Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) .Interventions: .splint application as recommended to right and left ext (extremity) .</p> <p>A care plan initiated on 12/19/19 documented, Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands .Goal: [Resident #25] will not have an increase of contracture by the next review in 90 days (initiated 06/14/16) .Interventions: .Apply carrot palm guards as ordered .</p> <p>A physician's order dated 08/01/23 read: Splinting order: Resident to wear bilateral [NAME] guard for 6 hours as tolerated to maintain skin integrity.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room.</p> <p>During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand.</p> <p>During a face-to-face interview on 11/03/23 at 1:48 PM, Employee #23 (Restorative Nursing Aide/RNA), stated that she had not applied the resident's palm guards to the resident's hands, because the resident removed them all the time. When asked if she had let the Restorative Nurse Manager know that Resident #25 was not keeping the splints (palm guards) on, Employee #23 said that everyone knew including the Restorative Nurse Manager (Employee #22).</p> <p>On 11/03/23 review of the Splint Monitoring Form for 11/01/23 to 11/03/23, showed that the Restorative Nursing Aides documented that they were applying Resident #25's splints at 7:00 AM and were removing the splints at 3:00 PM.</p> <p>During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), stated that the resident takes the palm guards off and throws them. When asked if she or any of the staff made the physician aware that the resident was removing the palm guards, she stated that she had not, but would do so.</p> <p>During an observation on 11/06/23 at 12:25 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrist. The resident's fingers on her right hand were tightly bent into her right palm. There were no palm guards applied to either hand.</p> <p>During a face-to-face interview on 11/06/23 at 12:20 PM, when asked about the Resident's palm guards, Employee #24 (Licensed Practical Nurse) observed that the Resident was not wearing the palm guards and stated that the RNA applied them earlier, but the Resident took them off. When asked if she had documented the resident's behavior or had mentioned the resident's behavior to the physician, she stated that she had not. The employee then opened the top drawer of the resident's nightstand, removed the resident's palm guards, and started to apply them to the resident's hands. When Employee # attempted to straighten the resident's contracted fingers on her right hand, to apply the right-hand palm guard, the resident grimaced and stated that it hurt. The Employee then stated that she would mention to the physician the resident's refusal to keep the palm guards on her hands.</p> <p>Based on three observations, record reviews and staff interviews, the evidence shows that the facility staff failed to provide appropriate treatment to increase Resident #25's range of motion or prevent the resident's further decrease in range of motion. In addition, facility staff failed to make the physician aware of the resident's refusal to wear her palm guards, so that alternative treatment for the resident's limited range of motion could be prescribed.</p> <p>Cross Reference 22B DCMR sect. 3213.2(e)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45102</p> <p>Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff failed to adequately supervise Resident #331, while toileting as required by the residents Minimum Data Set (MDS) assessment which staff coded as requiring supervision and a one person staff assist with toileting. (Resident #331.)</p> <p>The Findings Included:</p> <p>A review of the facility's policy titled Fall and Fall Management documents .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .Staff will monitor if interventions have been successful in preventing falling .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .</p> <p>Resident #331 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit.</p> <p>A review of a complaint intake #DC00011545, that was submitted to the State Agency on 01/23/23, documented .There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted .In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection .</p> <p>Review of Resident #331's medical record revealed the following:</p> <p>[Baseline Care Plan] dated 01/06/23, documents .Toilet use: support provided One-person physical assist .</p> <p>Review of an Admission Minimum Data Set assessment (MDS) dated [DATE], showed that the facility staff coded Resident #331 as having a Brief Interview for Mental status (BIMS) summary score of 14 which indicates intact cognition. The facility staff coded that the resident required supervision and one-person physical assist with toileting.</p> <p>[Nursing Progress Note] 01/11/23 at 2:00 AM, documents .At approximately 11:15 pm, a Night shift Staff answered a call bell light in room [ROOM NUMBER] B, the Resident in room [ROOM NUMBER] A was on the floor. She called another Staff to assist her with the Resident. Writer was called to assist and assess the Resident. She was on the floor in a sitting Position on her buttocks and leaning on the bed. Resident said that she was going to the bathroom, urinated on the floor and missed her step and slidded on the floor. Pain assessment was done, she denied Pain, Neurological assessment was done, she is alert, oriented, no injury noted, she can move all her extremities, she did not verbalize any Pain or discomfort. Three Staff assisted her to her bed, call bell was already within reach. She was encouraged to call for assistance any time she needs help .</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Post Fall Huddle] 01/11/23 at 1:12 AM, .Post- Fall Huddle Recommendations /New Intervention to prevent another fall (what could have been done differently-Encourage resident to use call bell and call for assistance .</p> <p>[Nursing Progress Note] 01/20/2023 at 9:52 AM, documents .around 5:40 am, Resident was taken to the bathroom and placed on the commode, and was told to pull the call light when she is done, the CNA (Certified Nurse Aide) was cleaning Resident's room when she heard her call for help, on getting inside the bathroom, Resident was observed sitting on the bathroom floor, As per Resident, she said she fell on her back, but denied hitting her head on the floor, Head to toe assessment done, no injury noted, ROM (Range of Motion) tolerated and within Resident's baseline, .</p> <p>[Post Fall Huddle] 01/20/23 at 6:57 AM, . Description of Fall- Resident was getting up from commode without calling for help .Post- Fall Huddle Recommendations /New Intervention to prevent another fall what could have been done differently- Re educated to use call light .</p> <p>[Release of Responsibility for Discharge] was signed by Resident #331 on 01/20/23 at 7:30PM.</p> <p>The medical record lacked documented evidence that the facility staff provided supervision while toileting Resident #331.</p> <p>During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that supervision with toileting means that the staff should be in the bathroom with the resident and acknowledged the findings.</p> <p>Cross Reference 22B DCMR Sec. 3211.1 (d)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>43776</p> <p>Based on observation, record review and staff interview, facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed.</p> <p>The findings included:</p> <p>During an observation on 11/01/23 at 8:13 AM of the 3rd Floor narcotic book, it was noted that there was no signature in the section Balance verified by nurse coming on duty for the 7:00 AM - 3:00 PM shift on 11/01/23.</p> <p>The evidence showed that facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed as evidenced by failing to sign off that the narcotic count was correct with the off-going nurse.</p> <p>During a face-to-face interview done at the time of the observation, Employee #19 (Licensed Practical Nurse/LPN) stated that her shift started 7:00 AM. The employee further stated, I had to run to the bathroom during the [narcotic] count and forgot to sign off.</p> <p>Cross Reference 22B DCMR Sec. 3224.3</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45102</p> <p>Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff failed to show documented evidence in the medical record that the physician reviewed the pharmacy regimen review for Resident #137.</p> <p>The Findings included:</p> <p>A review of the facility's policy titled Medication Regimen Review with a revision date of 06/2023 documents . The Consultant Pharmacist shall review the medication regimen of each resident at least monthly .Routine reviews will be done monthly .Copies of drug/medication regimen review reports including physician responses will be maintained as part of the permanent medical record .</p> <p>Resident #137 was admitted to the facility on [DATE], with multiple diagnoses that included the following: Dementia, Paranoid Schizophrenia, and Gastrostomy Status.</p> <p>Review of Resident #137's medical record revealed the following:</p> <p>A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], shows that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 13 indicating intact cognition and as receiving antipsychotic medication.</p> <p>Pharmacy medication regimen reviews were reviewed in the medical record from 01/01/2023 to 10/02/2023. The pharmacist made recommendations on the following dates: 02/02/23, 03/01/23, 04/01/23, 04/28/23, 06/01/23, 09/01/23, and 10/02/23.</p> <p>The physician response to the medication regimen reviews were not present in Resident #137's medical record.</p> <p>During a face-to-face interview conducted on 11/06/23 at approximately 12:00 PM, Employee #10 (QA Quality Assurance) stated that the facility is in the process transitioning into 100% electronic health records and that the physician response to the pharmacist was in a binder in an office. Employee #10 acknowledged the findings.</p> <p>Cross Reference 22B DCMR Sec. 3231.9</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43776</p> <p>Based on two (2) of ten (10) observations and facility interviews, facility staff failed to store and label biologicals in accordance with currently accepted professional practices.</p> <p>The findings included:</p> <p>According to the Institute for Safe Medication Practices (ISMP)</p> <ul style="list-style-type: none"> <li>- Vials of insulin dispensed from the pharmacy should be labeled appropriately and include the patient's name.</li> </ul> <p><a href="https://www.ismp.org/resources/clinical-reminder-about-safe-use-insulin-vials">https://www.ismp.org/resources/clinical-reminder-about-safe-use-insulin-vials</a></p> <p>According to Healthline:</p> <ul style="list-style-type: none"> <li>- Insulin is effective for 28 days after opening</li> <li>- Users are supposed to mark the date they open a vial or began using a pen, and then keep track and discard it after 28 days</li> </ul> <p><a href="https://www.healthline.com/diabetesmine/what-to-do-with-expired-insulin">https://www.healthline.com/diabetesmine/what-to-do-with-expired-insulin</a></p> <p>1. During an observation of the 4th floor medication storage room on [DATE] at 2:10 PM, one opened Lantus (type of Insulin) vial stored for use that was not labeled with an open or expire date</p> <p>During a face-to-face interview at the time of the observation, Employee #21 (Licensed Practical Nurse/LPN), acknowledged the finding and appropriately discarded the Lantus vial.</p> <p>2. During an observation of the 2nd floor, team 2 medication cart with Employee #20 (Licensed Practical Nurse/LPN) on [DATE] at 8:00 AM, one (1) Novolog (type of Insulin) pen stored for use that did not contain a resident label and one other Novolog pen that was not labeled with the date it was opened or the expire date.</p> <p>During a face-to-face interview at the time of the observation, Employee #20 acknowledged the findings and stated that she would discard the Novolog pens.</p> <p>Cross Reference 22B DCMR Dec. 3227.19</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43776</p> <p>Based on two (2) observations of the dishwashing cycle and staff interview, facility staff failed to ensure that the dishwasher reached the required temperature (150 degrees to 165 degrees Fahrenheit) to clean dishes and utensils under sanitary conditions.</p> <p>The findings included:</p> <p>During an observation in the facility kitchen on 10/31/23 at 10:55 AM, it was noted that the high temperature dishwasher, during the wash cycle, reached a high of 130 degrees Fahrenheit.</p> <p>In a second observation on 10/31/23 at 11:00 AM, the wash cycle temperature reached a high of 132 degrees Fahrenheit.</p> <p>During a face-to-face interview at the time of the both observations, Employee #25 (Food Service Director) acknowledged the findings and stated that the Maintenance Director would be notified to address the issue.</p> <p>Cross Reference 22B DCMR Sec. 3219.1</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41645</p> <p>Based on record review and staff interview, for three (3) of 47 sampled residents, facility staff failed to ensure resident's records contained accurate information. Residents' #229, #132 and #128.</p> <p>The findings included:</p> <p>1A. The facility's staff failed to ensure Resident #229's Post Fall Huddle dated [DATE] contained accurate information as evidence by documenting the resident's fall as witnessed.</p> <p>Resident #229 was admitted to the facility on [DATE] with multiple diagnoses including Stage 4 Malignant Neoplasm of Lower Lobe,</p> <p>A nursing note dated [DATE] at 11:30 PM documented the following but not limited to: Resident was observed by medication nurse at 11:00 pm and she was sleeping. Around 11:15 pm resident was observed on floor, unresponsive resident was transferred back to bed. CPR was initiated. 911 was called.</p> <p>A review of a Post Fall Huddle dated [DATE] at 11:40 PM documented the following but not limited to: Was fall witnessed? Yes.</p> <p>1B. The facility's staff failed to ensure accurate information was included in the Facility Reported Incident. As evidenced by, not including the resident expired in the facility and discharged to a funeral home.</p> <p>Resident #229 was admitted to the facility on [DATE] with multiple diagnoses including Stage 4 Malignant Neoplasm of Lower Lobe, Generalized Muscle Weakness, and Legally Blind.</p> <p>A nursing note dated [DATE] at 11:30 PM showed, Resident was observed by medication Nurse at 11:00 PM and she was sleeping. Around 11:15 PM resident was observed on floor, unresponsive resident was transferred back to bed. CPR was initiated. 911 was called and arrived around 11:43. Dr [NAME] was called and ordered to transferred to nearest Hospital for evaluation and treatment via EMS. Responsible Party was called.</p> <p>A nursing note dated [DATE] at 2:10 AM documented, EMS (Emergency Medical Services) team pronounced resident dead at approximately 12:35 am, CPR terminated, [doctor's name] made aware and he stated that cause of death is Malignant Neoplasm of Lower Lobe of Left Bronchus or Lung. RP (responsible party) could not be reached on phone immediately but a call back message was left. Resident was given postmortem care with dignity. Writer will continue to follow up with RP.</p> <p>A State Survey Facility Reported Incident Intake form# DC-11434 dated [DATE] at 4:39 AM documented, According to the charge nurse, resident was last seen lying on her bed with bed on lowest position and respiration un-labored at 11PM. By 11:15 PM, resident was observed on the floor unresponsive. Code called, resident was assisted back to the bed. MD was made aware and MD gave order to transfer resident to the nearest ER via 911 for treatment and further evaluation.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated [DATE] at 6:56 AM documented, The remains of resident body was collected by two DC morgue personnel by 6:26am. RP could not be reached on [phone number]. Next shift will follow up.</p> <p>During a telephone interview on [DATE] at 2:58 PM, Employee #5 (Nurse Supervisor) stated that she sent the Facility Report Incident to the State Survey Agency. However, she did not provide an explanation as to why she did not include that the resident had expired in the facility and discharged to the funeral home.</p> <p>43776</p> <p>2. Facility staff failed to accurately document Resident b#132's refusal of care in the Treatment Administration Record (TAR).</p> <p>Resident #132 was admitted to the facility on [DATE] with diagnoses that included: Muscle Weakness and Cognitive Communication Deficit.</p> <p>Review of Resident #132's medical record revealed the following:</p> <p>A physician's order dated [DATE] directed, Continue use of brace when sitting up or out of bed, every shift</p> <p>A physician's order dated [DATE] directed, Resident needs to get out of bed to recliner daily, every day and evening shift</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition.</p> <p>A Complaint, DC12341, received by the State Agency on [DATE] documented:</p> <p>- [Resident #132] has been recommended by a chiropractor to wear her back brace. This recommendation request the use of the back brace when she's sitting in a chair. I have witnessed back brace not being used as directed</p> <p>A care plan focus area: [Resident #132] is noncompliant with getting out of bed to the [NAME] chair, back brace was initiated on [DATE].</p> <p>During an initial observation of Resident #132 on [DATE] at 10:50 AM, she was observed lying in bed in bed. While the surveyor was in the room, the resident's assigned Certified Nurse Aide (CNA), Employee #26 entered the room and told the resident that she would be getting ready to put on her back brace and then getting her up into the chair. Resident #132 refused, stating, I'm not getting out of bed today. The CNA asked again with the resident still refusing.</p> <p>During a second observation of Resident #132, on [DATE] at 2:40 PM, the resident was noted in bed.</p> <p>During a face-to-face interview on [DATE] at 2:43 PM, Employee #26 stated, Resident refused to get out of bed today, I tried multiple times. I let the nurse know. She gets a shower tomorrow and usually on those days she'll sit up in the chair.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Treatment Administration Record (TAR) on [DATE] at approximately 11:30 AM showed that on [DATE], day shift (7:00 AM - 3:00 PM), facility staff documented a check mark and their initials to indicate that the following order was administered and or carried out, Resident needs to get out of bed to recliner daily every day and evening shift.</p> <p>The evidence showed that facility staff failed to accurately document that Resident #132 refused to get out of bed care on the TAR on [DATE].</p> <p>During a face-to-face interview on [DATE] at 11:52 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, We don't document things that weren't done or didn't happen.</p> <p>Cross Reference 22B DCMR Sec 3231.11</p> <p>45102</p> <p>3.The facility staff failed to accurately document the presence of open areas on Resident #128's weekly skin assessments.</p> <p>Resident #128 was admitted to the facility [DATE] with multiple diagnoses that included the following: Cutaneous Abscess of Right Lower Limb, Pressure Ulcer left Buttock Unstageable, and Pressure Ulcer of Unspecified Heal Stage 3.</p> <p>A review of the facility's policy titled Clinical Documentation Record revised on ,d+[DATE] documents .It is the policy of this facility to ensure accurate documentation of important elements contributing to high quality care of our residents .Documentation Entries into organization documents or the health record (including but not limited to provider orders) must be: Accurate, valid, and complete .</p> <p>Review of Resident #128's medical record revealed the following:</p> <p>[Admission Note] [DATE] at 2:22 AM documents ., has altered skin issues on unstageable Sacral decubitus ulcer measuring 11 x 13 cm (centimeters), Left hip DTI (Deep Tissue Injury) 9 x 10 cm, Right heel 9 x6 cm, R (Right) /foot 4 x 5 cm, R/knee eschar 5 x 3 cm, Left foot dorsal 2 x 4 cm, and double lumen Picc (peripherally inserted central catheter) line on right upper arm .</p> <p>A review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that the facility staff coded the following: Brief Interview for Mental Status (BIMS) summary score of 14 indicating intact cognition, the resident is at risk of developing pressure ulcers, the resident has one or more unhealed pressure ulcers, two (2) stage 3 pressure ulcers present on admission, one (1) stage 4 pressure ulcer present on admission, three (3) unstageable pressure ulcers present on admission and an infection of the foot. The facility staff coded that Resident #128 received the following skin and Ulcer/Injury treatments: Pressure reducing device for chair, turning /repositioning program, nutrition hydration intervention, pressure ulcer injury care, application of nonsurgical dressing, application of ointments/medications and application of dressing to feet.</p> <p>[Skilled Documentation] [DATE] at 10:22 PM, documents .Skin issues: osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection Active Infection</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Weekly Skin Assessment] [DATE], at 10:48 PM documents .Describe the skin impairment No new skin alteration The interventions section was blank.</p> <p>[Weekly Skin Assessment] [DATE] at 9:06 AM, documents .Describe the skin impairment none The interventions section was blank.</p> <p>[Skilled Documentation] [DATE] at 2:02 PM, documents .Wound location(s) .osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection.</p> <p>[Weekly Skin Assessment] [DATE] at 10:52 AM, documents .Describe the skin impairment none . The interventions section is left blank.</p> <p>[Skilled Documentation] [DATE] at 11:17 AM, documents Wound location(s) .osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection.</p> <p>[Weekly Skin Assessment] [DATE] at 2:30 PM, documents .Describe the skin impairment none . The interventions section is blank.</p> <p>[Skilled Documentation] [DATE] at 8:29 PM, documents .Wound locations: Osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection .</p> <p>The weekly skin assessments from [DATE] through [DATE] inaccurately document the condition of Resident #128's skin.</p> <p>During a face-to-face interview conducted on [DATE] at 10:20 AM, Employee #18 (Wound Nurse) stated that the weekly skin assessments are inaccurate and acknowledged the findings.</p> <p>During a face-to-face interview conducted on [DATE] at approximately 12:00 PM, Employee #9 (Licensed Practical Nurse) stated they do skin assessments every week and she thought she was only to document if there were new wounds.</p> <p>Cross Reference 22B DCMR Sec. 3231.11</p>

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45104</p> <p>Based on record review and staff interviews, the facility staff failed to ensure that one (1) of 47 sampled residents had a current written hospice care plan that included both the most recent hospice plan of care and a description of the care and services furnished by the long term care facility. Resident #15</p> <p>The findings included:</p> <p>A review of the facility's Hospice agreement documented, .Hospice Plan of Care means a written plan which is established, maintained, reviewed and modified if necessary by an Interdisciplinary Hospice Team .</p> <p>Nursing Home Plan of Care means a written care plan which is established, maintained, reviewed and modified if necessary by a Nursing Home Interdisciplinary Team .</p> <p>Design and Maintenance of Hospice Plan of Care .Hospice shall furnish the Nursing Home with a copy of the following items: .2) the most current Hospice Plan of Care . The Hospice Plan of Care will identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.</p> <p>Design and Maintenance of Nursing Home Plan of Care .Nursing Home shall furnish Hospice with a copy of the Nursing Home Plan of Care. The Nursing Home will periodically review and modify the Nursing Home Plan of Care in coordination with Hospice .</p> <p>Compilation of Records .Each medical record shall completely, promptly, and accurately document all services provided to, and events concerning, each Residential Hospice patient .</p> <p>Resident #15 was admitted to the facility on [DATE] with the following diagnoses: Polyosteoarthritis, Age-Related Physical Debility, Parkinson's Disease, Legal Blindness, Schizophrenia, Dementia, and Encounter for Palliative Care.</p> <p>A review of Resident #252's medical record revealed:</p> <p>A Face Sheet documented that Resident #15 had an Court Appointed Guardian/Representative.</p> <p>A Physician's Order dated 01/21/22 documented: Resident readmitted to [Name of Hospice] with a diagnosis of Parkinson's Disease with a prognosis of six (6) months or less if the disease goes the normal course. Please call [Name of Hospice] at .when there is a change of care condition. Symptoms management concern, death of a patient, clinical changes prior to any test/hospitalization s.</p> <p>An Informed Consent Form documented that Resident #15 was to receive hospice services from [Name of Hospice], signed by Resident #15's Representative on 04/21/21.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Medicare Hospice Benefit Election Form that documented that the Resident was to receive hospice benefits and signed by Resident #15's Representative on 04/21/21.</p> <p>A care plan initiated on 04/27/21 documented: Focus: Advanced directive form has been completed and Resident is currently on hospice care with [Name of Hospice and Phone Number] with a diagnosis of Parkinson's Disease .Care Plan Goals reviewed 05/17/23.</p> <p>A care plan initiated on 06/29/23 documented: Focus: [Resident #15] admitted with Hospice [Name of Hospice] with a diagnosis of Parkinson's Disease. Interventions: Allow/resident/family to discuss feelings, etc, Arrange visits with clergy, social worker, or psychological services prn (as needed), [NAME] with ADL care and pain management as needed, Encourage loved ones to keep in contact/visit, Evaluate for unmet needs such as toileting, hunger, thirst, fatigue, Hospice referral, Observe for and medicate for pain/discomfort as needed. Notify MD of unrelieved pain. Of note, the Nursing home care plans for Resident #15 had not been updated since 06/29/23 and did not include or specify the care and services that were to be provided by the Hospice agency.</p> <p>A Hospice Plan of Care for Resident #15 from [Name of Hospice] dated 06/23/22 documented:: DME/Supplies: DME: Oxygen concentrator; Safety Measures: Aspiration precautions, Equipment, Safety start, Fall precautions, .Support during transfer and ambulation, Standard precautions/infection control, Use of assistive devices; Diet/Hydration: Pureed diet .Goals/Interventions/Summary of Problems: Pain/Alteration in comfort .Interventions: Administer pain medication as prescribed . Respiratory: Alteration in Respiratory Status . Interventions: Assess respiratory status .Patient/Caregiver will demonstrate safe use and maintenance of respiratory equipment .GU/GI Nutritional/Endocrine: Alteration in Nutrition related to disease progression as evidenced by weight .Interventions: Determine nutrition hydration needs and desires . Integumentary: Potential for skin breakdown due to immobility .Medical Social Services Interventions: Assist family/caregiver with coping, .Counseling for family/patient coping, Counseling for planning decision making, Facilitate problem-solving and decision making, and Financial counseling/linkage for additional resources .</p> <p>Of note the Hospice Plan of Care included in Resident 25's medical record, had not been updated since 06/23/22 and did not specifically identify which hospice provider was responsible for performing the respective functions that were agreed upon and included in Resident #25's Hospice Plan of Care.</p> <p>A review of the Quarterly Minimum Data Set Assessment on 08/03/23 documented that the Resident had received hospice services within the last 14 days of the assessment.</p> <p>Further review of Resident #15 medical record lacked documented evidence that facility staff updated the Resident's comprehensive person-centered care plan to include the hospice agency's care plan for the Resident.</p> <p>During a face-to-face interview on 11/14/23 at 10:14 AM, Employee #28 (Hospice Nurse) stated Resident #15's Hospice Plan of Care had been updated since 06/29/23 and she was not aware that the facility did not have a copy of Resident #15's most recent Hospice Plan of Care. She then added that she would print the resident's most recent hospice plan of care and would leave it with the Resident's nurse.</p> <p>(continued on next page)</p>		

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  11/14/2023
NAME OF PROVIDER OR SUPPLIER  Inspire Rehabilitation and Health Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a face-to-face interview on 11/14/23 at 10:28 AM, Employee #27 (Registered Nurse) acknowledged that Resident #15's comprehensive care plan had not been updated and did not include the hospice plan of care for the resident.</p>		