

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Forest Hills of DC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #57 was admitted to the facility on [DATE] with diagnoses that included: Memory, T12 Vertebral Fracture, Fracture of Femoral Neck, Dementia, Osteopenia, and Glaucoma.</p> <p>A review of Resident #57 s medical record revealed an admission Minimum Data Set (MDS) assessment dated [DATE] showing that facility staff coded a BIMS summary Score of 6, indicating the resident's cognition was severely impaired, no behavioral symptoms, partial assistance for mobility, and the resident had a fall prior to admission.</p> <p>An Incident Note dated 10/26/24 at 11:59 PM documented: .At 10:30 pm, [the] resident turned the call light on. When answered, [the Resident] stated that [pronoun]was on the floor in [pronoun] room. [The] Resident stated that [pronoun] did not know how [pronoun] got on the floor .[The] Writer immediately went to the room and Resident was observed on the floor beside [pronoun] bed laying on [pronoun] back. Head-to-toe assessment completed. [The] Resident was alert and oriented x 3. [The] Resident is [was] able to move all extremities . No apparent injury noted .</p> <p>A Health Status Note dated 10/27/24 at 2:30 PM, documented: Resident found on the floor bedside [ponroun] bed. When asked what happen(ed). [The] resident said, I'm looking for my son, does he know that I'm in this place, I'm trying to go home, my son is waiting for me. Upon assessment, [the] resident denies hitting [pronoun] head on the floor, denies pain, no bleeding or redness noted on the skin, ROM (range-of-motion) within [the] limit on bilateral lower extremities and upper extremities. No discomfort or pain noted.</p> <p>A Post-Fall Evaluation Note dated 11/01/24 documented: Date / Time of Fall: 11/01/2024 6:45 PM Fall was not witnessed. [A] Fall occurred in the Resident's room. Activity at the time of fall: Resident crawled out of bed. [The] bed was in the lowest position. The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did [the] fall result in an ER (Emergency Room)visit/hospitalization: No.</p> <p>A review of a Psychosocial Note dated 11/11/24 at 1:47 PM documented: Resident was discharged at her family's request over the weekend - on 11/09/24 .</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 095038
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Discharge MDS assessment dated [DATE] showed facility staff coded: in response to questions in Section J regarding falls: Has the resident had any falls since admission/entry or reentry or the prior assessment), whichever is more recent? No. Number of falls since admission or Prior assessment - (with No Injury). [The] Response was left blank. Of note, there was no documented evidence that facility staff noted the resident's unwitnessed falls with no injury on the resident's discharge assessment.</p> <p>During a face-to-face interview on 12/05/24 at 10:00 AM, Employee #4 acknowledged the deficient practice and stated that the Resident #57's falls on 10/26/24, 10/27/24 and 11/01/24 should have been captured on the resident's Discharge MDS assessment.</p> <p>Cross Reference 22B DCMR &sect; Sec. 3231.11</p> <p>Based on record reviews and staff interviews, for two (2) out of 19 sampled residents, facility staff failed to accurately code their Minimum Data Set (MDS) assessments. (Residents #11 and #57)</p> <p>The findings included:</p> <p>1. Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus and Hypothyroidism.</p> <p>Review of the resident's medical record revealed the following:</p> <p>A physician's order dated 01/04/23 that directed, Aripiprazole 5 mg (milligrams) by mouth every night for Depression.</p> <p>A physician's order dated 03/23/23 that directed, Remeron Oral Tablet 15 MG, give 1 tablet by mouth at bedtime for Depression.</p> <p>A physician's order dated 10/02/23 that directed, Fetzima Oral Capsule Extended Release 24 Hour 120 MG, give 1 capsule by mouth one time a day for Depression.</p> <p>Physician's order dated 03/12/24 that directed, Abilify Oral Tablet 5 MG (Aripiprazole), give 1 tablet by mouth one time a day for Depression.</p> <p>In addition, the medical record contained a Geriatric Psychiatry Note dated 07/12/24 which documented under diagnosis: Dementia with Behavioral Disturbance, Depression; other - psychosis.</p> <p>A Social Services Psychosocial Note for 10/11/24 at 1:33 PM documented:</p> <ul style="list-style-type: none"> - Social worker met with the resident 1:1 for MDS assessment. - Resident admitted to feeling depressed usually each day (this is not new for her). - Resident is diagnosed with Dementia and Depression and her presentation was consistent with her diagnoses. - Resident is followed regularly by a psychologist for Depression. <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Quarterly MDS assessment dated [DATE] showed that facility staff coded: clear speech; usually makes self-understood; usually understands others; a BIMS summary score of 11, indicating moderately impaired cognitive response; feeling down, depressed or hopeless occurred 12-14 days; Feeling bad about yourself - or that you are a failure or have let yourself or your family down occurred 12-14 days; Resident Mood Interview (PHQ-2 to 9) total severity score of 06, indicating mild depression; for the area active diagnoses, facility staff coded No for Depression.</p> <p>The evidence showed that facility staff failed to accurately code Resident #11's Quarterly MDS to reflect Diagnoses of Depression.</p> <p>During a face-to-face interview on 12/03/24 at 3:14 PM, Employee #4 (MDS Coordinator) stated, Somehow the Depression diagnoses was accidentally deleted from the resident's diagnoses page. But it should have been captured based off the progress notes.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) out of 19 sampled residents, facility staff failed to develop a care plan with goals and interventions to address Resident #11's use of antibiotics.</p> <p>The findings included:</p> <p>Review of the facility's Care plans, Comprehensive Person-Centered policy (not dated) documented:</p> <p>- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus and Hypothyroidism.</p> <p>Review of the resident's medical record revealed a physician's order dated 03/14/24 that directed, Trimethoprim (type of antibiotic) oral tablet 100 MG (milligrams), give 1 tablet by mouth at bedtime for UTI (urinary tract infection) prophylaxis.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 11, indicating moderately impaired cognitive response and received Antibiotic medications.</p> <p>Review of the resident's comprehensive resident care plan on 12/04/24 showed no documented evidence that a care plan was developed with goals and interventions to address the resident's use of an antibiotic for UTI prophylaxis.</p> <p>During a face-to-face interview on 12/04/24 at 10:36 AM, Employee #2 (Director of Nursing/DON) reviewed the residents medical record and acknowledged the findings.</p> <p>Cross Reference 22B DCMR &sect; Sec. 3210.4</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of 19 sampled residents, the facility staff failed to update and revise the care plan with resident-centered goals for Resident #55 following a fall that occurred on 07/13/24.</p> <p>The findings included:</p> <p>A review of the facility's policy titled Managing Falls and Falls Risks with a revision date of 08/21/21, documented the following: If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.</p> <p>Resident #55 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Difficulty Walking, Unspecified Lack of Coordination, Cognitive Communication Deficit, and Repeated Falls.</p> <p>A review of Resident #55's medical record revealed a progress note dated 07/12/24 at 8:24 AM, documenting, During the shift report, staff heard (sp) noise from room [ROOM NUMBER]. Immediately responded to noise and all of us went to room [ROOM NUMBER]. Upon arrival resident (sp) observed lying on floor on her left side by the bathroom. On assessment there is injury noted to bilateral elbows. Resident was alert and verbally responsive. C/O (complains of) intense pain to the right arm. Denies hitting her head. ROM (range of motion) performed and WNL (within normal limits) except right arm. MD (medical doctor) notified and gave order to send resident to the nearest ER (emergency room).</p> <p>A progress note dated 07/12/24 at 7:03 PM, documented, The resident returned from (Hospital Name) at approximately 4:00 PM. in a wheelchair with her friend with no distress. Alert and able to make needs known. (Resident #55's) new diagnosis is a closed fracture of the olecranon process to the right Ulna initial encounter. Continues on neuro check post fall and denies pain at this time. Resident back from (Hospital Name) with soft cast /sling to Rt (right) arm.</p> <p>A review of the Care Plan Focus area with an initiation dated of 07/12/24 revealed, had an actual fall with c/o (complain of) pain to right hand, Dx (diagnosis) from hospital fx (fracture) to the right elbow. The documented interventions with a revision date of 07/12/24 included, Rehab (rehabilitation) to evaluate and treat, Safety hourly rounding for staff to anticipate and meet the residents needs at all times, ling and soft cast to right lower arm, Toilet resident upon arising, before meals at bedtime and prn (as needed).</p> <p>An Incident Progress Note dated 07/13/24 at 10:51 PM, documented At 10:30 pm I was called to the room by the nurse who was making rounds and found the resident was sitting up in the floor in front of her wheelchair. A two-person lift was conducted to place her back in wheelchair. She has a hx (history) of falls with the last one being 3 days ago. She stated she went to the bathroom and came out and slipped and fell on her buttock then stabilized herself with her right elbow so she did not fall backwards. She was not wearing socks or shoes (barefoot) at the time of incident. She admitted that she forgot to use call bell and that was reoriented to both bed and bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a [Care Plan] focus area revised on 08/05/24 documented, 7/13/2024 had a fall without c/o (complaints of) pain to the right elbow or buttock.</p> <p>It is noted that there was no documented evidence in the medical record of any updated or revised care plan interventions after Resident #55's fall that occurred on 07/13/24.</p> <p>During a face-to-face interview conducted on 12/05/24 at approximately 11:35 AM, Employee #3 (Clinical Manager) stated, Whenever there is a fall, we update the care plan. Employee #3 then stated she did not know why the care plan was not updated after the residents fall on 07/13/24 and acknowledged the findings.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interview, facility staff failed to distribute and serve foods under sanitary conditions. These findings have the potential to affect all residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. An open pack of provolone cheese and a pan with chunks of grapefruit were stored in a refrigerator undated, in the kitchen on unit Healthcare 1. 2. Two (2) of 14 white cutting boards, and two (2) of 14 green cutting boards in the main kitchen were soiled and discolored. 3. Food temperature logs from the main kitchen, and the kitchen on healthcare 1 and 2, were missing several entries throughout the month of October 2024. 4. One (1) of two (2) convection ovens in the main kitchen (bottom), was soiled. 5. Two (2) of eight (8) fire suppression nozzles, located above the grease fryer and the gas stove were soiled with grease deposits, and one (1) of eight (8) was corroded. 6. One (1) of two (2) fire sprinkler heads in the walk-in refrigerator was soiled and rusty. <p>Employee #5 (Director of Dietary Services) acknowledged the findings during a face-to-face interview on 12/5/2024, at approximately 11:00 AM.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) out of 19 sampled residents, facility staff failed to implement their antibiotic stewardship system for monitoring antibiotic use and adverse reactions for one (1) resident since 03/14/24, approximately nine (9) months. (Resident #1)</p> <p>The findings included:</p> <p>Review of the facility's Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes policy (not dated) documented:</p> <ul style="list-style-type: none"> - Antibiotic usage and outcome data will be collected and documented using facility-approved antibiotic surveillance tracking form. - The IP (Infection Preventionist) or designee, will review antibiotic utilization as part of the antibiotic stewardship program. - All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. <p>Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus and Hypothyroidism.</p> <p>Review of the resident's medical record revealed a physician's order dated 03/14/24 that directed, Trimethoprim (type of antibiotic) oral tablet 100 MG (milligrams), give 1 tablet by mouth at bedtime for UTI (urinary tract infection) prophylaxis.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 11, indicating moderately impaired cognitive response and received Antibiotic medications.</p> <p>During a face-to-face interview on 12/04/24 at 10:36 AM, Employee #2 (Director of Nursing/DON) presented the surveyor with the facility's antibiotic stewardship binder that documented a line listing of all the residents who were previously and currently taking antibiotic medications since January 2024. Upon review of the antibiotic surveillance tracking forms, it revealed that Resident #11's name was not listed on any of the forms since she was started on antibiotics as of 03/14/24 through today, and was still taking them as of 12/04/24. When asked to provide documented evidence that the facility was tracking the resident's use of an antibiotic and monitoring for adverse reactions, the employee was not able to provide it and stated, It's an oversight on my part.</p> <p>The findings show that facility staff failed to implement their antibiotic stewardship system for monitoring antibiotic use and adverse reactions for Resident #11, who has been on an antibiotic medication since 03/14/24, approximately nine (9) months.</p>		