STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095040	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hsc Pediatric Skilled Nursing Facility	1731 Bunker Hill Road NE Washington, DC 20017

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Facility staff failed to implement its written policies and procedures for abuse that included staff training after an alleged incident of staff-to-resident sexual abuse for one (1) resident. ([NAME]) Based on observation record review and staff interviews, for one of eleven (11) sampled residents, facility staff failed to implement its written policies and procedures for abuse that included staff training after an incident of alleged staff-to-resident sexual abuse for one (1) resident. Resident #2The findings included:A facility policy entitled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property (effective date 02/06/2020) .Prevention. 1. Procedures must be in place to provide the resident with a safe, protected environment during the investigation. 2. Other measures as deemed appropriate and by existing safety policies and procedures.i. Education will be provided as needed to all parties involved.Resident #2 was admitted to the facility on [DATE] with diagnoses that included: Lesch Nyhan Syndrome, Expressive Language Disorder, Self-Injurious Behavior, Aggressive Behaviors, and Global Developmental Delay.A review of Resident #2's medical record revealed the following:A comprehensive minimum data set (MDS) assessment dated [DATE] which documented that the resident: had a Brief Interview for Mental Status Summary Score of,12 indicating moderately impaired cognition; had displayed physical behaviors towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually; had displayed verbal behaviors towards others threatening others, screaming at others, cursing at others) for one to three days during the assessment; had upper and lower extremity impairments on both sides; required substantial of maximal assistance with rolling from side to side while in bed; was dependent on staff for all ADLs (activities of daily living-bathing personal hygiene getting dressed, transfers, eating, incontinent care) and used a manual or electrical wheelchair for mobility. A facility reported incident (FRI), Intake Number DC00013832, submitted online on 7/10/25 at 1:51 pm, that documented: Summary of Allegation: On [Insert Date], our facility was notified by [Name of Resident #2]'s educational team regarding a disclosure he made at school. According to the report, [First Name of Resident #2] told his classroom staff and a school representative that he had been touched on his [expletive] (his words) by a female staff member at our facility earlier that morning. He also reported that the staff member was wearing blue. The school representative noted that [First Name of Resident #2] was visibly upset, and his physical demeanor indicated discomfort. They reported the incident to the Child and Family Services Hotline and are awaiting follow-up. Resident Background: [Name and age of Resident #2] Diagnosis: Lesch Nyhan Syndrome, Expressive Language Disorder, Self-Injurious Behavior, Aggressive Behaviors, Global Developmental Delay Communication Ability: Communicates primarily using one to two-word responses. Immediate Actions Taken by Facility: Notification: The allegation was reported to facility leadership, and the appropriate internal reporting protocols were initiated. FUP [Follow-up report] received on 07/15/25 at 5:38 PM: Situation: This correspondence serves as the required five-day follow-up regarding the abuse allegation reported on July 10, 2025, involving resident [Name of Resident #2] at [Name of Facility]. Background: As previously shared, after being notified of the allegation, we promptly notified and fully cooperated with the Metropolitan Police Department (Report #2510407) and the Child and Family Services Investigative Social Worker. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the initial report, an extensive internal investigation was conducted. Based on the specifics of the resident's allegation (a female dressed in blue), one staff member was placed on administrative leave per our standard process pending the outcome of the investigation .A thorough review, including but not limited to the individual's HR (Human Resources) file and a background check, revealed no findings of concern. Assessment: After interviewing all relevant personnel and reviewing available documentation, we found no evidence to substantiate the claim.Although the allegation could not be substantiated, we will collaborate with our Medical Director and education team to provide further training focused on caring for pubescent residents. A review of the education and training files for nursing staff who provided care for Resident #2, both the night before and the morning of the alleged incident, showed no evidence of education and training for abuse from 07/10/25 to 07/24/25.During a telephone interview on 07/24/25 at 3:40 PM, Employee #3 (Certified Nurse Aide/ CNA) stated that she was assigned to Resident #2 during the evening shift (3:00 PM-11:00 PM). The Employee stated that she recalled being interviewed about the statement, but she did not receive any recent education or training on abuse after the incident.During a telephone interview on 07/25/25 at 12:41 PM, Employee #4 (Certified Nurse Aide/ CNA) stated that she received abuse education and training when she was first hired approximately two years ago and annually thereafter. She stated further that she worked from 11:00 PM on 07/09/25 to 7:30 AM on 07/10/25, and she was the CNA who bathed Resident #2 and got the resident dressed for school on 07/10/25. She added that after her shift on 07/10/25, Employee #2 (Director of Nursing) called to inform her that the facility had initiated an investigation, and she was being placed on administrative leave until the investigation was resolved. Employee #4 further stated that she was contacted by Employee #2 and was informed that she could return to work on 07/15/25; however, she did not return until 07/16/25. She added that she was informed both verbally and via email from Employee # 2 that two staff members had to be present when providing care for Resident #2. She added that she had not been assigned to the Resident since the alleged incident, and she had not received or completed any additional training on abuse upon her return on 07/16/25.Of note, the assigned nurse was not available for interview during the survey.During a face-to-face interview at 1:15 PM [Employee #2/ Director of Nursing/DON], when asked if any additional abuse education or training was provided to all parties (staff) involved in the alleged incident on 07/10/25, per the facility's policy, the Employee stated, No, there was no addition education or training provided after the incident. Additional education and training is provided by me or the nurse educator on an as-needed basis after a reported or alleged incident, depending on the incident itself and the staff involved. After the incident on 07/10/25 with Resident #2, I sent an email (return receipt requested) to the nursing staff, informing them that two staff were required when providing care for the Resident; however, I didn't provide an additional educational or training in-service on abuse. The Employee then acknowledged the finding.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Facility staff failed to develop and implement a comprehensive person-centered care plan that included new interventions for one (1) resident following an alleged incident of injury of unknown origin and an alleged incident of staff-to-resident sexual abuse. Based on observation record review and staff interviews, for one of eleven (11) sampled residents, facility staff failed to develop and implement comprehensive person-centered care plans for a resident following: 1) an incident of injury of unknown origin and 2) an alleged incident of sexual abuse by facility staff. Resident #2The findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses that included: Lesch Nyhan Syndrome, Expressive Language Disorder, Self-Injurious Behavior, Aggressive Behaviors, and Global Developmental Delay.A review of Resident #2's medical record revealed the following:A quarterly minimum data set (MDS) assessment dated [DATE] which documented that the resident: had a Brief Interview for Mental Status (BIMS) Summary Score of,12 indicating moderately impaired cognition; had displayed physical behaviors towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually; had displayed verbal behaviors towards others threatening others, screaming at others, cursing at others) for one to three days during the assessment; had upper and lower extremity impairments on both sides; required substantial of maximal assistance with rolling from side to side while in bed; was dependent on staff for all ADLs (activities of daily living-bathing personal hygiene getting dressed, transfers, eating, incontinent care) and used a manual or electrical wheelchair for mobility. 1. Incident #1 -Injury of Unknown Origin on 06/17/25A State Agency Complaint Incident Report Form dated 06/17/25 at 3:48 PM that documented: 6/16/25 [Name of Resident #2] was observed with a bruise under his eye, which appears to have occurred overnight and was unwitnessed. At this time, we believe the injury may have happened while he was in bed. [First Name of Resident #2] has a medical diagnosis of [NAME]-[NAME] syndrome, a condition that includes involuntary limb movements and self-injurious behaviors. Due to this, he wears arm immobilizers at all times. It is possible that despite these precautions, he may have inadvertently injured himself during sleep. In response: Medical providers have been notified and have assessed the resident. A State Agency Complaint Incident Report Form dated 06/23/25 at 4:53 PM that documented: This is the follow-up from the 6/17/25 incident report. Injury of unknown origin. After investigation, the resident's helmet needed readjustment along with his neck brace. It appears the injury came from his helmet that slipped down over his eye and cheek. Our therapy tea[m] has assessed the helmet and made adjustments to the neck brace. We have ordered material to fix the ill-fitting helmet. The resident is doing well with no complaints of pain or discomfort.A Case Management Narrative Note dated 06/27/25 at 10:31 AM that documented: Comment: Tuesday weekly Shared Nursing Facility (SNF) Rounds: late entry-->pt (patient) is going through a growth spurt--> home from school due to damage to helmet that might have been loose and smashed when fell off; prefer he doesn't go back until helmet is replaced; also making adjustments to helmet; school aware of what is happening.A review of Resident #2's comprehensive person-centered care plan showed no documented evidence that facility staff developed or implemented a care plan to include a focus, goals, or interventions to prevent further injury to the resident, after the resident's injury of unknown origin was observed by facility staff on 06/17/25.2. Incident #2- Alleged Incident of Staff-to-Resident Sexual Abuse on 07/10/25A comprehensive MDS assessment dated [DATE] which documented that the resident: had a BIMS score of,08 indicating moderately impaired cognition; had displayed physical behaviors towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually; had displayed verbal behaviors towards others threatening others, screaming at others, cursing at others) for one to three days during the assessment; had upper and lower extremity impairments on both sides; required substantial of maximal assistance with rolling from side to side while in bed; was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dependent on staff for all ADLs (activities of daily living-bathing personal hygiene getting dressed, transfers, eating, incontinent care) and used a manual or electrical wheelchair for mobility. A facility reported incident (FRI), Intake Number DC00013832, submitted online on 7/10/25 at 1:51 PM, that documented: Summary of Allegation: On [Insert Date], our facility was notified by [Name of Resident #2]'s educational team regarding a disclosure he made at school. According to the report, [First Name of Resident #2] told his classroom staff and a school representative that he had been touched on his [expletive] (his words) by a female staff member at our facility earlier that morning. He also reported that the staff member was wearing blue. The school representative noted that [First Name of Resident #2] was visibly upset, and his physical demeanor indicated discomfort. They reported the incident to the Child and Family Services Hotline and are awaiting follow-up. Resident Background: [Name and age of Resident #2] Diagnosis: Lesch Nyhan Syndrome, Expressive Language Disorder, Self-Injurious Behavior, Aggressive Behaviors, Global Developmental Delay Communication Ability: Communicates primarily using one to two-word responses. Immediate Actions Taken by Facility: Notification: The allegation was reported to facility leadership, and the appropriate internal reporting protocols were initiated. FUP [Follow-up report] received on 07/15/25 at 5:38 PM: Situation: This correspondence serves as the required five-day follow-up regarding the abuse allegation reported on July 10, 2025, involving resident [Name of Resident #2] at [Name of Facility]. Background: As previously shared, after being notified of the allegation, we promptly notified and fully cooperated with the Metropolitan Police Department (Report #2510407) and with the Child and Family Services Investigative Social Worker, . Following the initial report, an extensive internal investigation was conducted.Based on the specifics of the resident's allegation (a female dressed in blue), one staff member was placed on administrative leave per our standard process pending the outcome of the investigation .A thorough review, including but not limited to the individual's HR (Human Resources) file and a background check, revealed no findings of concern. Assessment: After interviewing all relevant personnel and reviewing available documentation, we found no evidence to substantiate the claim.Although the allegation could not be substantiated, we will collaborate with our Medical Director and education team to provide further training focused on caring for pubescent residents.Of note, a review of Resident #2's comprehensive person-centered care plan showed no documented evidence that facility staff developed or implemented a care plan to include a focus, goals, or interventions to prevent the resident from staff abuse after the alleged incident of staff-to-resident sexual abuse was reported on 07/10/25. During a face-to-face interview on 07/25/25 at 2:30 PM, Employee #2, Director of Nursing DON stated that care plans are implemented upon admission, quarterly, and as needed. When asked if care plans are developed and implemented after incidents of abuse or injuries of unknown origin, she acknowledged that they should be developed by the nurse or by herself (DON). After review of Resident#2's care plan. The Employee then acknowledged that the care plans for Resident #2 should have been developed and implemented after the observation of the resident's skin(/injury of unknown origin) reported on 06/17/25 and after the alleged incident of sexual abuse by staff reported on 07/10/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility failed to ensure: (1) food was not stored past its expiration date for seven (7) of 7 packages of green beans (baby food); and (2) sanitizer solution concentration for cleaning the service line area meet professional standards for one (1) of 1 sanitizer solution buckets.Based on an observations, record review, and staff interviews, the facility failed to ensure: (1) food was not stored past its expiration date for seven (7) of 7 packages of green beans (baby food); and (2) sanitizer solution concentration for cleaning the service line area meet professional standards for one (1) of 1 sanitizer solution buckets. The findings included: An observation of the kitchen's dry storage area on 07/23/25 starting at 10:01AM revealed one (1) of 1 package of green beans (baby food) with an expiration date 05/31/25 and six (6) of 6 packages of green beans (baby food) with expiration dates 06/30/25. During a face-to-face interview on 07/23/25 at 10:05 AM, Employee #5 (Director of Nutrition) stated that the porters check the dry storage area daily for expired food. The employee said that the porters document their finding on the Associate Cleaning Responsibilities form daily. At the time of the interview, the employee stated that the dry storage room had not yet been checked for expired food for 07/23/25. Additionally, the employee was unable to provide documented evidence that the dry storage area was checked for expired foods on 07/22/25. During a face-to-face interview on 07/24/25 at approximately 9:00 AM, Employee #8 (Porter/Nutrition Service Aide) stated, I check for expired food most days, but I don't always check every day. At the time of the observation, the employee reviewed a blank Associate Cleaning Responsibilities and stated that he has never seen the form before and he doesn't document when he checks for expired foods. 2. An observation of the service line on 07/23/25 at approximately 10:30 AM revealed that one (1) of 1 sanitizer bucket. The bucket contained quaternary ammonium sanitizer solution with a concentration level that tested above 400 Parts Per Million (ppm). According to FDA Food Code 7-204.11 and Title 25-A DCMR 1813.4, sanitizer solution shall be prepared according to the manufacturer's use directions. The Quaternary ammonium sanitizing chemical manufacturer directs the concentration of the sanitizer solution to be in the range of 200 to 400 Parts Per Million (ppm) for sanitizing food contact surfaces. FDA-FoodCode2022-FullDocument-01182023_0 (3).pdf Cleaning and Sanitizing in Commercial Kitchens | Clatsop County OR During a face-to-face interview on 07/23/25 at approximately 8:30 AM, Employee #9 (Food Production Lead) said The employee who prepared the sanitizer solution added too much sanitizing chemical to the bucket. At the time of the survey, this was corrected on-site. Cross Reference 22B DCMR Sec. 3219.1

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. The facility staff failed to maintain one (1) of 1 walk-in freezer and one (1) of 1 ice making machine in safe operating conditions. Based on observations and staff interviews, the facility failed to maintain one (1) of 1 walk-in freezer and one (1) of 1 ice making machine in safe operating conditions. The findings included: An observation on 07/23/25 starting at approximately 8:15 AM showed the following: 1.A walk-in freezer with ice built-up from a leaking condensation pipe. Also, noted was sheet pans placed on top shelf under air condenser from a leaking condensate pipe. 2. An ice-making machine with leaking water onto a soiled blanket lying on the floor under the machine. Also, noted was duct tape on the edges of ice machine to stop the water leak for one (1) of 1. At the time of the observations, Employee #5 (Director of Nutrition) acknowledged the findings. During a face-to-face interview on 07/23/25 at approximately 11:00 AM, Employee #7 (Facility Operation Manager) stated that the walk-in freezer and ice machine were old, and they require frequent maintenance. Cross Reference 22 B DCMR Sec. 3258.13

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. The facility staff failed to maintain an effective pest control program so that it remains free of pests (mice).Based on observations, record reviews and staff interviews, the facility failed to maintain an effective pest control program so that it remains free of pests and rodents. The findings includedAn observation of the kitchen floor at cookline and dry storage areas on 07/23/25 starting at 8:15 AM revealed rodent droppings and dead two dead mice on glue boards. A review of a Pest Elimination Service Report dated 07/03/25 revealed that the Kitchen Area-Interior.Cafeteria-Interior was treated to exterminate for pests (mice) with glue boards. A review of a Pest Elimination Service Report dated 07/18/25 revealed that the exterior area was treated to exterminate for pests (mice) with bait stations.During a face-to-face interview on 07/23/25 at approximately 10:00 AM, Employee #5 (Director of Nutrition) stated that the facility receives scheduled and as needed pest extermination services from a professional pest exterminating company