STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095038	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills of DC	4901 Connecticut Avenue, NW Washington, DC 20008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 Based on record review and staff interview, for one (1) of three (3) sampled residents, the facility's staff failed to ensure a resident's assessment reflected the type of facility where she was previously admitted . (Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE] with a history of Acute Pulmonary Embolism and Hypertension. According to the admission intake form dated 12/13/24, Resident #1 was being discharged from an out-of-state nursing home. An Entry Minimum Data Set (MDS) assessment dated [DATE] documented that the resident was discharged from short-term general hospital. During a telephone interview on 12/27/24 at 1:34 PM, Employee #8 (MDS Coordinator) stated that she coded the resident as being discharged from a hospital based on the hospital discharge summary provided by the nursing staff. She said that she was informed by Employee #2 (Director of Nursing) that the resident had been discharged from a nursing home.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 Based on record review and staff interviews, for one (1) of three (3) sampled residents, the facility failed to: administer Eliquis(anticoagulant)at the currently prescribed dose [5mg by mouth two-times a day]. And, Metoprolol (beta blocker) in the currently prescribed formulary [Succinate Extended Release].(Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE] with a history of Acute Pulmonary Embolism and Hypertension. A review of Resident #1's admission packet from the facility's Admission Office revealed the following pre-admission documents: -An out-of-state hospital discharge summary dated 12/10/24 documented that the resident was hospitalized between 12/05/24 and 12/10/ 24 with Acute Pulmonary Embolism. The discharge summary also revealed that the following medications were prescribed: Apixaban (Eliquis) 5 mg 2 tablets (10 mg) by mouth daily 2 times a day for 6 days. Then take [Eliquis 5 mg] 1 tablet (5mg) by mouth two (2) times daily . Metoprolol Succinate ER (exten release) 50 mg one (1) tablet by mouth nightly . -A facility's (Forest Hills) admission intake form dated 12/13/24 indicating that the resident was being discharged from an out-of-state skilled nursing facility. -A discharge summary from an out-of-state skilled nursing facility revealed that the resident was admitted between 12/10/24 and 12/19/24. In addition, the summary showed the resident was prescribed the following medications: (Eliquis)5mg 2 tablets (10 mg) by mouth twice a day for 6 days starting on 12/10/24 and ending on 12/17/24 . Eliquis 5mg one (1) tablet by mouth every 12 hours . Metoprolol Succinate Extended Release (Generic name -Toprol XL) 50 mg one (1) tablet by mouth at bedtime . -A Complete Blood Count with Differential lab result dated 12/11/24 documented in part, Hemoglobin 11.7 g/dL range 11. 2 - 15.7 g/dL (grams per deciliters) . Please note: The documents listed above, except for the facility's admission intake form, were included in the resident's hard medical record on the unit the resident resided. A nursing progress note dated 12/19/24 at 5:32 PM, documented in part, Resident .admitted today at the facility at 1:00 PM with history of Acute PE (pulmonary embolism) . Alert, oriented X3 . speech is clear .Heart rate and rhythm are normal. Vital signs stable .oriented to call light and bed control. Resident is adjusting well to .surroundings. A physician order dated 12/19/24 instructed: Apixaban (Brand name- Eliquis) 5mg give 2 tablets by mouth two (2) times a day for a clot in lung for 6 days. Give 10 mg (milligrams) . Metoprolol Tartrate (Generic name -Lopressor) 50 mg give one (1) tablet by mouth at bedtime . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan dated 12/19/24 documented in part, Focus - [Resident's name] is on anticoagulant therapy (Apixaban/Eliquis) related to clot in lung .Interventions- Administer anticoagulant medication as ordered by physician. Monitor for side effects and effectiveness every shift A physician order dated 12/22/24 instructed, Monitor resident for bleeding and report any abnormal. Phone findings to the attending physician every shift for 7 days. A Director of Nursing progress note dated 12/23/24 at 6:30 PM, documented in part, During the medication administration on 12/22/24, it was noted that Eliquis 10 mg BID was inadvertently given instead of prescribed Eliquis 5 mg BID. Upon discovery, the attending physician was promptly notified , and the medication order was corrected to reflect the proper dosage of Eliquis 5mg BID .A head-to-toe assessment was completed and revealed no evidence of active bleeding or bruising .Laboratory results .a hemoglobin [test dated12/23/24] showed a level 10.5 g/dL, a decrease from 11.7 g/dL compared to lab work from the previous facility (12/11/24) .[NP's name] was on-site around 6:00 PM to assess the resident, an no abnormal findings were noted during the assessment. According to the Medication Administration Record (MAR) for December 2024, the resident received Apixaban (Eliquis) 10 mg two (2) times a day between 12/20/24 and 12/21/24 (four occasions). The MAR also revealed that the resident received Metoprolol Tartrate (Generic name-Lopressor) 50 mg at bedtime between 12/19/24 and 12/22/23 (four occasion). A Complete Blood Count with Differential lab result dated 12/23/24 documented in part, Hemoglobin 11.7 g/dL range 11.1 - 15.9 g/dL (grams per deciliter) . A review of the resident's blood pressure levels between 12/19/24 to 12/23/24 revealed the resident's systolic blood pressure ranged from 113 to 128 mmHg (millimeter of mercury) and diastolic blood pressure ranged from 58 to 80 mmHg (millimeter of mercury). During a telephone interview on 12/26/24 at 11:32 AM, Resident #1's daughter/POA stated that when she brought her mother to the facility, she gave the nurse on duty copies of her mother's medications and physical medication from her previous nursing home. The daughter also said that she coordinated a call between the facility's nurse and the nurse from the previous nursing home. While visiting her mother on the evening on 12/22/24, she noticed the nurse attempting to administer Eliquis 10mg. When she asked the nurse why her mother was receiving 10 mg instead of 5mg, the nurse informed her that her mother had a physician order for Eliquis 10 mg twice a day for six days. The daughter stated that she informed the nurse that was a onetime order that was completed at the previous nursing home. The supervisor was called, and the medication was held. The Director of Nursing came in the next morning and apologize for the mistake. As a result of the medication error, she decided to discharge her mother home. Additionally, as she reviewed her mother's mediation list during discharge, she discovered that her mother was receiving Metoprolol Tartrate (Lopressor) 50 mg instead of Metoprolol Succinate Extended Release (Toprol XL) that she received while in the previous nursing home. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/26/24 at 1:19 PM, Employee # 3 (assigned RN) stated that she and Employee #5 (LPN) admitted Resident #1 on 12/19/24. She said that although she received report via phone from the unit manager of the discharge facility, it did not include the resident's medications. The resident's daughter did provide her with a discharge summary that included a medication list from the discharging nursing home. After receiving the medication list, she reviewed it and handed it to Employee #5 (LPN) to transcribe. When asked if the summary was from a nursing home or hospital? She said that the medication list was from the nursing home. During a telephone interview on 12/27/24 at 8: 20 AM, Employee #4 (primary care physician) stated that she gave medication orders based on the hospital discharge summary. According to the documents, Eliquis 10 mg by mouth two times a day was prescribed, along with Metoprolol Succinate Extended Release 50 mg one (1) tab at bedtime every evening was ordered. According to the employee, she said she didn't recall seeing a discharge summary from the nursing home. Additionally, the employee stated that staff informed of the error with Resident #1receiving10 mg twice a day instead of Eliquis 5 mg twice a day. She also stated that staff did not inform her that that the resident was receiving Metoprolol Tartrate 50 mg a day instead of Metoprolol Succinate 50 mg a day. In addition, the employee stated that the resident should have been given Eliquis and Metoprolol as documented on her discharge summary from the nursing home. During a telephone interview on 12/27/24 starting at 8:42 AM, Employee #5 (LPN) stated that she helped Employee #3 (RN) admit Resident #1. She reviewed the hospital discharge summary given to her by Employee #3. She was not given a discharge summary from a nursing home. She reviewed the medications and took a picture of the medication list and sent it to the physician. After the physician approved the medications, she entered the orders into Resident #1's electronic medication record and sent the ordered the medications from pharmacy. During a face-to-face interview on 12/27/24 at approximately 2 PM, Employee #2 (DON) stated that the staff transcribed hospital orders for Eliquis 10 mg twice daily by mouth for six (6) days instead of Eliquis 5 mg twice daily as indicated on the nursing home discharge summary. Additionally, she said that unaware that the resident was receiving Metoprolol [Tartrate] instead of Metoprolol [Succinate] as ordered by the physician. Please note: The surveyor and Employee #2 (DON) reviewed Resident #1's electronic pharmacy record on 12/27/24 at approximately 2 PM, the review revealed that Employee # 5 entered Metoprolol Tartrate 50 mg by mouth at bedtime [daily] instead of Metoprolol Succinate 50 mg by mouth at bedtime [daily] as indicated on the both the hospital and nursing home discharge medication orders. During a face-to-face interview on 12/27/24 at 9:01 AM, Employee #6 (Director of Admissions/Marketing) stated that she received several documents from the nursing home on 12/17/24 via email, including a discharge summary from the nursing home [dated 12/17/24] and a discharge summary from the hospital [dated 12/10/24]. A copy of the documents was sent to the Administrator/RN for approval. After the Administrator approved Resident #1 for admission, the documents were given to a nurse on the resident's assigned unit for review. This was prior to her admission on 12/19/24. Employee #6 could not recall the date or the nurse's name who was provided the documents for review.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 Based on record review and staff interview, the facility failed to ensure Resident #1 was not administered unnecessary medications. This was evident for one (1) of three (3) sampled residents. The findings included: Resident #1 was admitted to the facility on [DATE] with a history of Acute Pulmonary Embolism and Hypertension. A review of Resident #1's medical record showed that the resident was discharged from an out-of-state nursing home prior to her admission on 12/19/24. Continued review of the resident's medical record revealed multiple documents from the discharging nursing home including: -A hospital discharge summary dated 12/10/24 documenting the resident was hospitalized between 12/05/24 and 12/10/ 24 with Acute Pulmonary Embolism. The discharge summary also revealed that the following medications were prescribed: Apixaban (Eliquis) 5 mg 2 tablets (10 mg) by mouth daily 2 times a day for 6 days. Then take [Eliquis 5 mg] 1 tablet (5mg) by mouth two (2) times daily . -A discharge summary from an out-of-state skilled nursing facility indicating the resident was admitted between 12/10/24 and 12/19/24. The summary also showed the Apixaban (Eliquis) 5 mg 2 tablets (10 mg) by mouth daily 2 times a day for 6 days was completed on 12/17/24. In addition, the resident was prescribed . Eliquis 5mg one (1) tablet by mouth every 12 hours . A physician order dated 12/19/24 instructed the following: Apixaban (Brand name- Eliquis) 5mg give 2 tablets by mouth two (2) times a day for a clot in lung for 6 days. Give 10 mg (milligrams). A Director of Nursing progress note dated 12/23/24 at 6:30 PM, documented in part, During the medication administration on 12/22/24, it was noted that Eliquis 10 mg BID was inadvertently given instead of prescribed Eliquis 5 mg BID. Upon discovery, the attending physician was promptly notified, and the medication order was corrected to reflect the proper dosage of Eliquis 5mg BID . According to the Medication Administration Record (MAR) for December 2024, the resident received Apixaban (Eliquis) 10 mg two (2) times a day between 12/20/24 and 12/21/24 (four occasions). During a face-to-face interview on 12/26/24 at approximately 10 AM, Employee #2 stated that there was an error with Resident #1's medication (Eliquis). The employee said that staff transcribed the order for Eliquis 10 mg by mouth twice-a-day from a hospital discharge summary [dated 12/10/24]. The staff should have transcribed medications from the discharging nursing home discharge summary [dated 12/19/24] which instructed Eliquis 5 mg by mouth two times a day. The employee stated the when the resident's daughter brought it to staff attention on 12/22/24. They quickly notified the physician (Employee #4) and corrected the order. The resident was assessed, monitored, and labs were drawn. The resident did not have any bleeding or other apparent side effects from the error with Eliquis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/26/24 at 11:32 AM, Resident #1's daughter/POA stated that while visiting her mother on the evening on 12/22/24, she noticed the nurse attempting to administer Eliquis 10mg. When she asked the nurse why her mother was receiving 10 mg instead of 5mg, the nurse informed her that her mother had a physician order for Eliquis 10 mg twice a day for six days. The daughter stated that she informed the nurse that was a onetime order that was completed at the previous nursing home. The supervisor was called, and the medication was held. The Director of Nursing came in the next morning and apologize for the mistake. As a result of the medication error, she decided to discharge her mother home. During a telephone interview on 12/27/24 at 8: 20 AM, Employee #4 (primary care physician) stated that when the resident was admitted on [DATE] she gave an order for Eliquis 10 mg by mouth for six (6) days based on a hospital discharge summary [dated 12/10/24]. According to the documents, Eliquis 10 mg by mouth two times a day was prescribed. According to the employee, she said she didn't remember seeing the discharge summary from the discharging nursing home in the resident's record. When staff informed her of the error, she gave orders to change Eliquis to 5 mg by mouth twice a day, monitor resident for bleeding, and have labs drawn [complete blood count with differential]. In addition, she instructed the nurse practitioner to go to the facility and assess the resident. The assessment found no negative outcome. Cross reference: 483.25 Quality of Care (F689)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41645 Based on observation, record review, and staff interview, the facility staff failed to ensure a medication cart was locked and secure from residents, visitor, and other personnel for one (1) of two medications observed on Unit 2. The findings included: A policy titled, Security of Medication Cart, instructed staff to secure medications carts during medication passing to prevent unauthorized use when parking carts in hallways place cart against the wall with drawers facing the wall .carts must be securely lacked at all times when out of the nurse's view . On 12/27/24 at approximately 9:24 AM, an unlocked medication cart was observed parked in a common with drawers facing forward, visible and accessible to anyone passing by. There were no staff members in view of the medication cart. Additionally, residents and staff were gathered in a dining area nearby. During a face-to-face interview on 12/27/24 at 9:25 AM, Employee #8 (RN) stated that the cart should be locked, and he would go get Employee #9 (LPN) who was passing medication in the dining area. During a face-to-face interview on 12/27/24 at 9:26 AM, Employee #9 (LPN) stated she should have locked the cart before leaving. The employee then said, I prefer not to give any further comments.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41645 Based on record review and staff interview, the facility failed to ensure a resident's Medication Administration Record included the correct formulary for a medication used to treat elevated blood pressure for one (1) of three (3) sampled residents. (Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE] with a history of Acute Pulmonary Embolism and Hypertension. A review of Resident #1's medical record revealed that the resident was discharged from an out-of-town nursing home on 12/19/24. The discharge summary documented that the resident was prescribed . Metoprolol Succinate [Toprol XL] Extended Release 50 mg one (1) tablet by mouth at bedtime. A physician order dated 12/19/24 instructed, Metoprolol Tartrate [Lopressor] 50 mg one (1) tablet by mouth at bedtime for elevated blood pressure. The December 2024 Medication Administration Record (MAR) showed an order for Metoprolol Tartrate [Lopressor] 50 mg one (1) tablet by mouth at bedtime for elevated blood pressure. According to the MAR, the staff administered Metoprolol Tartrate [Lopressor] on five different occasions between 12/19/24 and 12/23/24. During a telephone interview on 12/26/24 at 11:32 AM, Resident #1's daughter/POA stated that when her mother was discharged from the facility on 12/23/24 she discovered that her mother had been receiving Metoprolol Tartrate [Lopressor] fast-acting, instead of Metoprolol Succinate [Toprol XL] slow-acting, as she had previously been prescribed. During a telephone interview on 12/27/24 at 8:20 AM, Employee #4 (physician) stated that staff that she ordered Metoprolol Succinate [Toprol XL] extended release 50 mg a day when the resident was admitted on [DATE]. She said that staff did not inform her that Metoprolol Tartrate [Lopressor] was being administered. Furthermore, the employee explained that Metoprolol Succinate [Toprol XL] should have been administered rather than Metoprolol Tartrate [Lopressor]. During a face-to-face interview on 12/27/24 at approximately 3 PM, Employee #2 (Director of Nursing) after reviewing Resident #1's electronic pharmacy record she stated that when Employee #5 (LPN) ordered Resident #1's medications from pharmacy she selected Metoprolol Tartrate [Lopressor] instead of Metoprolol Succinate [Toprol XL].