STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted at Bridge Point National Harbor on the following dates- August 23, 2021 - September 16, 2021. The survey team conducted the recertification survey onsite at the facility on August 23 - 26, and 30, 2021 and September 3, 8 and 15, 2021. Survey activities consisted of a review of 44 sampled residents. The facility's census during the survey was 122. The following complaints and facility reported incidences were investigated during this survey: DC00010058, DC0001006, DC00010184, DC00010199, DC00010201, DC00010202, DC00010198, DC00010227 and DC00010240. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Substandard quality of care was identified at F600, F610, and F686 and the survey team conducted the extended survey on September 8, 2021. During this survey an immediate jeopardy (IJ) was identified at 42 CFR§483.12 Freedom from Abuse, Neglect, and Exploitation, F600 on September 8, 2021 at 1:55 PM. The facility's Administrator provided a plan of corrective action to address the identified concerns on September 8, 2021 at 7:32 PM. After the plan was verified the IJ was removed on September 16, 2021 at 7:52 PM. An immediate jeopardy (IJ) was identified at 42	F 000	F 000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	11/02/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SWashington LNHA, DHA	Interim Administrator	11/02/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

CFR§483.25 Quality of Care- Treatment/Services to Prevent/Heal Pressure Ulcers, F686 on September 8, 2021 at 2:01 PM. The facility's Administrator provided a plan of corrective action to address the identified concerns on September 8, 2021 at 7:31 PM. After the team verified that the plan of correction was in place on September 16, 2021 at 7:52 PM, the IJ was removed.

The following deficiencies are based on observation, record review, and resident and staff interviews.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	F 550 1. Corrective action for resident Resident #102 has been given a privacy bag. The urine collection bag was measured and emptied. 2. Identify other residents An audit of other residents with urine collection bags did not identify any other residents affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on the importance of resident's rights to include privacy. The Director of Nursing and Unit Managers will be responsible for validating privacy rounds/inspections and subsequent follow up on findings.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 44, sampled residents the facility ' s staff failed to ensure a resident was provided dignity and privacy due to not covering the urine collection bag. (Resident #102). The findings include: Resident #102 was re-admitted to the facility on 06/25/2021 with multiple diagnoses including Stage 4 Pressure Ulcer of sacral area, Stage 4 bilateral buttocks pressure ulcers, Multiple Fractures of Ribs, and Unspecified Fracture of lower end of right Femur. On 08/24/2021 at approximately 4:00 PM, Resident #102 was observed in his room with his urine collection bag uncovered and filled to capacity with urine. Review of a physician order dated 06/26/2021, directed - "Foley (catheter) size # 18 ...Measure urine output every shift ..."	F 550	4. Monitor corrective actions The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility’s date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ____ B. WING ____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 Review of the Quarterly Minimum Data Set (MDS) dated 08/17/2021 revealed in Section H (Bladder and Bowel) the resident was coded as "A" indicating the presence of an indwelling catheter. During a face-to-face interview on 08/24/2021 at approximately 4:00 PM, Employee # 36 (Registered Nurse) stated "A family member was going and she touch it (urine collection bag) by accident". The employee made no further comments to address why Resident #102's urine collection bag was not covered.	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578	F 578 1. Corrective action for resident Resident #105 no longer resides in the facility. Residents' #3, #5, #21, #37, #76, and #95 and/or their representatives have been given the opportunity to exercise their rights to formulate Advance Directives and Staff have validated corresponding orders. 2. Identify other residents An audit of all resident's Advance Directives was completed. There were no additional findings related to this citation. 3. Systemic changes Social Services staff have been educated on the importance of resident's/responsible party's rights to formulate an Advance Directive and their responsibility to ensure that there is a corresponding order and armband. The Director of Social Services will be responsible for validating that all residents have been offered	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for seven (7) of 44 sampled residents, the facility's staff failed to inform residents or their representatives of their rights to formulate Advance Directives for six (6) residents and failed to confirm one (1) resident's code status. (Residents' #3, #5, #21, #37, #76, #95 and #105) The findings include: 1. Resident #3 was admitted to the facility on 07/10/2021 with multiple diagnoses that included: Morbid Obesity, Obstructive Sleep Apnea, Cellulitis, Fibromyalgia, and Lymphedema. Review of the Admission Minimum Data Set (MDS) dated 07/17/2021 revealed in section C (Brief Interview for Mental Status) the resident was given a summary score of "15" indicating that the	F 578	the opportunity to formulate an Advance Directive and have corresponding physician orders. 4. Monitor corrective actions The Director of Social Services/Designee will complete audits of all Advance Directives on all new admissions weekly and monthly on all other residents to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 7 resident was cognitively intact. Review of the resident's face sheet revealed she was her own responsible party. Review of Resident #3's medical record documented, "Full Code". However, the record lacked documented evidence that the facility's staff provided the resident with verbal or written information regarding Advance Directives. During a face-to-face interview on 08/31/2021 at approximately 10:30 AM, Employee #3 (Director of Social Services) stated that she had not provided the resident with information regarding Advance Directives. The employee then said, "I will offer it to her today." 2. Resident #5 was admitted to the facility on 02/22/2017, with multiple diagnoses that included: Anxiety Disorder, Depression and Tracheostomy Status. Review of the Annual Minimum Data Set (MDS) dated 08/08/2021 revealed in Section C (Cognitive Patterns) facility staff coded Resident #5 as "severely [cognitively] impaired". Review of Resident #5's electronic health record (EHR) and paper medical record lacked documented evidence that facility staff provided the resident's representative with information regarding formulating Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advance Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8	F 578		

with residents or family members much during the COVID-19 Pandemic."

3. Resident #21 was re-admitted to the facility on 06/29/2021, with multiple diagnoses that included: Degenerative Joint Disease, Respiratory Failure, Dysphagia, and Cerebral Vascular Accident.

During an observation of Unit 3 West on 08/23/2021 at approximately 10:00 AM, Resident #21 was noted with a "DNR (Do Not Resuscitate)" bracelet on his left wrist.

Review of the Admission Minimum Data Set dated 07/07/2021, revealed in Section C (Cognitive Patterns), facility staff coded Resident #21 as, "Severely cognitively impaired".

Review of Resident #21's care plan with the focus area of: [Resident ' s name] end of life wishes are to remain a full code" revised on 05/18/2021 documented the following interventions: "IDT (interdisciplinary team) will review residents code status quarterly ... document wishes in medical record, review any existing wishes".

Continued review of Resident #21 ' s electronic and paper medical record revealed that facility staff failed to review and confirm the resident ' s code status with his representative .

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advanced Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed with residents or family members much during the COVID-19 Pandemic. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9	F 578		

4. Resident #37 was re admitted to the facility 09/01/2020 with multiple diagnoses that included: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia and Cerebral Vascular Accident (CVA).

A review of the Admission Minimum Data Set (MDS) dated 08/12/2021 revealed:

In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating intact cognition.

Review of the medical record revealed a physician's order dated 11/21/2020 that directed, "Full Code."

Review of the End of Life Care Plan revised on 07/24/2021, noted, "Resident #37's end-of-life wishes will be honored. Her desire is to remain a "full code". The goal documented that the IDT (interdisciplinary team) will review the resident's goal status quarterly or if there is a change in condition.

The medical record lacked documented evidence that the facility's staff provided Resident #37 with verbal or written information regarding Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:22 AM, Employee #3 (Director of Social Services) stated that she did not offer the resident an Advance Directive, but she did complete the Five Wishes document (facility's document of resident's end of life wishes). The employee then said that she would ask Resident #37 about Advance Directive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10	F 578		

5. Resident #76 was admitted to the facility on 03/27/2020 with the following diagnoses: Anemia, Respiratory Failure, Atrial Fibrillation, Colostomy Status, and Obstructive Sleep Apnea.

A review of the Admission Minimum Data Set (MDS) dated 03/27/2020 revealed:

In Section C (Brief Interview for Mental Status), the resident was given a summary score of "12" indicating Resident #76 was mildly impaired cognitively.

Review of the medical record revealed a physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)".

Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, "[Resident's name] end-of-life wishes are to remain DNR/DNI." One goal documented that the IDT will review the resident's goal status quarterly or if there is a change in condition.

There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident did not have an Advance Directive, but I think she has a Medical Orders for Scope of Treatment (M.O.S.T) document."

6. Resident #95 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 11	F 578		

01/19/2021, with multiple diagnoses that included: Cerebral Infarct due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation.

Review of the Admission Minimum Data Set (MDS) dated 01/26/2021, revealed in Section C (Cognitive Patterns), facility staff coded Resident #95 as "Severely [cognitively] impaired".

Review of Resident #95's Electronic Health Record (EHR) and paper medical record lacked documented evidence that facility staff provided the resident's representative with information regarding formulating Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advanced Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed with residents or family members much during the COVID-19 Pandemic."

7. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome.

Review of the Significant Change MDS dated 07/13/2021, revealed in Section C (Cognitive Patterns), the facility ' s staff coded the resident with a Brief Interview for Mental Status (BIMS) score of "15", indicating that the resident was cognitively intact.

Review of Resident #105's EHR and paper medical record lacked documented evidence that facility staff provided the resident with information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 12 regarding formulating Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advance Directives are offered quarterly but it is not documented. Advance Directives have not been discussed with residents or family members much during the COVID-19 Pandemic." During the Quality Assurance and Performance Improvement (QAPI) meeting on 09/01/2021 at 2:33 PM, Employee #1 (Administrator) stated that the facility's staff had not looked at Advance Directives for most of their residents. The employee then said, "We used the Medical Orders for Scope of Treatment (M.O.S.T) forms. The Advanced Directives is a federal requirement."	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	F 584 1. Corrective action for resident The ceiling tiles in the main supply room and the staff break room have been replaced. 2. Identify other residents An audit of other areas throughout the facility were inspected. There were no additional findings related to this citation. 3. Systemic changes Engineering staff have been educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Plant Operations will be responsible for maintaining a safe, clean, and comfortable	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	**4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by five (5) ceiling tiles in the supply room that were stained throughout and two (2) ceiling tiles in the staff breakroom that were also soiled. The findings include: During an environmental walkthrough of the facility storage room in material management on September 1, 2021, at approximately 1:00 PM, five (5) ceiling tiles in the main supply room and	F 584	environment. 4. Monitor corrective actions The Director of Plant Operations/Designee will complete random audits of ceiling tiles on one unit weekly and will follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 14 two (2) ceiling tiles in the staff break room were marred with dark stains throughout. Employee #37 acknowledged the findings during a face-to-face interview on 09/01/2021, at approximately 4:00 PM.	F 584		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on a review of clinical records, facility documentation, facility policies, and resident and staff interviews, for one (1) of 44 sampled residents, the facility's staff failed to prevent and protect Resident #105 from psychological and physical abuse by Employee #5 and because of the Employee's employment history, there is a likelihood of the employee abusing other residents. Due to these failures, an immediate jeopardy	F 600	F 600 1. Corrective action for resident Identified resident #105 (no longer resides in the facility) was interviewed 9-8-2021 and signed their statement. The identified Aide was terminated on 9-01-2021. 2. Identify other residents An audit of all other resident's completed. There were no additional findings related to this citation. 3. Systemic changes All FRIs from January 2021 to present were reviewed to ensure that they were properly investigated. Education files of any staff involved in the FRIs were reviewed to ensure that appropriate actions were taken regarding their involvement. Education/Designee will in-service all staff on the Abuse Policy and procedures. New Administrator and Governing Board will in-service leadership on the Abuse Policy and procedures. In the future, any employees involved in allegations of abuse, neglect, exploitation, or mistreatment will receive immediate in-servicing on the facility's Abuse Policies and Procedures. All future FRIs/	09/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 15

situation was identified on September 8, 2021 at 1:55 PM. The facility submitted a plan of action to the survey team that was on onsite at 7:32 PM on September 8, 2021, and the plan was accepted. The survey team returned on September 16, 2021 to validate the facility's plan, and the immediate jeopardy was lifted on September 16, 2021, at 7:52 PM. After removal of the immediacy, the deficient practice remained at a harm level and the scope and severity was lowered to an H.

The findings include:

Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, "... The administrator will ensure that further potential abuse, neglect exploitation or mistreatment is prevented ..."

Review of the facility's policy entitled, "Abuse and Neglect- Clinical Protocol" with a review date of 08/2020 revealed, " ... The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect ..."

Facility staff failed to provide a safe environment to prevent and protect Resident #105 from the likelihood of abuse from Employee #5.

Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome.

On 08/19/2021 a complaint was received by the

F 600

allegations conclusions will be forwarded by email/writing the LNHA/HR/DON/Departmental Supervisor [Licensed Nursing Home Administrator/Human Resource/Director of Nursing] with the results and preventative measures that have been put in place to protect the resident.

4. Monitor corrective actions

Administrator/ Designee will conduct an audit all FRIs weekly for 2 months to ensure the facility has completed a thorough investigation of the alleged violation; prevented further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress; and took appropriate corrective action, as a result of investigation findings. Results of finding will be forward to QAPI for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is September 15, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16 State Agency that documented, "[Resident #105... reported to the Ombudsman... on the night of August 18th [2021] the nursing Aide stuffed [Resident #105's] brief with pieces from a chuck (incontinence pad) and said 'I am not changing you again tonight' ..." Review of a memo from Employee #1 (Administrator) dated 08/24/2021, documented, " ... We interviewed the staff and other residents on the unit (3 west) along with examining the medical chart. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident [Resident #105] in question. Therefore, the case has been unsubstantiated due to these findings." On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]...The residents daughter reported to the Ombudsman ... C.N.A. (Certified Nurse's Aide) ... told the resident 'she caused him three days of pay, and that she talks too much." Review of Resident #105's Significant Change Minimum Data Set (MDS) dated 07/13/2021, revealed that facility staff coded the following: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) score "15", indicating intact cognitive response. In Section E (Behavior), Hallucinations (perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No";	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

and in Section GG (Functional Abilities and Goals), Toileting hygiene "... total dependence ... one-person physical assist".

During a face-to-face interview conducted on 08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was floated to 3 west (where Resident #105 resided). He was not originally assigned to that unit. He [Employee #5] reported that he did not say anything to [Resident #105] while he was providing care. The supervisor is getting reprimanded, and the involved CNA was suspended (on 08/27/2021) and is being terminated as of today."

During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2 (Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient care and responsibility from one healthcare provider to another) communication with the supervisors during the week. The supervisors were made aware that the CNA involved was not to work on the third floor at all."

During a telephone interview conducted on 08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 west because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 east. I was not made aware about the issues on 3 west."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

During a telephone interview conducted on 08/30/2021 at 10:50 AM, Employee #5 stated, "I was working on 2 East and was pulled to 3 West because they were short. I was told the investigation was resolved and no issues were found, so I went to the unit (3 west). I was taking care of the roommate (room 333 bed B) when [Resident #105] stated that she was wet and needed assistance as well. I reminded her that she made a report on me and that I didn't want any problems. The resident stated that she wanted me to help her and so I did. There were no issues during the ADL (activities of daily living) care. I have been doing this for 17 years. I have never done anything to her nor intimidate her in any way."

Review of Employee #5's personnel file on 09/08/2021 revealed a form entitled; "[Facility's Name] Employee Warning Notice" dated 07/29/2020. The form revealed that Employee #5 received a verbal warning on (07/16/2020) and a written warning on (07/20/2020) for "violation of policy/procedure".

Attached to the previously mentioned warning notice was a document written by the (previous) Director of Nursing that revealed the following:

"On the morning of July16, 2020, it was brought to the attention of the Director of Nursing by Wound Care Team member... a resident [that resided on unit 3 east] was observed with a urine filled incontinence brief on and a urine saturated Ultrasorb (under pads) in the incontinence Brief. CNA (Employee #5) ... was asked about the use of the under pads inside of the resident ' s diaper. [Employee #5] said [Resident's Name] is a heavy wetter..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

"On the morning of July 20 [2020] ... [Resident #105] had a urine stained Ultrasorb under pad taped together to form a incontinence brief and was taped to the resident's skin...[Resident 105's roommate] was observed with the same makeshift incontinence brief and in addition urine soaked towel was found between the resident's legs... This is the second occurrence within one week where [Employee #5] provided care to residents in a manner ... The type of care provided by [Employee #5] to the residents is a Type B Offense... Acting in a way that can be considered abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally."

Review of the investigation notes and documents revealed there was no documented evidence that the facility's staff reviewed Employee #5's personnel record or implemented measures to protect all residents including Resident #105, from the potential of "abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally." Additionally, Employee #5's personnel record failed to outline why the employee was not allowed to work on unit 3 East.

During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #7 (Director of Human Resources) stated, "The previous disciplinary actions (that occurred in 07/2020) were not mentioned to the Director of Nursing until a meeting that occurred on 08/31/2021 when termination (of Employee #5) was discussed."

During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #2 (Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	**4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

of Nursing) stated, "I was not aware of any previous allegations made for Employee #5 (CNA) until the meeting on 08/31/2021."

During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #1 (Administrator) stated, "I was not aware of any previous allegations or disciplinary actions for the employee (Employee #5). I did not review his personnel file as part my investigation."

Based on these findings, on September 8, 2021, at 1:55 PM an Immediate Jeopardy (IJ)-"K" situation was identified.

On September 8, 2021 at 7:32 PM, the facility's Administrator provided a corrective action plan to the State Agency Survey Team, which included:

"1. Identified resident #105 was interviewed 9-8-2021 and signed the attestation. The identified Aide was terminated on 9-01-2021.

2. An audit will be conducted on all SNF [Skilled Nursing Facility] personnel files to identify if any have been under investigation for allegations of abuse, neglect, exploitation, or mistreatment to ensure all identified corrective disciplinary and follow up interviews and investigations were completed to prevent and protect residents from further abuse, neglect, exploitation, or mistreatment from occurring. The facility will also audit all IRF's [Incidences Reported by the Facility], complaints, grievances from January of 2021 to ensure all pertinent staff and residents were interviewed to reevaluate the complaint or incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21 3. Education/Designee will in-service all staff and leadership on the Abuse Policy and procedures . All future employees with allegations of abuse, neglect, exploitation, or mistreatment will receive immediate in servicing on the facilities Abuse Policies and procedure. All future IRF allegations conclusions will be forwarded by email/writing the LNHA/HR/DON/Departmental Supervisor [Licensed Nursing Home Administrator/Human Resource/Director of Nursing] with the results and preventative measures that have been put in place to protect the resident. 4. LNHA/ Designee will conduct an audit all IRF's weekly for two months to ensure the facility has completed a thorough investigation of the alleged violation; prevented further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress; and took appropriate corrective action, as a result of investigation findings. Results of finding will be forward to QAA for review and recommendations. 5. All actions to be completed by 9-15-2021" The State Agency Survey Team returned to the facility and verified that the plan of correction was in place on 09/16/2021, at 7:52 PM, and the Immediate Jeopardy was removed.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for	F 604	F 604 1. Corrective action for resident Resident #95 has a restraint for their safety that is being used appropriately.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 604 Continued From page 22

purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for one (1) of 44 sampled residents, facility staff failed to ensure that one resident was free from a physical restraint. (Resident #95)

The findings include:

Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarct due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy.

F 604

2. Identify other residents

An audit of all residents with restraints did not reveal any residents whose restraints were not being used appropriately. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that restraints are used appropriately. The Director of Nursing will be responsible for ensuring that residents are not inappropriately restrained.

4. Monitor corrective actions

The Director of Nursing/Designee will complete weekly audits of all residents with orders for restraints to ensure that no restraints are being used inappropriately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 23	F 604		

Review of the facility's policy, "Use of Restraints" with a revision date of 04/2017 revealed, " ... Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted ..."

Review of a facility reported incident (FRI) on 01/27/2021 documented, " ... During rounds on 1-27-2021 her (Resident #95) mitten was found tied to the rail. It was immediately released, and the patient was assessed ...Investigation is ongoing ..."

Review of Resident #95's Admission Minimum Data Set)dated 01/26/2021, revealed that facility staff coded the following:

In Section C (Cognitive Patterns), "Severely impaired"

In Section E (Behavioral Symptoms), " ... Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) ... Behavior of this type occurred 1 to 3 days"

In Section G (Functional Status), "Bed mobility ... total dependence, one-person physical assist"

In Section P (Restraint), "Limb restraint [hand mitten] ...Used daily"

Review of the physician's orders revealed the following:

01/19/2021- "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 604 Continued From page 24 F 604

01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy) - Tube q shift"

Review of the progress notes revealed:

01/27/2021 at 1:18 PM (Administrator note) "[Resident's name] is a 60 year old resident... who was admitted on 1-19-2021. During rounds on 1-27-2021 her mitten was found tied to the rail. It was immediately released and patient was assessed and not found to be in distress, pain or fearful. Resident's physician, RP (representative) and appropriate agencies were notified. House wide sweep conducted no other residents were found to have an inappropriate restraint. Investigation is ongoing. Son was satisfied and we told him we will be in communication with the conclusion."

Review of the facility's investigation notes and documents on 08/31/2021 revealed that only six (6) staff members were interviewed as part of the investigation. There was no documented evidence of interviews from the respiratory therapist who provided Resident #95 with tracheostomy care or from the environmental staff who cleaned Resident #95's room.

It was also noted that two staff members answered "no" when asked, "Do you know the abuse reporting policy and procedure" as part of the investigation's interview questions.

There was no documented evidence that the investigator(s) followed up with those staff members or is there documented evidence that any additional training/education was provided on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 25	F 604		

restraints or the facility's abuse reporting policy and procedure.

Employee #1 (Administrator) acknowledged that Resident #95 was physically tied to the bedrail however, he did not substantiate that abuse occurred.

During a face-to-face interview conducted on 08/31/2021 at 10:54 AM, Employee #4 (Speech and Language Pathologist) stated, "The resident is nonverbal with right hemiparesis- pretty close to paralyses. Left side is intact. She had an order for left [hand] mitten. I walked into the room (on 01/27/2021) and noticed the straps to the mitten were wrapped around and tied to the upper bed rail, fully restricting her (Resident #95) movement of the left hand. I immediately removed the restraint, made the nurse aware and educated the nurse that the mitten was not to be used as a restraint. I then reported the incident to my supervisor and the administrator."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #2 (Director of Nursing) stated, "Mittens are used for residents who are a danger to themselves. After the incident, we interviewed the staff, assessed the resident and did audits of the other residents in the facility with hand mittens. We did not find any other residents with mittens tied to the bedrail."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #1 (Administrator) stated, "We couldn't substantiate the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 26 not find any other resident with hand mittens tied to the bed." It should be noted that a review of facility's visitation log on 08/31/2021 at 10:00 AM revealed that Resident #95 did not have any visitors on 01/26/2021 or 01/27/2021.	F 604		
F 610 SS=F	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for five (5) of 11 complaints and facility reported incidences, facility staff failed to thoroughly conduct an investigation: for three (3) residents who alleged physical abuse from an employee; for an allegation of misappropriation of one (1) resident's property; and for improper use of a restraint for one (1) resident. (Residents' #23,	F 610	F 610 1. Corrective action for resident Investigations were reviewed and reinvestigated and appropriate actions taken to resolve the concerns for all residents. Employees #5 and #49 were terminated. Resident #95 is restrained for their safety appropriately. Resident #37 has her IPAD at her bedside. Resident #102's concerns were reviewed and addressed during the IJ abatement process. Residents #23and Resident # 105 no longer reside in the facility. 2. Identify other residents An audit of all other resident's completed. There were no additional findings related to this citation. All FRIs from January 2021 to present were reviewed and reinvestigated and appropriate actions taken to resolve the concerns for all residents. Education files of any staff involved in the FRIs were reviewed to ensure that appropriate actions were taken regarding their involvement.	09/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 27 #37, #95, #102 and #105). The findings include: Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, " ...The individual conducting the investigation will, as minimum... interview the resident (as medically appropriate) .. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ... interview other residents to whom the accused employee provides care or services ..." 1. Facility staff failed to thoroughly investigate an incident for Resident #23 who alleged physical abuse. Resident #23 was admitted to the facility on 11/14/2020, with diagnoses that included: Anemia, Heart Failure, Hypertension, Renal Insufficiency, Diabetes Mellitus, Anxiety Disorder and Asthma. According to the Quarterly MDS dated 02/21/2021, Resident #23 was coded as "rarely/never understood" and was not able to conduct the Brief Interview for Mental Status. Review of the incident report dated 04/22/2021 revealed: " ...the daughter called to say that her mother accused staff member [Employee #49] (Certified Nurse's Aide) of hitting her. She was not able to give a date or time or when the incident occurred." " ...the resident is not a reliable witness and the daughter could also not give the place of the alleged strike. The employee was suspended, and an investigation	F 610	3. Systemic changes Staff and Leadership have been educated on the importance of ensuring that all allegations of abuse are reported and investigated appropriately to ensure that residents are not subjected to potential abuse. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse. 4. Monitor corrective actions The Administrator will complete weekly audits of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the QAPI Committee monthly x 2 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is September 15, 2021.	

F 610 Continued From page 28 F 610

was initiated ...the resident was assessed for bruises and pain and found to not be in distress."

During an interview with Employee #1 (Administrator) on 09/08/2021 at approximately 9:40 AM, he stated the investigation was unsubstantiated and the employee was allowed to return to work.

During the time of the survey, a review the facility's investigation was conducted and revealed that four (4) residents were interviewed, and three (3) staff were interviewed.

The interview questions posed to the residents related to the care that the CNA provided.

One resident stated, "Her care is poor. She don't do what I want her to do. A couple of time she had me I thought I was going to die."

One resident stated, "She is okay, but sometimes she gives me a hard time with my colostomy."

One resident stated, "Her care with me is average. She sometimes forgets to feed me. I get mad a her."

One resident stated, "She does not come to my room to care for me. I have been complaining about her, nobody does anything. When she has me, she don't do nothing for me. She is always hiding."

The staff/co-workers of the CNA provided the following responses to the interview questions:

"She is good but grudgingly do stuff."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 29 "Her care is not good. She does not care for the residents. We have to wash the residents." "I think her care is pretty good. I have heard the residents complain about her." There was no evidence that the facility staff who conducted the interviews further investigated the other four (4) residents and three (3) other staff complaints/reported concerns related to the involved CNA. During a face-to-face interview conducted on 09/08/2021, at approximately 9:40 AM with Employee #1, he had no comments about the findings. 2. Facility staff failed to thoroughly investigate the family's complaint that Resident #37's IPAD (electronic device) was missing. Resident #37 was re-admitted to the facility on 09/01/2020 with the following diagnoses: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia and Cerebral Vascular Accident (CVA). A review Resident #37's Admission Minimum Data Set (MDS) dated 08/12/2021 revealed: In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating intact cognition. In Section G (Functional Status), Resident #37 was coded as, "total dependence, one-person physical assist," for dressing, toilet use, and personal hygiene.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 30	F 610		

A review of a Facility Reported Incident (FRI) dated 8/19/2021 at 4:52 PM documented the following:

" ... The resident's daughter complained that her mother's IPAD (electronic device) was missing, and then when it was found under her mother the DON (Director of Nursing) failed to give a report as to how the IPAD fell off the device it was connected to...after she complained the aide [Employee #25] yelled at her mother [Resident #37], [and] closed the door isolating her mother. [Employee #25] was the identified aide, the facility suspended the associate [Employee #25] and initiated an investigation."

On 08/20/2021 a memo to the State Agency from Employee #1 (Administrator) documented, " ...We interviewed the staff, roommate, and other residents on the unit along with examining the medical chart. The resident was currently under quarantine, so the door was closed per protocol. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident in question, Therefore, the case has been unsubstantiated due to these findings."

A review of the facility's investigative notes and documents on 08/30/2021 lacked documented evidence of interview statements from Resident #37, Resident #37's daughter and Employee #25.

During a face-to-face interview conducted on 08/31/2021 at 3:57 PM, Employee #1, stated that all interview questions and statements should have been included in the folder with the other documents for the investigation. He reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 31	F 610		

the initial complaint made by Resident #37's representative (daughter) was considered the interview statement of what happened. He also stated that he would check with Employee #2 (Director of Nursing) in regards to the interview questions from Employee #25 (CNA involved). The Administrator did not provide the missing interview questions and statements from Resident #37 prior to the survey exit.

3. Facility staff failed to thoroughly investigate the incident of Resident #95's hand mitten being tied to the bedrail.

Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarc due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy.

Review of the physician's orders revealed the following:

01/19/2021 "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours"

01/19/2021 "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy) - Tube q shift"

Review of Resident #95's Admission (MDS) dated 01/26/2021, revealed that facility staff coded the following:

In Section C (Cognitive Patterns), "Severely impaired"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 32	F 610		

In Section E (Behavioral Symptoms), " ... Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) ... Behavior of this type occurred 1 to 3 days"

In Section G (Functional Status), "Bed mobility ... total dependence, one-person physical assist"

In Section P (Restraint), "Limb restraint [hand mitten] ...Used daily"

Review of a Facility Reported Incident (FRI) on 01/27/2021 documented, " ... During rounds on 1/27/2021 her (Resident #95) mitten was found tied to the rail. It was immediately released, and the patient was assessed ...Investigation is ongoing ..."

Review of the progress notes revealed:

01/27/2021 1:18 PM (Administrator note) "[Resident name] ...During rounds on 1-27-2021 her mitten was found tied to the rail. It was immediately released and patient was assessed and not found to be in distress, pain or fearful. Resident's physician, RP (representative) and appropriate agencies were notified. House wide sweep conducted no other residents were found to have an inappropriate restraint. Investigation is ongoing. Son was satisfied and we told him we will be in communication with the conclusion."

Review of the facility's investigation notes and documents on 08/31/2021 revealed that only six (6) staff members were interviewed as part of the investigation. There was no documented evidence of interviews from the respiratory therapist who provided Resident #95 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 33 tracheostomy care or from the environmental staff who cleaned Resident #95's room. It was also noted that two staff members answered "no" when asked, "Do you know the abuse reporting policy and procedure" as part of the investigation ' s interview questions. There was no documented evidence that the investigator(s) followed up with those staff members nor is there documented evidence that any additional training/education was provided on restraints or the facility ' s abuse reporting policy and procedure. Employee #1 (Administrator) acknowledged that Resident #95 was physically tied to the bedrail however, he did not substantiate that abuse occurred. During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #2 (Director of Nursing) stated, "Mittens are used for residents who are a danger to themselves. After the incident, we interviewed the staff, assessed the resident and did audits of the other residents in the facility with hand mittens. We did not find any other residents with mittens tied to the bedrail." During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #1 (Administrator) stated, "We couldn't substantiate the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did not find any other resident with hand mittens tied to the bed."	F 610		

F 610 | Continued From page 34 | F 610

During a face-to-face interview conducted on 08/31/2021 at 10:54 AM, Employee #4 (Speech and Language Pathologist) stated, "The resident is nonverbal with right hemiparesis- pretty close to paralyses. Left side is intact. She had an order for left [hand] mitten. I walked into the room (on 01/27/2021) and noticed the straps to the mitten were wrapped around and tied to the upper bed rail, fully restricting her movement of the left hand. I immediately removed the restraint, made the nurse aware and educated the nurse that the mitten was not to be used as a restraint. I then reported the incident to my supervisor and the administrator."

It should be noted that a review of facility's visitation log on 08/31/2021 at 10:00 AM revealed that Resident #95 did not have any visitors on 01/26/2021 or 01/27/2021.

4. Facility staff failed to thoroughly investigate Resident #102's complaint that a staff member snatched his leg and slung it during care.

Resident #102 was re-admitted to the facility on 06/25/2021, with multiple diagnoses that included: Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, and Pressure Ulcer of Sacral Region.

The Employee #50's (Certified Nurse's Aide) statement dated 07/10/2021, documented, "Unfortunately I went to [Resident #102] said to him we are here to clean ... My nurse was [Employee name] we turned over the patient ..."

Review of a complaint and facility reported incident dated 07/14/2021 revealed the following: " ... [Resident #102] stated when staff was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 35 providing him with care snatched his leg and slung it requesting he [turn] over resident stated that he is in pain. Resident alleges that staff person told him big boy you can take a little pain. Resident was able to identify staff persons who were providing him care. An investigation is being conducted staff has been suspended pending ongoing investigation." Review of a memo from Employee #1 (Administrator) dated 07/14/2021, revealed, " ... The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident in question. Therefore, the case has been unsubstantiated due to these findings." Review of the facility's investigation notes and documents on 08/26/2021, revealed that the investigation failed to obtain a statement from the Registered Nurse (RN) who was mentioned as being present in Resident #102's room during the alleged incident. There were seven (7) pre-printed interview questionnaire forms and one handwritten statement written by the involved Employee #50. The pre-printed interview questions were answered by staff and other residents. Three (3) out of the seven (7) investigation questionnaire forms had questions that were left blank. All the pre-printed investigation questionnaire forms had names that were illegible. During a face-to-face interview conducted on 08/26/2021, at approximately 9:50 AM, Employee #1(Administrator) stated, "I came in, did investigations and interviewed staff."	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 36	F 610		

5. Facility staff failed to thoroughly investigate Resident #105's complaint that Employee #5 stuffed her brief with pieces from a incontinence pad and made a negative verbal comment.

Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome.

Review of Resident #105's Significant Change Minimum Data Set (MDS) dated 07/13/2021, revealed that facility staff coded the following:

"In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) score "15", indicating intact cognitive response.

"In Section E (Behavior), Hallucinations (perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No";

"and in Section GG (Functional Abilities and Goals), Toileting hygiene "... total dependence ... one-person physical assist".

Review of Employee #5's personnel file on 09/08/2021 revealed a form entitled; "[Facility's Name] Employee Warning Notice" dated 07/29/2020. The form revealed that Employee #5 received a verbal warning on (07/16/2020) and a written warning on (07/20/2020) for "violation of policy/procedure".

Attached to the previously mentioned warning notice was a document written by the (previous)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 37	F 610		

Director of Nursing that revealed the following:

"On the morning of July 16, 2020, it was brought to the attention of the Director of Nursing by Wound Care Team member... a resident [that resided on unit 3 east] was observed with a urine filled incontinence brief on and a urine saturated Ultrasorb (under pads) in the incontinence Brief. CNA (Employee #5) ... was asked about the use of the under pads inside of the resident ' s diaper. [Employee #5] said [Resident's Name] is a heavy wetter..."

"On the morning of July 20 [2020] ... Resident 330 A [unit 3 west] had a urine stained Ultrasorb under pad taped together to form a incontinence brief and was taped to the resident's skin...Resident 330 B [the previously mentioned resident's roommate] was observed with the same makeshift incontinence brief and in addition urine soaked towel was found between the resident's legs... This is the second occurrence within one week where [Employee #5] provided care to residents in a manner ... [Employee #5] should not provide... The type of care provided by [Employee's Name] to the residents is a Type B Offense... Acting in a way that can be considered abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally."

On 08/19/2021 a complaint was received by the State Agency that documented, "[Resident #105] ...reported to the Ombudsman... on the night of August 18th the nursing Aide stuffed [Resident #105's] brief with pieces from a chuck (incontinence pad) and said 'I am not changing you again tonight' ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 38	F 610		

Review of a memo from Employee #1 (Administrator) dated 08/24/2021, documented, " ... We interviewed the staff and other residents on the unit (3 west) along with examining the medical chart. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident [Resident #105] in question. Therefore, the case has been unsubstantiated due to these findings."

On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]... The residents daughter reported to the Ombudsman ... C.N.A. (Certified Nurse's Aide) ... told the resident 'she caused him three days of pay, and that she talks too much."

During a face-to-face interview conducted on 08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was floated to 3 west (where Resident #105 resided). He was not originally assigned to that unit. He [Employee #5] reported that he did not say anything to [Resident #105] while he was providing care. The supervisor is getting reprimanded, and the involved CNA was suspended (on 08/27/2021) and is being terminated as of today."

During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2 (Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 39	F 610		

care and responsibility from one healthcare provider to another) communication with the supervisors during the week. The supervisors were made aware that the CNA involved was not to work on the third floor at all."

During a telephone interview conducted on 08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 West because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 East. I was not made aware about the issues on 3 West."

During a telephone interview conducted on 08/30/2021 at 10:50 AM, Employee #5 stated, "I was working on 2 East and was pulled to 3 West because they were short. I was told the investigation was resolved and no issues were found, so I went to the unit (3 west). I was taking care of the roommate (room 333 bed B) when [Resident #105] stated that she was wet and needed assistance as well. I reminded her that she made a report on me and that I didn't want any problems. The resident stated that she wanted me to help her and so I did. There were no issues during the ADL (activities of daily living) care. I have been doing this for 17 years. I have never done anything to her nor intimidate her in any way."

Review of the investigation notes and documents for Resident #105's complaint revealed there was no documented evidence that the facility's staff reviewed Employee #5's personnel record or implemented measures to protect all residents including Resident #105, from the potential of "abuse or neglect, or mistreatment of a patient/resident either physically, mentally or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 40 verbally." Additionally, Employee #5's personnel record failed to outline why the employee was not allowed to work on unit 3 East. During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #7 (Director of Human Resources) stated, "The previous disciplinary actions (that occurred in 07/2020) were not mentioned to the Director of Nursing until a meeting that occurred on 08/31/2021 when termination (of Employee #5) was discussed." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated, "I was not aware of any previous allegations made for Employee #5 (CNA) until the meeting on 08/31/2021." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #1 (Administrator) stated, "I was not aware of any previous allegations or disciplinary actions for the employee (Employee #5). I did not review his personnel file as part my investigation."	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622	F 622 1. Corrective action for resident Residents #97 and #103 are currently residents in the facility. We are unable to retrospectively complete the documents. The Acute care Transfer Document Checklist has been updated to include Comprehensive Care Plan Goals.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 41	F 622		

services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care

2. Identify other residents

An audit of other residents with transfers out of the facility was conducted. Moving forward, the documents will be included in transfer packets. An audit of the Acute Care Transfer Document Checklist noted that the Comprehensive Care Plan Goals was not included in the list of documents automatically to include in the transfer packet (this has been corrected). There were no additional findings related to this citation.

3. Systemic changes

Nursing staff and Unit Secretaries have been educated on the updated Transfer Document Checklist and the need to include the Comprehensive Care Plan Goals in the transfer packet. The Acute Care Transfer Checklist has been updated to include the Comprehensive Care Plan Goals. The Shift Supervisors will be responsible for ensuring that Comprehensive Care Plan Goals are included in the transfer packets.

4. Monitor corrective actions

The Director of Social Services/Designee will complete weekly audits of all residents transferred out of the facility to ensure that the Comprehensive Care Plan Goals were included in the transfer packet. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 42 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Surveyor: Gena, Gemina Based on record review and staff interview, facility's staff failed to ensure all the required	F 622	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 43	F 622		

documents were conveyed to the receiving health care provider for two (2) of 44 sampled residents that were transferred from the facility. (Residents' #97, and #103)

The findings include:

1. Resident #97 was admitted to the facility on 07/27/2021 with multiple diagnoses that included: Acute and Chronic Respiratory Failure and Encounter for Tracheostomy.

Review of the physician's order dated 08/17/2021 at 10:57 AM, directed, "Transfer to hospital to [Hospital's name] via 911".

Review of Resident #97's transfer documents dated 08/17/2021, lacked documented evidence that the facility's staff included the care plan goals with the resident's transfer packet.

During a face-to-face interview conducted on 08/26/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated that care plan goals were not part of the documents included in the transfer packet.

2. Resident #103 was admitted to the facility on 07/21/2021 with diagnoses that included Myopathy, Gout, Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, and Chronic Kidney Disease.

Review of the resident's progress notes revealed:

07/13/2021 at 16:07 [4:07 PM] " ... new order to make arrangements for resident to be transfer to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 44	F 622		

LTACH (Long Term Acute Care Hospital). Waiting for open bed they will give us a call when room available."

07/13/2021 at 21:46 [9:46 PM] "resident left the unit at 8:30 PM to LTACH I/C (Intensive Care) Unit ..."

Review of the facility's "Acute Care Transfer Document Checklist" last updated June 2018 revealed the following:

"Copies of Documents Sent with Resident/Patient

Documents Recommended to Accompany Resident/Patient

Resident /Patient Transfer Form

Personal belongings identified on Resident/Patient Transfer Form are enclosed

Face Sheet

Current Medication List or Current MAR (Medication Administration Record)

SBAR (Situation, Background, Assessment and Recommendation) and/or other Change in Condition Progress Note (if completed)

Advance Directives (Durable Power of Attorney for Health Care, Living Will)

Advance Care Orders ...

Send These Documents if available:

Most Recent History and Physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 45 Recent Hospital Discharge Summary Recent MD/NP (Nurse Practitioner) /PA (Physician ' s Assistant) and Specialist Orders Flow Sheets Relevant Lab Results ... Relevant X-rays and other Diagnostic Test Results SNF (Skilled Nursing Facility)/NF (Nursing Facility) Capabilities Checklist .... " Although the facility had the aforementioned protocol for staff to complete a checklist before transferring residents, the form does not list "Comprehensive Care Plan Goals" as a document to be sent to the receiving facilities. A review of the documents [transfer packet] sent to the LTACH with Resident #103 on 07/13/2021 was conducted. There was no evidence that the resident's comprehensive care plan goals were included in the documents sent to the hospital (receiving provider). During a face-to-face interview with Employee #45 (Unit Secretary 1 South) on 08/30/2021 at 12:48 PM, and with Employee #2 (Director of Nursing) on 09/01/2021 at 8:26 AM, they both acknowledged that comprehensive care plans goals are not sent to the hospital with residents when they are transferred.	F 622	F 641 1. Corrective action for resident	11/02/2021
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641	Resident #87's MDS was corrected. The resident is no longer residing in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 46 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility's staff failed to ensure a Minimum Data Set Assessment accurately reflected a resident's mental status for one (1) of 44 sampled residents. (Resident #87) The findings include: Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Obesity, Gastrostomy and Stage 4 Sacral Pressure Ulcer. Review of the History and Physical dated 03/01/2021, the physician documented, " ...On February 2nd 2021 she (Resident #87) suffered a cardiopulmonary arrest ...Currently, the patient appears to be in a vegetative state and on full mechanical support (Ventilator) ..." Review of a Quarterly Minimum Data Set dated 06/02/2021 revealed, In Section C (Brief Interview of Mental Status) [BIMS] the resident was given a summary score of "11" for the indicating that Resident #87 was moderately impaired cognitively. During a face-to-face interview conducted on 09/16/2021 at approximately 12:30 PM, Employee #3 (Director of Social Services) stated that she incorrectly coded the resident's BIMS	F 641	2. Identify other residents An audit of all current residents MDSs revealed that cognitive statuses were correct. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that resident's cognitive status is correctly documented in the MDS. The Director of Reimbursement will be responsible for ensuring that resident's MDSs accurately reflect their cognitive status. 4. Monitor corrective actions The Director of Reimbursement/Designee will complete random weekly audits of 10% of the resident's MDSs to ensure that mental status is documented correctly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _______ B. WING _______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 47 score.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655	F 655 1. Corrective action for resident The baseline Care Plans cannot be recreated retrospectively. However, comprehensive care plans are in place for Resident #95, #105, and #372. Resident #95 has a care plan in place to address the use of a hand mitten. Residents #105 and #372 no longer reside in the facility. 2. Identify other residents An audit of all new admissions baseline care plans was conducted and all current residents have had their baseline care plans in place to address pertinent resident specific concerns. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that baseline care plans are created for each resident within 48 hours of admission. The Director of Reimbursement will be responsible for ensuring that all residents have interim care plans within 48 hours of admission. 4. Monitor corrective actions The Director of Reimbursement/Designee will complete daily audits of all new admissions to ensure that all residents have interim care plans within 48 hours (weekend/holiday admissions will be audited the next business day). The results will be reported to the QAPI Committee monthly x 3 months for review and	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 48 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 44, sampled residents, facility staff failed to develop and implement a baseline care plan within 48 hours of admission. (Residents' #95, #105 and #372). The findings include: 1. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of the physician's orders revealed the following: 01/19/2021-"Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours" 01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy)- Tube q shift" Review of Resident #95's Admission Minimum Data Set (MDS) dated 01/26/2021 revealed that facility staff coded the following: In Section P (Restraint), "Limb restraint [hand	F 655	recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 49	F 655		

mitten] ... Used daily"

During a review of Resident #95's care plan, there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her use of a hand mitten.

During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings.

2. Resident #105 was admitted to the facility on 05/26/2021 with multiple diagnoses that included: Chronic Pain Syndrome, Polyneuropathy, Anxiety Disorder and Bipolar Disorder.

Review of the physician's orders revealed:

05/26/2021 "Pain assessment every shift"

05/26/2021 "Acetaminophen(pain reliever) tablet 650 MG (milligram) give 1 tablet by mouth every 6 hours as needed for mild pain ..."

08/22/2021 "Dilaudid (opioid pain reliever) tablet 2 MG give 1 tablet by mouth every 6 hours as needed for pain"

Review of the Significant Change Minimum Data Set dated 07/13/2021, revealed that facility staff coded the following:

In Section J (Health Conditions), "... At any time in the last 5 days, has the resident: received scheduled pain medication regimen facility staff documented "Yes",

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 50	F 655		

"Received PRN (as needed) pain medications or was offered and declined Facility staff documented "Yes",

"How much of the time have you experienced pain or hurting over the last 5 days" facility staff documented "Frequently ..."

In Section N (Medications), "Indicate the number of days the resident received the following medications by pharmacological classification ...during the last 7 days... Medication received: "Opioid (Dilaudid)", Days: "6".

During a review of Resident #105's Care Plan, there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her pain.

During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings.

3. Resident #372 was admitted to the facility on 08/10/2021, with diagnoses that included Metabolic Encephalopathy, Tracheostomy, Gastrostomy, Chronic Respiratory Failure with Hypoxia, Bacteremia, Epilepsy, Pneumonitis due to Inhalation of Food and Vomit, Schizophrenia, Anxiety Disorder, and Restlessness and Agitation.

Review of the nursing progress notes revealed:

08/10/2021 at 18:26 [6:26 PM] (Admission Note) "...Resident ... admitted from [Hospital ' s name] with vent in place due to respiratory failure... PEG

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 51 (Percutaneous Endoscopic Gastrostomy) tube on upper center abdomen ...Jevity 1.5 is continuous for 24 hours at 55 ml (milliliters) per hour ...condom [catheter] in place and draining clear yellow urine ..." Review of the care plan section of the electronic health record revealed there was no Baseline Care Plan developed including a focus area, goals or approaches to address Resident #372's needs for Respiratory Care/Treatment, Gastrostomy Tube Care and Enteral Feeding, and diagnoses of Schizophrenia, Anxiety Disorder, Restlessness or Agitation. Also, there was no evidence that the facility's staff provided the resident and their representative with a summary of the Baseline Care Plan. During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656	F 656 1. Corrective action for resident Residents #56, #68, #87, #95, and #100 have had their comprehensive care plans reviewed and updated. Resident #105 no longer resides in the facility. 2. Identify other residents An audit of all current resident's care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 52 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for seven (7) of 44 sampled residents, facility staff failed to develop and implement comprehensive person -centered care plans. (Residents' #56, #68, #87, #95, #100, #102 and #105) The findings include: 1.The facility's staff failed to develop and implement a comprehensive person-centered	F 656	3. Systemic changes IDT team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The Director of Reimbursement will be responsible for ensuring that all residents have comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 53 care plan that included Resident #56's smoking preference. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Peripheral Vascular Disease (PVD), Diabetes Mellitus, Acquired Absence of Right Foot, Opioid Dependence, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression. During an entrance conference on 08/23/2021 at approximately 9:00 AM, Employee #1 (Administrator) stated that the facility did not have residents that smoke. Review of the care plan revealed it was last updated on 08/24/2021 lacked documented evidence the facility's staff developed a comprehensive, person-centered care plan with goals and interventions to address the resident's preference to smoke. During a face-to-face interview on 08/24/2021 at 4:01 PM, Resident #56 said that she smokes. During a face-to-face interview conducted on 08/26/2021 at 9:22 AM, Employee #23 (Unit Manager) stated that Resident #56 is a smoker and she will update the care plan to reflect the resident's preference to smoke. 2. The facility's staff failed to elevate Resident #68's Head of Bed (HOB) at a 45-degree angle while the resident's tube (enteral) feeding was infusing. Resident #68 was re-admitted to the facility on 04/19/2021. The medical record revealed that the resident had several diagnoses including	F 656		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 54	F 656		

Continued From page 54
Gastrostomy, Gastro-Esophageal Reflux Disease, Feeding Difficulties, Quadriplegia, Respiratory Failure, and Dependence on Respirator [Ventilator].

Observation on 08/30/2021 at approximately 2:30 PM, Resident #68 was observed lying flat in bed while her tube feeding (Glucerna 1.5 at 45 milliliters per hour) was infusing.

Review of the medical record revealed the following physician orders:

04/02/2021- " ...Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding stopped."

04/23/2021- "Enteral feed order every shift Glucerna 1.5 at 45ml/hr (milliliters/hour) X (times) 24 hr."

Review of the care plan with a focus area of: Gastrostomy Tube (Enteral) Feeding dated 04/01/21 revealed multiple interventions including ... The resident needs the HOB elevated 45 degrees during ...tube (enteral) feeding.

During a face-to-face interview on 08/30/21 at approximately 2:30 PM, Employee #20 (Registered Nurse) stated that the nursing assistant had just provided care for the resident and forgot to elevate the head of the bed.

3. The facility's staff failed to develop a comprehensive person-centered care plan to address Resident #87's use of a urinary catheter and PICC (Peripherally Inserted Central Line)/mid-line (intravenous access).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 55 Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed that the resident had several diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Obesity, Gastrostomy and Stage 4 Sacral Pressure Ulcer ... During an observation of Resident #87 on 08/25/2021 at approximately 3:30PM, the resident was noted to have a urinary catheter and right upper arm PICC/MID-line. Review of the physician orders showed the following: 05/31/2021- "Change Foley (urinary) catheter every month ..." 08/05/2021- "Change PICC/MID line dressing once a week ..." The medical record lacked documented evidence that the facility's staff developed care plans to address the resident's use of a urinary catheter and a PICC/MID-line. During a face-to-face interview on 09/01/2021 at approximately 11:00 AM, Employee #14 (Unit Manager) stated that she would develop a care plan to address Resident #87's use of a urinary catheter and a PICC/MID line. 4. The facility's staff failed to develop a comprehensive, person-centered care plan to address Resident #95's use of a hand mitten. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included:	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 56 Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of Resident #95's Admission Minimum Data Set (MDS) dated 01/26/2021, revealed that facility's staff coded the following: In Section P (Restraint) "Limb restraint [hand mitten] ... Used daily" Review of the physician's orders revealed the following: 01/19/2021- "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours " 01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy)- Tube q shift" Review of Resident #95's care plan revealed there was no documented evidence that the facility's staff developed a comprehensive, person-centered care plan with goals and interventions to address the resident's use of a hand mitten. During a face-to-face interview on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address findings. 5. The facility's staff failed to develop a care plan to address Resident #100's diagnosis of Anxiety. Resident #100 was admitted to the facility on 04/26/2021, with multiple diagnoses that	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 57 included Anxiety and Depression... Review of physician orders revealed the following: 04/26/2021- "Diazepam (antianxiety) Tablet 5 mg (milligram) give 1 tablet via G (gastrostomy) tube every twelve hours for anxiety ..." 04/27/2021- "Antipsychotic medication- monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin. 07/09/2021- "Quetiapine Fumarate (antipsychotic) Tablet 25 mg give 3 tablet via G (Gastrostomy) -tube every 8 hours for Depression ..." 07/15/2021-"Klonopin (antianxiety) ... give 1 tablet via G-tube two times a day for Anxiety ..." Review of the Quarterly MDS dated 08/02/2021 showed that in Section C (Cognitive Patterns), C0100 "Should a Brief Interview for Mental Status be conducted" facility staff coded, "0" meaning "Resident is rarely/never understood". Section D (Mood) Facility staff coded "0"(meaning no symptoms present). In Section E (Behavior - Potential Indicators of Psychosis) facility staff coded, "Z" indicating none of the above. In Section "I" (Active Diagnosis) facility staff coded Anxiety Disorder and Depression. Review of Resident #100's care plans lacked documented evidence that the facility's staff developed a comprehensive person-centered care plan to address Resident 100's diagnosis of Anxiety.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _______ B. WING _______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 58	F 656		

Continued From page 58

During a face-to-face interview on 09/16/2021, Employee #42 (Unit Manager) stated that she is responsible for the care plan. However, the employee failed expalin why the resident's anxiety diagnose was not address in the previosly mentioned care plans.

6. The facility's staff failed to update Resident #102's care plan to address his needs for mental health care.

Resident #102 was admitted to the facility on 05/12/2021, with multiple diagnoses including, Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, Unspecified Fracture of Lower End of Right Femur, and Pressure Ulcer of Sacral Region.

Review of the nursing progress notes dated from 07/07/2021 to 07/31/2021 revealed the following:

07/01/2021 at 5:27 AM- "Refused wound care, stated "don't you touch my wounds they are already done" resident was educated the importance of wounds being done but refused"

07/07/2021 at 6:14 PM- "Resident refused to have his wound VAC (a type of therapy to help wounds heal ...device decreases air pressure on the wound this can help the wound heal more quickly ...)" done writer made attempts to do the wound, but he refused care as well as therapy. He indicated that he does not want to be bothered."

https://www.hopkinsmedicine.org/health/treatmen t-tests-and-therapies/vacuumassisted-closure-of- a-wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 59	F 656		

07/26/2021 at 9:25 PM -"resident refused fs [finger stick] check and insulin. risk and benefit explained to resident"

07/27/2021 at 7:35 AM - "...patient refused morning care he said it is too early for him to get cleaned..."

07/27/2021 at 6:58 PM - " Resident refused, stated I do not need any pain medication [Oxycodone (opioid pain reliever)...5 MG Give 1 tablet via G (gastrostomy)-Tube every day and night shift for Prior to wound care] ..."

Review of Resident #102 ' s comprehensive care plan lacked documented evidence that the facility ' s staff developed a person-centered care plan to address his refusal of care.

During a face-to-face interview conducted on 09/16/2021 at approximately 3:15 PM, Employee #14 (Unit Manager) stated that she was not sure if the resident was evaluated by a Psychiatrist to address his refusal of care.

7. The facility's staff failed to develop a comprehensive, person-centered care plan to address Resident #105's pain.

Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Chronic Pain Syndrome, Polyneuropathy, Anxiety Disorder and Bipolar Disorder.

Review of the Significant Change MDS dated 07/13/2021, revealed that facility staff coded the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 60 In Section J (Health Conditions), "... At any time in the last 5 days, has the resident: received scheduled pain medication regimen facility staff documented "Yes", "received PRN (as needed) pain medications or was offered and declined" facility staff documented "Yes", "How much of the time have you experienced pain or hurting over the last 5 days" facility staff documented "Frequently ..." In Section N (Medications), "Indicate the number of days the resident received the following medications by pharmacological classification ...during the last 7 days... Medication received: "Opioid (Dilaudid)", Days: "6". Review of the physician's orders revealed the following: 05/26/2021- "Pain assessment every shift" 05/26/2021- "Acetaminophen (pain reliever) tablet 650 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for mild pain ..." 08/22/2021- "Dilaudid (opioid pain reliever) tablet 2 MG Give 1 tablet by mouth every 6 hours as needed for pain" During a review of Resident #105's care plan, there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her pain. During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 61 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 44 sampled residents, the facility's staff failed to revise the person-centered care plan to address resident needs and diagnoses. (Residents' #56 #78, #87) The findings include:	F 657	F 657 1. Corrective action for resident Residents #56 and #78 have had their comprehensive care plans reviewed and updated. Resident #87 no longer resides in the facility. 2. Identify other residents An audit of all current residents care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated/revised as needed. The Director of Reimbursement will be responsible for ensuring that all residents have updated/revised comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have updated/revised comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 62 1A. The facility's staff failed to revise and update the comprehensive care plan to address Resident's #56 discontinued use of an indwelling urinary catheter. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Peripheral Vascular Disease , Diabetes Mellitus, Acquired Absence of Right Foot, Opioid Dependence, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression. Review of the Quarterly Minimum Data Set dated 07/19/2021 revealed in Section C (Cognitive Patterns), that Resident #56 was documented as having a Brief Interview for Mental Status Summary Score of "15" indicating the resident was intact cognitively. In Section H (Bowel and Bladder), the resident was not coded for the use of an indwelling urinary catheter. During a tour of the facility on 08/23/2021 at 9:04 AM, Resident #56 was observed lying in bed, watching television. At the time of the observations, the resident did not have an indwelling urinary catheter. Review of the physician's order dated 06/02/2021, directed, "Change foley catheter, "q (every) monthly and as needed." This order was discontinued on 07/01/2021. Review of the care plan revealed a focus area of: " The resident has urinary retention related to presence of foley catheter." initiated on 06/03/2021. At the time of this review, (08/26/2021) Resident #56 no longer had the indwelling urinary catheter in place. However, the care plan was not updated to reflect the resident's	F 657	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 63	F 657		

current urinary status.

During a face-to-face interview on 08/24/2021 at 4:01 PM, Resident #56 stated, "I had "one" [indwelling urinary catheter] a few months ago, but it was removed."

During a face-to-face interview on 08/26/2021 at 1:07 PM, Employee #23 (Unit Manager) stated that she would remove it (urinary retention related to presence of foley catheter care plan) from the resident's comprehensive care plan.

B. The facility's staff failed to revise and update the comprehensive care plan for Resident #56 after a fall/accident on 08/03/2021.

Review of a nursing progress note dated 08/03/2021 at 15:36 (3:36 PM), documented, " It was reported ...that [Resident's name] fell out of her wc (wheelchair) [while] off the property...resident was navigating her electric wheel chair in the parking lot...she fell while backing up and a person walking by and a metro access driver helped her up...[resident] states I have a scratch on my arm... refused ...medical attention."

Review of the care plan with a revision date of 08/24/2021 with the focus area: "...at risk for fall..." However, the last update on 08/24/2021 failed to address Resident #56's fall on 08/03/21.

During a face-to face interview with Employee #23 at 9:22 AM, acknowledged that Resident #56 had a fall on 08/03/2021 and that the care plan for Resident #56 had not been updated to include the recent fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 64 2. Facility staff failed to update and revise Resident #78's care plan to include all of the diagnoses. Resident #78 was admitted to the facility on 04/14/2020, with multiple diagnoses including, Depression, Bipolar Disorder, Anoxic Brain Damage, and Acute and Chronic Respiratory Failure. Review of the Quarterly Minimum Data Set (MDS) dated 08/22/2021, showed that in Section C (Cognitive Patterns), C0100 asked, "should a brief interview for mental status be conducted" facility staff coded "0" indicating "no". In Section I (Active Diagnosis) Resident #78, was coded as having Depression, Bipolar Disorder and Anoxic Brain Damage. Review of the document entitled "History and Physical" revealed the following: 04/15/2020 - "... history of present illness", " ...H/O (history of) ...Bipolar Disorder, Depression and PCP (Phencyclidine or Phenylcyclohexyl Piperidine) [a hallucinogenic drug] use ..." 05/17/2021- "... history of present illness", "h/o Depression, Bipolar, Anoxic Brain Damage ..." Review of Resident #78's "Comprehensive Care Plan" dated 08/18/2021, failed to have focus areas that addressed the resident ' s diagnoses of Depression and Anoxic Brain Damage. During a face-to-face interview conducted on 09/16/2021, Employee #42 (Unit Manager) stated that she is responsible for updating the care plan.	F 657		

F 657 Continued From page 65 F 657

3. The facility's staff failed to revise Resident #87's care plan with new interventions to address the resident's skin integrity issues.

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: ,Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, and Obesity

During an observation on 08/25/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) and Employee #20 (Registered Nurse) were observed providing wound care for Resident #87's Stage 4 sacral pressure injury/wound, Stage 4 Right Calf pressure injury/wound, and Right Heel Deep Tissue Injury.

Review of Skin &Wound Evaluation sheets revealed the following:

04/28/2021-new, in-house acquired, right buttocks blister, length 4.2cm (centimeters),width 1.1 cm, depth not applicable, undermining not applicable, tunneling not applicable.

It should be noted that staff is currently classifying this wound as a Stage 4 (full thickness skin and tissue loss) pressure injury.

05/04/2021 -new, in-house acquired, Stage 4 pressure injury to left ear, length 0.9cm, width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 66 05/18/2021 - new, in-house acquired, right heel blister, length 4.1cm, width 4.3 cm, depth not applicable, undermining not applicable, tunneling not applicable. It should be noted that staff is currently classifying this wound [right heel] as a Deep Tissue Injury (persistent non-blanchable deep red, maroon, or purple discoloration). 07/06/2021- new, in-house acquired, right calf unstageable (obscured full-thickness skin and tissue loss) pressure ulcer/injury, length 3.0 cm, width 2.0 cm, depth not applicable, undermining not applicable, tunneling not applicable, and wound bed - 100% of wound filled with slough (a mass of dead tissue). Review of physicians orders revealed the following: 05/18/2021- directed, "Cleanse blister right heel gently with wound cleanser spray, pat dry, apply skin prep twice a day to protect ...Every day and night shift for wound care." 05/21/2021 - directed, "Cleanse wound left ear with wound cleanser spray, pat dry, apply Exuderm RCD (Regulated Colloidal Dispersion), change every three days every night ...for wound care." 05/21/2021 - directed, "Cleanse wound to sacrum with Anasept wound cleanser spray, pat dry, apply Anasept gel, cover with 4X4's and pad, and secure with coversite [stratasorb] dressing daily and prn (as needed) every night shift for wound care".	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 67 07/07/2021 - directed," Cleanse wound to right calf with Anasept wound cleanser spray, pat dry, apply Anasept gel, cover with 4 X 4's, abd (abdominal) pad, wrap with kling daily and prn (as needed)." Review of the June 2021 and July 2021 Treatment Administration Record (TAR) revealed that nursing staff initialed the TAR from 06/01/2021 to 07/29/2021indicating that they were providing wound care as prescribed. Review of the Quarterly Minimum Data Set (MDS) dated 06/02/2021 revealed the following: In Section C (Brief Interview for Mental Status) the resident was coded as an "11" indicating that the resident was moderately impaired cognitively. In Section G (Functional Status) the resident was coded as total dependent on staff and requiring physical assistance of one or two staff members for bed mobility, dressing, eating, toileting, and personal hygiene. Section I (Active Diagnoses) the resident was coded for Aphasia, Dependency on Respirator [Ventilator] Status, Tracheostomy, Gastrostomy, and Generalized Muscle Weakness. In Section M (Skin Condition) the resident was coded for being at risk for pressure ulcers/injuries and having one Stage 2, one Stage 3 and one Stage 4 pressure ulcer/injury. The resident was also coded for having surgical wound(s). Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In Section C (Brief Interview for Mental Status)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 68 the area was blank. In Section G (Functional Status) the resident was coded as total dependent on staff and requiring physical assistance with one or two staff members for bed mobility, dressing, eating, toileting, and personal hygiene. Section I (Active Diagnoses) the resident was coded for Stage 4 Pressure Ulcer, Aphasia, Dependency on Respirator [Ventilator] Status, Tracheostomy, Gastrostomy, and Generalized Muscle Weakness. In Section M (Skin Condition) the resident was coded for: being at risk for pressure ulcers/injuries, one Stage 3 and one Stage 4 Pressure Ulcer/Injury, one Unstageable Wound, one Unstageable Deep Tissue Injury, and surgical wound(s) and In Section V (Care Area Assessment Summary) indicated that pressure ulcer care area was triggered for this assessment. Review of the care plan with an initial date of 02/26/2021 with the focus area of: "The resident has Stage 4 (pressure injury) to sacrum ... New pressure injury unstageable to right lateral calf...". The care plan lacked documented evidence that the facility's staff updated it with new (current) interventions after each assessment (06/02/2021 and 07/26/2021) to address Resident #87's skin integrity issues including pressure ulcers/injuries. During a face-to-face interview on 09/01/2021 at approximately 1:30 PM, Employee #14 (Unit Manager) stated that she had not revised Resident #87's care plan with new interventions to address the resident's skin integrity issues, but she would update the care plan moving forward.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677 Continued From page 69 F 677

F 677 SS=D

ADL Care Provided for Dependent Residents
CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff and resident interview, for two (2) of 44 sampled residents, facility staff failed to ensure residents who are unable to carry out Activities of Daily Living (ADL) received the necessary personal hygiene. (Residents ' #25 and #37)

The findings include:

Review of the facility's policy entitled, "Activities of Daily Living (ADLs), Supporting" with a revision date of 03/2018 documented, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently ... including appropriate support and assistance with... hygiene (bathing, dressing, grooming, and oral care) ..."

1. The facility's staff failed to empty the urinal (urine collection device) for Resident #25.

Resident #25 was admitted to the facility on 10/16/2013 with multiple diagnoses that included: Blindness Right Eye Category 4, Muscle Weakness, Anemia, Hypertension, and Type 2 Diabetes Mellitus with Hyperglycemia.

During a face-to-face interview on 08/23/2021 at 4:46 PM, Resident #25 stated, "The staff take a long time to empty out my urinals."

F 677 — 11/02/2021

1. Corrective action for resident

Resident #25 has been having his urinals emptied regularly. Resident # 37 has been offered a shower 3 x week and has given a bed bath with a wash cloth water and body wash when she declines her shower. Her fingernails and toenails have been cleaned and trimmed. She has been put on the list to be seen by the podiatrist on the next scheduled visit.

2. Identify other residents

An audit of other residents have been conducted to ensure that ADLs are being addressed. Resident shower/bath preferences have been reviewed and documented. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that resident's ADLs are addressed appropriately. The Director of Nursing will be responsible for ensuring that resident's ADL needs are being met.

4. Monitor corrective actions

The Director of Nursing/Designee will complete weekly audits of shower sheets/documentation to ensure that residents are receiving showers/bed baths. Random room audits/resident interviews of 10% of resident rooms will be completed to ensure that urinals are being emptied timely. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 677 Continued From page 70

During an observation on Unit 3 West on 08/25/2021 at 8:59 AM, three (3) full urinals that contained approximately 1000 milliliters of clear, yellow liquid were observed at Resident #25's bedside.

During a second observation on 08/25/2021 at 11:16 AM, the same three (3) full urinals remained at Resident #25's bedside.

Review of the Annual Minimum Data Set (MDS) dated 07/21/2021 showed that facility staff coded the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of "15", indicating intact cognitive response.

In Section G (Functional Status), Mobility devices, "wheelchair", toilet use, "limited assist, one-person physical assist"

In Section H (Bowel and Bladder), urinary continence, "always continent"

Review of the care plan with the focus area of: [Resident #25] has impaired visual function r/t (related to) right eye blindness..." revised on 07/16/2019 revealed the interventions, "... Provide ADL assistance with the appropriate staff support as needed..."

Review of the care plan with the focus area of "[Resident #25] has an ADL self-care performance deficit r/t limited mobility..." revised on 09/25/2019, revealed the following interventions, " ...personal hygiene ... Resident requires set up, supervision, 1 staff assistance

F 677

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 71	F 677		

and encouragement to maintain self care ..."

During a face-to-face interview conducted on 08/25/2021 at approximately 11:20 AM, Employee #21 (Registered Nurse) stated, "I will go empty them (urinals) now."

2. The facility's staff failed to bath and provide oral and nail care for Resident #37.

Resident #37 was re-admitted to the facility on 09/01/2020, with the following diagnoses: Muscle Weakness (Generalized), Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebral Vascular Accident (CVA), Hemiplegia, Seizure Disorder, Depression, Schizophrenia, and Paranoid Personality Disorder.

During an observation on 08/25/2021 at approximately 9:30 AM, Employee #21 (Certified Nurse Aide) was observed providing a bed bath for Resident #37. The employee washed the resident with "incontinent care wipes". The resident said to Employee #21, "I want a bath with a washcloth, bodywash, and water, not a wipe." Continued observation revealed Resident #37's fingernails and toenails were long and dirty. Also, the skin on her feet was dry and scaly.

During a face-to-face interview on 08/25/2021 at approximately 9:45 AM, Resident #37 stated that she is given a wipe bath most days and she had not received mouth care in the past three days. She also reported that podiatry comes once a month, but she did not remember seeing them recently.

Review of the Quarterly Minimum Data Set (MDS) dated 08/12/2021 revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 72	F 677		

In Section C (Cognitive Patterns),had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating that the resident was cognitively intact.

In Section G (Functional Status), the resident was coded as total dependence and requiring one-person physical assist with dressing, toilet use, and personal hygiene.

Review of a physician orders revealed the following:

09/02/2020, directed, "Oral care two times a day"

08/02/2021, directed, "Shower resident 3 times a week, one time a day every Mon, Thu, and Sun.

Review of the care plan with a focus of area of: [Resident ' s name] had an ADL self-care deficit r/t: Hemiplegia (right-side) Status Post (s/p) CVA, Impaired Mobility, Muscle Weakness", revised on 07/24/2021 included the following interventions: "Bathing/Showering: Check nail length and trim and clean on bath day and as necessary Report any changes to nurse... Provide sponge bath when a full bath or shower cannot be tolerated... The resident is totally dependent on 1 staff..."

Review of the Treatment Administration Record (TAR) dated from 08/01/2021 to 08/31/2021, shows that facility staff signed off that they had been giving Resident #37 a shower every Monday, Thursday and Sunday and that they had been providing mouth care to Resident #37 twice a day.

However, review of the shower book revealed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 73 document entitled, "Skin Monitoring: Comprehensive Certified Nurse Aide (CNA) Shower" dated from 07/01/2021 to 08/31/2021 that showed Resident#37 received a bed bath on two (2) occasions 07/31/2021 and 08/28/2021. During a face-to-face interview on 08/31/2021 at 2:52 PM, Employee #22 (CNA) stated that after giving residents a bath, bed bath, or shower, she notes it on the skin monitoring sheets in the shower/bath book located at the nurse ' s station on the unit. During a face-to-face interview conducted on 09/01/2021 at 12:15 PM, Employee #2 (Director of Nursing), admitted that Resident #37 had only one documented bed bath for August 2021 and one documented bed bath for July 2021.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for five (5) of 44 sampled residents, the facility's staff failed to ensure residents received treatment and care in accordance with professional standards of practice and in accordance with residents' choices as evidenced	F 684	F 684 1. Corrective action for resident Resident #68 is being turned and repositioned as prescribed. Resident #68's head of the bed is being elevated during and at least 30-40 minutes after tube feedings (only lowered to provide care). Resident #76's mattress has been changed and is being monitored 2 x day (once per shift). Resident #87 no longer resides in the facility. Resident #100 was assessed by therapy and deemed inappropriate for the restorative program. Resident #372 no longer resides in the facility.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 74

by: facility staff failed to turn and reposition two (2) residents as prescribed for wound prevention; failed to elevate head of bed at a 45-degree angle while one (1) resident's tube (enteral) feeding was infusing; failed to ensure one (1) received restorative nursing for contracture management; failed to follow the physician's orders to obtain one (1) resident's trough levels (lab value). (Residents' #68, #76, #87, #100 and #372)

The findings include:

1. The facility ' s staff failed to turn and reposition Residents #68, as prescribed for wound prevention.

Review of the Comprehensive Care Plan revealed a focus area of: Activity of Daily Living ...Deficit related to Immobility with a revision date on 04/01/2021. The care plan outlined multiple including: the resident needs total assistance to turn/reposition at least every 2 hours.

Resident #68 was admitted to the facility on 04/01/2021. The medical record revealed that the resident had several diagnoses including Cerebral Palsy, Quadriplegia, Respiratory Failure, Dependence on Respirator [Ventilator], Tracheostomy and Gastrostomy.

Review of a physician order dated 04/20/2021 directed, "Turn and reposition every 2 hrs (hours) to prevent skin break down."

F 684

2. Identify other residents

An observation audit of other residents requiring turning and repositioning, residents on tube feeding, and residents who require therapeutic drug monitoring did not reveal any additional concerns. All mattresses were observed and audited and were in good repair. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that residents are turned and repositioned appropriately, the HOB is raised during tube feedings/30-40 minutes after feedings, and that therapeutic drugs are monitored per physician orders. The engineering department was educated on ensuring that resident equipment is kept in good repair. The Director of Nursing will be responsible for ensuring that residents receive quality care.

4. Monitor corrective actions

The Unit Managers and Supervisors/Designee will complete daily audits of turning and repositioning. Dietician/Designee will audit 25% of tube feeding residents weekly to ensure that the head of the bed is properly raised during/after feedings. The Director of Nursing/Designee will audit therapeutic medications weekly to ensure that corresponding laboratory tests are completed and results addressed. Materials Management will audit 25% of resident beds monthly for signs of disrepair and address any issues. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 75 Review of the Quarterly Minimum Data Set (MDS) dated 07/6/2021 revealed the following: In section C (Brief Interview for Mental Status Summary Score) this section was blank. In section G (Functional Status - Bed mobility) the resident was coded as a"4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section I (Active Diagnoses), the resident was coded for Cerebral Palsy, Quadriplegia, Respiratory Failure, Dependence on Respirator [Ventilator] Status Tracheostomy and Weakness. In section M (Skin Condition), the resident was coded for surgical wounds (gastrostomy and tracheostomy) and using a pressure reducing device for bed. During an observation on 08/30/2021 from 7:55 AM to 11:57 AM (3 hours) the following was noted: At 7:55 AM, Resident #68 was in bed, lying on her back. At 10:30 AM, Resident #68 remained in bed, lying on her back. and at 11:57 AM, Resident #68 was observed to still be lying on her back. During the three (3) hours of the observation, facility staff failed to reposition Resident #68.	F 684	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 76	F 684		

During a face-to-face interview on 08/30/2021 at approximately 12:40 PM, Employee #20 (RN) stated that the resident had been reposition by the certified nursing assistant (CNA) [Employee #17].

During a face-to-face interview on 08/30/2021 at approximately 12:45 PM, Employee #17 (CNA) stated, "I have not provided any care or turned/reposition the resident (Resident #68) today."

2. The facility's staff failed to elevate Resident #68's Head of Bed (HOB) at a 45-degree angle while the resident's tube (enteral) feeding was infusing.

Resident #68 was re-admitted to the facility on 04/19/2021. The medical record revealed that the resident had several diagnoses including Gastrostomy, Gastro-Esophageal Reflux Disease, Feeding Difficulties, Quadriplegia, Respiratory Failure, and Dependence on Respirator [Ventilator].

Observation on 08/30/2021 at approximately 2:30 PM, Resident #68 was observed lying flat in bed while her tube feeding (Glucerna 1.5 at 45 milliliters per hour) was infusing.

Review of the medical record revealed the following physician orders:

04/02/2021- " ...Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding stopped."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 77	F 684		

Continued From page 77

04/23/2021- "Enteral feed order every shift Glucerna 1.5 at 45ml/hr (milliliters/hour) X (times) 24 hr."

Review of the care plan with a focus area of: Gastrostomy Tube (Enteral) Feeding dated 04/01/21 revealed multiple interventions including ... The resident needs the HOB elevated 45 degrees during ...tube (enteral) feeding.

During a face-to-face interview on 08/30/21 at approximately 2:30 PM, Employee #20 (Registered Nurse) stated that the nursing assistant had just provided care for the resident and forgot to elevate the head of the bed.

3. Facility staff failed to assess Resident #76 's low air mattress every shift, as ordered by the physician.

Resident #76 was admitted to the facility on 03/27/2020 with the following diagnoses: Anemia, Respiratory Failure, Atrial Fibrillation, Colostomy Status, GERD, and Obstructive Sleep Apnea.

A review of the Quarterly Minimum Data Set (MDS) dated 06/27/2021 revealed the following: In Section C (Cognitive Patterns), Resident #76 had a Brief Interview for Mental Status (BIMS) Summary Score is, "12" indicating that the resident was mildly impaired cognitively. In Section G (Functional Status), Resident #76 was coded as, "total dependence, requiring one-person physical assist," for dressing, toilet use, and personal hygiene.

During an observation on 08/25/2021 at 11:08 AM, Resident #76 was lying in her bed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 78	F 684		

resident stated that it felt like there was a hole in her mattress, and she had reported it to the staff back in February or March. Upon further observation, there appeared to be a raised area in the middle of Resident #76 ' s mattress.

A record review of Resident #76 ' s clinical record shows a physician ' s order dated 03/28/2020 that directed," Check DPS (Digital Pump System) low-air mattress every shift."

A review of the Treament Administration Record (TAR) from 08/01/2021 to 08/31/2021, showed that nursing staff initialed the TAR twice a day (every shift) indicating that they had been checking the resident's mattress.

During a face-to face interview on 08/25/2021 at 11:10 AM, Employee #27 (Registered Nurse)stated, that she had not checked Resident #76 ' s mattress before today. However, she did feel a bulging wire in the resident's mattress today, after the resident complained of her mattress having a hole. The employee then said that she would put in a request for another mattress for the resident.

4. The facility ' s staff failed to turn and reposition Resident #87 as prescribed for wound prevention.

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 79 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer. Review of the resident weight record showed on 07/02/2021 she weighed 265.9 pounds. Review of a physician ' s order dated 02/26/2021 directed, "Turn and reposition every 2 hrs (hours) and as needed to prevent pressure injury. Every day and night shift. (Facility had 12-hour shifts)." Review of the Comprehensive Care Plan revealed a focus area of: Pressure Injury (Stage 4 left ear, Stage 4 sacrum, Stage 2 right heel, and Unstageable right lateral calf) with a revision date on 07/30/2021. The care plan outlined several interventions including, the resident needs total assistance to turn/reposition at least every 2 hours, more often as need (with an initiation/revision date of 02/26/2021). Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In section C (BIMS Summary Score) this section was blank. In section G (Functional Status - Bed mobility) the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section I (Active Diagnoses), the resident was coded for Anemia, Hypertensin, Diabetes Mellitus, Cerebrovascular Accident, Dependence on Respirator [Ventilator] Status, and Pressure Ulcer- Stage4. In section M (Skin Condition), the resident was coded for have one (1) Stage 3	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 80	F 684		

pressure ulcer, one (1) Stage 4 pressure ulcer, one (1) Unstageable pressure ulcer and one (1) Unstageable Deep Tissue Injury.

During an observation on 08/26/2021 from 8:10 AM to 12:40 PM (4 and a half hours) the following was noted:

At 8:10 AM, Resident #87 was observed in her room, in bed, laying on her right side.

At 10:46 AM, Resident #87 remained in bed, lying on her right side.

At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed.

During the four and half hours of the observation, facility staff failed to turn and reposition Resident #87.

During a face-to-face interview on 08/26/2021 at approximately 12:40 PM, Employee #16 (Registered Nurse) stated that the resident had not been turned and repositioned every two hours because the certified nursing assistance was working her way down to Resident #87 ' s room to provide morning care.

5. The facility's staff failed to ensure Resident #100 received restorative nursing for contracture management.

Resident #100 was admitted to the facility on 04/26/2021, with multiple diagnoses ' that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 81 included Cerebral Palsy, Quadriplegia, Neuralgia and Neuritis. On 08/24/2021 at approximately 12:30 PM Resident #100, was observed having his mittens removed by staff and the writer observed that both Residents hands were closed tightly and Resident# 100 ' s limbs appear stiff and staff had difficulty moving residents arms. According to the Quarterly Minimum Data Set (MDS) dated 08/02/2021, Resident#100 received Physical therapy that started on 04/27/2021 and ended on 06/29/2021. In section G (Functional Status) G0400, facility staff coded resident as a "1" for upper extremity meaning there is impairment on one side and facility staff coded the resident as a "2" for lower extremity meaning there is impairment on both sides. Review of the medical record revealed a documents entitled "PT (Physical Therapy) and OT (Occupational Therapy) Progress & Discharge Summary" dated 06/24/2021 for OT and 06/29/2021 for PT, which stipulated that resident #100 was to receive Restorative Nursing services for contracture management upon discharge from OT and PT case load. During a face-to-face interview conducted on 08/31/2021 at 10:50 AM with Employee #13 (Director of Rehabilitation Services) she stated " Resident #100 is not on case load and had been discharged (06/29/2021) to restorative nursing program. During a face-to-face interview conducted on 08/31/2021 at 11:37 AM with Employee # 2 (Director of Nursing) she stated "Currently we do	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 82	F 684		

not have one [Restorative Nursing]"

6. Facility staff failed to follow the physician ' s orders to obtain Resident #372's Trough levels (lab value).

Resident #372 was admitted to the facility on 08/10/2021, with diagnoses that included Metabolic Encephalopathy, Tracheostomy, Gastrostomy, Chronic Respiratory Failure with Hypoxia, Bacteremia, Epilepsy, Pneumonitis due to inhalation of food and vomit, Schizophrenia, Anxiety Disorder, and Restlessness and Agitation.

Review of Resident #372 ' s physician ' s orders showed the following:

08/11/2021 -"Vancomycin (antibiotic medication) HCI (hydrochloride) Solution 750 mg (milligrams) intravenously every 12 hours for Bacteremia for 8 days."

08/17/2021-"Hold vancomycin on 8/17. High trough- 42"

08/17/21 at 1:56 PM [order category-laboratory], "Vanco (vancomycin) trough daily for 3 days"

Review of the Medication Administration Record for August 2021 revealed the following:

On 08/11/2021, 08/12/2021, 08/13/2021, 08/14/2021, 08/15/2021 and 08/16/2021 Vancomycin HCI Solution 750 mg was administered twice daily at 10: 00 AM and 10:00 PM.

On 08/17/2021, Vancomycin HCI Solution 750

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 83 mg was administered at 10:00 AM and held at 10:00 PM as ordered by the physician. On 08/18/2021, Vancomycin HCI Solution 750 mg was held at 10:00 AM as ordered by the physician. On 08/18/2021 at 10:00 PM, Vancomycin HCI solution 750 mg was administered. Review of the laboratory results for 08/17/2021 showed: "Vancomycin trough results 42.6 reference range 10.0 -20.0, Flag-HH (indicating the laboratory values are out of range) and the physician was notified at 13:52 [1:52 PM]." There was no evidence that vancomycin trough levels were drawn on two additional days (08/18/2021 and 8/19/2021) in accordance with the physician ' s orders. During a face-to-face interview conducted on 08/26/2021 at 2:52 PM, Employee #14 (Unit Manager) acknowledged that three vancomycin trough levels were not drawn.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686	F 686 1. Corrective action for resident Residents #87, #83, #73, #62, and #42 were assessed on 9/8/2021 to ensure that any changes in skin condition were identified and treated appropriately. Resident #87 no longer resides in the facility. Staff were educated on identifying and reporting changes in skin conditions.	09/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 84

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, record reviews and staff interviews, facility staff failed to ensure that staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). (Residents' #87, #83, #73, #62, and #42)

Due to these failures an immediate jeopardy situation was identified on September 8, 2021 at 2:01 PM. The facility submitted a plan of action to the survey team on site at 7:31 PM on September 8, 2021 and the plan was accepted. The survey team returned on September 16, 2021 to validate the facility's plan, and the immediate jeopardy was lifted on September 16, 2021 at 7:52 PM. After removal of the immediacy, the deficient practice remained at a harm level and the scope and severity was lowered to an H.

The findings include:

Review of the facility policy entitled, "Prevention of Pressure Ulcers/Injuries" with a revision date of 07/2017 revealed the policy instructed staff to, " ...Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (Activities of Daily Living) ... turn and reposition bedbound resident at least every two

F 686

2. Identify other residents

Facility completed house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the License Nursing staff during the residents showers/bed baths to document any changes in the resident' s skin condition.

3. Systemic changes

The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. The corporate wound nurse or designee will in-serviceAll Nursing staff including registry on the process of reporting head and toe assessment and reporting documenting changes in residents skin condition to the Physician and wound team as soon as identified. An in-service including a sign-in sheet will be provided to track Nursing staff. All Nursing Staff including registry will be in-serviced on Wound Policy and procedures.The Corporate wound nurse will educate the Director of Nursing on the Wound policy and procedures.

4. Monitor corrective actions

Turning and repositioning will be monitored every two hours by the nursing supervisor to ensure proper turning and repositioning is being conducted. A turning and reposition audit tool will be used to monitor turning and reposition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 85 hours ..." 1. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer, Unstageable Right Heel Pressure Ulcer and a Stage 2 Left Heel Pressure Ulcer. Review of the Care Plan revealed the following focus: "Anti-coagulant Therapy" with a revision date of 11/20/2020. Intervention: "... daily skin inspections ..." Review of the medical record revealed the following: -02/26/2021 Physician's order- Turn and reposition every 2 hrs (hours) and as needed to prevent pressure injury. Every day and night shift. [Facility staff worked 12-hour shifts]. -02/26/2021 Physician's order- Daily head to toe skin assessments Q (every) shift. Notify MD/NP (medical doctor/nurse practitioner) of any abnormalities and document your assessment -03/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. -05/04/2021 Skin & Wound Evaluation - "Pressure (injury), Stage 4 (full-thickness skin and tissue loss), Left ear, new, in-house acquired,	F 686	Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staff responsible for not properly documenting skin assessments, and conducting turning and repositioning. This will be monitored by The Director of Nursing and Nursing Supervisors. A "skin tag violation card" will be implemented to address any staff found not doing proper turning and repositioning of residents. Nursing staff with over3 violations will be taken off the floor immediatelyfor training and a weekly Quality Audit will be conducted by the QAPI team. All finding will be addressed at the weekly QAPI meeting for 2 months. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality Director and addressed in the weekly QAPI meetings. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is September 15, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 86 wound measurements - length 0.9 cm (centimeters), width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% granulation, exudate - light, serosanguineous, no odor .... Resident seen by wound care staff for weekly assessment. Stage 4 pressure injury to left ear ..." -06/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. -07/02/2021 weight record: "265.9 [pounds]". -07/06/2021 Skin & Wound Evaluation - "Pressure (injury), Unstageable (Obscured full-thickness skin and tissue loss), Right calf lateral, new, in-house acquired, wound measurements - length 3.0 cm (centimeters), width 2.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% slough (a mass of dead tissue in, or cast out from, living tissue), exudate - none .... Resident seen by wound care staff for weekly assessment... Noted new pressure injury to right lateral calf, unit manager made aware ... " Review of the Treatment Administration Record (TAR) for May, June and July 2021 showed nurses signed their initials indicating that they had conducted head to toe skin assessments for Resident #87 twice a day (day and night shift). Review of all progress notes (nursing, physician, dietary) from 04/19/2021 to 05/03/2021 and 06/21/2021 to 07/05/2021 lacked documented evidence that Resident #87's Stage 4 Left Ear	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 87 pressure (injury) and the Unstageable Right Calf pressure (injury) were observed by staff prior to the assessments conducted by the wound team on 05/04/2021 and 07/06/2021 [when the wounds were first observed at an advanced stage]. Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In Section C (Cognitive Patterns) the BIMS (Brief Interview for Mental Status) summary Score was blank. In Section G (Functional Status - Bed mobility), the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section M (Skin Condition), the resident was coded for have one (1) Stage 3 pressure ulcer, one (1) Stage 4 pressure ulcer, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury. Further review of the care revealed the following focus: "Pressure Injury (Stage 4 left ear, Stage 4 sacrum, Stage 2 right heel, and Unstageable right lateral calf)" with a revision date of 07/30/2021. Interventions: "... the resident needs total assistance to turn/reposition at least every 2 hours, more often as need..." On 08/25/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) and Employee #20 (Registered Nurse) were observed providing wound care for Resident #87's Stage 4 sacral pressure injury/wound, Stage 4 Right Calf pressure injury/wound, and Right Heel Deep Tissue Injury. During an observation on 08/26/2021 from 8:10 AM to 12:40 PM (4 ½ hours) the following was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 88	F 686		

noted:

-At 8:10 AM, Resident #87 was observed in her room, in bed, laying on her right side.

-At 10:46 AM, Resident #87 remained in bed, lying on her right side.

-At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed.

During the four and half hours of the observation, facility staff failed to reposition Resident #87.

Although the facility's nursing staff documented that they conducted head-to-toe assessments on the resident daily, there was no evidence that facility staff identified changes in the residents ' skin condition and failed to implement approaches identified in the resident's care plan (turn and reposition). Subsequently, Resident #87 developed in-house acquired wounds (Left ear and Right Calf Lateral) Stage 4 pressure injuries/ulcers.

During a face-to-face interview conducted on 08/26/2021 at 12:45 PM, Employee #16 (Registered Nurse) stated, "The resident should be turned and repositioned every 2 hours and as needed. The CNA (certified nurse's aide) is working her way down to the resident's room now to provide care."

It should be noted that Resident #87''s left calf Stage 4 pressure injury/ulcer required bedside serial excisional debridement (the use of a scalpel to remove devitalized [slough/necrotic] tissue) on 08/31/2021.

F 686 Continued From page 89 F 686

During a face-to-face interview conducted on 09/08/2021 at approximately 10:00 AM, Employee #2 (Director of Nursing) was asked how did residents' wounds (pressure injuries) get to advanced stages before staff (wound team) observed them, Employee #2 stated, "I'm looking for nursing staff to have good assessment skills. I believe that there is a need for (nursing) training." When asked how often IS residents' skin assessed by nursing staff, Employee #2 stated that nursing staff assess residents' skin at least twice-a-week during bathing times.

During a face-to-face interview conducted on 09/08/2021 at approximately 5:30 PM, Employee #15 (Registered Nurse) was asked how often does she assess residents' skin, the employee stated that she conducts a head-to-toe assessment of the residents one (1) to two (2) times per shift depending on her workload. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No".

During a face-to-face interview on 09/08/2021 at approximately 5:30 PM, Employee #14 (Unit Manager/ RN) was asked how often she assess' residents' skin. The employee stated that when she is assigned a team, she conducts a head-to-toe assessment of the residents every shift. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No".

2. Resident #83 was re-admitted to the facility on 07/20/2021 with diagnoses that included: Acute and Chronic Respiratory Failure with Hypoxia, Tracheostomy, Gastrostomy, Hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 90	F 686		

Cerebral Infraction Affecting Right Dominant Side, and Pressure Ulcer Stage 4.

According to the Admission MDS dated 07/20/2021, Resident #83 was coded as "rarely/never understood" under Section C (Cognitive Patterns). Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating toilet use, and personal hygiene, G0400, "Functional Limitation in Range of Motion" the resident was coded for "no impairment to upper and lower extremities". In Section M (Skin Conditions), the resident was coded as at risk for pressure ulcer/injury and one (1) unhealed pressure ulcer that was present on admission to the facility.

According to the Braden Scale, on 07/21/2021 the resident was assessed and scored at a "10" indicating that the resident was "high risk" for skin breakdown.

Review of the care plans showed the following:

Focus area, " ... Stage 4 pressure injury to the sacrum"; Interventions: "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested dated 07/21/2021."

Focus area, " ... ADL self-care performance deficit r/t (related to) CVA (cerebral vascular accident), MI (myocardial infarction), Impaired cognition ..." Interventions: "Skin Inspection: the residents skin requires skin inspection q shift, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse initiated on 7/21/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 91	F 686		

Review of the physician's orders show the following:

07/20/2021 "Daily head-to-toe skin assessment q (every) shift. Notify MD/NP for any abnormalities and document your assessment two times a day"

07/21/2021 "Turned and reposition every 2 hours and as needed to prevent pressure injury ..."

08/17/2021 "Cleanse wound right shoulder with Anasept wound cleanser spray ... then apply Anasept wound gel cover with 4x4 and secure with border gauze daily every night shift for wound care- start date"

Review of the TAR from 07/20/2021, to 08/17/2021, showed that facility staff signed that they: "performed daily head to toe skin assessment Q shift (twice daily), would notify MD/NP of any abnormalities and document the assessment and turned and repositioned the resident every two hours and as needed to prevent pressure injury ..."

However, review of the Skin and Wound Evaluation V5.0 form dated 08/17/2021 showed the following:

"... Stage- unstageable: obscured full thickness skin and tissue loss; 22. Location: right shoulder; In-house acquired; Exact Date- [left blank]; Wound Measurements= Area-7.8 cm, length 4.3 cm x width 2.4 cm x depth not applicable ...slough- 100%, ...Progress -New ...Notes: Resident seen on wound rounds, noted new pressure injury to right shoulder, wound is 100% slough covered. Periwound area has intact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 92	F 686		

blister and redness ...

Facility staff were signing in the medical record that they were assessing Resident #83's skin daily and turned and repositioned the resident every two hours. However, Resident #83 developed an in-house acquired pressure injury noted at an advanced stage (unstageable pressure injury to his right shoulder at the first observation and assessment).

During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."

3. Resident #73 was admitted to the facility on 03/11/2020 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Damage and Chronic Kidney Disease.

Review of the medical record revealed the following:

03/11/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

04/28/2020 [Physician Order]- "Weekly skin assessment and report any abnormality to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ____ B. WING ____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 93	F 686		

MD (medical doctor)/NP (nurse practitioner)"

04/28/2020 [Physician Order]-"Moisturize skin with hydroguard (skin lotion) every shift"

04/28/2020 [Physician Order]- "Turn and reposition q (every) two hours."

04/29/2020 [Physician Order]- "Administer bed bath or sponge bath to resident daily and as needed ..."

07/19/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

07/30/2020- [Physician Order] - "Apply skin prep to DTI (Deep Tissue Injury) left heel twice a day, monitor, and report any redness or drainage every day and night shift for wound care."

07/30/2020 [Physician Order] - Cleanse right heel wounds with Anesept spray (wound cleanser) pat dry then apply Anesept gel (antimicrobial skin gel)... off load both heels with pillows continuously every 12 hours ..."

08/18/2020 [Skin & Wound Evaluation]- "Left lateral malleolus ... Resident seen by wound care staff for weekly assessment. New Stage 4 pressure injury noted to left malleolus area has 0.5 cm (centimeters) area of slough also able to palpate bone in wound bed. Unit manager made aware ..."

"08/18/2020 [Skin & Wound Evaluation] -"Right lateral malleolus ... Resident seen by wound care staff for weekly assessment. New unstageable pressure injury to right malleolus noted. wound is

F 686 Continued From page 94 F 686

dry eschar, with no redness or drainage noted at edges ..."

Review of all progress notes (such as, nursing, physician, dietary) from 07/01/2020 to 08/17/2020 lacked documented evidence that Resident #73 ' s Stage 4 Left Malleolus pressure injury and the Unstageable Right Malleolus pressure injury was observed by staff prior to the wound team ' s assessment on 08/18/2020.

Review of the Treatment Administration Record (TAR) from 08/01/2020 to 08/18/2020 revealed that facility staff documented that Resident #73; received a bed or sponge during the day shift, bilateral heels were off loaded during the day and at night, skin was moisturized during the day, evening and night shifts, and was being turned and repositioned every two hours at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM.

Review of Resident #73's "CNA Activity of Daily Living (ADL) Notes" from 08/01/2021 to 08/18/2021 revealed that facility staff documented "No" to the question that asked, "Is there a new skin condition?"

Review of the Admission MDS dated 03/18/2021 revealed that facility staff coded the following:

In Section G (Functional Status), "bed mobility... total dependence... two+ (plus) persons physical assist ..."

In Section H (Bowel and Bladder), "urinary continence ... bowel continence ... always incontinent ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 95	F 686		

In Section M (Skin Conditions), " ... risk of pressure ulcers ...yes ..."; " ... resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device ...no ...", " ...is this resident at risk of developing pressure ulcers/injuries?... yes", " ... does this resident have one or more unhealed pressure ulcers/injuries?... no"

Review of the Care Plan revealed the following:

Focus: "Activities of Daily Living Self-care Performance Deficit" dated 03/11/2020 revealed several interventions including, "provide sponge bath when a full bath or shower cannot be tolerated ...bed mobility, and the resident is totally dependent on staff for repositioning and turning in bed every 2 hour."

Focus: "Alteration in Neurological Status" dated 03/12/2020 revealed several interventions including "... skin inspections daily and report any findings to the nurse."

Although the facility implemented approaches identified in the resident care plan (turn and reposition and inspect skin daily). Subsequently, Resident #73 developed an in-house acquired Stage 4 Left Malleolus pressure injury and a Unstageable Right Malleolus pressure on 08/18/2020.

During a face-to-face interview conducted on 09/08/2021 at approximately at 9:35 AM, Employee #9 (Director of Wound Care) stated, "The wound team has educated the nursing staff multiple times on assessment, documenting and reporting of resident ' s skin. I have brought this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 96	F 686		

issue of the nursing staff not documenting or making the wound team aware of skin issues at an early stage to the attention of the Director of Nursing and the Administrator."

4. Resident #62 was re-admitted to the facility on 07/31/2021. The medical record showed the resident had several diagnoses including: Dependency on Respirator [Ventilator], Tracheostomy, Diabetes Mellitus, Protein-Calorie Malnutrition, Stage 4 Left Calf Pressure Ulcer, Stage 4 Scapula Pressure Ulcer, Stage 4 Left Trochanter Pressure Ulcer, Stage 3 Left Heel Pressure Ulcer, Left Foot Deep Tissue Injury, and Surgical Sacral Wound.

During an observation on 08/24/2021 starting at 12:12 PM, the wound care team provided wound care for Resident #62's wounds for the left hip, left leg, back and sacrum.

Review of the medical record revealed the following:

05/07/2021 [Braden Scale] - Resident #62 scored a "10" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

05/08/2021 [Physician Order] - Turn and reposition every 2hrs (hours) for comfort and to help prevent pressure injury every shift.

05/08/2021 at 4:15 AM (Nursing Admission Summary Note) - "Resident...admitted... at 7pm ...Resident has a sacral wound stage IV (4), (6cm (centimeters) X 5(cm) X 1 (cm) deep). Moderate amount of serosa (serosanguinous) drainage noted. (Left lower leg wound 0.6cm X 1.0cm). (Left buttock pressure 0.1cm)...with multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 97 scattered wound. Multiple scars noted to bilateral lower extremities. Old surgical sites to chest and abdomen." 05/09/2021 at 2:16 AM (Nursing Progress Note)- "Resident alert and responsive, 2nd day of readmission ...skin warm and dry to touch ...ADL and wound cares (sp) provided ... turn (sp) and reposition (sp) every two hours and as needed to prevent pressure ulcer ..." 05/10/2021 at 1:06 PM (Nursing Progress Note) - "Resident is alert and responsive, skin warm and dry to touch ...ADL care provided, turning, and repositioning every two hours as needed to prevent pressure ulcer (sp) ..." 05/10/2021 1:58 PM (Skin & Wound Evaluation)- "new, in-house acquired, Left calf, Stage 3 (Full-thickness skin loss), pressure(injury), length 3.2 cm (centimeters), width 2.7 cm, depth 0.1 cm, undermining not applicable, tunneling not applicable. wound bed 100% granulation -pink or red, exudate light, seropurulent ..." Review of the Treatment Administration Records for May 2021 revealed the following: Nursing staff signed their initials indicating that they had turned and repositioned Resident #62 every (2) hours from 05/08/2021 to 05/10/2021. Review of the Care Plans revealed the following: Focus: "Skin Impairment related to Immobility" with am initial date of 05/07/2021, outlined multiple interventions including turn and reposition resident to prevent pressure injuries.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 98 Review of the Minimum Data Set dated 04/21/2021 revealed, In section C (Cognitive Patterns), Brief Interview for Mental Status summary score was blank. In section G (Functional Status - Bed mobility) the resident was coded as a "4" indicating that the resident was totally dependent on the staff. The support section was left blank. In section M (Skin Condition), the resident was coded to having four (4) Stage 3 pressure ulcers, three (3) Stage 4 pressure ulcers, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury. Although the facility implemented approaches identified in the resident care plan (turn and reposition). Subsequently, Resident #62 developed in-house acquired wound (Left Calf) Stage 3 pressure injury within 48 hours of his re-admission date of 05/08/2021. During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #10 (Wound Team Nurse) stated that on 05/10/2021 she assessed Resident #62 ' s skin and observed an in-house acquired Stage #3 pressure injury on the resident ' s left calf. During a face-to-face interview on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 99	F 686		

staff is not bathing residents."

5. Resident #42 was re-admitted to the facility on 09/12/2020 with diagnoses that included Acute and Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Tracheostomy, Gastrostomy, Hypertension, Contractures (Right and Left Elbow), and Pressure Ulcer Left Heel Stage 4.

According to the Quarterly MDS dated 06/30/2021 the resident was coded as "rarely/never understood" under Section C (Cognitive Patterns); Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating, toilet use, and personal hygiene; Functional Limitation in Range of Motion the resident was coded for "impairment to upper and lower extremities". Section M (Skin Conditions), the resident was coded as at risk for pressure ulcers and one (1) unhealed pressure ulcer.

According to the Braden Scale, Resident #42 was assessed and scored at a "9" indicating that she was "very high risk" for skin breakdown on 04/03/2021 and was assessed and scored at a "10" indicating "high risk" for skin breakdown on 07/03/2021.

Review of the care plan with the focus area, "Stage 4 pressure injury to left lateral malleolus" revealed the following interventions, "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested" dated 07/23/2021, "Follow facility policies/protocols for the prevention/treatment of skin breakdown" initiated 12/04/2020.

Review of the physician ' s orders revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 100	F 686		

following:

06/11/2021 "Cleanse left medial heel wound with Anasept wound cleanser spray ... every day and PRN (as needed). Please float heels continuously to prevent pressure every night shift for wound care"

09/13/2020 "Float heels while in bed with a pillow to prevent skin breakdown and pressure every shift (day, evening , night)"

09/13/2020 "Daily head to skin assessments per protocol every shift and as needed, and they would notify MD (medical doctor) for any abnormality every day and night shift"

05/30/2021 "Turn and reposition every 2 hours and as needed for relieving and redistribution"

Review of the Treatment Administration Record from 07/01/2021 to 07/14/2021 showed that facility staff signed that they: performed wound care to the resident ' s left heel, floated the resident ' s heels twice daily, performed head-to-toe notify MD (medical doctor) for any abnormality every day and night shift, and turned and repositioned the resident every two hours and as needed for reliving and retribution.

However, review of the Skin and Wound Evaluation V5.0 form dated 07/14/2021 showed the following:

"... Stage 4 full thickness and tissue loss... Location: Left Lateral Malleolus (ankle) ... Acquired; In-house acquired... Exact Date- 7/14/21; Wound Measurements= Area-2.5 cm, length 2.2cm x width 1.8 cm x 0.5 depth,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 101	F 686		

undermining 1.0 cm; Wound bed -slough 100% of wound filled; exudate-light; type seropurulent; Notes: Resident seen by wound care team, noted development of new pressure injury to left lateral malleolus (sp). Wound is stage 4, full thickness with palpable bone in wound bed full description and pictures in PPC (point click care) ..."

Facility staff were signing that they: conducted wound treatments to the residents left heel twice daily, were assessing the residents skin daily, floated the resident ' s heels twice daily, and turned and repositioned the resident every two hours. However, Resident #42 developed an in-house acquired pressure injury noted at an advanced stage (stage 4 pressure ulcer to the Left Lateral Malleolus).

During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."

Based on these findings, on September 8, 2021 at 2:01 PM an immediate jeopardy (IJ) situation was identified.

On September 8, 2021 at 7:31 PM, the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 102 administrator provided a corrective action plan to the State Agency Survey team which included: "1. Facility will complete house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the License Nursing staff during the resident ' s showers to document any changes in the resident ' s skin condition. The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. The corporate wound nurse or designee will in-service All Nursing staff including registry on the process of reporting head and toe assessment and reporting documenting changes in resident ' s skin condition to the Physician and wound team as soon as identified. An in-service including a sign-in sheet will be provided to track Nursing staff. 2. All Nursing Staff including registry will be in-serviced on Wound Policy and procedures. The Corporate wound nurse will educate the Director of Nursing on the Wound policy and procedures. 3. Turning and repositioning will be monitored every two hours by the nursing supervisor to ensure proper turning and repositioning is being conducted. A turning and reposition audit tool will be used to monitor turning and reposition. Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staff responsible for not properly documenting skin assessments, and conducting turning and repositioning. 4. This will be monitored by The Director of	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 103 Nursing and Nursing Supervisors. A "skin tag violation card" will be implemented to address any staff found not doing proper turning and repositioning of residents. Nursing staff with over 3 violations will be taken off the floor immediately for training and a weekly Quality Audit will be conducted by the QAPI team. All finding will be addressed at the weekly QAPI meeting for two months. 5. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality Director and addressed in the weekly QAPI meetings. All Items to be completed by 9-15-2021." The State Agency Survey team returned to the facility and verified that the plan of correction was in place on September 16, 2021 at 7:52 PM, and the immediate jeopardy was removed.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688	F 688 1. Corrective action for resident Resident #48 has been assessed by therapy and deemed not appropriate for restorative care at this time. We have an active Restorative program. 2. Identify other residents An audit of all current residents was conducted to determine if restorative care and/or orthotics were needed. Residents were picked up on the restorative case load and orthotics were ordered if indicated. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 688

Continued From page 104

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview for one (1) of 44, sampled residents, facility staff failed to implement the use of orthotics to prevent decrease in range of motion and mobility. Resident #48

The findings include:

Resident #48 was admitted to the facility on 04/19/2019, with multiple diagnoses including: Paraplegia, Muscle Weakness, Other Muscle Spasm, Pain Unspecified, Aphasia and Respiratory Failure.

Resident #48 was observed on 08/23/2021 at approximately 9:05 AM receiving care from Employee #43 (Licensed Practical Nurse) and it was noted that Resident #48's hands were tightly clasped in a fist like position and residents arms were stiff and difficult for staff to move.

Review of Resident #48's Quarterly Minimum Data Set (MDS) dated 06/13/2021, revealed: In Section C (Cognitive Patterns) C0100 facility staff coded resident as a "0" meaning resident is "rarely/never understood". In Section G (Functional Status) G0110 facility staff coded resident a "4" for bed mobility meaning resident is totally dependent on staff to perform this function every time during a seven day period. In Section G (Functional Limitation Range of

F 688

3. Systemic changes

Nursing and Administrative staff have been educated on the importance of ensuring that residents receive appropriate restorative care. The Director of Rehabilitation will be responsible for maintaining the restorative program with assistance from the Director of Nursing. The IDT team will refer residents to therapy for the restorative program as needed.

4. Monitor corrective actions

The Director of Rehabilitation/Designee will complete weekly audits of 10% residents to ensure that ordered orthotics are being used appropriately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 105	F 688		

Motion) G0400 facility staff coded resident as a "0" for Upper extremity meaning no impairment and coded resident a "2" for lower extremity meaning impairment to both sides. In Section O (Special Treatments, Procedures, and Programs), under "Restorative nursing programs" for "Range of Motion (passive), Range of motion (active) and Splint Brace assistance", facility staff coded all three as "0" meaning the activities were not performed.

Review of the Comprehensive Care Plan revealed with a focus area of: "[Resident ' s name] has limited physical mobility r/t (related to) Contractures of the bilateral hand and legs ..." revised on 02/07/2019 had multiple interventions including: "Apply roll towel to bilateral hands at all times remove every 2 hours for hygiene and skin check ..."

Review of nursing progress noted and Treatment Administration Record dated from 07/01/2021 to 08/22/2021, lacked documented evidence that staff applied a rolled towel to both hands the resident's hands.

During a face-to-face interview on 08/31/2021 at 11:30 AM, Employee #13 (Director of Rehabilitation) stated "The resident (Resident #48) was discharged to restorative nursing (staff that applies rolled towels for hands and splints)".

During a face-to-face interview on 08/31/2021 at 11:37 AM, Employee #2 (Director of Nursing) "Currently we do not have one [Restorative Nursing]."

F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 106 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review for one (1) of 44 sampled residents, facility staff failed to provide adequate supervision to monitor the residents whereabout in and out of the facility for Resident #93 who left the facility without the staff knowledge; and facility staff failed to provide an environment free from accident hazards as evidenced by a portable space heater that was seen in one (1) of 76 resident's rooms. The findings include: 1.Resident #93 was admitted to the facility on 01/07/2021 with diagnoses that included: Fracture of the Lower End of Right Tibia, Anemia, Unsteadiness on Feet, Weakness, Schizoaffective Disorder, and Bipolar Type. According to the Quarterly Minimum Data Set (MDS) dated 07/16/2021 the resident's Brief Interview for Mental Status (BIMS) Score was "15" indicating that the resident was cognitively intact. In Section G (Functional Status), the resident was coded as requiring supervision and set up help only for bed mobility; he was coded as independent in transferring, eating, toilet use, personal hygiene, and dressing. He required set up help from staff with dressing, eating and	F 689	F 689 1. Corrective action for resident Resident #93 was educated on signing out when leaving the facility. The heater was removed from room 335. The resident was educated that such devices are a safety hazard and not permitted. 2. Identify other residents An audit of other resident LOAs was completed. An audit of resident rooms did not yield any additional heaters. There were no additional findings related to this citation. 3. Systemic changes Nursing and security staff have been educated on the importance of ensuring that residents are signed out appropriately and accounted for and no heaters are present. Nursing staff have been educated on the importance of accurate documentation and validation of resident whereabouts throughout the shift. The Director of Security will be responsible for ensuring that residents are engaged upon exit of the facility to ensure that they have notified nursing staff of their whereabouts. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of all residents who go out on LOAs to ensure that their absence and related documentation is accurate. The Engineering department will audit 25% of resident's rooms monthly for unauthorized appliances. The results will be reported to the QAPI Committee monthly x 3 months for review and	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 107 personal hygiene. The resident was coded as having impairment to his lower extremities on both sides and was coded as using a wheelchair for mobility. Review of the progress notes showed: 08/30/2021 at 4:28 AM "Upon change of shift round, resident was not in his room, off going nurse stated that the resident is in the facility and did not sign himself out, his dinner tray was in the room untouched. Usually resident goes to another floor to visit, but up to the end of the medication pass, resident did not come back to the floor, resident was call on his cell phone, the number showed up wrong number, R/R (responsible party) was also called no answer, message left on the answering service for them to call the unit, supervisor made aware and she was on the floor to assessed the situation, couple of phone calls was made to his family member by her without success, resident still out at this time." 08/30/2021 at 6:46 AM "Security informed this writer at 06:00 that the resident had just returned back to the facility. Resident arrived on the unit at 06:10 AM stated that he had a family emergency and one of his family came and took him home at 02:00 PM yesterday (Sunday, 8/29/21) and that he did not [have] time the time to sign himself out, supervisor made aware and she was on the unit to [assess] the situation, refused to be assess instead asking for his sleeping medication, staff will continue to monitor the resident status." Review of the security camera footage on 08/31/2021 at 4:18 PM showed that the resident exited the building at 1:09 PM on 08/29/2021.	F 689	recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 108	F 689		

Review of the Treatment Administration Record for 08/29/2021 shows that facility staff signed that they were turning, and repositioning Resident #93 every two hours as needed from 12:00 AM to 8:00 PM (0000, 0200, 0400, 0600, 0800, 1000, 1200, 1400, 1600, 1800, 2000).

During a face-to-face interview with Resident #93 on 08/31/2021 at 10:00 AM he stated, "It was my fault." And made no other statements.

Review of the clinical record, facility staff were documenting that they were providing care to Resident #93 on 08/29/2021 from 1:00 PM to 8:00 PM. However, the resident was not in the facility. The facility's staff noticed that the resident did not eat his dinner, but they failed to check/verify Resident # 93's location in the building.

Subsequently, the resident was gone from the building for approximately seven (7) hours before facility staff discovered that the resident was no longer present in the building and began to search for him.

During a face-to-face interview on 09/01/2021 at 8:45 AM, Employee #2 reviewed the documentation and made no comments on about the findings.

2. Facility staff failed to provide an environment free from accident hazards as evidenced by a portable space heater that was observed in one (1) of 76 resident's rooms.

During a walkthrough of the facility on 08/30/2021, at approximately 12:00 PM, a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 109 portable space heater was stored on the floor in resident room #335 [private room] on the unit 3 west. The space heater was plugged in an electrical outlet, ready for use. Employee #1 (Administrator) acknowledged the findings during a face-to-face interview on 09/01/2021, at approximately 4:00 PM.	F 689		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, for one (1) of 44 sampled residents, facility staff failed to change Resident #76's colostomy bag (a plastic bag attached to the abdomen that collects fecal matter from the digestive tract through an opening in the abdominal wall called a stoma...), when it was full, in accordance with the physician's order and professional scope and standards of practice. The findings include: According to The American Cancer Society,"...Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems...	F 691	F 691 1. Corrective action for resident Resident #76's colostomy was changed/emptied at the time of the observation. Resident #76 is having her colostomy bag changed/emptied as prescribed and as needed. 2. Identify other residents An audit of other residents with colostomies did not reveal any other residents that were affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that resident's colostomy bags are being emptied/changed as prescribed. The Director of Nursing will be responsible for ensuring that residents are having their colostomy bags emptied/cleaned regularly.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 691

Continued From page 110

There may be less bowel activity at certain times in the day. It's easiest to change the pouching system during these times. You may find that early morning before you eat or drink is best..."

https://www.cancer.org/treatment/treatments-and-side-effects/treatment-types/surgery/ostomies/colostomy/management.html

Resident #76 was admitted to the facility on 03/27/2020 with multiple diagnoses including: Colostomy, Gastroesophageal Reflux Disease (GERD), and Generalized Muscle Weakness.

Review of the Quarterly Minimum Data Set (MDS) dated 06/29/2021 revealed the facility staff coded Resident #76 as followed:

In Section C (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) Summary Score of "12" indicating she is mildly cognitively impaired. In Section G (Functional Status), facility staff coded "totally dependent on staff for dressing, toilet use, and personal hygiene" and required "one-person physical assist". In Section H (Bowel and Bladder), Appliance, facility staff coded "ostomy".

Review of a physician's order dated 03/28/2020 directed, "Colostomy care every shift as needed."

During an observation and face-to-face interview on 08/23/2021 at 6:53 AM, Resident #76 stated that two days ago she waited a long time for staff to change her colostomy bag. She further stated, "It (colostomy bag) got so full that it started to leak. I'm afraid to leave my room to participate in activities because my bag (colostomy bag) might leak." The resident then attempted to pull her

F 691

4. Monitor corrective actions

The Director of Nursing/Designee will complete weekly audits of residents with colostomies to ensure that they are being emptied/cleaned as prescribed and as needed. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 691	Continued From page 111 over-the-bed table close to her body, but she couldn't because the colostomy bag was full. On further observation, at 6:54 AM, Resident #76 pressed the call light in order to tell the nurse her colostomy bag is full and in need of changing. At 7:05 AM (11 minutes later), Employee #44 (Registered Nurse) came in the room to see what the resident wanted. Resident #76 stated to Employee #44 that she needed her colostomy bag changed. Employee #44 then stated to the resident and surveyor,"I did not change the bag (colostomy) because I was looking for my scissors, they were on the medication cart and now they are not." Employee #44 then left the resident's room and came back at 7:15 AM to change the resident's bag. Employee #44 pulled back the covers to assess the colostomy bag and stated, "It is mostly air, but I will change it anyway." There was no evidence that facility staff provided the necessary care and treatment to Resident #76 when her colostomy bag was full and in need of changing.	F 691		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692	F 692 1. Corrective action for resident Residents #37 and #95 have been weighed per their physician's orders. 2. Identify other residents An audit of other residents with orders for weights has be completed and all residents have been weighed and their weights documented and verified. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 112 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation and record review, for two (2) of 44 sampled residents, facility staff failed to weigh a resident every 30 days as ordered and verify accurate weights were being obtained. Residents' #37 and #95. The findings include: Review of the facility's policy entitled, "Charting and Documentation" revised 07/2017, revealed, " ... Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate ..." 1. Facility staff failed to weigh Resident #37 every 30 days as ordered by the physician. Resident #37 was re-admitted to the facility on 09/01/2020. The record showed resident had the following diagnoses: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebral Vascular Accident (CVA), Hemiplegia, Seizure Disorder, Depression, Schizophrenia, and Paranoid Personality Disorder.	F 692	3. Systemic changes Nursing staff and the Dietician have been educated on the importance of ensuring that residents are weighed and weights documented per physician orders. The Dietician will be responsible for ensuring that residents are weighed and weights documented and verified. 4. Monitor corrective actions The Dietician/Designee will complete weekly audits of all residents with orders to be weighed to ensure that weights are obtained, documented, and verified. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 113 A review of the Quarterly Minimum Data Set (MDS) dated 08/12/2021 revealed the following: In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact cognition. In Section G (Functional Status), Resident #37 was coded as, "total dependence, one-person physical assist," for dressing, toilet use, and personal hygiene. Review of the clinical record revealed the following: 09/08/2020 at 10:00 AM [physician order] -"Weekly weight one time a day every Tuesday." 07/13/2021 at 11:36 AM - recorded weight of 167.2 lbs. (pounds) Review of the nursing progress notes and the Treatment Administration Record (TAR) dated from 07/14/2021 to 08/31/2021 lacked documented evidence that facility staff weighed Resident #37 weekly as ordered. During a face-to-face interview on 09/01/2021 at 12:15 PM, Employee #2 (Director of Nursing/ Unit Manager) stated that residents' weights are documented in the TAR and progress notes. 2. Facility staff failed to ensure accurate weights were being documented for Resident #95. Resident #95 was admitted to the facility on 01/19/2021 with multiple diagnoses that included: Encounter for Gastrostomy, Acute and Chronic Respiratory Failure, Restlessness and Agitation. Review of the Quarterly MDS dated 07/18/2021	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 114	F 692		

revealed that facility staff coded the following: In Section C (Cognitive Patterns), the resident was coded as being severely cognitively impaired. In Section I (Active Diagnoses), the resident was coded for "Malnutrition (protein, calorie) ..."

Review of the physician's orders revealed:

05/21/2021 "Dietary consult as needed"

06/03/2021 "Monthly weight one time a day starting on the 3rd and ending on the 3rd every month ..."

Review of the facility documented weights for Resident #95 revealed:

"05/11/2021 156.0 Lbs (pounds), 05/12/2021 126.0 Lbs, 05/20/2021 129.0 Lbs, 05/21/2021 130.0 Lbs, 05/28/2021 156.4 Lbs, 06/10/2021 150.6 Lbs, 07/20/2021 146.2 Lbs".

Review of the care plan with a focus area of: "[Resident's name] has nutritional problem" with a revision date of 05/16/2021 revealed the following interventions " ... monitor/record/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition ... significant weight loss ..."

Review of the progress notes revealed:

05/27/2021 at 12:15 PM (Nutrition/Dietary Note) "Spoke to son about current nutrition and weight status. Writer [Registered Dietician] discussed plan for GT (gastrostomy tube) removal ..."

06/16/2021 at 12:43 PM (Nutrition/Dietary Note) "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 115 ... PO (by mouth) intake S/p (status post) PEG (percutaneous endoscopic gastrostomy) removal ... PO intake: 50-100% of meals - requires assistance with meals ... Current BW (body weight): 150.6 (pounds) - 6/10, 156 (pounds) ... Will continue to monitor PO intake/TF (tube feed) tolerance, weights ..." Although Employee #28 (Registered Dietician) reviewed and recorded clinical notes regarding the residents nutritional status, there was no evidence that she reviewed the weights to determine their accuracy or if the resident sustained a significant weight loss. During a face-to-face interview conducted on 08/30/2021 at 10:08 AM, when asked about the weights that were documented on 05/12/2021, 05/20/2021 and 05/21/2021, Employee #28 stated that the weights on those days in May [2021] were not accurate.	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review staff and resident interview, for one (1) of 44 sampled, residents, facility staff failed to provide respiratory	F 695	F 695 1. Corrective action for resident Resident #21 currently has an order for oxygen that matches his oxygen delivery. 2. Identify other residents An audit of other residents on oxygen did not reveal any other residents that were missing orders. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 116 care consistent with the professional standards of practice as evidenced by failure to ensure one (1) resident receiving oxygen therapy had physician's orders to direct the amount of oxygen to be delivered to the resident. Resident #21. The findings include: Resident #21 was readmitted to the facility on 06/29/2021, with multiple diagnoses that included: Respiratory Failure, Encounter for Attention to Tracheostomy and Degenerative Joint Disease. Review of the Admission MDS dated 07/07/2021 revealed that facility staff coded the following: In Section I (Active Diagnoses), "dependence supplemental oxygen ...". In Section O (Special Treatments, Procedures and Programs), Oxygen, "Yes". On 08/2520/2021 at approximately 09:45 AM the resident was observed in bed with a tracheostomy and oxygen in place. Review of the physician's orders revealed no documented evidence of oxygen orders in place to specify how much oxygen Resident #21 was required to be on. During a face-to-face interview conducted on 08/30/2021 at 9:42 AM, Employee #26 (Respiratory Therapist) stated, "He [Resident #21] should have an oxygen order. I will message the pulmonologist now."	F 695	3. Systemic changes Nursing and Respiratory Therapy staff have been educated on the importance of ensuring that residents have oxygen orders that corresponds with what they are receiving. The Director of Nursing will be responsible for ensuring that residents have orders for all modalities received. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of residents on oxygen to ensure that they have orders that match what they are receiving. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
F 697 SS=E	Pain Management CFR(s): 483.25(k)	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 697

Continued From page 117

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview for two (2) of 44 sampled residents, facility staff failed to accurately reassess and evaluate the resident pain after administering her pain medication. Residents' #56 and #87.

The findings include:

Review of the facility's policy entitled: "Pain Assessment and Management" revised March 2015, documented:

"Assessing Pain
1. During the comprehensive pain assessment [staff is to] gather the following information as indicated from the resident (or legal representative):

a. History of pain (as measured on a standardized pain scale);

b. Characteristics of pain:
(1) Intensity of pain (as measured on a standardized pain scale);
(2) Descriptors of pain;
(3) Pattern of pain (e.g. constant or intermittent);
(4) Location and radiation of pain; and
(5) Frequency, timing and duration of pain.

c. Impact of pain on quality of life;
d. Factors that precipitate or exacerbate pain;

F 697

F 697

1. Corrective action for resident

Resident #56 is currently out of the facility, upon readmission the resident's orders for pain medication will be reviewed to ensure clear indicators for administration. The resident will also be assessed pre/post medication delivery. Resident #87 no longer resides in the facility.

2. Identify other residents

An audit of other residents with orders for pain medications was completed and residents were assessed for indications and effectiveness. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that residents are given pain medication as ordered and assessed for indications and effectiveness of pain medication and administration as prescribed prior to wound care treatments. The Director of Nursing will be responsible for ensuring that residents are assessed for effectiveness of pain medication.

4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of 10% of residents receiving pain medication to ensure that the medication was given per physician orders and has been effective. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 118 e. Factors and strategies to reduce pain; and f. Symptoms that accompany pain (e.g., nausea, anxiety)... Implementing Pain Management Strategies: ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions. Monitoring and Modifying Approaches: ---2. Monitor the following factors to determine if the resident ' s pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time; b. The status of the underlying cause(s) of pain, if identified previously; and c. The presence of adverse consequences to treatment." According to the facility's Pain Assessment and Management policy last reviewed May 2016 the pain scale rating is as follows: 0= none; 1-3= mild; 4-6=moderate, 7-10=severe 1. Facility staff failed to reassess Resident #56's pain level after the administration of ordered pain medication. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Opioid Dependence, Peripheral Vascular Disease (PVD), Diabetes Mellitus, Acquired Absence of Right Foot, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression. A review of Resident #56's clinical record	F 697	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 119	F 697		

revealed the following physician's orders:

06/01/2021 "assessment every shift and prn (as needed)

06/01/2021 "Methadone (opioid pain reliever) HCL (hydrochloride) tablet 5 mg (milligram), " Give one tablet by mouth every 12 hours as needed for Pain 4-6 (Moderate)."

07/08/2021 for Tramadol (opioid pain reliever) HCL tablet 50 mg" Give 1 tablet by mouth every 6 hours as needed for pain

09/02/2021 for Oxycodone (opioid pain reliever) HCL tablet 5 mg Give 1 tablet by mouth two times a day for pain

Review of the Medication Administration Record for September 2021 showed:

On 08/12/2021 and 08/15/2021 staff administered Methadone for a pain level of 3 out of 10 and on 8/21/21 staff administered Methadone for a pain level of 0 out of 10.

On 09/11/2021 facility staff administered Tramadol at 9:17 AM for a pain level 4 out of 10 and again at 12:00 PM for a pain level of 5 out of 10. The tramadol was administered approximately 3 hours apart, however the physician's order dated 07/08/2021 directs staff to give Tramadol every 6 hours as needed for pain.

On 09/11/2021 and 09/12/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 0/10

On 09/12/2021 staff administered Tramadol at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 120	F 697		

9:00 AM for a pain level 5 out of 10 and again at 9:45 AM for a pain level of 4 out of 10.

Continued review of the Medication Administration Record for September 2021 showed Resident #56 was to receive Methadone 5 mg every 12 hours for pain 4-6 (moderate); however there were no pain level parameters listed to direct staff when to administer the Tramadol 50 mg, and Oxycodone 5 mg, for example for mild, moderate or severe pain.

Lastly, review of Resident #56's Medication Administration Record for August and September 2021 lacked documented evidence that facility staff performed a post pain assessment to determine if the pain medication administered to the resident was effective and what was the resident's pain level post medication administration.

During a face-to-face interview conducted on 08/26/2021 at 9:22 AM, Employee #23 (Unit Manager) stated that pain assessments should be performed before and after pain medication is administered to residents. She acknowledged that pain was not consistently noted the progress notes nor on the medication administration record, for Resident #56. She reported that nurses cannot e-sign that a pain medication was administered without performing a post assessment, however she was not able to provide documented evidence that post assessments for pain were done for Resident #56.

2. The facility's staff failed to administer pain medication for Resident #87 prior to providing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 121	F 697		

wound care.

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer.

During an observation on 08/24/2021 at approximately 11:20 AM, Employee #16 (Registered Nurse) was administering medication to Resident #87 via the resident's gastrostomy tube. When asked what medication she was administering, the employee stated that she was administering pain medication before she provides wound care for the resident.

Observation of the resident's wound dressings to her right leg and sacral area revealed they were clean, dry and intact. The dressings were also signed and dated by Employee #10 (Wound Team Nurse) "08/24/2021 at 7:00 am to 7:00 PM" indicating that wound care had been provided prior to the administration of the pain medications by Employee #16.

Review of physician's orders revealed the following:

05/10/2021- "Norco (opioid pain reliever) Tablet 5-325 milligram (Hydrocodone-Acetaminophen) give 1 tablet via PEG (percutaneous endoscopic gastrostomy) tube every day shift ...prior to wound care for pain."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 122	F 697		

07/23/2021 - " ...Cleanse (sacral and left calf) wound with Dankin's solution then apply moist to dry dankin ' s solution dressing covering with abd (abdominal) pad and secure with coversite [stratasorb] dressing every 12 hours and PRN (as needed)."

Review of the Narcotic Count Sheet for Hydrocodone/Acetaminophen revealed that Employee #16 signed indicating that she had administered the medication on 08/24/2021 at 11:20 AM.

There is no evidence that facility staff administered pain medication to Resident #87 in accordance with the physician's order.

During a face-to-face interview on 08/24/2021 at approximately 11:25 AM, Employee #16 stated that she was unaware that Resident #87's wound care had been provided. She then stated that she administered the pain medication (Hydrocodone-Acetaminophen) in error.

During a face-to-face interview on 08/24/2021 at approximately 11:40 AM, Employee #10 (Wound Team Nurse) stated that she had provided wound care to the resident around 8:00 AM or 9:00 AM because she was told by Employee #14 (Unit Manager) Resident #87 had received pain medication.

During a face-to-face interview on 08/24/2021 at approximately 11:41 AM, Employee #14 (Unit Manger) stated that she misunderstood Employee #10. Employee 14 then stated that Resident #87 did not receive pain medication prior to wound care on 08/24/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to maintain sufficient nursing staff to provide a shower to resident; to turn and reposition two (2) of 44 sampled residents as prescribed for wound prevention; and failed to ensure that staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5)	F 725	F 725 1. Corrective action for resident Resident #37 has received baths and oral care as appropriate. Resident #68 is being turned and repositioned as ordered. Resident #87 no longer resides in the facility. Residents #83, #73, #62, and #42 have been assessed and are being turned and repositioned per physician orders and their wounds are being monitored by the wound team. The organization has been using a number of strategies to increase facility patient care staffing to include but not limited to licensed managerial support, job fairs, and schedule adjustments. 2. Identify other residents An observation audit related to baths, oral care and turning and repositioning of other residents was conducted. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are turned and repositioned per physician orders and ADL care is provided to residents per physician orders and as needed. The Director of Nursing will be responsible for ensuring that residents are provided care per physician orders.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 124 residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). The findings include: Review of the facility policy entitled, "Activities of Daily Living (ADLs), Supporting" with a revision date of 03/2018 documented, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently ... including appropriate support and assistance with... hygiene (bathing, dressing, grooming, and oral care) ..." 1. Facility staff failed to bathe, provide oral and nail care to Resident #37. Resident #37 was re-admitted to the facility on 09/01/2020, with the following diagnoses: Muscle Weakness (Generalized), Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebral Vascular Accident (CVA), Hemiplegia, Seizure Disorder, Depression, Schizophrenia, and Paranoid Personality Disorder. Review of a physician orders revealed the following: 09/02/2020, directed, "Oral care two times a day" Review of the Admission Minimum Data Set	F 725	4. Monitor corrective actions The Unit Managers and Nursing Supervisors/Designee will complete daily audits of all residents with turning and positioning orders to ensure that residents are being turned and repositioned per physician orders. The Unit Managers and Nursing Supervisors/Designee will also audit 10% residents dependent for ADLs to ensure that they receive ADL care per physician orders weekly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 125	F 725		

(MDS) dated 08/12/2021 revealed the following:

In Section C (Cognitive Patterns),had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating that the resident was cognitively intact.

In Section G (Functional Status), the resident was coded as total dependence and requiring one-person physical assist with dressing, toilet use, and personal hygiene.

Review of the care plan with a focus of area of: [Resident ' s name] had an ADL self-care deficit r/t: Hemiplegia (right-side) Status Post (s/p) CVA, Impaired Mobility, Muscle Weakness", revised on 07/24/2021 included the following interventions: "Bathing/Showering: Check nail length and trim and clean on bath day and as necessary Report any changes to nurse... Provide sponge bath when a full bath or shower cannot be tolerated... The resident is totally dependent on 1 staff..."

Further review of the physician orders revealed an order dated 08/02/2021, which directed, "Shower resident 3 times a week, one time a day every Mon, Thu, and Sun."

During an observation on 08/25/2021 at approximately 9:30 AM, Employee #21 (CNA) was providing Resident # 37 with a bed bath. The employee washed the resident with incontinent care wipes. The resident said to Employee #21, "I want a bath with a washcloth, bodywash, and water, not a wipe." Continued observation revealed Resident #37's fingernails and toenails

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 126	F 725		

were long and dirty. Also, the skin on the resident's feet was dry and scaly.

During a face-to-face interview on 08/25/2021 at approximately 9:45 AM, Resident #37 stated that she is given a wipe bath most days and she had not received mouth care in the past three days. She also reported that podiatry comes once a month, but she did not remember seeing them recently.

Review of the Treatment Administration Record (TAR) dated from 08/01/2021 to 08/31/2021, showed that facility staff signed off that they had been giving Resident #37 a shower every Monday, Thursday and Sunday and that they had been providing mouth care to Resident #37 twice a day.

However, review of the shower book revealed a document entitled, "Skin Monitoring: Comprehensive Certified Nurse Aide (CNA) Shower" dated from 07/01/2021 to 08/31/2021 that showed Resident#37 received a bed bath on two (2) occasions 07/31/2021 and 08/28/2021.

During a face-to-face interview on 08/31/2021 at 2:52 PM, Employee #22 (CNA) stated that after giving residents a bath, bed bath, or shower, she notes it on the skin monitoring sheets in the shower/bath book located at the nurse ' s station on the unit.

During a face-to-face interview conducted on 09/01/2021 at 12:15 PM, Employee #2 (Director of Nursing), admitted that Resident #37 had only one documented bed bath for August 2021 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 127	F 725		

one documented bed bath for July 2021.

The assignment schedule for 8/25/21 showed that two Registered Nurses (RN), one certified nurse aides, and one certified nurse aide in orientation were assigned to care 29 residents on Unit 3 West.

Cross Reference 42 CFR§ 483.24(a)(2), F677 ADL Care Provided for Dependent residents

2A. The facility ' s staff failed to turn and reposition Residents #68, as prescribed for wound prevention.

Review of the Comprehensive Care Plan revealed a focus area of: Activity of Daily Living ...Deficit related to Immobility with a revision date on 04/01/2021. The care plan outlined multiple including: the resident needs total assistance to turn/reposition at least every 2 hours.

Resident #68 was admitted to the facility on 04/01/2021. The medical record revealed that the resident had several diagnoses including Cerebral Palsy, Quadriplegia, Respiratory Failure, Dependence on Respirator [Ventilator], Tracheostomy and Gastrostomy.

Review of a physician order dated 04/20/2021 directed, "Turn and reposition every 2 hrs (hours) to prevent skin break down."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 128 Review of the Quarterly Minimum Data Set (MDS) dated 07/6/2021 revealed the following: In section C (Brief Interview for Mental Status Summary Score) this section was blank. In section G (Functional Status - Bed mobility) the resident was coded as a"4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section I (Active Diagnoses), the resident was coded for Cerebral Palsy, Quadriplegia, Respiratory Failure, Dependence on Respirator [Ventilator] Status Tracheostomy and Weakness. In section M (Skin Condition), the resident was coded for surgical wounds (gastrostomy and tracheostomy) and using a pressure reducing device for bed. During an observation on 08/30/2021 from 7:55 AM to 11:57 AM (3 hours) the following was noted: At 7:55 AM, Resident #68 was in bed, lying on her back. At 10:30 AM, Resident #68 remained in bed, lying on her back. and at 11:57 AM, Resident #68 was observed to still be lying on her back. During the three (3) hours of the observation, facility staff failed to reposition Resident #68.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 129	F 725		

During a face-to-face interview on 08/30/2021 at approximately 12:40 PM, Employee #20 (RN) stated that the resident had been reposition by the certified nursing assistant (CNA) [Employee #17].

During a face-to-face interview on 08/30/2021 at approximately 12:45 PM, Employee #17 (CNA) stated, "I have not provided any care or turned/reposition the resident (Resident #68) today."

Facility staffing on this day 8/30/21 was two (2) certified nurse's aide, one of which was on orientation, and three (3) registered nurse to care for 33 residents.

2B. The facility ' s staff failed to turn and reposition Resident #87 as prescribed for wound prevention.

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer. Review of the resident weight record showed on 07/02/2021 she weighed 265.9 pounds.

Review of a physician ' s order dated 02/26/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 130	F 725		

directed, "Turn and reposition every 2 hrs (hours) and as needed to prevent pressure injury. Every day and night shift. (Facility had 12-hour shifts)."

Review of the Comprehensive Care Plan revealed a focus area of: Pressure Injury (Stage 4 left ear, Stage 4 sacrum, Stage 2 right heel, and Unstageable right lateral calf) with a revision date on 07/30/2021. The care plan outlined several interventions including, the resident needs total assistance to turn/reposition at least every 2 hours, more often as need (with an initiation/revision date of 02/26/2021).

Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In section C (BIMS Summary Score) this section was blank. In section G (Functional Status - Bed mobility) the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section I (Active Diagnoses), the resident was coded for Anemia, Hypertensin, Diabetes Mellitus, Cerebrovascular Accident, Dependence on Respirator [Ventilator] Status, and Pressure Ulcer- Stage4. In section M (Skin Condition), the resident was coded for have one (1) Stage 3 pressure ulcer, one (1) Stage 4 pressure ulcer, one (1) Unstageable pressure ulcer and one (1) Unstageable Deep Tissue Injury.

During an observation on 08/26/2021 from 8:10 AM to 12:40 PM (4 and a half hours) the following was noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 131 At 8:10 AM, Resident #87 was observed in her room, in bed, laying on her right side. At 10:46 AM, Resident #87 remained in bed, lying on her right side. At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed. During the four and half hours of the observation, facility staff failed to turn and reposition Resident #87. During a face-to-face interview on 08/26/2021 at approximately 12:40 PM, Employee #16 (Registered Nurse) stated that the resident had not been turned and repositioned every two hours because the certified nursing assistance was working her way down to Resident #87 ' s room to provide morning care. Facility staffing on this day 8/26/21 was two (2) certified nurse's aide and three (3) registered nurse to care for 32 residents. Cross reference 42 CFR §483.25(b)(1) Pressure Ulcers (F684) 3. Facility staff failed to ensure that staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 132 Unstageable). (Residents ' #87, #83, #73, #62, and #42). A. Resident #42 - diagnoses: Type 2 Diabetes Mellitus, Contractor Left and Right elbow, abnormal posture. Facility staff first documented on 07/14/2021, observing/finding an in-house acquired left lateral malleolus at Stage 4. Care Plan interventions in place- Monitoring/ reminding/ assistance to turn and reposition at least every 2 hours or more often as needed. B. Resident #62 - The resident had multiple diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy Insulin Dependent Diabetes Mellitus, and Anemia. 5/10/2021; 7/13/2021 stage 3 left calf pressure ulcer; the resident also multiple surgical debrided wounds including sacrum, left trochanter, left shin, and left heel. Care Plan intervention in place- Turn and reposition q (every) two hours. C. Resident #73 - diagnosis: Chronic Respiratory Failure. Facility staff first documented on 08/18/2021 observing/finding an in-house acquired Stage 4 left lateral malleolus pressure ulcer and an unstageable right lateral malleolus unstageable pressure ulcer. The resident also had a Stage 4 pressure injury to the sacrum. Care Plan interventions in place- Turn and reposition q (every) two hours. D. Resident #83 - diagnoses: Hemiplegia, Hemiparesis following Cerebral Infarction, and	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 133	F 725		

Weakness. Facility staff first documented on 08/17/2021 observing/finding an in-house acquired right shoulder unstageable pressure ulcer.

Care plan interventions in place- Monitoring/ reminding/ assistance to turn and reposition at least every 2 hours or more often as needed.

E. Resident #87 - The medical record had multiple diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Obesity, Gastrostomy, Insulin Dependent Diabetes Mellitus and Anemia. The facility's staff first documented on 5/4/2021 observing finding an in-house acquired pressure ulcer on the left ear and on 07/06/2021, an unstageable pressure injury of left calf.

The resident also had: Stage 4 sacrum pressure ulcer; Stage 2 right heel pressure ulcer; DTI of the right heel.

Care Plan intervention dated 02/26/2021- The resident needs total assistance to turn/reposition at least every 2 hours, more often as needed or requested.

On 8/26/21 the state representative monitored Resident #87's position from 8:33 AM to 12:40 PM. During this time the resident was observed lying on her right side. At no time did the staff reposition the resident for the duration of the four (4) hour observation.

Facility staff were documenting in the treatment administration record for the previously mentioned residents that they were conducting head to toe skin assessments every shift (twice a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 134 day); and they were to notify the physician/ or nurse practitioner of any abnormalities. There was no documented evidence that the physician or the nurse practitioner were notified of the resident's skin impairment prior to the aforementioned dates when the pressure ulcers/injuries were first observed by the wound team (who conduct weekly visits to the residents) at an advanced stage. Facility staffing on this day 9/8/21 was two certified nurse aides and three registered nurses to care for 32 residents, with 14 residents receiving ventilator treatment. Cross reference 42 CFR §483.25(b)(1) Pressure Ulcers (F686)	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726	F 726 1. Corrective action for resident Staff #36, #23, #33, #34, and #35 were pulled from their assignments and educated immediately on Infection Control and Prevention Practices to include enhanced barrier precautions, appropriate medication pass practices, ensuring that soap and sanitizer dispensers are filled and working properly, and proper disposal of soiled linen. Residents were not affected by these practices. 2. Identify other residents All residents could have been affected by this practice. Random observations to observe am/pm care and medication passes on all shifts were completed. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 135 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for one (1) of 44 sampled residents, the facility staff failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety as evidence by: failure to maintain Infection Control Practices when administering medications to Resident #47. The findings include: 1.Employee #36 failed to maintain Infections Control Standards of Practice when administering medications for Resident #47. Review of the Administering Medication policy with a revised date of December 2012 instructed staff to " ...to follow established facility infection control procedures (e.g ... antiseptic technique ...) for the administration of medications, as applicable." During an observation on 08/23/21 starting at	F 726	3. Systemic changes Nursing, Respiratory, Rehabilitation, Therapeutic Recreation, Housekeeping, and Maintenance staff have been educated on Infection Control and enhanced barrier precautions. Random medication pass observations will be completed. The Infection Preventionist will be responsible for ensuring that staff are adequately trained on Infection Control and Prevention practices. 4. Monitor corrective actions The Infection Preventionist/Designee will complete weekly random audits on all units to ensure that infection prevention practices are being used by all staff. Audits (Environmental Services) will include validation that soap dispensers and hand sanitizer dispensers are filled and in working order daily. Any concerns will be addressed immediately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 136 9:28 AM, Employee #36 (RN) failed to maintain Infection Control Standards of Practice while administering Resident #47 ' s medications, as evidenced below: The employee removed the resident ' s 10 AM medication packets from the medication cart, placed them on top the "dirty clothes hamper" that was in the resident ' s room. Employee also placed the 30cc cup, a straw and a cup of water on top of the "dirty clothes hamper". Employee #36 opened the medications packets one at a time and administered them. While administering the resident ' s medications, Employee #36 was observed wearing gloves and touching the top of the "dirty clothes hamper" multiple times. The employee was then observed picking up the straw off the "dirty clothes hamper" and removing all the paper covering. Employee #36 was also observed touching the straw while mixing the Miralax and water. When the employee attempted to walk towards the resident to administer the Miralax, the state surveyor asked the employee to step out the room and speak with her in the hallway. It should be noted that Resident #47 ' s room door had signage from the Center for Disease Prevention and Control (CDC) indicating that the resident was on Enhanced Barrier Precautions (are intended to provide an approach for gown/glove use that is based on resident risk factors and type of care, rather than based on MDRO (multidrug-resistant organism) status, especially for residents at risk for acquisition (i.e., presence of indwelling medical devices or wounds).	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 137 And the unit had six (6) residents with Candia Aureus (classified by CDC as a MDRO). Resident #47 was admitted to the facility on 04/12/21. The medical record revealed the resident had the following diagnoses Respiratory Failure with Hypoxia, Tracheostomy, Dysphonia, Kidney Disease and Anemia. Review of the physician's orders revealed the following: Polyethylene Glycol (Miralax)3350 Kit give 17 mg by mouth one time a day for laxative. Ascorbic Acid tablet give 500 mg (milligrams) by mouth one time a day for supplement. Docusate Sodium tablet give 100 mg by mouth every 12 hours for laxative. Escitalopram Oxalate tablet give 10 mg by mouth one time a day for antidepressants. Lisinopril tablet 5mg give 1 tablet by mouth one time a day for hypertension ... Nephro-vite tablet 0.8mg give by mouth one time a day for multivitamin. Sennoside Tablet give 8.6 mg one time a for laxative. During a face-to-face interview on August 23, 2021 at approximately 9:40 AM, Employee #36 was asked, if she was going the administer the Miralax after touching the straw with her gloved hand that touched the "dirty clothes hamper" She stated that she was going to administer because she did not realize she had touched the resident ' s straw. The employee then stated that she would discard the Miralax and start over. The employee was then asked if it was the facility ' s policy to administer medications from the top of the "dirty clothes hamper", the employee stated, "I cleaned	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 138	F 726		

it when I came in this morning at 8:00 AM." When asked, how could she ensure the "dirty clothes hamper" was still clean at 9:40 AM, Employee #36 failed to provide an answer.

2. Employees #23, #33, #34, and #35 failed to maintain Infection Control Practices while providing direct resident care and disposing dirty linen, as evident below:

Review of the facility ' s policy entitled, "COVID-19 Guidelines for Quarantine and Testing of Patients & Healthcare Providers" revised on 10/09/2020, documented, "PPE (personal protective equipment) requirements ... eye shield (goggles or face shield) at all times when working with the patients/residents ..."

2A. During an observation on Unit 3 West on 08/23/2021 at 5:40 AM, Employee #33 (Certified Nurse ' s Aide) was observed providing direct patient care on a resident without an eye field. It should be noted that the resident had a sign at his door that directed, "Droplet Precautions ...everyone must ... wear eye protection if splash/spray to eyes likely ..."

During a face-to-face interview conducted on 08/23/2021 at 11: 00 AM, Employee #1 (Administrator) stated, "All staff are required to wear a face shield when they are doing any direct patient care."

2B. During an observation on Unit 3 West on 08/24/2021 at 11:52 AM, it was noted that the soap dispenser in room 337 was not functioning. Right below the non-functioning soap dispenser

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 139 was a bottle of "soothe & cool cleanse shampoo and body wash". It should be noted that room 337 had a sign on the door that directed, "Enhanced Barrier Precautions ... Everyone must clean their hands, including before entering and when leaving the room ..." During a face-to-face interview conducted at the time of the observation, Employee #34 (Environmental Services) stated, "I was not made aware that the soap dispenser was out. I checked it and it only needs new batteries." 2C. During an observation on Unit 2 East on 08/24/2021 at 1:11 PM, a pile of soiled linens was noted sitting on top of the sink in resident's room 207. During a face-to-face interview conducted at the time of the observation, Employee #23 (Unit Manager) acknowledged the findings and stated, "I know, I should've brought a dirty linen bin to place the dirty linens in." 2D. During an observation on Unit 3 West on 08/31/2021 at 11:58 AM, Employee #35 (Registered Nurse) was observed leaning on bed of the resident in room 333 bed A while assisting the resident to drink. The employee was not wearing a gown or gloves. It should be noted that room 333 had a sign on the door that directed, "Enhanced Barrier Precautions ... providers and staff must wear gown and gloves ..." During a face-to-face interview conducted at the time of the observation, Employee #35 stated that he should've been wearing a gown.	F 726		
F 732 SS=D	Posted Nurse Staffing Information	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 140 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	F 732 1. Corrective action for resident Daily Nurse Staffing is now posted as required on each unit. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that the daily nurse staffing information is posted on each unit. The Director of Nursing will be responsible for ensuring that the information is posted as required. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits of each unit to ensure that the required daily nurse staffing information is posted as required. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 141 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that the required daily nurse staffing information was posted. The findings include: An observation on unit 1 south on 08/23/2021 [08/22/2021 night shift] at 6:00 AM, revealed the posted daily nurse staffing information on the wall board across from the nurse's station on unit 1 south that was dated 08/20/2021. However, Employee #48 (Night Supervisor) provided the surveyor with a "written" daily assignment sheet for the current shift (night dated 08/22/2021). During a face-to-face interview conducted at the time for the observation, Employee #48 failed to provide a comment to address why the most current daily nurse staffing information was not posted (08/22/2021).	F 732		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740	F 740 1. Corrective action for resident Residents #100 and #102 are currently being assessed for the effectiveness of their psycho tropic medications. They have also been evaluated by a psychiatrist.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 740

Continued From page 142

and substance use disorders.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for two (2) of 44 sampled residents facility, staff failed to: monitor for side effects and effectiveness of the resident's prescribed psychotropic medications for depression and anxiety; and ensure a resident was evaluated by a psychiatrist, as ordered by the physician. Residents' #100 and #102.

The findings include:

1. The facility's staff failed to monitor Resident #100 for side effects and effectiveness of his prescribed psychotropics medications.

Resident #100 was admitted to the facility on 04/26/2021 with multiple diagnoses including Anxiety and Depression.

Review of physician orders revealed the following:

04/26/2021- " Diazepam (antianxiety) 5 mg (milligram) 1 tablet via G(Gastrostomy) tube every twelve hours for anxiety."

04/27/2021- "Antipsychotic medication-monitor for dry mouth, constipation, blurred vision, disorientation/confusion difficulty urinating, hypotension, dark urine, yellow skin ..."

07/09/2021-"Quetiapine Fumarate (antipsychotic) 25 mg Give 3 tablet via G-tube every 8 hours for depression."

07/15/2021- "KlonoPin (Antianxiety) Tablet 1 mg

F 740

2. Identify other residents

An audit of other residents on psychotropic medications and orders for psychiatric evaluations has been completed. Residents have been evaluated as needed and are being assessed for effectiveness of their psychotropic medications. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that residents received ordered medical evaluations and are evaluated for the effectiveness of their medications. The Director of Social Services will be responsible for ensuring that residents are evaluated by the psychiatrist per physician orders and that the effectiveness of the psychotropic medications is assessed.

4. Monitor corrective actions

The Director of Social Services/Designee will complete weekly audits of Behavior Monitoring sheets of all residents on psychotropic medications to ensure that they are assessed for the effectiveness of their medications and that they have been evaluated by a psychiatrist as ordered. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility’s date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 143	F 740		

(clonazepam) Give 1 tablet via G- tube two times a day for anxiety ..."

Review of the Quarterly Minimum Data Set dated 08/02/2021 showed facility staff coded the following: In Section C (Cognitive Patterns), "Should a brief Interview for Mental status be conducted", "0" meaning "Resident is rarely/never understood". In Section D (Mood). "0". In Section E (Behavior), potential indicators of psychosis, "Z", "none of the above".

Review of the care plan revealed a focus area of: "[Resident's name] uses psychotropic medications r/t depression ...with a revision dated of 05/04/2021. The care plan outlined multiple interventions including monitor for side effects and effectiveness Q-Shift (Every shift)".

During a face-to-face interview on 08/30/2021 at 3:31 PM, Employee #11 (Registered Nurse) stated that the last time a Behavioral Assessment was conducted for the resident was in June of 2021.

2. The facility's staff failed to ensure Resident #102 was assessed by a mental health provider/psychiatrist as ordered by the physician.

Resident #102 was readmitted to the facility on 06/25/2021 with multiple diagnoses including: Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, Unspecified Fracture of lower end of right Femur, and Pressure Ulcer of sacral region.

Review of the physician's orders revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 144 06/26/2021- "Psych consult ..." 08/07/2021- "Psych consult one time only for agitation and refusal of medication ..." 08/9/2021- "Psych consult one time only for agitation and refusal of medication ... " 08/10/2021- "Psych consult one time only for agitation ...- 08/26/2021-"Psych Consult asap (as soon as possible) and PRN ..." Review of the Quarterly Minimum Data Set (MDS) dated 08/17/2021 revealed the following: In Section C (Brief Interview for Mental Status) - the resident was given a score of "15: indicating that the resident intact cognitively. In Section D (Mood) - the resident was coded as a "01" indicating minimal depression. In Section E (Rejection of Care-Presence & Frequency) the resident was coded as "2" indicating this behavior occurred 4 to 6 days but less than daily. Review of the medical record revealed that there was no documented evidence from 06/26/2021 to 09/16/2021 that Resident #102 was evaluated/assessed by a mental health provider. During a face-to-face interview conducted on 09/16/2021 at 3:15 PM, Employee #14 (Unit Manager) stated, "I' m not sure if a psych (psychiatric) consult (evaluation/assessment) was done."	F 740	F 755 1. Corrective action for resident	11/02/2021
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	The nurse signed out the medication that had been previously given and all counts were reconciled and correct. Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 145 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics. The findings include: During a review of the narcotic storage box on 08/23/2021 at 6:51 AM on Unit 3 West, it was observed that a resident's medication blister	F 755	2. Identify other residents All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits of 10 % of narcotic count sheets to ensure that medication counts match the medication on hand correctly and are documented when given. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 146 packet labeled, "Diazepam (antianxiety) 2 mg (milligram) tab (tablet) 1 tab by mouth at bedtime", had 20 remaining tablets. However, the narcotic book documented, "21" tablets should be remaining. During a face-to-face interview conducted at the time of the observation, Employee #31 (Registered Nurse) stated, "I gave the resident one tablet last night at 10:00 PM but I forgot to sign it off in the book."	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757	F 757 1. Corrective action for resident Resident #56 has had their medication regimen reviewed by the Pharmacist with recommendations given to the physician for their regimen with parameters. Resident #56 is currently being assessed pre and post medication administration. Resident #87 no longer resides in the facility. 2. Identify other residents An audit of other resident's medication regimens was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents do not receive unnecessary medications and that medications are given per physician orders. The Pharmacist will complete a pharmacy review for the facility. The Director of Nursing will be responsible for ensuring that residents are not given unnecessary medications.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 147 Based on record review and staff interview, facility staff failed to ensure two (2) of 44 sampled residents were free from unnecessary pain medications. Resident #56 and #87. The findings include: Review of the facility's policy entitled: "Pain Assessment and Management" revised March 2015, documented: "Assessing Pain 1. During the comprehensive pain assessment [staff is to] gather the following information as indicated from the resident (or legal representative): a. History of pain (as measured on a standardized pain scale); b. Characteristics of pain: (1) Intensity of pain (as measured on a standardized pain scale); (2) Descriptors of pain; (3) Pattern of pain (e.g. constant or intermittent); (4) Location and radiation of pain; and (5) Frequency, timing and duration of pain. c. Impact of pain on quality of life; d. Factors that precipitate or exacerbate pain; e. Factors and strategies to reduce pain; and f. Symptoms that accompany pain (e.g., nausea, anxiety)... Implementing Pain Management Strategies: ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions.	F 757	4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of 10% resident's orders and medication administration records to ensure that they are not receiving unnecessary medications and are given per physician orders. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 148	F 757		

Monitoring and Modifying Approaches:
---2. Monitor the following factors to determine if the resident ' s pain is being adequately controlled:

a. The resident's response to interventions and level of comfort over time;
b. The status of the underlying cause(s) of pain, if identified previously; and
c. The presence of adverse consequences to treatment."

According to the facility's Pain Assessment and Management policy last reviewed May 2016 the pain scale rating is as follows: 0= none; 1-3= mild; 4-6=moderate, 7-10=severe

1. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Opioid Dependence, Peripheral Vascular Disease (PVD), Diabetes Mellitus, Acquired Absence of Right Foot, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression.

A review of Resident #56's clinical record revealed the following physician's orders:

06/01/2021 "assessment every shift and prn (as needed)

06/01/2021 "Methadone (opioid pain reliever) HCL (hydrochloride) tablet 5 mg (milligram), " Give one tablet by mouth every 12 hours as needed for Pain 4-6 (Moderate)."

07/08/2021 for Tramadol (opioid pain reliever) HCL tablet 50 mg" Give 1 tablet by mouth every 6 hours as needed for pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 149	F 757		

Continued From page 149

09/02/2021 for Oxycodone (opioid pain reliever) HCL tablet 5 mg Give 1 tablet by mouth two times a day for pain

Review of the Medication Administration Record for September 2021 showed:

On 08/12/2021 and 08/15/2021 staff administered Methadone for a pain level of 3 out of 10 and on 8/21/21 staff administered Methadone for a pain level of 0 out of 10.

On 09/11/2021 facility staff administered Tramadol at 9:17 AM for a pain level 4 out of 10 and again at 12:00 PM for a pain level of 5 out of 10. The tramadol was administered approximately 3 hours apart, however the physician's order dated 07/08/2021 directs staff to give Tramadol every 6 hours as needed for pain.

On 09/11/2021 and 09/12/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 0/10

On 09/12/2021 staff administered Tramadol at 9:00 AM for a pain level 5 out of 10 and again at 9:45 AM for a pain level of 4 out of 10.

Continued review of the Medication Administration Record for September 2021 showed Resident #56 was to receive Methadone 5 mg every 12 hours for pain 4-6 (moderate); however there were no pain level parameters listed to direct staff when to administer the Tramadol 50 mg, and Oxycodone 5 mg, for example for mild, moderate or severe pain.

Lastly, review of Resident #56's Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 150 Administration Record for August and September 2021 lacked documented evidence that facility staff performed a post pain assessment to determine if the pain medication administered to the resident was effective and what was the resident's pain level post medication administration. During a face-to-face interview conducted on 08/26/2021 at 9:22 AM, Employee #23 (Unit Manager) stated that pain assessments should be performed before and after pain medication is administered to residents. She acknowledged that pain was not consistently noted the progress notes nor on the medication administration record, for Resident #56. She reported that nurses cannot e-sign that a pain medication was administered without performing a post assessment, however she was not able to provide documented evidence that post assessments for pain were done for Resident #56. 2. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer. During an observation on 08/24/2021 at approximately 11:20 AM, Employee #16 (Registered Nurse) was administering medication to Resident #87 via the resident's gastrostomy	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 151 tube. When asked what medication she was administering, the employee stated that she was administering pain medication before she provides wound care for the resident. Observation of the resident's wound dressings to her right leg and sacral area revealed they were clean, dry and intact. The dressings were also signed and dated by Employee #10 (Wound Team Nurse) "08/24/2021 at 7:00 am to 7:00 PM" indicating that wound care had been provided prior to the administration of the pain medications by Employee #16. Review of physician's orders revealed the following: 05/10/2021- "Norco (opioid pain reliever) Tablet 5-325 milligram (Hydrocodone-Acetaminophen) give 1 tablet via PEG (percutaneous endoscopic gastrostomy) tube every day shift ...prior to wound care for pain." 07/23/2021 - " ...Cleanse (sacral and left calf) wound with Dankin's solution then apply moist to dry dankin ' s solution dressing covering with abd (abdominal) pad and secure with coversite [stratasorb] dressing every 12 hours and PRN (as needed)." Review of the Narcotic Count Sheet for Hydrocodone/Acetaminophen revealed that Employee #16 signed indicating that she had administered the medication on 08/24/2021 at 11:20 AM. There is no evidence that facilty staff administerd pain medication to Resident #87 in accordance with the physician's order.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 152 During a face-to-face interview on 08/24/2021 at approximately 11:25 AM, Employee #16 stated that she was unaware that Resident #87's wound care had been provided. She then stated that she administered the pain medication (Hydrocodone-Acetaminophen) in error. During a face-to-face interview on 08/24/2021 at approximately 11:40 AM, Employee #10 (Wound Team Nurse) stated that she had provided wound care to the resident around 8:00 AM or 9:00 AM because she was told by Employee #14 (Unit Manager) Resident #87 had received pain medication. During a face-to-face interview on 08/24/2021 at approximately 11:41 AM, Employee #14 (Unit Manger) stated that she misunderstood Employee #10. Employee 14 then stated that Resident #87 did not receive pain medication prior to wound care on 08/24/2021.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761	F 761 1. Corrective action for resident Medication carts and rooms are free of expired medications. 2. Identify other residents An audit of all medication carts and medication rooms was completed. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 153 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to safely store medications. The findings include: During an observation of 3 west, Team 2 medication cart on 08/25/2021 at 10:50 AM, three (3) resident's Glucagon (treatment for low blood sugar) pens documented an expiration date of "01/2021". During a face-to-face interview conducted at the time of the observation, Employee #21 (Registered Nurse) stated that she would remove the expired Glucagon pens from the medication cart.	F 761	3. Systemic changes Nursing staff have been educated on the importance of ensuring that no expired medications are left on medication carts or in medication rooms. The Director of Nursing will be responsible for ensuring that no expired medications are left in medication carts or medication rooms. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete random weekly audits of 1 unit to ensure that no expired medications are present. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	F 812 1. Corrective action for resident Cooling fan has been removed and food temperatures have been consistently within required range.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 154 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to prepare, serve, and distribute foods under sanitary conditions, as evidenced by a cooling fan that was in use in the kitchenh and food temperatures that were below 135 degrees Fahrenheit (F) on three (3) of nine (9) observations. The findings include: 1. During an observation on 08/23/2021 at approximately 6:00 AM, a cooling fan was noted being used in the kitchen. 2. During food test tray assessment on 08/30/2021, at approximately 1:15 PM, and on 09/01/2021, at approximately 1:30 PM, hot foods such as noodles (110 F), spinach (120 F), and puree fish (114 F) tested below the required 135 degrees Fahrenheit (F). These observations were acknowledged by Employee #46 (Food Service Employee) on	F 812	2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes Dietary and Engineering staff have been educated on the importance of ensuring that cooling fans are not used in the kitchen. The Dietary staff was also educated on food safety to include proper food temperatures. The Director of Dietary will be responsible for ensuring that food safety requirements are met. 4. Monitor corrective actions The Director of Dietary/Designee will complete daily audits of food temperatures to ensure that food temperatures are within acceptable range. In addition, the Director of Dietary/Designee will complete random test tray audits weekly. The Director of Facility Management will do weekly audits of the kitchen to ensure that no cooling fans are in use. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 155 09/01/2021 at approximately 3:00 PM.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, Administration failed to ensure that action plans were developed and implemented to ensure freedom from abuse, neglect and exploitation, to ensure a resident was restraint free, to thorough investigate all allegations of abuse, failed to implement measures to protect a resident involved in the abuse investigation, and to ensure that staff were reporting and documenting changes in resident skin condition as so identified. The resident census was 122. Findings include: 1.In the area of 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, the Administration failed to ensure that action plans were developed and implemented to protect and provide a safe environment for one (1) resident from the likelihood of abuse and failed to ensure one (1) resident was free from a physical restraint. Based on the facility's failures, an Immediate Jeopardy (IJ)-"K" in 42 CFR (Code of Federal Regulations) § 483.10 Abuse, Neglect,	F 835	F 835 1. Corrective action for resident The Administrator and Director of Nursing at the time of the survey are no longer with the organization. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes A new Administrator and Regional Director of Operations for Skilled Nursing Services have been hired. The Administrative team has been educated on the QAPI process (including goals and metrics) and all areas of concern from this survey. The findings of this survey will be monitored through the new QAPI committee and the results will be shared with the Governing Board monthly. The Administrator will be responsible for ensuring that the findings of this survey and other issues identified are reported to the QAPI committee and addressed appropriately in accordance with state and federal regulations. 4. Monitor corrective actions The Administrator/Designee will complete Monthly reviews of all findings of this survey and other issues identified to ensure appropriate follow up and interventions are in place. The results will be reported to the QAPI Committee	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 156 and Exploitation on 09/08/2021 at 1:55 PM. A face-to-face interview was conducted with Employee #1 on 8/30/21 at 9:06 AM. The employee acknowledged the findings. Cross reference 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600. 2. In the area of 42 CFR §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated, the administration failed to ensure that action plans were developed and implemented to ensure facility staff failed to thoroughly conduct an investigation: for one (1) resident who stated a staff member hit her; for one (1) resident's family who complained that her mother ' s IPAD (electronic device) was missing, and then when it was found under her mother; for one (1) resident whose hand mitten was found tied to the bedrail; for one (1) resident who shared that staff snatched his leg and slung it requesting he [turn] over and made a negative verbal comment; and one (1) resident who shared that a staff member stuffed her brief with pieces from a chuck (incontinence pad) and made a negative verbal comment. A face-to-face interview was conducted with Employee #1 on 8/30/21 at 9:06 AM. The employee acknowledged the findings. Cross reference 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F610. 3.In the area of 42 CFR§483.25 Quality of Care-Treatment/Services to Prevent/Heal Pressure	F 835	and Governing Board monthly x 3 months for review and recommendations. The QAPI Committee and Governing Board are responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 157 Ulcers, the Administration failed to ensure that staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). Based on the facility's failures, and an immediate jeopardy (IJ) was identified at 42 CFR§483.25 Quality of Care-Treatment/Services to Prevent/Heal Pressure Ulcers, F686 on September 8, 2021 at 2:01 PM. Cross reference 42 CFR§ 483.25, Quality of Care - Treatment/Services to Prevent/Heal Pressure Ulcers, F686.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on staff interview, the Governing Body failed to ensure that action plans were developed	F 837	F 837 1. Corrective action for resident The Administrator and Director of Nursing at the time of the survey are no longer with the organization. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes A new Administrator and Regional Director of Operations for Skilled Nursing Services have been hired. The Governing Board has been educated on the QAPI process (including goals and metrics) and all areas of concern from this survey. The findings of this survey will be monitored through the new QAPI committee and the results will be shared with the	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 158 and implemented to ensure freedom from abuse, neglect and exploitation, to ensure a resident was restraint free, to thorough investigate all allegations of abuse, failed to implement measures to protect a resident involved in the abuse investigation, and to ensure that staff were reporting and documenting changes in resident skin condition as so identified. The resident census was 122. Findings include: 1. In the area of 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, the governing body failed to ensure that administration developed and implemented actions to developed and implemented to protect and provide a safe environment for one (1) resident from the likelihood of abuse and failed to ensure one (1) resident was free from a physical restraint. Based on the facility's failures, an Immediate Jeopardy (IJ)-"K" in 42 CFR (Code of Federal Regulations) § 483.10 Abuse, Neglect, and Exploitation on 09/08/2021 at 1:55 PM. A face-to-face interview was conducted with Employee #1 on 8/30/21 at 9:06 AM. The employee acknowledged the findings. Cross reference 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600. 2. In the area of 42 CFR §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated, the governing body failed to ensure that administration developed and implemented	F 837	Governing Board monthly. The Administrator will be responsible for ensuring that the findings of this survey and other issues identified are reported to the QAPI committee and addressed appropriately in accordance with state and federal regulations. 4. Monitor corrective actions The Administrator/Designee will complete Monthly reviews of all findings of this survey and other issues identified to ensure appropriate follow up and interventions are in place. The results will be reported to the QAPI Committee and Governing Board monthly x 3 months for review and recommendations. The QAPI Committee and Governing Board are responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 159	F 837		

actions to thoroughly conduct an investigation: for one (1) resident who stated a staff member hit her; for one (1) resident's family who complained that her mother ' s IPAD (electronic device) was missing, and then when it was found under her mother; for one (1) resident whose hand mitten was found tied to the bedrail; for one (1) resident who shared that staff snatched his leg and slung it requesting he [turn] over and made a negative verbal comment; and one (1) resident who shared that a staff member stuffed her brief with pieces from a chuck (incontinence pad) and made a negative verbal comment.

A face-to-face interview was conducted with Employee #1 on 8/30/21 at 9:06 AM. The employee acknowledged the findings.

Cross reference 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F610.

3.In the area of 42 CFR§483.25 Quality of Care-Treatment/Services to Prevent/Heal Pressure Ulcers, the governing body failed to ensure that administration developed and implemented actions to ensure that staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). Based on the facility's failures, and an immediate jeopardy (IJ) was identified at 42 CFR§483.25 Quality of Care-Treatment/Services to Prevent/Heal Pressure Ulcers, F686 on September 8, 2021 at 2:01 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 160 Cross reference 42 CFR§ 483.25, Quality of Care - Treatment/Services to Prevent/Heal Pressure Ulcers, F686.	F 837		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and	F 838	F 838 1. Corrective action for resident The Facility Assessment has been updated to reflect current average census, bed capacity, staffing, and changes in leadership. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes The leadership team has been educated on the importance of ensuring that the Facility Assessment is accurate and kept updated as facility characteristics change. The Administrator will be responsible for ensuring that the Facility Assessment is updated. 4. Monitor corrective actions The Administrator/Designee will complete monthly audits of the Facility Assessment to ensure that it is accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 161 food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to update the Facility Assessment to reflect the facility's current operations and emergencies. The resident census on the first day of survey was 122. The findings include: Review of the "Bridge Point Sub-Acute and Rehabilitation National Harbor" Facility Assessment document revealed the following:	F 838	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 162	F 838		

"Person involved in completing assessment ...Administrators Name, name of the Director of Nursing ...Name of Medical Director ...
Dates of assessment or update ...11/26/2018 (leadership changes only)
Date(s) assessment reviewed with QAA (quality assessment and assurance)/QAPI committee 12/3/2020

Part 1: Our Resident Profile lists 1.1 94 beds; 1.2 - average Daily Census:100-105. 3 East- 33 beds ...3 West-29 beds, 1 South 16 beds, 2 South 16 beds; ...
Part 3: 3.2 staffing- licensed nurses providing direct care- 14; nurse aides- 17"

On 9/8/2021 at 10:27 AM, during a face-to-face interview with Employee #1, he stated that the current medical director started in March 2021.

Review of the resident alpha census on the first day of survey, 8/23/2021-lists 122 residents in house and lists the residents in rooms on 3East, 3West, 1 South, 2 South and 2 East. According to Employee #1 residents have resided on 2 East since February 2021.

Review of the facility staffing from 8/2021 to 9/8/2021, showed the facility had licensed nursing staff and nurse aides to care for residents residing unit 2 East with a bed capacity of 31.

There was no evidence that staff updated the facility assessment to include the change in the medical director, to reflect that the facility now has 2 East as a resident care unit and to reflect the increase in the number of license nurses and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 163 certified nurse aides working on 2 East.	F 838		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842	F 842 1. Corrective action for resident Resident #3 has been re-weighed and their current weight has been documented and verified by the Dietician. Resident #5 has been evaluated by a psychiatrist and assessed for the effectiveness of their psychotherapeutic medications. Resident #119 has received the ordered respiratory medications and treatments and they are being signed off as appropriate on the Treatment Administration Record and Respiratory Medication Administration Record. 2. Identify other residents An audit of other residents was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff and Dietician have been educated on the importance of ensuring that residents are weighed accurately and weights documented. Nursing and Social Services staff have been educated on the importance of ensuring that residents are evaluated by a psychiatrist and their psychotherapeutic medications are assessed for effectiveness per physician orders. Respiratory Therapists were educated on the importance of documenting respiratory medications and treatments are documented on the Treatment Administration Record and Respiratory Medication Administration record. The Director of Nursing, Dietician, Director of Cardiopulmonary Services, and Director of	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 164 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 44 sampled residents, facility's staff failed to: accurately document the resident's weight for one (1) resident; accurately document the side effects as ordered by the physician and as directed in the care plan for a resident receiving psychotropic medications for one (1) resident; and record the administration of the	F 842	Social Services will be responsible for ensuring that medical records are complete for their respective disciplines. 4. Monitor corrective actions The Unit Managers and Nursing Supervisors/Designee will complete weekly audits of 10% of residents to ensure that medical records are complete and accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 165 resident receiving Symbicort Aerosol and Peri trach care on the Treatment Administration Record and Respiratory Medication Administration for one (1) resident. Residents' #3, #5 and #119. The findings include: 1. Resident #3 was admitted to the facility on 07/10/2021 with multiple diagnoses including Morbid Obesity, Cellulitis, and Lymphedema ... Review of the medical record showed a hospital discharge summary from a local hospital that documented Resident #3 ' s weight as 179.7 kilogram (396 pounds) on 07/02/2021. Review of Resident #3 ' s Weight Summary List revealed that the resident weighed 285 pounds on 07/10/2021 and 497.5 pounds on 08/04/2021, which was difference of 212.5 pounds (72.15% weight gain) in 25 days. During a face-to-face interview with 08/30/2021 at approximately 10:00 AM, Employee #28 (Registered Dietician) stated that she recognized the weight discrepancy and instructed staff to re-weight the resident. Employee # 28 was asked which weight was the accurate weight? She stated, "The 497.5 pounds was the resident ' s accurate rate." 2. Resident #5 was admitted to the facility on 02/22/2017 with multiple diagnoses that included: Anxiety Disorder, Depression and Tracheostomy Status. Review of the physician ' s orders revealed:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 166	F 842		

01/02/2020 "Is resident free from side effects of psychotherapeutic medications if no, document side effects in PN [progress note] very shift"

07/10/2021 "Quetiapine Fumarate (antipsychotic) tablet 25 MG (milligram) give 0.5 tablet via PEG (percutaneous endoscopic gastrostomy)- Tube at bedtime for agitation hold for sedation"

Review of the Annual Minimum Data Set (MDS) dated 08/08/2021 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), cognitive skills, "severely [cognitively] impaired"

In Section D (Mood), staff assessment of resident mood, " total severity score 00" (indicating the resident shows no sign of depression)

In Section E (Behavior), psychosis, behavioral symptoms, "none ... behavior not exhibited"

In Section I (Active Diagnosis), "Non Alzheimer's Dementia, Restlessness and Agitation"

In Section N (Medications), medications received, "antipsychotic"

Review of the care plan revealed:

Focus area: "12/26/2019 [Resident #5] is receiving psychoactive medication Seroquel (Quetiapine Fumarate) daily for depression ..., interventions: " ... assess/monitor/document behavior daily on behavior monitoring sheet ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 167	F 842		

Focus area "04/25/2018 [Resident #5] is on 9+ medicines ..., interventions: " ...Monitor for possible signs and symptoms of adverse drug reaction: falls, weight loss, fatigue, incontinence, agitation, lethargy, confusion, agitation, depression, poor appetite, constipation, gastric upset ..."

Review of the Treatment Administration Record (TAR) revealed a section labeled, "Is resident free from side effects of psychotherapeutic medications (if no, document side effects in PN) every shift". In this section, it was noted that from dates 08/01/2021 to 08/25/2021, facility staff documented nine (9) times, "N (no)", indicating Resident #5 was not free of psychotherapeutic side effects.

Review of the progress notes from 08/01/2021 to 08/25/2021 lacked documented evidence that the facility staff documented Resident #5's chotherapeutic side effects.

During a face-to-face interview conducted on 08/26/2021 at 11:11 AM, Employee #2 (Director of Nursing) had no comments about the findings.

3. Resident #119 was admitted to the facility on 08/03/2021 with diagnosis that included Chronic Obstructive Pulmonary Disease (Acute) Exacerbation, Chronic Respiratory Failure with Hypoxia, and Encounter for Attention to Tracheostomy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 168	F 842		

Continued From page 168

According to the Admission MDS completed on 08/10/2021,the resident was coded as having a Brief Interview for Mental Status (BIMS) of "15" indicating she had no cognitive impairment and under Section O (Special Treatments and Programs) she was coded as "While a Resident" she received oxygen therapy, suctioning and tach care.

Review of the Treatment Administration Record and Respiratory Medication Administration Record for August 2021 showed the following:

"Symbicort Aerosol 160-4.5 Mcg/ACT 2 (helps to control asthma and used for maintenance treatment of chronic obstructive pulmonary disease) puff inhale orally two times a day was not signed as being administered on 8/12/2021, 8/14/2021, 8/16/2021, 8/18/2021 at 2200 (10:00 PM); and 8/19/2021 and 08/22/2021 at 1000 AM.

"Clean Peri trach with normal saline, pat dry apply gauze every (unable to read) care and as needed was not signed as being completed on day 08/06/2021, 08/16/2021, and 08/22/2021; and on "night" 08/05/2021, 08/12/2021, and 08/18/2021."

Review of the Respiratory Treatment Care Assessment for the aforementioned dates showed that a respiratory therapist administered the Symbicort Aerosol and performed Peri trach care as ordered by the physician.

Although the medication and treatment were administered by the Respiratory Therapist, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 169 staff failed to record the administration of the resident receiving Symbicort Aerosol and Peri trach care on the Treatment Administration Record and the Respiratory Medication Administration record. During a face-to-face interview on 09/01/2021 at 8:36 AM, Employee #2 (Director of Nursing Services) made no comments to address the findings.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failing to ensure that they developed plans of action to identify quality deficiencies. The resident census during the survey was 122. Findings include: A review of the facility's previous survey dated 11/19/2019 showed that the facility was cited for the following deficiencies: F578 Request/Refuse/Discontinue/Treatment;	F 867	F 867 1. Corrective action for resident The Administrator and Director of Nursing at the time of the survey are no longer with the organization. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes A new Administrator and Regional Director of Operations for Skilled Nursing Services have been hired. The Administrative team has been educated on the QAPI process (including goals and metrics) and all areas of concern from this survey. The findings of this survey will be monitored through the new QAPI committee and the results will be shared with the Governing Board monthly. The Administrator will be responsible for ensuring that the findings of this survey and other issues identified are reported to the QAPI committee and addressed appropriately in accordance with state and federal regulations.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 170 Formulate Advance Directive F584 Safe/Clean/Comfortable/Homelike Environment F656 Develop/Implement Comprehensive Care Plan F600 Free from Abuse and Neglect F610 Investigate/Prevent/Correct Alleged Violation F641- Accuracy of Assessments F655 -Baseline Care Plan F656 Develop/Implement Comprehensive Care Plan F657 Care Plan Timing and Revision F677- ADL care Provided for Dependent Residents F684 - Quality of Care F686- Treatment/Services to Prevent/Heal Pressure Ulcer F732- Posted Nurse Staffing Information F812- Food Procurement, Store/Prepare/Serve F880- Infection Prevention & Control The aforementioned deficiencies were again cited in this current survey ending September 16, 2021. Based on the repeated deficiencies, there is no evidence that the facility staff continuously monitored their deficient practices from the prior survey and implemented the corrective actions as they indicated in their Plan of Correction from the recertification survey of 11/19/2019 with a compliance date of 1/10/2020. In addition, the facility failed to: Develop and implement appropriate plans of action to correct identified quality deficiencies as follows:	F 867	4. Monitor corrective actions The Administrator/Designee will complete Monthly reviews of all findings of this survey and other issues identified to ensure appropriate follow up and interventions are in place. The results will be reported to the QAPI Committee and Governing Board monthly x 3 months for review and recommendations. The QAPI Committee and Governing Board are responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 171 Under F600 Free from Abuse and Neglect-facility staff failed to thoroughly investigate and provide corrective action for one male Employee who was accused of abusing a female resident; and Under F610 Investigate/Prevent/Correct Alleged Violation- Failed to thoroughly conduct and investigate allegations of abuse. A face-to-face interview was conducted with Employee #1 on 9/8/2021 at approximately 2:36 PM, at the time of the QAPI interview. We review abuse weekly. No further comment(s) were made. Under F686- Treatment/Services to Prevent/Heal Pressure Ulcer Failed to develop and implement a policy for ensuring that staff reported and documented changes in residents skin condition as soon as identified. A face-to-face interview was conducted with Employee #2 on 9/8/2021 at approximately 2:36 PM at the time of the QAPI interview, she stated we started doing huddles on it (wounds), we have no formal plan. Under F880- Infection Control - Employee #2 on 9/8/2021 at approximately 2:36 PM at the time of the QAPI interview, she we have daily reminders of staff protocols, we update staff on training (infection control training) like basic handwashing, donning and doffing of personal protective equipment. During the Quality Assurance and Performance Improvement (QAPI) meeting on 09/01/2021 at	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 172 2:33 PM, Employee #1 (Administrator) stated that the facility's staff had not looked at Advanced Directives for most of their residents. The employee then stated, "We used the Medical Orders for Scope of Treatment (M.O.S.T) forms. The Advanced Directives is a federal requirement." Through interview with Employee #1 and Employee #2 on 9/8/2021 at approximately 2:36 PM at the time of the Quality Assessment and Assurance review, it was determined that the facility has no process to track and measure its performance, no established goals and thresholds for performance measurement(s) and failed to develop and implement action plans to correct identified quality deficiencies in the respective areas listed above.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	F 880 1. Corrective action for resident The cooling fan has been removed from the kitchen. The air handler is being addressed. The architects are preparing plans to be submitted for permitting prior to beginning project. Resident #87 no longer resides in the facility. Residents #47 and #100 have been observed receiving medications and patient care with proper infection control practices. The batteries in the soap dispenser in room 337 have been replaced. Random room audits have not yielded any soiled linen on clean surfaces. Audits of rooms with enhanced barrier precautions are being conducted. Staff #20, #36, #33, #34, #23, and #47 were educated on proper infection control and prevention practices.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 880 Continued From page 173

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

F 880

2. Identify other residents

An initial audit of infection control practices was completed. All residents have the potential to be affected. There were no additional findings related to this citation.

3. Systemic changes

Staff have been educated on the importance of ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, enhanced barrier precautions, proper use of PPE, wound care, and medication administration). Policies and procedures were reviewed and updated. The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices.

4. Monitor corrective actions

The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 174 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, for three (3) of 44 sampled residents, the facility's staff failed to maintain Infection Control Practices when: preparing, serving, and distributing foods under sanitary conditions, as evidenced by using a cooling fan in the kitchen; while providing wound care for one (1) resident, administering medications to one (1) resident; and not sanitizing their hands before entering a resident's room to provide care. (Residents' #87 #47 and #100). The findings include: 1.Facility staff failed to prepare, serve, and distribute foods under sanitary conditions, as evidenced by a cooling fan that was in use, in the kitchen. During a walkthrough of dietary services on 08/23/2021, at approximately 6:45 AM, three cooling fans were being used in the food preparation area. The temperature in the main kitchen at the time of the observation was 86 degrees Fahrenheit. During a face-to-face interview with Employee #1	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 175 (Administrator) and Employee # 37, Employee #1 stated "The air is not sufficient in the kitchen. The air handler that services the kitchen, 2 West and 3 West is not working. The air handler has been down prior to 5/25/2021". This deficient practice could potentially cause dust and/or foreign substances to spread through the kitchen and contaminate food items. These observations were acknowledged by Employee #46 on September 1, 2021, at approximately 3:00 PM. 2.Employee #20 failed to maintain Infection Control Practices while providing wound care for Resident #87. Review of the Wound Care Policy with a revision date of October 2010 instructed staff to: place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites ...loosen tape and remove dressing ...discard into appropriate receptacle. wash and dry your hands thoroughly. put on gloves ... Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer, Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, and Obesity.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 176	F 880		

Review of physician order dated 07/23/2021 directed, " ...cleanse wound with Dankin's solution, then apply moist to dry Dankin's solution dressing, cover with abd (abdominal) pad and secure with cover site [Stratasorb] dressing every 12 hours [and] prn (as needed)."

During an observation on 08/25/2021 starting at 3:30 PM, Employee # 20 (Registered Nurse) failed to maintain Infection Control Practices while providing wound care for Resident #87, as evidenced below:

1st -While setting up the clean field with wound care supplies, the employee removed sterile 4X4's (used internally in the sacral wound) from the packaging and placed them on the clean field set up on the bedside table.

2nd - After removing the wound packing including 4X4's from the resident's sacral wound (Stage #4 pressure wound), Employee #20 placed the soiled packing on an incontinent pad that she set at the foot of the resident's bed.

3rd - The employee then provided incontinent (bowel) care. However, she failed to recover the resident's sacral wound before providing incontinent care.

4th- The employee placed all dirty supplies used to provide incontinent care on an incontinent brief at the foot of Resident #87's bed. Employee #20 then removed her gloves but failed to perform hand hygiene before putting on a new pair of gloves.

5th -Employee #20 failed to remove and discard the dirty material (dressing gauze and supplies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 177	F 880		

used to provide incontinent care) at the foot of the resident's bed before providing wound care to Resident #87's Stage 4 sacral wound.

6th - Additionally, Employee #20 failed to place a clean field under the resident's sacral area before providing wound care. The employee provided wound care on top of a clean draw sheet.

During a face-to-face interview on 08/25/21 at approximately 4:00 PM, Employee #20 stated that she should have performed hand hygiene after removing her gloves when she provided incontinent care. The employee also said that she should have discarded the dirty supplies at the foot of the resident's bed before providing wound care.

3.Employee #36 failed to maintain Infections Control Standards of Practice when administering medications for Resident #47.

Review of the Administering Medication policy with a revised date of December 2012 instructed staff to "... follow established facility infection control procedures (e.g ... antiseptic technique ...) for the administration of medications, as applicable."

During an observation on 08/23/2021 starting at 9:28 AM, Employee #36 (RN) failed to maintain Infection Control Standards of Practice while administering Resident #47 ' s medications, as evidenced below:

The employee removed the resident's 10 AM medication packets from the medication cart, placed them on top the "Soiled Clothes Hamper"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 178	F 880		

that was in the resident ' s room. Employee also placed the 30cc (cubic centimeters) cup, a straw and a cup of water on top of the "dirty clothes hamper". Employee #36 opened the medications packets one at a time and administered them.

While administering the resident ' s medications, Employee #36 was observed wearing gloves and touching the top of the "Solied Clothes Hamper" multiple times. The employee was then observed picking up the straw off the "dirty clothes hamper" and removing all the paper covering. Employee #36 was also observed touching the straw while mixing the Miralax and water. When the employee attempted to walk towards the resident to administer the Miralax, the state surveyor asked the employee to step out the room and speak with her in the hallway.

It should be noted that Resident #47 ' s room door had signage from the Center for Disease Prevention and Control (CDC) indicating that the resident was on Enhanced Barrier Precautions (are intended to provide an approach for gown/glove use that is based on resident risk factors and type of care, rather than based on MDRO (multidrug-resistant organism) status, especially for residents at risk for acquisition (i.e., presence of indwelling medical devices or wounds).

https://www.cdc.gov/hai/containment/PPE-Nursin g-Homes.html

Additionally, the unit had six (6) residents with Candia Aureus (classified by CDC as a MDRO).

Resident #47 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 179	F 880		

04/12/2021. The medical record revealed the resident had the following diagnoses Respiratory Failure with Hypoxia, Tracheostomy, Dysphonia, Kidney Disease and Anemia.

Review of the physician's orders revealed the following:

Review of the August 2021 Medication Adminstration Record revealed Employee #36 administered the following medication during the previously mentioned observation.

Polyethylene Glycol (Miralax)3350 Kit give 17 mg by mouth one time a day for laxative.
Ascorbic Acid tablet give 500 mg (milligrams) by mouth one time a day for supplement.
Docusate Sodium tablet give 100 mg by mouth every 12 hours for laxative.
Escitalopram Oxalate tablet give 10 mg by mouth one time a day for antidepressants.
Lisinopril tablet 5mg give 1 tablet by mouth one time a day for hypertension ...
Nephro-vite tablet 0.8mg give by mouth one time a day for multivitamin.
Sennoside Tablet give 8.6 mg one time a for laxative.

During a face-to-face interview on 08/23/2021 at approximately 9:40 AM, Employee #36 was asked, if she was going the administer the Miralax after touching the straw with her gloved hand that touched the "dirty clothes hamper?" She stated that she was going to administer because she did not realize she had touched the resident ' s straw. The employee then stated that she would discard the Miralax and start over. Employee #36 was then asked if it was the facility ' s policy to administer medications from the top

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 180	F 880		

of the "dirty clothes hamper", the employee stated, "I cleaned it when I came in this morning at 8:00 AM." When asked, how could she ensure the "dirty clothes hamper" was still clean at 9:40 AM, Employee #36 failed to provide an answer.

4. Review of the facility ' s policy entitled, "COVID-19 Guidelines for Quarantine and Testing of Patients & Healthcare Providers" revised on 10/09/2020, documented, "PPE (personal protective equipment) requirements ... eye shield (goggles or face shield) at all times when working with the patients/residents ..."

Facility signage for Enhanced Barrier Precautions stipulated the following:
"Enhanced Barrier Precautions
Everyone Must:
Clean their hands, including before entering and when leaving the room.

Providers and Staff must also:
Wear gloves and a gown for the following:
High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting
Device care or use:
Central line, urinary catheter, feeding tube, tracheostomy
Wound Care: any skin opening requiring a dressing
Do not wear the same gown and gloves for the care of more than one person"

4A. During an observation on Unit 3 West on 08/23/2021 at 5:40 AM, Employee #33 (Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 181	F 880		

Nurse ' s Aide) was observed doing direct patient care on a resident without an eye field. It should be noted that the resident had a sign at his door that directed, "Droplet Precautions ...everyone must ... wear eye protection if splash/spray to eyes likely ..."

During a face-to-face interview conducted on 08/23/2021 at 11: 00 AM, Employee #1 (Administrator) stated, "All staff are required to wear a face shield when they are doing any direct patient care."

4B. During an observation on Unit 3 West on 08/24/2021 at 11:52 AM, it was noted that the soap dispenser in room 337 was not functioning. Right below the non-functioning soap dispenser was a bottle of "soothe & cool cleanse shampoo and body wash". It should be noted that room 337 had a sign on the door that directed, "Enhanced Barrier Precautions ... Everyone must clean their hands, including before entering and when leaving the room ..."

During a face-to-face interview conducted at the time of the observation, Employee #34 (Environmental Services) stated, "I was not made aware that the soap dispenser was out. I checked it and it only needs new batteries."

4C. During an observation on Unit 2 East on 08/24/2021 at 1:11 PM, a pile of soiled linen was noted sitting on top of the sink in resident room 207.

During a face-to-face interview conducted at the time of the observation, Employee #23 (Unit Manager) acknowledged the findings and stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 182	F 880		

"I know, I should've brought a dirty linen bin to place the dirty linens in."

4D. During an observation on Unit 3 West on 08/31/2021 at 11:58 AM, Employee #35 (Registered Nurse) was observed leaning on the bed of the resident in room 333 Bed A while assisting the resident to drink. The employee was not wearing a gown or gloves. It should be noted that room 333 had a sign on the door that directed, "Enhanced Barrier Precautions ... providers and staff must wear gown and gloves ..."

During a face-to-face interview conducted at the time of the observation, Employee #35 stated that he should've been wearing a gown.

5.Facilty staff failed to sanitize her hands prior to entering a resident's room to provide care.

On 8/23/2021 at approximately 5:50 AM, Employee # 47 was observed caring for Resident #100 in room #159-A. The signage outside the door to room 159 stated, "Enhanced Barrier Precautions" Everyone must: Clean their hands including before entering and when leaving the room."

Employee # 47 was observed leaving her medication cart and entered room #159 without first sanitizing/cleaning her hands. She then hung an enteral feeding bottle for Resident #100. Employee #47 then changed her gloves while in the room and proceeded to suction Resident #100's tracheostomy. Employee #47 then removed her gloves and sanitized her hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 183 when she exited the room. At the time of the observation, Employee #47 acknowledged being aware of the hand hygiene policy and offered no comment about why she did not perform hand hygiene before entering the residents room. There was no eveidence that facilty staff sanitized her hands prior to entering a resident's room to provide care.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883	F 883 1. Corrective action for resident Residents #21 and #95 have been offered the Influenza and Pneumonia vaccines and vaccines have been administered as appropriate. Resident #105 no longer resides in the facility. 2. Identify other residents An audit of all current residents has been completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are offered vaccines and ensuring that the residents and/or their responsible party are given information/education regarding the benefits and risks of immunization. The Director of Nursing will be responsible for ensuring that vaccines are offered with information/education regarding the benefits and risks of immunization.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 184 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 44 sampled residents, facility staff failed to: (1) document in the resident's medical record the information/education provided regarding the benefits and risks of immunization. (2) ensure eligible residents received their immunizations. Residents' #21, #95 and #105. The findings include:	F 883	4. Monitor corrective actions The MDS Nurse/Designee will complete weekly audits of vaccination reports to ensure that vaccines are being offered and the medical records of residents with new vaccinations to ensure that information/education regarding the benefits and risks of immunization. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883		F 883		

Continued From page 185

Review of the facility's policy entitled, "Influenza Vaccine" revised 07/2020, revealed, "All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually ... A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the
resident's medical record ..."

1. Resident #21 was readmitted to the facility on 06/29/2021, with multiple diagnoses that included: Degenerative Joint Disease, Respiratory Failure, Dysphagia, and Cerebral Vascular Accident.

Review of the Admission Minimum Data Set (MDS) dated 07/07/2021, revealed that the facility staff coded the resident as follows:

In Section C (Cognitive Patterns), "Severely [cognitively] impaired"

In Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No";
"If influenza vaccine not received, state reason" facility staff documented, "Not offered";
"Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No",
"If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered".

Continued review of Resident #21's electronic and paper health record lacked documented evidence that facility staff provided the resident's representative with information regarding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 186 benefits and risks of immunizations or the opportunity to receive immunizations. 2. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarc due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of the Admission MDS dated 01/26/2021, revealed that facility staff coded the following: In Section C (Brief Interview for Mental Status), "Severely cognitively impaired" In Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" facility staff documented "No"; "If influenza vaccine not received, state reason" facility staff documented, "Not offered"; "Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No", "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered". Continued review of Resident #95's electronic and paper health record lacked documented evidence that facility staff provided the resident's representative with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations. 3. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 187 Chronic Pain Syndrome. Review of the Significant Change MDS dated 07/13/2021, revealed facility staff coded the following: In Section C (Brief Interview for Mental Status) summary score of "15", indicating intact cognitive response. In Section O (Special Treatments, Procedures and Programs), "... Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No", "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered". Continued review of Resident #105's electronic and paper health record lacked documented evidence that facility staff provided the resident with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations. During a face-to-face interview conducted on 08/30/2021 at 3:39 PM, Employee #2 (Director of Nursing) stated that she would follow-up about the immunizations.	F 883		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain mechanical/electrical	F 908	F 908 1. Corrective action for resident No areas are greater than 81°F. Resident #68's low-air pressure mattress has been replaced. The air handler is being addressed. Residents were checked with no concerns raised about individual room temperatures.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 188 equipment in safe operating condition as evidenced by: failure to ensure the air handler was working as intended, and failed to ensure a residents's low-air pressure bed was operating as intended. Resident # 68. The findings include: 1. During a walkthrough of dietary services on August 23, 2021, at approximately 6:45 AM, a cooling fans were being used in the food preparation area. The temperature in the main kitchen at the time of the observation was 86 degrees Farenheit. During a face-to-face interview on 8/23/2021 at approximately 6:45 AM, with Employee #1 and Employee #37, Employee #1 stated, "The air is not sufficient in the kitchen." Employee #37 stated, "The air handler that services the kitchen, 2 West and 3 West is not working. The air handler has been down prior to 5/25/2021. We are losing 25-40% of the air from the unit..." During a walkthrough of unit 3 west on 08/23/2021 at approximately 8:30 AM resident room temperatures with Employee #37 (Director of Plant Operations), using the facility's infrared thermometer, temperature levels registered above 81 degrees Fahrenheit in five (5) out of (five) resident rooms: room 337, 81.9 degrees Fahrenheit; room 336, 85.5 degrees Fahrenheit; room 339, 86.7 degrees Fahrenheit; room 335, 89.4 degrees Fahrenheit and room 334, 81.7 degrees Fahrenheit. At the time of the observation, Employee #37 acknowledged the findings.	F 908	2. Identify other residents An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F. An audit of resident beds was completed. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patient care equipment are in safe working condition. 4. Monitor corrective actions Engineering/Designee will complete weekly audits of mechanical, electrical, and patient care equipment service requests to ensure that they are in safe working condition. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 189	F 908		

2. Facilty staff failed to ensure Resident #68's low-air pressure bed was operating as intended.

Review of the medical record revealed that Resident #68 was re-admitted to the facility with multiple diagnoses including Chronic Respiratory Failure, Dependence on Respirator [Ventilator], Tracheostomy, and Spastic Quadriplegic Cerebral Palsy ...

Review of the Quarterly Minimum Data Set with an Assessment Reference Date of 07/06/21 revealed in Section C (Brief Interview for Mental Status) the section was blank. In Section G (Functional Status) - the resident was coded as a "4" and "2" indicating that the resident was totally dependent on the physical assistance of one (1) staff person for bed mobility. In Section I (Active Diagnoses)- the resident was coded for Cerebral Palsy, Quadriplegia, Respiratory Failure, Dependence on Respirator [Ventilator], and Weakness. In Section M (Other Ulcers, Wounds and Skin Problems) the resident was coded for surgical wounds and using pressure reducing device for bed.

During several observations on 08/26/2021 from 11:00 AM to 1:00 PM, Resident #68's low-air pressure mattress pump?alarm was beeping indicating "low pressure and power failure."

During a face-to-face interview on 08/25/2021 at 1:05 PM, Employee #38 (Registered Nurse) stated that she had to unplug the bed and then re-plug the and the sound alarm would stop beeping.

During several observations on 08/30/2021 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 190 1:00 PM to 3:00 PM, Resident #68's low-air pressure mattress pump alarm was beeping indicating "low pressure and power failure." During a face-to-face interview on 08/30/2021 at 3:30 PM, Employee #39 (Maintenance) stated that pump was alarming because the three-prong -plug was missing a prong. three-prong plug was missing a prong. The employee then stated that he would change the "cord and pump". During several observations on 09/01/2021 from 8:00 AM to 2:00 PM, Resident #68's low-air pressure mattress pump alarm was beeping indicating "low pressure and power failure." During a face-to-face interview on 08/30/2021 at 3:30 PM, Employee #40 (put in work request for maintenance) was asked if the maintenance department was aware that the resident bed continues to alarm, the employee pointed to a mattress that was in the hallway in front of the resident's room and stated that the maintenance department had brought the new mattress up to the floor because of the alarming. Employee #40 then stated that the whole mattress and pump needed to be change, and all staff would need to help to switch out the mattress.	F 908		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse,	F 943	F 943 1. Corrective action for resident All staff have been trained on abuse. 2. Identify other residents All residents have the potential to be affected. There were no additional findings related to this citation.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 191 neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure all staff participated in an abuse, neglect, and exploitation prevention training program and failed to have a process in place to track attendance. The census on the first day of survey was 122. The findings include: Review of the "2020 Skills Competency Packet" included training and skills check-off on subjects to include, abuse policy and reporting, restraints, infection control and wound care. Review of the document entitled, "2020 Skills Fair ... sign in sheet" revealed that 19 out of 135 staff signatures were missing from required training (that included: two (2) Nurse Supervisors, five (5) Registered Nurses, one (1) licensed Practical Nurse and eight (8) Certified Nurse's Aides) indicating that they did not participate in the annual skills annual fair. During a face-to-face interview conducted on 09/08/2021 at 11:30 AM, Employee #2 (Director of Nursing) stated, "All nursing staff are required to attend the annual skills fair. It is mandatory." When asked about the staff who did not sign in,	F 943	3. Systemic changes Staff have been educated on Abuse, Neglect, and Exploitation. The Director of Education will be responsible for ensuring that employees participate in annual required trainings. 4. Monitor corrective actions The Director of Education/Designee will complete weekly audits of all required trainings and reconcile attendance with work schedules to ensure that all staff receive the education. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 192 she stated, "The educator reconciles the sign- in roster, then tracks and follows up to make sure those individuals complete and receive the trainings." During a face-to-face interview conducted on 09/08/2021 at 11:35 AM, when asked to provide documented evidence that all staff received/participated in the mandatory the trainings, Employee #8 (Educator) could provide any documentation.	F 943		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to provide sufficient training to	F 947	F 947 1. Corrective action for resident Staff have been trained on restraints. 2. Identify other residents All residents have the potential to be affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on Restraints. The Director of Education will be responsible for ensuring that employees participate in annual required trainings. 4. Monitor corrective actions The Director of Education/Designee will complete weekly audits of all required trainings and reconcile attendance with work schedules to ensure that all staff receive the education. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 193 nurse's aides after it found that residents were observed/being treated in a manner that indicated additional training was needed. The resident census on the first day of survey was 122. The findings include: 1. Review of Employee #5's personnel file revealed a facility document dated 07/20/2020 that showed, " ... This is the second occurrence within the week where [Employee #5] provided care to residents in a manner previously instructed to [Employee #5] should not provide to the residents. The type of care provided by [Employee #5] to the residents is ......Acting in away that can be considered abuse or neglect or mistreatment of a patient/resident either physically, mentally, or verbally." Review of Employee #5's education and training file lacked documented evidence that any additional training was conducted after these incidences occurred, yet he was allowed to return the unit(s) to perform resident care. During a face-to-face interview conducted on 09/08/2021 at approximately 12:15 PM, Employee #7 (Director of Human Resources) stated, "No additional education was provided, he [Employee #5] just got the verbal warning." 2. Review of the facility's policy, "Use of Restraints" with a revision date of 04/2017 revealed, " .... Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted ... " Review of a facility reported incident (FRI) on	F 947	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 194	F 947		

01/27/2021 documented, " ... During rounds on 1-27-2021 her (Resident #95) mitten was found tied to the rail. It was immediately released, and the patient was assessed ...Investigation is ongoing ..."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #1 (Administrator) stated, "We couldn't substantiate the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did not find any other resident with hand mittens tied to the bed."

Review of the facility's training, "Inservice Record Sheet Title/Subject: Restraints" dated 03/04/2021 (conducted 36 days after the incident) revealed the signatures of 22 of 127 staff members (RN, LPNs CNAs), indicating only 22 staff members received the training.

During a face-to-face interview conducted on 09/08/2021 at 11:35 AM, when asked about the previously mentioned training, Employee #8 (Educator) stated that the training was ongoing and was done on different dates. When asked to provide documented evidence that all the nurse's aides received the restraints training, Employee #8 was not able to provide any further documentation.