PRINTED: 11/15/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
							С	
		095024	B. WING	B. WING			09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		46	TREET ADDRESS, CITY, STATE, ZIP CODE 501 MARTIN LUTHER KING JR AVENUE SW VASHINGTON, DC 20032			
(X4) ID PREFIX TAG			ID PREFII TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 000	conducted at Bridge following dates- Augu 2021. The survey tear recertification survey August 23 - 26, and 3 and 15, 2021. Surve review of 44 sampled census during the survey DC00010058, DC000 DC00010199, DC000 DC00010199, DC000 DC00010240. After analysis of the fithat the facility was not requirements of 42 CR Requirements for Lor Substandard quality F600, F610, and F68 conducted the extend 2021. During this survey and was identified at 42 CR Abuse, Neglect, and September 8, 2021 at Administrator provided to address the identified 3, 2021 at 7:32 PM. The IJ was removed 67:52 PM. An immediate jeopare	Point National Harbor on the ust 23, 2021 - September 16, am conducted the onsite at the facility on 30, 2021 and September 3, 8 y activities consisted of a diresidents. The facility's rvey was 122. Aints and facility reported stigated during this survey: 01006, DC00010184, 010201, DC00010202, 010227 and Airindings, it was determined of in compliance with the EFR Part 483, Subpart B, and ang Term Care Facilities. Of care was identified at 36 and the survey team ded survey on September 8, and mediate jeopardy (IJ) EFR§483.12 Freedom from Exploitation, F600 on at 1:55 PM. The facility's end a plan of corrective action fied concerns on September After the plan was verified on September 16, 2021 at dy (IJ) was identified at 42	F		F 000-Preparation and/or execution of the force of correction do not constitute admission agreement by provider of the truth of the alleged or conclusions set forth in the state of deficiencies. The plan of correction is prepared and/or executed solely because provisions of federal and state law requiples plan is submitted as evidence of our compliance.	n or e facts atement s the re it. r	11/02/2021	
_ABORATORY [011-1	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	
	Mashing	JENY IZNHA, 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.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	095024 B. WING			C 09/16/2021		
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, Z 4601 MARTIN LUTHER KING JR WASHINGTON, DC 20032		••••
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG		TO THE APPROPRIA	
F 000	to Prevent/Heal Pre September 8, 2021 Administrator provid to address the iden 8, 2021 at 7:31 PM. the plan of correction 16, 2021 at 7:52 PM. The following deficition observation, recordinterviews. The following is a diand/or acronyms the report: AMS - Altered Mark Arteriovenory BID - Twice-a-B/P - Blood Precent Centime CFR- Code of CMS - Centers Services CNA- Certified CRF - Communication CRNP- Certified D.C District of CRSP- Centers CRGP- Communication CRNP- Certified D.C District of CRSP- Centers DCMR- DCM	y of Care- Treatment/Services assure Ulcers, F686 on at 2:01 PM. The facility's ded a plan of corrective action tified concerns on September After the team verified that on was in place on September M, the IJ was removed. The rectory of abservations at may be utilized in the last at may be utilized in the la	F			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 000	HVAC - Heating ver ID - Intellectual IDT - Interdiscipl IPCP- Infection Program LPN- Licensed FL - Liter Lbs - Pounds (u MAR - Medication MD - Medical Do MDS - Minimum EMG - milligrams M	rvice Center Itilation/Air conditioning I disability inary team revention and Control Practical Nurse Init of mass) Administration Record Octor Octa Set (metric system unit of mass) Imetric system measure of Itilities per deciliter Initial air I	F				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)				
F 550 SS=D	RN- Registered NROM Range of RP R/P - Responsit SBAR - Situation, Barecommendation SCC Special Control Sol- Solution TAR - Treatment Ug - Microgram Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a right self-determination, an access to persons aroutside the facility, in this section. §483.10(a)(1) A facility with respect and digresident in a manner promotes maintenancher quality of life, recindividuality. The facility promote the rights of \$483.10(a)(2) The facility access to quality care severity of condition, must establish and man practices regarding to provision of services residents regardless §483.10(b) Exercise of The resident has the	Jurse f Motion ble party ckground, Assessment, are Center Administration Record cise of Rights (2)(b)(1)(2) Rights. that to a dignified existence, and communication with and d services inside and cluding those specified in ty must treat each resident ity and care for each and in an environment that the or enhancement of his or cognizing each resident's lity must protect and the resident. cility must provide equal the regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.	F 00	1. Corrective action for resident Resident #102 has been given a privacy. The urine collection bag was measured a emptied. 2. Identify other residents An audit of other residents with urine co bags did not identify any other residents affected. There were no additional findir related to this citation. 3. Systemic changes Staff have been educated on the importar resident's rights to include privacy. The Director of Nursing and Unit Managers responsible for validating privacy rounds/inspections and subsequent followindings.	llection ngs nce of will be			

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F 550	or resident of the Unit §483.10(b)(1) The factoresident can exercise interference, coercion from the facility. §483.10(b)(2) The resident free of interference, coreprisal from the facility reprisal from the facility rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on observation interviews for one (1) the facility 's staff fail provided dignity and the urine collection bath the urine collection bath the urine facility and the urine collection bath the urine collection bath of the pressure Ulcohilateral buttocks preservatures of Ribs, and lower end of right Ferron 08/24/2021 at apprentice of Resident #102 was of urine collection bag to capacity with urine. Review of a physicial	cility must ensure that the his or her rights without a discrimination, or reprisal sident has the right to be oercion, discrimination, and try in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ans, record review and staff of 44, sampled residents and to ensure a resident was privacy due to not covering ag. (Resident #102). Peradmitted to the facility on ple diagnoses including agree of sacral area, Stage 4 assure ulcers, Multiple do Unspecified Fracture of mur. Proximately 4:00 PM, poserved in his room with his nocovered and filled to an order dated 06/26/2021, neter) size # 18Measure	F 55	4. Monitor corrective actions The Director of Therapeutic Recreation/Designee will complete audiresident rooms per week for privacy rounds/inspections to assess compliance follow up on any subsequent findings. Tresults will be reported to the QAPI Commonthly x 3 months for review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	e and The mmittee	

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F 578 SS=E	(MDS) dated 08/17/2 (Bladder and Bowel) "A" indicating the precatheter. During a face-to-face approximately 4:00 (Registered Nurse) signing and she touch accident". The emplicomments to address collection bag was in Request/Refuse/Dsci CFR(s): 483.10(c)(6) The ridiscontinue treatment to participate in experimental and advances of the provision of medical and provide with the providental specification and provide with the providental concerning medical or surgical tresident's option, for	erly Minimum Data Set 2021 revealed in Section H the resident was coded as esence of an indwelling e interview on 08/24/2021 at PM, Employee # 36 stated "A family member was a it (urine collection bag) by oyee made no further as why Resident #102's urine not covered. Intuue Trmnt;FormIte Adv Dir 1)(8)(g)(12)(i)-(v) ght to request, refuse, and/or nt, to participate in or refuse erimental research, and to be directive. In gin this paragraph should be the of the resident to receive lical treatment or medical edically unnecessary or facility must comply with the fied in 42 CFR part 489,	F 57	Resident #105 no longer resides in the far Residents' #3, #5, #21, #37, #76, and #9 their representatives have been given the opportunity to exercise their rights to for Advance Directives and Staff have valid corresponding orders. 2. Identify other residents An audit of all resident's Advance Directives and Staff have valid corresponding orders. 3. Systemic changes Social Services staff have been educated importance of resident's/responsible par rights to formulate an Advance Directive their responsibility to ensure that there is	estives al I on the ty's e and			
	facility's policies to in and applicable State	nplement advance directives e law.		corresponding order and armband. The of Social Services will be responsible for validating that all residents have been of	r			

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NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2021
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
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F 578	entities to furnish this legally responsible for requirements of this so (iv) If an adult individual time of admission an information or articular has executed an adversa give advance di individual's resident rewith State Law. (v) The facility is not provide this information or she is able to receful for the information to the appropriate time. This REQUIREMENT by: Based on record reviseven (7) of 44 samp staff failed to inform representatives of the Advance Directives failed to confirm one (Residents' #3, #5, #5). The findings include: 1. Resident #3 was a 07/10/2021 with multimorbid Obesity, Obs Cellulitis, Fibromyalg	mitted to contract with other information but are still or ensuring that the section are met. Itual is incapacitated at the distriction is unable to receive attemption at the distriction are met. Itual is incapacitated at the distriction is unable to receive attemption at the distriction and the representative in accordance are directive, the facility rective information to the representative in accordance are lieved of its obligation to on to the individual once he review such information. It is not met as evidenced are and staff interview for obled residents, the facility's residents or their eir rights to formulate for six (6) residents and (1) resident's code status. 21, #37, #76, #95 and #105) Admitted to the facility on iple diagnoses that included: tructive Sleep Apnea, itia, and Lymphedema.	F 5	the opportunity to formulate an Advance Directive and have corresponding physicorders. 4. Monitor corrective actions The Director of Social Services/Design complete audits of all Advance Directive new admissions weekly and monthly or other residents to assess compliance and up on any subsequent findings. The reside reported to the QAPI Committee momonths for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	ee will res on all n all d follow rults will nthly x 3 as. the on-	
	(MDS) dated 07/17/2 Brief Interview for Me	sion Minimum Data Set 2021 revealed in section C (ental Status) the resident was ore of "15" indicating that the				

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F 578			F 5	578			
	resident was cognitive	vely intact.					
	Review of the reside was her own respons	nt's face sheet revealed she sible party.					
	lacked documented staff provided the res	#3's medical record ode". However, the record evidence that the facility's sident with verbal or written g Advance Directives.					
	approximately 10:30 of Social Services) s provided the residen	e interview on 08/31/2021 at AM, Employee #3 (Director tated that she had not t with information regarding The employee then said, "I ay."					
	02/22/2017, with mul	admitted to the facility on tiple diagnoses that included: pression and Tracheostomy					
	dated 08/08/2021 re	facility staff coded Resident					
	(EHR) and paper me documented evidence the resident's repres	#5's electronic health record edical record lacked the that facility staff provided entative with information g Advance Directives.					
	08/30/2021 at 11:32 of Social Services) s are offered quarterly	e interview conducted on AM, Employee #3 (Director tated, "Advance Directives but it is not documented. have not been discussed					

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F 578	8 Continued From page 8 with residents or family members much during		F 57	8		
	the COVID-19 Pande					
	06/29/2021, with mult	iple diagnoses that included: isease, Respiratory Failure,				
		imately 10:00 AM, Resident "DNR (Do Not Resuscitate)"				
	dated 07/07/2021, re-	facility staff coded Resident				
	area of: [Resident ' s to remain a full code" documented the follo (interdisciplinary team	21's care plan with the focus name] end of life wishes are revised on 05/18/2021 wing interventions: "IDT n) will review residents code cument wishes in medical isting wishes".				
	and paper medical re	Resident #21 's electronic cord revealed that facility and confirm the resident 's epresentative .				
	08/30/2021 at 11:32 and of Social Services) state offered quarterly be Advanced Directives	interview conducted on AM, Employee #3 (Director ated, "Advanced Directives but it is not documented. have not been discussed ily members much during mic."				

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F 578	O9/01/2020 with mu. Anemia, Hypertens Hyperlipidemia and (CVA). A review of the Adm (MDS) dated 08/12 In Section C (Cogn had a Brief Intervie Summary Score of cognition. Review of the medi physician's order da "Full Code." Review of the End 07/24/2021, noted, wishes will be hono "full code". The goal (interdisciplinary tergoal status quarterl condition. The medical record that the facility's staverbal or written information of Social Services) the resident an Adva complete the Five Vidocument of reside	Itiple diagnoses that included: ion, Diabetes Mellitus, Cerebral Vascular Accident Mission Minimum Data Set /2021 revealed: Itive Patterns), Resident #37 w for Mental Status (BIMS) "15" indicating intact cal record revealed a ated 11/21/2020 that directed, of Life Care Plan revised on "Resident #37's end-of-life red. Her desire is to remain a all documented that the IDT am) will review the resident's y or if there is a change in lacked documented evidence of provided Resident #37 with rmation regarding Advance ce interview conducted on 2 AM, Employee #3 (Director stated that she did not offer ance Directive, but she did Vishes document (facility's int's end of life wishes). The I that she would ask Resident	F 5	78		

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F 578	F 578 Continued From page 10		F 5	78			
	O3/27/2020 with the Respiratory Failure, Status, and Obstruct A review of the Adm (MDS) dated O3/27/In Section C (Brief I the resident was givindicating Resident cognitively. Review of the mediphysician's order da "Code status is: DN Resuscitate/Do Not Review of the End orevised date of 07/2" [Resident's name] remain DNR/DNI." the IDT will review the quarterly or if there There was no documedical record that Resident #76 with viegarding Advance During a face-to-face 08/30/2021 at 11:28 of Social Services) have an Advance Direction of the Code of the Resident Social Services of the Resident Social S	nission Minimum Data Set '2020 revealed: Interview for Mental Status), Iren a summary score of "12" #76 was mildly impaired Cal record revealed a Itted 03/29/2021 that directed, R/DNI (Do Not Intubate)". Intubate)". Intubate Care Plan with a 15/2021, noted that, Interview for Mental Status Item Care Plan with a 15/2021, noted that, Item Cone goal documented that Item Cone goal documented that Item Cone goal status Item Cone goal sta					
	document." 6. Resident #95 was	s admitted to the facility on					

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F 578	Cerebral Infarct due Cerebral Artery, Resident Artery, Resident (MDS) dated 01/26/2 (Cognitive Patterns) #95 as "Severely [constitute Patterns] #96 and patterns] #97 and pattern	Itiple diagnoses that included: to Embolism of Left Middle stlessness and Agitation. Ssion Minimum Data Set 2021, revealed in Section C , facility staff coded Resident ognitively] impaired". #95's Electronic Health saper medical record lacked be that facility staff provided sentative with information g Advance Directives. The interview conducted on AM, Employee #3 (Director stated, "Advanced Directives but it is not documented. The have not been discussed shave no	F	578			
		I the resident with information					

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F 578	regarding formulating During a face-to-face 08/30/2021 at 11:32 of Social Services) stare offered quarterly be Advance Directives heresidents or family medical Covid-19 Pandemic During the Quality Assumprovement (QAPI) 2:33 PM, Employee the facility's staff had Directives for most of	Advance Directives. Interview conducted on AM, Employee #3 (Director tated, "Advance Directives but it is not documented. The avenue have not been discussed with embers much during the st." Surance and Performance meeting on 09/01/2021 at #1 (Administrator) stated that not looked at Advance	F 5	78		
F 584 SS=D	Orders for Scope of The Advanced Direct requirement." Safe/Clean/Comforta CFR(s): 483.10(i)(1)- §483.10(i) Safe Envir The resident has a ricomfortable and hom but not limited to rece supports for daily living The facility must prove	Treatment (M.O.S.T) forms. tives is a federal ble/Homelike Environment (7) conment. ght to a safe, clean, elike environment, including eiving treatment and ang safely.	F 5	1. Corrective action for resi The ceiling tiles in the main suppl the staff break room have been rep 2. Identify other residents An audit of other areas throughout were inspected. There were no add	y room and placed.	11/02/2021
	homelike environmer use his or her person possible. (i) This includes ensureceive care and sen physical layout of the independence and do	clean, comfortable, and ht, allowing the resident to al belongings to the extent uring that the resident can vices safely and that the facility maximizes resident coes not pose a safety risk. xercise reasonable care for		findings related to this citation. 3. Systemic changes Engineering staff have been educa importance of maintaining a safe, comfortable environment. The Di Operations will be responsible for safe, clean, and comfortable	nted on the clean, and irector of Plant	

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F 584	the protection of the ror theft. §483.10(i)(2) Housek services necessary to and comfortable interest and comfortable interest services necessary to and comfortable in good condition; §483.10(i)(4) Private resident room, as specified in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfortable levels. Facilities initiate 1990 must maintain at 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation failed to provide house necessary to maintaite environment as evide in the supply room the and two (2) ceiling tild were also soiled. The findings include: During an environment facility storage room is september 1, 2021, as and the supplement of the sup	deeping and maintenance of maintain a sanitary, orderly, rior; and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); ate and comfortable lighting table and safe temperature ally certified after October 1, a temperature range of 71 to maintenance of comfortable is not met as evidenced and interview, facility staff	F 5	environment. 4. Monitor corrective actions The Director of Plant Operations/De complete random audits of ceiling til unit weekly and will follow up on an subsequent findings. The results will reported to the QAPI Committee momonths for review and recommendat The QAPI Committee is responsible going monitoring for compliance. 5. Date correction action compliance. The facility's date of alleged compliance. November 2, 2021.	les on one by 1 be nthly x 3 ions. for the on-		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		095024	B. WING		C 09/16/2021			
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE IE APPROPRIATE			
F 584 F 600 SS=K	marred with dark stail Employee #37 acknot a face-to-face intervious approximately 4:00 Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria	the staff break room were ns throughout. wledged the findings during ew on 09/01/2021, at e.m. Neglect m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This	F 584	F 600 1. Corrective action for resident Identified resident #105 (no longer resid facility) was interviewed 9-8-2021 and s their statement. The identified Aide was terminated on 9-01-2021.	les in the	09/15/2021		
	any physical or chem treat the resident's m §483.12(a) The facilit	y must- e verbal, mental, sexual, or		 Identify other residents An audit of all other resident's complete There were no additional findings relate citation. Systemic changes 				
	involuntary seclusion This REQUIREMENT by: Based on a review of documentation, facility staff interviews, for or residents, the facility protect Resident #10 physical abuse by Er the Employee's empl likelihood of the emp residents.	is not met as evidenced f clinical records, facility y policies, and resident and ne (1) of 44 sampled s staff failed to prevent and from psychological and nployee #5 and because of oyment history, there is a		All FRIs from January 2021 to present were viewed to ensure that they were proper investigated. Education files of any staff involved in the FRIs were reviewed to e that appropriate actions were taken regartheir involvement. Education/Designee service all staff on the Abuse Policy and procedures. New Administrator and Gover Board will in-service leadership on the Ab Policy and procedures. In the future, any employees involved in allegations of about the procedure of the procedure of the factorial forms and Procedures. All future and Procedures and Procedures. All future	rly ff nsure rding will in- rning suse use, ill cility's			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		095024	B. WING			09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
				4601 MARTIN LUTHER KING JR AV	ENUE SW		
BRIDGEP	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION		(X5)
PRÉFIX TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				COMPLETION DATE		
				allegations conclusions will	l be forwarde	ed by	
F 600	Continued From page	e 15	F 6	email/writing the			
	situation was identifie	ed on September 8, 2021 at		LNHA/HR/DON/Departme			
	1:55 PM. The facility	submitted a plan of action		[Licensed Nursing Home A			
	to the survey team that	at was on onsite at 7:32 PM		Resource/Director of Nursi			
	on September 8, 202	1, and the plan was		and preventative measures		n put in	
	accepted. The survey			place to protect the resident	t.		
		to validate the facility's plan,		4 34 34 34 34 34 34 34 34			
	and the immediate je			4. Monitor corrective	e actions		
		at 7:52 PM. After removal		Administrator/ Designee w	ill conduct or		
of the immediacy, the deficient practice remained at a harm level and the scope and severity was		•		audit all FRIs weekly for 2		1	
			ensure the facility has comp				
	lowered to an H.			thorough investigation of the			
	The findings include:			violation; prevented further	-		
	The illialitys illolade.			-			
	Review of the facility's	s policy entitled, "Abuse		neglect, exploitation and m			
		porting" with a review date of	from occurring while the investigation				
		. The administrator will		was in progress; and took a			
	ensure that further po	otential abuse, neglect	corrective action, as a result of investigation findings. Results of finding will be forward to QAPI for review and				
	exploitation or mistrea	atment is prevented"					
		s policy entitled, "Abuse and		recommendations.			
		ocol" with a review date of					
		The facility management		The QAPI Committee is res		the on-	
		measures to address the		going monitoring for comp	liance.		
		d minimize the possibility of		5		. 1	
	abuse and neglect'			5. Date correction ac	tion complet	ea	
				The facility's date of allege	ed compliance	e is	
		provide a safe environment		September 15, 2021.			
to prevent and protect Resident #105 from the							
	likelihood of abuse fro	om Employee #5.					
	Resident #105 was a	dmitted to the facility on					
		iple diagnoses that included:					
	Polyneuropathy, Anxi						
	Disorder, Major Depre						
	Chronic Pain Syndror						
	- 12121 a 27a.or						
	On 08/19/2021 a com	plaint was received by the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 600	reported to the Ombaugust 18th [2021] the Rugust 18th [2021] the IResident #105's] by (incontinence pad) a you again tonight' Review of a memo of (Administrator) dated We interviewed the the unit (3 west) alonedical chart. The administration has condetermined from the evidence presented was committed toward #105] in question. The unsubstantiated due On 08/27/2021, a constant Agency that doname]The resident Ombudsman C.N. told the resident 'she pay, and that she talk Review of Resident: Minimum Data Set (revealed that facility In Section C (Cognit for Mental Status (Brintact cognitive response) In Section E (Behave (perceptual experience external sensory stires).	commented, "[Resident #105 audsman on the night of the nursing Aide stuffed dief with pieces from a chuck and said 'I am not changing " rom Employee #1 d 08/24/2021, documented, " the staff and other residents on the same and neglect and serious and neglect and the resident [Resident therefore, the case has been to these findings." complaint was received by the commented, "[Resident the daughter reported to the A. (Certified Nurse's Aide) the caused him three days of liks too much." #105's Significant Change MDS) dated 07/13/2021, staff coded the following: ive Patterns), Brief Interview IMS) score "15", indicating onse.	F	500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021	
	NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 600	Continued From page	e 17	F 60	0		
	•	unctional Abilities and ene " total dependence assist".				
	08/30/2021 at 9:06 A (Administrator) stated [Employee #5] and the not to assign him to verificate (Resident #105). The breakdown in the system of the was not originally [Employee #5] report anything to [Resident providing care. The sepriment of the suspended (on 08/27 terminated as of todal	d, "The staff member the Nurse Supervisor knew work with the resident are was obviously a stem. The involved CNA was there Resident #105 resided). The assigned to that unit. He the detect that he did not say a #105] while he was a upervisor is getting a involved CNA was a provided CNA was a provided to the standard of the standard o				
	08/30/2021 at 9:17 A (Director of Nursing), tolerate abuse. I do h care and responsibility provider to another) of supervisors during the	she stated, "We don't and-off (transfer of patient by from one healthcare communication with the e week. The supervisors at the CNA involved was not				
	08/30/2021 at 10:36 a Supervisor) stated, "T floated to 3 west beca- for that unit. I was tol-	Interview conducted on AM, Employee #6 (Nurse I'he CNA [Employee #5] was I ause we didn't have a CNA I that the CNA shouldn't be I s not made aware about the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 600	08/30/2021 at 10:50 was working on 2 Ea because they were s investigation was res found, so I went to th care of the roommat [Resident #105] state needed assistance as she made a report of any problems. The rewanted me to help he no issues during the care. I have been do never done anything any way." Review of Employee W 07/29/2020. The form received a verbal was written warning on (0 policy/procedure". Attached to the prevenotice was a docume Director of Nursing the "On the morning of the Wound Care Team resided on unit 3 eas filled incontinence be Ultrasorb (under pace CNA (Employee #5) of the under pads inserted.	AM, Employee #5 stated, "I ast and was pulled to 3 West short. I was told the solved and no issues were ne unit (3 west). I was taking e (room 333 bed B) when ed that she was wet and as well. I reminded her that n me and that I didn't want esident stated that she er and so I did. There were ADL (activities of daily living) sing this for 17 years. I have to her nor intimidate her in a form entitled; "[Facility's	F	500				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP 4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		00/10/2021
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F 600	#105] had a urine state taped together to for	luly 20 [2020] [Resident ained Ultrasorb under pad m a incontinence brief and ident's skin[Resident 105's	Fé	600		
	soaked towel was fo legs This is the sec week where [Employ residents in a manne provided by [Employ Type B Offense Ac considered abuse or	ace brief and in addition urine und between the resident's cond occurrence within one wee #5] provided care to er The type of care see #5] to the residents is a cting in a way that can be neglect, or mistreatment of a er physically, mentally or				
	revealed there was not the facility's staff revenue personnel record or in protect all residents in from the potential of mistreatment of a paraphysically, mentally of Employee #5's personnel.	gation notes and documents to documented evidence that iewed Employee #5's implemented measures to including Resident #105, "abuse or neglect, or trient/resident either or verbally." Additionally, onnel record failed to outline as not allowed to work on				
	approximately 10:30 of Human Resources disciplinary actions (were not mentioned until a meeting that of	e interview on 09/08/2021 at AM, Employee #7 (Director s) stated, "The previous that occurred in 07/2020) to the Director of Nursing occurred on 08/31/2021 when oyee #5) was discussed."				
	_	e interview on 09/08/2021 at AM, Employee #2 (Director				

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(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	of Nursing) stated, "I previous allegations in (CNA) until the meetic During a face-to-face approximately 10:30 (Administrator) stated previous allegations of employee (Employee personnel file as parts. Based on these finding at 1:55 PM an Immediate and the State Agency Sursituation was identified. On September 8, 202 Administrator provide the State Agency Sursituation and signed identified Aide was testing. An audit will be consuring Facility personal identified of follow up interviews a completed to prevent further abuse, neglect mistreatment from or audit all IRF's [Incide Facility], complaints, 2021 to ensure all personal identire all personal identire all personal identire all personal identires, 2021 to ensure all personal identires.	was not aware of any made for Employee #5 ng on 08/31/2021." interview on 09/08/2021 at AM, Employee #1 d, "I was not aware of any or disciplinary actions for the e #5). I did not review his my investigation." ags, on September 8, 2021, diate Jeopardy (IJ)-"K" ed. 21 at 7:32 PM, the facility's ed a corrective action plan to vey Team, which included: a #105 was interviewed the attestation. The rminated on 9-01-2021. Inducted on all SNF [Skilled connel files to identify if any estigation for allegations of obtation, or mistreatment to corrective disciplinary and and investigations were and protect residents from	F	500		

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F 604 SS=D	leadership on the Abus All future employees neglect, exploitation, immediate in servicing Policies and procedur conclusions will be for LNHA/HR/DON/Departices and procedur conclusions will be for LNHA/HR/DON/Departices and procedure place to protect of preventative measure place to protect the result of the services	se will in-service all staff and se Policy and procedures with allegations of abuse, or mistreatment will receive gon the facilities Abuse re. All future IRF allegations rwarded by email/writing the artmental Supervisor ome Administrator/Human Nursing] with the results and est that have been put in esident. Will conduct an audit all IRF's as to ensure the facility has an investigation of the alleged ourther abuse, neglect, reatment from occurring in was in progress; and took exaction, as a result of action, as a result of Results of finding will be view and recommendations. Impleted by 9-15-2021" Tryey Team returned to the at the plan of correction was ear, at 7:52 PM, and the was removed. Physical Restraints	F 6	04 F 604	11/02/2021
	§483.10(e) Respect a The resident has a rig and dignity, including §483.10(e)(1) The rig physical or chemical r	that to be treated with respect: that to be free from any		 Corrective action for reside Resident #95 has a restraint for their is being used appropriately. 	
			1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021	
BRIDGEPOINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)				
required to treat the r consistent with §483. §483.12 The resident has the neglect, misappropria and exploitation as dincludes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(2) Ensure from physical or cher purposes of discipline are not required to tre symptoms. When the indicated, the facility alternative for the lead document ongoing rerestraints. This REQUIREMENT by: Based on record revone (1) of 44 sample failed to ensure that ophysical restraint. (Reference of the findings include: Resident #95 was ad 01/19/2021, with multicerebral Infarct due for the sample of the findings include:	e or convenience, and not esident's medical symptoms, 12(a)(2). right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. by must- e that the resident is free mical restraints imposed for e or convenience and that eat the resident's medical e use of restraints is must use the least restrictive st amount of time and e-evaluation of the need for is not met as evidenced iew and staff interview, for d residents, facility staff one resident was free from a	F 6	2. Identify other residents 04 An audit of all residents with restraint reveal any residents whose restraints being used appropriately. There were additional findings related to this citat 3. Systemic changes Nursing staff have been educated on timportance of ensuring that restraints appropriately. The Director of Nursin responsible for ensuring that residents inappropriately restrained. 4. Monitor corrective actions The Director of Nursing/Designee will weekly audits of all residents with orcestraints to ensure that no restraints a used inappropriately. The results will reported to the QAPI Committee monmonths for review and recommendati The QAPI Committee is responsible figoing monitoring for compliance. 5. Date correction action comp The facility's date of alleged complian November 2, 2021.	were not no ion. he are used g will be are not l complete ers for re being be thly x 3 ons. or the on-	

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F 604	Continued From page	23	F 6	604		
	with a revision date o					
	01/27/2021 documen 1-27-2021 her (Residued to the rail. It was	ported incident (FRI) on ted, " During rounds on lent #95) mitten was found immediately released, and issedInvestigation is				
		95's Admission Minimum /2021, revealed that facility ing:				
	In Section C (Cognitiving	ve Patterns), "Severely				
	behavioral symptoms (e.g., hitting, kicking,	ners sexually) Behavior of				
		nal Status), "Bed mobility e-person physical assist"				
	In Section P (Restrain mitten]Used daily"	nt), "Limb restraint [hand				
	Review of the physici following:	an's orders revealed the				
		left wrist restraint q (every) 2 any findings every 2 hours"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE AV CROSS-REFERENCED TO DEFICIE	CTION SHOULD B O THE APPROPRIA		
F 604	prevent patient from	left wrist restraint in place to a pulling on her trach (gastrostomy) - Tube q shift"	Fé	604			
	"[Resident's name] who was admitted on 1-27-2021 her m It was immediately assessed and not for fearful. Resident's properties and appropriate against wide sweep conduction to have an insulvestigation is ong	PM (Administrator note) is a 60 year old resident on 1-19-2021. During rounds itten was found tied to the rail. released and patient was ound to be in distress, pain or physician, RP (representative) encies were notified. House sted no other residents were appropriate restraint.					
	documents on 08/3 (6) staff members winvestigation. There evidence of intervieitherapist who provie tracheostomy care	y's investigation notes and 1/2021 revealed that only six were interviewed as part of the was no documented was from the respiratory ded Resident #95 with or from the environmental resident #95's room.					
	answered "no" whe abuse reporting pol the investigation's in There was no docu investigator(s) follow members or is there	at two staff members n asked, "Do you know the cy and procedure" as part of nterview questions. mented evidence that the wed up with those staff e documented evidence that ng/education was provided on					

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F 604	and procedure. Employee #1 (Admin Resident #95 was phowever, he did not occurred. During a face-to-face 08/31/2021 at 10:54 and Language Path is nonverbal with rig to paralyses. Left sid for left [hand] mitten 01/27/2021) and no were wrapped arour rail, fully restricting hof the left hand. I im restraint, made the interestraint. I then reposupervisor and the acceptance of the left hand of the left hand of the incident, we intervied resident and did aud the facility with hand other residents with During a face-to-face 08/31/2021 at 9:45 of (Administrator) state the allegation. Base could not determine bed rail. It could have	nistrator) acknowledged that hysically tied to the bedrail substantiate that abuse e interview conducted on AM, Employee #4 (Speech ologist) stated, "The resident the hemiparesis- pretty close de is intact. She had an order I. I walked into the room (on ticed the straps to the mitten and and tied to the upper bed her (Resident #95) movement mediately removed the nurse aware and educated hitten was not to be used as a bried the incident to my administrator." e interview conducted on AM, Employee #2 (Director of tens are used for residents of themselves. After the wed the staff, assessed the dits of the other residents in a mittens. We did not find any mittens tied to the bedrail."	F	504			

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2021
			4	601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR	,	NASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 604	Continued From page	26	F 604		
	not find any other res to the bed."	dent with hand mittens tied			
F 610 SS=F	that Resident #95 did 01/26/2021 or 01/27/2 Investigate/Prevent/Co CFR(s): 483.12(c)(2)	/2021 at 10:00 AM revealed not have any visitors on 2021. prect Alleged Violation (4)	F 610	F 610 1. Corrective action for resident	09/15/2021
	§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			Investigations were reviewed and reinversand appropriate actions taken to resolve concerns for all residents. Employees #. #49 were terminated. Resident #95 is refor their safety appropriately. Resident # her IPAD at her bedside. Resident #102 concerns were reviewed and addressed of the IJ abatement process. Residents #23	the 5 and estrained 437 has 2's during tand
	investigation is in pro §483.12(c)(4) Report investigations to the adesignated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revifive (5) of 11 complai incidences, facility state conduct an investigat who alleged physical for an allegation of m resident's property; a	gress.		Resident # 105 no longer reside in the fa 2. Identify other residents An audit of all other resident's complete There were no additional findings relate citation. All FRIs from January 2021 to were reviewed and reinvestigated and appropriate actions taken to resolve the for all residents. Education files of any involved in the FRIs were reviewed to e that appropriate actions were taken rega- their involvement.	ed. d to this present concerns staff nsure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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		095024	B. WING _		09	/16/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIDGER	OINT SUBACUTE AND E	REHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE	SW			
BRIDGER	DINT SUBACUTE AND P	REHAB NATIONAL HARBOR		WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
				3. Systemic changes				
F 610	Continued From pag	je 27	F6	10				
	#37, #95, #102 and #			Staff and Leadership have been				
	The findings include:			importance of ensuring that all allegations of abuse are reported and investigated appropriately to ensure that residents are not				
	Investigation and Re 08/2020 revealed, "the investigation will, resident (as medicall staff members (on all contact with the residualleged incident in whom the accused eservices" 1. Facility staff failed incident for Resident abuse.	r's policy entitled, "Abuse porting" with a review date ofThe individual conducting as minimum interview the ly appropriate) interview ll shifts) who have had dent during the period of the aterview other residents to employee provides care or to to thoroughly investigate an to #23 who alleged physical		subjected to potential abuse. The will be responsible for ensuring are not subjected to potential abuse secondary to the failure to proper allegations of abuse. 4. Monitor corrective action of all Incidents Reported by the ensure that all investigations are thoroughly. The results will be a QAPI Committee monthly x 2 more review and recommendations.	e Administrator that residents usive situations rly investigate ons e weekly audits Facility to investigated reported to the nonths for			
	11/14/2020, with diag Anemia, Heart Failur Insufficiency, Diabete and Asthma.	Heart Failure, Hypertension, Renal ncy, Diabetes Mellitus, Anxiety Disorder ma. 5. Date correction acoma. The facility's date of alleger	going monitoring for compliance	e. completed				
"rarely/never under		nt #23 was coded as tood" and was not able to erview for Mental Status.						
	revealed: "the dau mother accused staf (Certified Nurse's Aid not able to give a da incident occurred." " reliable witness and give the place of the	nt report dated 04/22/2021 ughter called to say that her f member [Employee #49] e) of hitting her. She was te or time or when thethe resident is not a the daughter could also not alleged strike. The ended, and an investigation						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND F	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE 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	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 610	was initiatedthe rebruises and pain and During an interview (Administrator) on 05 9:40 AM, he stated the unsubstantiated and return to work. During the time of the facility's investigation revealed that four (4) and three (3) staff we will be the care the control of the care the care the control of the care the care the control of the care the car	with Employee #1 2008/2021 at approximately he investigation was the employee was allowed to e survey, a review the he was conducted and residents were interviewed, ere interviewed. Ther care is poor. She don't do. A couple of time she has going to die." "She is okay, but sometimes time with my colostomy." "Her care with me is times forgets to feed me. I "She does not come to my I have been complaining bes anything. When she has hing for me. She is always of the CNA provided the to the interview questions:	F	510			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	"Her care is not good residents. We have to "I think her care is progresidents complain a There was no evident conducted the interviother four (4) resident complaints/reported cinvolved CNA. During a face-to-face 09/08/2021, at approximate Employee #1, he had findings. 2. Facility staff failed family's complaint that (electronic device) with the frequency of the employee with the frequency of the employee and Cerebral Vascula. A review Resident #37 was reconstructed to the employee with the frequency of the employee of	She does not care for the o wash the residents." etty good. I have heard the bout her." ce that the facility staff who ews further investigated the its and three (3) other staff concerns related to the entirely either investigated the interview conducted on ximately 9:40 AM with I no comments about the ett to thoroughly investigate the entirely either investigate the entirely either investigate the entirely either investigate the entirely either investigate investigate the entirely either investigate entirely e	F	510		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, 2 4601 MARTIN LUTHER KING JR WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT EIENCY)	
F 610	A review of a Facility	e 30 Reported Incident (FRI) :52 PM documented the	F€	610		
	mother's IPAD (elect and then when it was DON (Director of Nur as to how the IPAD for connected toafter s [Employee #25] yelle #37], [and] closed the [Employee #25] was	aughter complained that her ronic device) was missing, so found under her mother the rising) failed to give a report ell off the device it was the complained the aide at her mother [Resident ele door isolating her mother. It the identified aide, the facility ciate [Employee #25] and tion."				
	Employee #1 (Admin interviewed the staff, residents on the unit medical chart. The requarantine, so the do The abuse and negle concluded, and it was investigation there we prove abuse and negther resident in question been unsubstantiated.	mo to the State Agency from istrator) documented, "We roommate, and other along with examining the esident was currently under for was closed per protocol. Sect investigation has a determined from the as no evidence presented to glect was committed towards on, Therefore, the case has diduct to these findings."				
	documents on 08/30/ evidence of interview #37, Resident #37's of During a face-to-face 08/31/2021 at 3:57 P all interview question have been included i	2021 lacked documented statements from Resident daughter and Employee #25. interview conducted on M, Employee #1, stated that is and statements should in the folder with the other vestigation. He reported that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODI 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 610	the initial complaint in representative (dauginterview statement of stated that he would (Director of Nursing) questions from Employ The Administrator didinterview questions at Resident #37 prior to 3. Facility staff failed incident of Resident at to the bedrail. Resident #95 was ad 01/19/2021, with multiple Cerebral Infarc due to Cerebral Artery, Rest Attention for Encount Attention for Encount Attention for Encount Cerebral Artery, Rest Attention for Encount Review of the physici following: 01/19/2021 "Assess hours and document 01/19/2021 "Keep lef prevent patient from (tracheostomy) or G (Review of Resident #01/26/2021, revealed following:	nade by Resident #37's Inter) was considered the if what happened. He also check with Employee #2 In regards to the interview byee #25 (CNA involved). Inot provide the missing Ind statements from Ithe survey exit. Ito thoroughly investigate the Ite #95's hand mitten being tied Immitted to the facility on Itiple diagnoses that included: In Embolism of Left Middle Itelessness and Agitation, Iter Gastrostomy and Iter Tracheostomy. Iter wrist restraint q (every) 2 Iter wrist restraint in place to	F	510			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COL 4601 MARTIN LUTHER KING JR AVENI WASHINGTON, DC 20032			
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F 610	behavioral symptom (e.g., hitting, kicking grabbing, abusing or this type occurred 1 In Section G (Function total dependence, or In Section P (Restramitten]Used daily O1/27/2021 docume 1/27/2021 her (Resitied to the rail. It was the patient was assongoing" Review of the progressive of th	oral Symptoms), " Physical s directed towards others, pushing, scratching, thers sexually) Behavior of to 3 days" onal Status), "Bed mobility ne-person physical assist" int), "Limb restraint [hand Reported Incident (FRI) on onted, " During rounds on other the sexual sex	F	510			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION
F 610	tracheostomy care or staff who cleaned Re It was also noted that answered "no" when abuse reporting policity the investigation 's in the investigator(s) follows members nor is there any additional training restraints or the facility and procedure. Employee #1 (Admini Resident #95 was phhowever, he did not so occurred. During a face-to-face 08/31/2021 at 9:45 Al Nursing) stated, "Mitt who are a danger to incident, we interview resident and did audithe facility with hand to other residents with no During a face-to-face 08/31/2021 at 9:45 A (Administrator) stated the allegation. Based could not determine we family member. We as	from the environmental sident #95's room. It two staff members asked, "Do you know the y and procedure" as part of terview questions. The ented evidence that the end up with those staff adocumented evidence that the end up with those staff and the end that the end that the end that the end the staff, assessed the end the staff and the end the end the the end the the end the staff, assessed the end the staff and the end the staff and the end the end the staff and the end the end the staff and the end the staff and the end the end the staff and the end the staff and the end the end the staff and the end	F 61		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 -	IPLE CONSTRUCTION NG	` '	DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZI 4601 MARTIN LUTHER KING JR A WASHINGTON, DC 20032		30/10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 610	During a face-to-face 08/31/2021 at 10:54 and Language Pathe is nonverbal with rigit to paralyses. Left side for left [hand] mitten 01/27/2021) and not were wrapped aroun rail, fully restricting hand. I immediately the nurse aware and mitten was not to be reported the incident administrator." It should be noted the visitation log on 08/3 that Resident #95 di 01/26/2021 or 01/27. 4. Facility staff failed Resident #102's coms snatched his leg and Resident #102 was 106/25/2021, with mu Multiple Fractures of Respiratory Failure of Sacral Region The Employee #50's statement dated 07/"Unfortunately I wen him we are here to concern the statement of the statement dated 07/14. Review of a complaint incident dated 07/14.	e interview conducted on AM, Employee #4 (Speech ologist) stated, "The resident of hemiparesis- pretty close is intact. She had an order. I walked into the room (on ided the straps to the mitten of and tied to the upper bed for movement of the left removed the restraint, made educated the nurse that the used as a restraint. I then it to my supervisor and the at a review of facility's 1/2021 at 10:00 AM revealed do not have any visitors on 1/2021. It to thoroughly investigate in plaint that a staff member it slung it during care. The e-admitted to the facility on tiple diagnoses that included: Ribs, Acute Chronic with Hypoxia, and Pressure	F	310		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	providing him with casung it requesting he that he is in pain. Reperson told him big be Resident was able to were providing him obeing conducted staff pending ongoing inverse (Administrator) dated The abuse and negle concluded, and it was investigation there was prove abuse and negle concluded, and it was investigation there was prove abuse and negle concluded, and it was investigation there was prove abuse and negle concluded, and it was investigation failed to Review of the facility documents on 08/26/investigation failed to Registered Nurse (Registered Nurse (Registered Nurse (Registered Nurse) (Registered incident. The pre-printed interview handwritten statement Employee #50. The provestigation question that were left blank. A investigation question were illegible.	are snatched his leg and the [turn] over resident stated sident alleges that staff oy you can take a little pain. It is identify staff persons who are. An investigation is if has been suspended estigation." I om Employee #1 I o7/14/2021, revealed, " the investigation has so determined from the as no evidence presented to allect was committed towards on. Therefore, the case has did due to these findings." Is investigation notes and allowed and the involved as investigation in the involved as investigation in the involved one were seven (7) and in the involved ore-printed interview are do ystaff and other out of the seven (7) innaire forms had questions all the pre-printed interview are forms had names that the interview conducted on ximately 9:50 AM, Employee ated, "I came in, did	F	510		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	LDING		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE CORRECTION OF T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	5. Facility staff failed Resident #105's cor stuffed her brief with pad and made a neg Resident #105 was 05/26/2021, with mu Polyneuropathy, An Disorder, Major Dep Chronic Pain Syndro Review of Resident Minimum Data Set (revealed that facility "In Section C (Cogn for Mental Status (B intact cognitive resp "In Section E (Beha (perceptual experier external sensory still (misconceptions or contrary to reality) "I "and in Section GG Goals), Toileting hygone-person physica Review of Employee W 07/29/2020. The for received a verbal wa written warning on (policy/procedure".	It to thoroughly investigate inplaint that Employee #5 pieces from a incontinence gative verbal comment. admitted to the facility on litiple diagnoses that included: xiety Disorder, Bipolar ressive Disorder, and ome. #105's Significant Change MDS) dated 07/13/2021, staff coded the following: Itive Patterns), Brief Interview IMS) score "15", indicating onse. vior), Hallucinations inces in the absence of real muli) "No"; Delusions beliefs that are firmly held, No"; (Functional Abilities and giene " total dependence	F	510		

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	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, S 4601 MARTIN LUTHER K WASHINGTON, DC 20	KING JR AVENUE SW	33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	
F 610	Director of Nursing the "On the morning of Ji to the attention of the Wound Care Team in resided on unit 3 eas filled incontinence bri Ultrasorb (under paddic NA (Employee #5) of the under pads ins [Employee #5] said [I wetter" "On the morning of Ji 330 A [unit 3 west] had under pad taped toge brief and was taped to skinResident 330 E resident's roommate] same makeshift inconurine soaked towel we resident's legs This within one week whe care to residents in a should not provide [Employee's Name] to Offense Acting in a abuse or neglect, or patient/resident either verbally." On 08/19/2021 a constate Agency that do reported to the Oml August 18th the nursi #105's] brief with pied	at revealed the following: ally 16, 2020, it was brought a Director of Nursing by member a resident [that ti] was observed with a urine ef on and a urine saturated is) in the incontinence Brief. was asked about the use ide of the resident 's diaper. Resident's Name] is a heavy ally 20 [2020] Resident is a urine stained Ultrasorb either to form a incontinence to the resident's is a heavy as observed with the intinence brief and in addition is the second occurrence in	F	510		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _				C 1 6/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		4601 MAR	DDRESS, CITY, STATE, ZIP CODE RTIN LUTHER KING JR AVENUE SW IGTON, DC 20032	<u> </u>	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Review of a memo from (Administrator) dated We interviewed the the unit (3 west) along medical chart. The aninvestigation has condetermined from the evidence presented was committed toward #105] in question. The unsubstantiated due On 08/27/2021, a condition of the evidence presented was committed toward #105] in question. The unsubstantiated due On 08/27/2021, a condition of the evidence presented was committed toward #105] in question. The unsubstantiated due On 08/27/2021, a condition of the evidence of the evi	rom Employee #1 d 08/24/2021, documented, " e staff and other residents on ng with examining the buse and neglect included, and it was investigation there was no to prove abuse and neglect irds the resident [Resident inerefore, the case has been to these findings." Implaint was received by the ocumented, "[Resident its daughter reported to the A. (Certified Nurse's Aide) e caused him three days of ks too much." In the staff member the Nurse Supervisor knew work with the resident ere was obviously a stem. The involved CNA was here Resident #105 resided). In assigned to that unit. He ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the staff member the ted that he did not say to the t	F	310			

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F 610	care and responsibili provider to another) supervisors during the were made aware that to work on the third fill During a telephone in 08/30/2021 at 10:36 Supervisor) stated, "I floated to 3 West befor that unit. I was to floated to 3 East. I waissues on 3 West." During a telephone in 08/30/2021 at 10:50 was working on 2 Eabecause they were sinvestigation was resfound, so I went to the care of the roommate [Resident #105] state needed assistance as the made a report of any problems. The rewanted me to help heno issues during the care. I have been do never done anything any way." Review of the investif for Resident #105's cono documented evidereviewed Employees implemented measured including Resident #"abuse or neglect, or	ity from one healthcare communication with the ne week. The supervisors at the CNA involved was not loor at all." Interview conducted on AM, Employee #6 (Nurse The CNA [Employee #5] was cause we didn't have a CNA ld that the CNA shouldn't be as not made aware about the interview conducted on AM, Employee #5 stated, "I last and was pulled to 3 West short. I was told the solved and no issues were ne unit (3 west). I was taking the (room 333 bed B) when ed that she was wet and as well. I reminded her that in me and that I didn't want esident stated that she er and so I did. There were ADL (activities of daily living) ing this for 17 years. I have to her nor intimidate her in ingation notes and documents complaint revealed there was ence that the facility's staff #5's personnel record or res to protect all residents 105, from the potential of	F	510		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	СОМ	E SURVEY PLETED
		095024	B. WING _			C)/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 610	verbally." Additionally record failed to outlin allowed to work on unallowed to work on the work of Human Resources disciplinary actions (the were not mentioned the until a meeting that of termination (of Employments of Employments of Nursing) stated, "I previous allegations of Nursing) stated, "I previous allegations of (CNA) until the meeting that of the work of th	interview on 09/08/2021 at AM, Employee #5 (Director of Nursing occurred on 08/31/2021 when oyee #5) was discussed." interview on 09/08/2021 at AM, Employee #6 (Director of Nursing occurred on 08/31/2021 when oyee #5) was discussed." interview on 09/08/2021 at AM, Employee #2 (Director was not aware of any made for Employee #5 ong on 08/31/2021." interview on 09/08/2021 at AM, Employee #1 dt, "I was not aware of any or disciplinary actions for the effect with the serious for the discharge is necessary for the difference with the resident's needs	F 6	10 22 F 622 1. Corrective action for reside Residents #97 and #103 are currentlin the facility. We are unable to retromplete the documents. The Acut Transfer Document Checklist has be to include Comprehensive Care Plan	y residents cospectively e care een updated	11/02/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION (X3) DATE COMI	
					С
		095024	B. WING		09/16/2021
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
DDIDOED	NAT CUDACUTE AND D	THAR NATIONAL HARROR		4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEPC	DINI SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	•	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
				2. Identify other residents	
F 622	Continued From page	e 41	F 62		
	services provided by	the facility;		An audit of other residents with transfe	
		viduals in the facility is		the facility was conducted. Moving for	
	endangered due to the clinical or behavioral			documents will be included in transfer	
	status of the resident			An audit of the Acute Care Transfer Do	
	(D) The health of indi-	viduals in the facility would		Checklist noted that the Comprehensive	l l
	otherwise be endange			Plan Goals was not included in the list	
	` '	failed, after reasonable and		documents automatically to include in	
		pay for (or to have paid		transfer packet (this has been corrected were no additional findings related to the	
		edicaid) a stay at the facility.		citation.	.115
		if the resident does not		citation.	
	payment or after the	paperwork for third party		3. Systemic changes	
		I, denies the claim and the			
		y for his or her stay. For a		Nursing staff and Unit Secretaries have	been
		s eligible for Medicaid after		educated on the updated Transfer Docu	
		, the facility may charge a		Checklist and the need to include the	
		le charges under Medicaid;		Comprehensive Care Plan Goals in the	transfer
	or	-		packet. The Acute Care Transfer Chec	
	(F) The facility ceases	s to operate.		been updated to include the Comprehen	
		ot transfer or discharge the		Care Plan Goals. The Shift Supervisor	
		peal is pending, pursuant to		responsible for ensuring that Comprehe	
	§ 431.230 of this cha			Care Plan Goals are included in the transpackets.	isier
		ght to appeal a transfer or		packets.	
		the facility pursuant to §		4. Monitor corrective actions	
		chapter, unless the failure to would endanger the health		4. Womtor corrective actions	
		nt or other individuals in the		The Director of Social Services/Design	ee will
		ust document the danger		complete weekly audits of all residents	l l
		or discharge would pose.		transferred out of the facility to ensure	l l
		3		Comprehensive Care Plan Goals were i	
	§483.15(c)(2) Docum	entation.		in the transfer packet. The results will	be
	When the facility tran			reported to the QAPI Committee month	
		the circumstances specified		months for review and recommendation	as.
)(A) through (F) of this			
		ust ensure that the transfer		The QAPI Committee is responsible for	r the on-
		nented in the resident's		going monitoring for compliance.	
		ppropriate information is			
	communicated to the	receiving nealth care			
l			1	T. Control of the con	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
							С	
		095024	B. WING _			09/	16/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE			
DDIDGER	NINT CURACUTE AND D	FUAD NATIONAL HADDOD		4601 MARTIN	LUTHER KING JR AVENUE SW			
BRIDGEP	DINI SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTO	ON, DC 20032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		EACH CORRECTIVE ACTION SHOULD B COSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
				5. D	Date correction action complet	ed		
F 622	Continued From page	ontinued From page 42						
	institution or provider.				ty's date of alleged compliance	e is		
	•	he resident's medical record		November	r 2, 2021.			
	must include:							
	(A) The basis for the	transfer per paragraph (c)(1)						
	(i) of this section.							
		agraph (c)(1)(i)(A) of this						
		esident need(s) that cannot						
		ots to meet the resident						
		e available at the receiving						
	facility to meet the ne	rea(s). n required by paragraph (c)						
	(2)(i) of this section m							
	. , . ,	ysician when transfer or						
		ry under paragraph (c) (1)						
	(A) or (B) of this secti							
	. , . ,	transfer or discharge is						
	necessary under para	agraph (c)(1)(i)(C) or (D) of						
	this section.							
		led to the receiving provider						
	must include a minim							
	(A) Contact information							
	responsible for the ca							
	(B) Resident represer	ntative information including						
	(C) Advance Directive	e information						
	. ,	tions or precautions for						
	ongoing care, as app							
	(E) Comprehensive c							
		ry information, including a						
	copy of the resident's							
	_	21(c)(2) as applicable, and						
		tion, as applicable, to ensure						
	a safe and effective to							
		is not met as evidenced						
	by:	mina						
	Surveyor: Gena, Ger	IIIIIa						
	Based on record review	ew and staff interview,						
		ensure all the required						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	NG) DATE SURVEY COMPLETED
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	documents were concare provider for two that were transferred #97, and #103) The findings include: 1. Resident #97 was 07/27/2021 with multivacute and Chronic Fencounter for Trached Review of the physicat 10:57 AM, directe [Hospital's name] via Review of Resident dated 08/17/2021, lathat the facility's staff with the resident's trace of the provided in the trans. 2. Resident #103 was 07/21/2021 with diage Myopathy, Gout, Act Failure with Hypoxia Pulmonary Disease, Chronic Kidney Disease, Review of the reside 07/13/2021 at 16:07	admitted to the facility on iple diagnoses that included: despiratory Failure and destony. #97's transfer to hospital to 1911". #97's transfer documents cked documented evidence included the care plan goals ansfer packet. #911". #97's transfer documents cked documented evidence included the care plan goals ansfer packet. #910 AM, or of Nursing) stated that not part of the documents fer packet. #910 Sadmitted to the facility on gnoses that included the and Chronic Respiratory, Chronic Obstructive Type 2 Diabetes, and	Fé	322		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		33,13,2321
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	LTACH (Long Term / Waiting for open bed room available." 07/13/2021 at 21:46 unit at 8:30 PM to LTUnit" Review of the facility Document Checklist' revealed the followin "Copies of Documen Documents Recomm Resident/Patient Transcident/Patient Transcident/Patien	Acute Care Hospital). I they will give us a call when [9:46 PM] "resident left the TACH I/C (Intensive Care) I's "Acute Care Transfer I last updated June 2018 g: ts Sent with Resident/Patient ended to Accompany ansfer Form identified on nsfer Form are enclosed List or Current MAR tration Record) ckground, Assessment and nd/or other Change in Note (if completed) Durable Power of Attorney ng Will) rs ents if available:	F	522		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTI		COMPLET	
		095024	B. WING			C 09/16	/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		4601 MAR	DDRESS, CITY, STATE, ZIP CODE RTIN LUTHER KING JR AVENUE SW IGTON, DC 20032	00710	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE ((X5) COMPLETION DATE
F 622	Continued From page	e 45	F 62	22			
	Recent Hospital Disc	harge Summary					
	Recent MD/NP (Nurs (Physician ' s Assista	e Practitioner) /PA nt) and Specialist Orders					
	Flow Sheets						
	Relevant Lab Results	S					
	Relevant X-rays and Results	other Diagnostic Test					
	SNF (Skilled Nursing Facility) Capabilities	Facility)/NF (Nursing Checklist "					
	protocol for staff to co transferring residents "Comprehensive Car	nad the aforementioned omplete a checklist before s, the form does not list e Plan Goals" as a to the receiving facilities.					
	to the LTACH with Rewas conducted. Ther resident's compreher	ments [transfer packet] sent esident #103 on 07/13/2021 re was no evidence that the ensive care plan goals were ments sent to the hospital					
F 641 SS=D	#45 (Unit Secretary 1 12:48 PM, and with E Nursing) on 09/01/20 acknowledged that of goals are not sent to when they are transfe Accuracy of Assessm		F 64	Reside	Corrective action for resident ent #87's MDS was corrected. That is no longer residing in the facil	ne	/02/2021

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		09/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00,11	0,202.
DDIDOED	OINT CUDACUTE AND D	FUAD NATIONAL HARROD		4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEP	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	resident's status. This REQUIREMENT by: Based on observation interview, the facility! Minimum Data Set As reflected a resident's 44 sampled residents The findings include: Resident #87 was re- 02/26/2021. The med resident had several Dependency on Resp Tracheostomy, Obes 4 Sacral Pressure Uld Review of the History 03/01/2021, the phys February 2nd 2021 st cardiopulmonary arrea appears to be in a ver mechanical support (Review of a Quarterly 06/02/2021 revealed, of Mental Status) [BII a summary score of the	of Assessments. It accurately reflect the is not met as evidenced on, record review and is staff failed to ensure a sessment accurately mental status for one (1) of is. (Resident #87) admitted to the facility on dical record showed the diagnoses including birator [Ventilator], ity, Gastrostomy and Stage cer. and Physical dated ician documented, "On the (Resident #87) suffered a testCurrently, the patient getative state and on full Ventilator)" y Minimum Data Set dated In Section C (Brief Interview MS] the resident was given the orderately impaired interview conducted on	F 64	2. Identify other residents	ere were ation. ortance us is Director or y reflect ee will of the tatus is be ly x 3 s. the on-	
	09/16/2021 at approx Employee #3 (Directo					

PRINTED: 11/15/2021 FORM APPROVED OMB NO. 0938-0391

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE A. BUILDING					
		095024	B. WING			C 1 16/2021
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
				1601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL HARBOR	,	WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	e 47	F 641			
	score.			F 655		11/02/2021
F 655	Baseline Care Plan		F 655	F 655		11,02,2021
SS=D	CFR(s): 483.21(a)(1)	-(3)		1. Corrective action for resident		
	Planning §483.21(a) Baseline §483.21(a)(1) The fa implement a baseline that includes the inst effective and personthat meet profession. The baseline care pla (i) Be developed with admission. (ii) Include the minim necessary to properly including, but not lim (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services	cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's um healthcare information y care for a resident ted to- d on admission orders.		The baseline Care Plans cannot be recre retrospectively. However, comprehensiplans are in place for Resident #95, #100 #372. Resident #95 has a care plan in pladdress the use of a hand mitten. Resident #105 and #372 no longer reside in the factor of a light of the residents. An audit of all new admissions baseline plans was conducted and all current residents have had their baseline care plans in place address pertinent resident specific concernies the plans was conducted and findings related citation. Systemic changes	ve care 5, and lace to ents icility. care dents ce to erns.	
	§483.21(a)(2) The fa comprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (ex this section). §483.21(a)(3) The fa resident and their rep	plan in place of the baseline		IDT team has been educated on the import of ensuring that baseline care plans are of for each resident within 48 hours of adm. The Director of Reimbursement will be responsible for ensuring that all resident interim care plans within 48 hours of add. 4. Monitor corrective actions The Director of Reimbursement/Designate complete daily audits of all new admission ensure that all residents have interim care within 48 hours (weekend/holiday admissional will be audited the next business day). The results will be reported to the QAPI Commonthly x 3 months for review and	ereated hission. Is have mission. The will ons to be plans sssions on the missions of the mission of the plans of the missions of the mission o	

Facility ID: HADLEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		095024	B. WING _		,	C 09/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 655	(i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the facility) Any updated infoof the comprehensive This REQUIREMENT by: Based on record restrice (3) of 44, sample failed to develop and plan within 48 hours #95, #105 and #372 The findings include 1. Resident #95 was 01/19/2021, with mulice Restlessness and A Encounter Gastroston Encounter Tracheose Review of the physical following: 01/19/2021-"Assess hours and document of the physical following: 01/19/2021-"Keep In prevent patient from (tracheostomy) or Greview of Resident in Data Set (MDS) date facility staff coded the control of the physical facility staff coded the control of the physical facility staff coded the code	of the resident. e resident's medications and d treatments to be facility and personnel acting ity. ormation based on the details e care plan, as necessary. T is not met as evidenced view and staff interview, for oled residents, facility staff d implement a baseline care of admission. (Residents'). c admitted to the facility on ltiple diagnoses that included: gitation, Attention for my and Attention for my and Attention for tomy. cian's orders revealed the left wrist restraint q (every) 2 any findings every 2 hours" eft wrist restraint in place to pulling on her trach (gastrostomy)- Tube q shift" #95's Admission Minimum ed 01/26/2021 revealed that	F	recommendations. The QAPI Committee is responsion going monitoring for compliance. Date correction action The facility's date of alleged convovember 2, 2021.	completed	1-		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING			COMPLETED	
		095024	B. WING _	B. WING			C / 16/2021
	NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			46	REET ADDRESS, CITY, STATE, ZIP CODE 601 MARTIN LUTHER KING JR AVENUE SW (ASHINGTON, DC 20032		10,2021
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE COMPI TO THE APPROPRIATE DA	
F 655	mitten] Used daily During a review of R there was no docum staff developed a ba hours of admission) mitten. During a face-to-face 08/30/2021 at 10:35 of Nursing) failed to address the findings 2. Resident #105 wa 05/26/2021 with multohronic Pain Syndro Disorder and Bipolat Review of the physion 05/26/2021 "Pain as 05/26/2021 "Pain as 05/26/2021 "Pain as 05/26/2021 "Dilaudid MG give 1 tablet by needed for pain" Review of the Signifit Set dated 07/13/202 coded the following: In Section J (Health in the last 5 days, has	resident #95's care plan, ented evidence that facility seline care plan (within 48 to address her use of a hand interview conducted on AM, Employee #2 (Director provide any comments to admitted to the facility on tiple diagnoses that included: ome, Polyneuropathy, Anxiety Disorder. Scian's orders revealed: seessment every shift" inophen(pain reliever) tablet give 1 tablet by mouth every 6	F	355			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	IPLE CONSTRUCTION NG	` ,	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 655	Continued From pag	e 50	F6	555		
	"Received PRN (as r was offered and dec documented "Yes",	needed) pain medications or ined Facility staff				
		ne have you experienced he last 5 days" facility staff ently"				
	In Section N (Medications), "Indicate the number of days the resident received the following medications by pharmacological classificationduring the last 7 days Medication received: "Opioid (Dilaudid)", Days: "6".					
	there was no docume	esident #105's Care Plan, ented evidence that facility seline care plan (within 48 o address her pain.				
	08/30/2021 at 10:35	e interview conducted on AM, Employee #2 (Director provide any comments to				
	08/10/2021, with diag Metabolic Encephalo Gastrostomy, Chroni Hypoxia, Bacteremia	pathy, Tracheostomy, c Respiratory Failure with , Epilepsy, Pneumonitis due and Vomit, Schizophrenia,				
	Review of the nursing	g progress notes revealed:				
	"Resident admit	[6:26 PM] (Admission Note) red from [Hospital 's name] re to respiratory failure PEG				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	••••	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 655	upper center abdome for 24 hours at 55 ml	scopic Gastrostomy) tube on enJevity 1.5 is continuous	F 655			
	health record revealed Care Plan developed goals or approaches to needs for Respiratory Gastrostomy Tube Cand diagnoses of Sch Disorder, Restlessness was no evidence that the resident and their summary of the Base	are and Enteral Feeding, nizophrenia, Anxiety s or Agitation. Also, there the facility's staff provided representative with a line 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. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)		F 656	F 656 1. Corrective action for resident	11/02/2021	
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive apprehensive care plan must		Residents #56, #68, #87, #95, and #100 had their comprehensive care plans revie and updated. Resident #105 no longer rethe facility. 2. Identify other residents An audit of all current resident's care place conducted and all current residents have their care plans reviewed and updated. Were no additional findings related to the citation.	ewed esides in ans was had	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDIN	<u> </u>		С	
		095024	B. WING _		09/16/2021		
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4601 MARTIN LUTHER KING JR AVENUE SW			
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032			
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE	
				3. Systemic changes			
F 656	Continued From page	e 52	F 6				
	physical, mental, and	psychosocial well-being as		IDT team has been educated on the in			
		24, §483.25 or §483.40; and		of ensuring that comprehensive care			
		would otherwise be required		created for each resident and updated			
	• •	.25 or §483.40 but are not		The Director of Reimbursement will			
		esident's exercise of rights		responsible for ensuring that all resid	ents have		
	under §483.10, includ	ding the right to refuse		comprehensive care plans.			
	treatment under §483						
	(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			4. Monitor corrective actions			
				The MDS nurses will complete mont of comprehensive care plans to ensur			
	findings of the PASAI	RR, it must indicate its		residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the			
	rationale in the reside	ent's medical record.					
		h the resident and the					
	resident's representa			QAPI Committee monthly x 3 month	s for		
	(A) The resident's goa	als for admission and		review and recommendations.			
	desired outcomes.			The QAPI Committee is responsible	C .1		
		eference and potential for		for the on-			
	_	ilities must document		going monitoring for compliance.			
		s desire to return to the		5 Dete	1.4.1		
	=	ssed and any referrals to		5. Date correction action comp	ieted		
		s and/or other appropriate		The facility's date of alleged complia	ncais		
	entities, for this purpo			November 2, 2021.	1100 18		
		n the comprehensive care		110 VCIIIUCI 2, 2021.			
		in accordance with the					
	•	n in paragraph (c) of this					
	section.	is not met as evidenced					
		is not met as evidenced					
	by: Based on record revi	ews and staff interviews, for					
		led residents, facility staff					
		implement comprehensive					
		e plans. (Residents' #56,					
	#68, #87, #95, #100,						
	The findings include:						
	1.The facility's staff fa	ailed to develop and					
	implement a compreh	ensive person-centered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095024		B. WING _	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032	sw	00,	. 0, 202 :
(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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		COMPLETION
F 656	Resident #56 was at 06/01/2021 with the Peripheral Vascular Mellitus, Acquired At Dependence, Cirrho Chronic Viral Hepati. During an entrance of approximately 9:00 of (Administrator) state residents that smoke Review of the care pupdated on 08/24/20 evidence the facility's comprehensive, personals and intervention preference to smoke During a face-to-face 4:01 PM, Resident # During a face-to-face 4:01 PM, Resident # During a face-to-face 4:01 PM, Resident # Consider the facility's staff #68's Head of Bed (If while the resident's trinfusing.	dmitted to the facility on following diagnoses: Disease (PVD), Diabetes beence of Right Foot, Opioid sis, Chronic Pancreatitis, tis C, and Depression. Conference on 08/23/2021 at AM, Employee #1 dt that the facility did not have been depression as staff developed a son-centered care plan with the stop and that she smokes. Experimental interview on 08/24/2021 at 56 said that she smokes. Experimental interview conducted on AM, Employee #23 (Unit at Resident #56 is a smoker the care plan to reflect the experimental to smoke. If alled to elevate Resident HOB) at a 45-degree angle tube (enteral) feeding was	F	556			
	04/19/2021. The me	-admitted to the facility on dical record revealed that eral diagnoses including					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
	095024 B. WING		B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021	
(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 ((EACH CORRECTIVE ACTIVE) (CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Gastrostomy, Gastro Disease, Feeding Dif Respiratory Failure, a Respirator [Ventilator Observation on 08/30 PM, Resident #68 wa while her tube feedin milliliters per hour) w Review of the medica following physician o 04/02/2021- " Eleva 45 degrees at all time least 30 to 40 minute 04/23/2021- "Enteral Glucerna 1.5 at 45ml 24 hr." Review of the care p Gastrostomy Tube (E 04/01/21 revealed mi The resident need degrees during tub During a face-to-face approximately 2:30 F (Registered Nurse) s assistant had just pro and forgot to elevate 3. The facility's staff of comprehensive perse	r-Esophageal Reflux ficulties, Quadriplegia, and Dependence on order. 20/2021 at approximately 2:30 as observed lying flat in bed ag (Glucerna 1.5 at 45 as infusing. 21 record revealed the orders: 22 ate HOB (head of bed) 30 to be during feeding and for at a safter the feeding stopped." 23 feed order every shift (hr (milliliters/hour) X (times) 24 an with a focus area of: 25 Enteral) Feeding dated altiple interventions including as the HOB elevated 45 be (enteral) feeding. 25 interview on 08/30/21 at an enterview on 08/30	F	556			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/C

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		095024	B. WING _	B. WING		C 09/16/2021
	NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			STREET ADDRESS, CITY, STATE, Z 4601 MARTIN LUTHER KING JR A WASHINGTON, DC 20032		00,10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	
F 656	Resident #87 was re 02/26/2021. The med resident had several Dependency on Resident had several Dependency on Resident had several Dependency on Resident Pressure Ul During an observatio 08/25/2021 at approximate of the physicial following: Review of the physicial following: 05/31/2021- "Change every month" 08/05/2021- "Change once a week" The medical record late that the facility's staff address the resident and a PICC/MID-line During a face-to-face approximately 11:00 Manager) stated that plan to address Resident #95 was accomprehensive, persident #95 was accomprehensive, persident #95 was accomprehensive of the province of the prov	admitted to the facility on dical record showed that the diagnoses including pirator [Ventilator], ity, Gastrostomy and Stage cer In of Resident #87 on imately 3:30PM, the resident urinary catheter and right line. In orders showed the PICC/MID line dressing acked documented evidence developed care plans to se use of a urinary catheter interview on 09/01/2021 at AM, Employee #14 (Unit she would develop a care dent #87's use of a urinary MID line.	F6	656		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 656	Restlessness and A Encounter Gastrosto Encounter Tracheos Review of Resident Data Set (MDS) date facility's staff coded In Section P (Restramitten] Used daily Review of the physic following: 01/19/2021- "Assess hours and document of tracheostomy or G Review of Resident there was no docum facility's staff developerson-centered car interventions to additional mitten. During a face-to-face 10:35 AM, Employee.	gitation, Attention for my and Attention for tomy. #95's Admission Minimum ed 01/26/2021, revealed that the following: int) "Limb restraint [hand." cian's orders revealed the s left wrist restraint q (every) 2 any findings every 2 hours "	Fé	556		
	to address Resident	failed to develop a care plan #100's diagnosis of Anxiety. admitted to the facility on Itiple diagnoses that				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	095024 B. WI		B. WING		C 09/16/2021	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021	
(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 E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE COMPLETION	
F 656	Continued From page		F 65	6		
	included Anxiety	and Depression				
	Review of physician of following:	orders revealed the				
	•	am (antianxiety) Tablet 5 mg let via G (gastrostomy) tube r anxiety"				
	for dry mouth, constip	on, difficulty urinating,				
	-	ine Fumarate (antipsychotic) cablet via G (Gastrostomy) or Depression"				
	07/15/2021-"Klonopir via G-tube two times	n (antianxiety) give 1 tablet a day for Anxiety"				
	showed that in Section CO100 "Should a Brief be conducted" facility "Resident is rarely/ne (Mood) Facility staff of symptoms present). I Potential Indicators of coded, "Z" indicating	agnosis) facility staff coded				
	documented evidence developed a compreh	100's care plans lacked e that the facility's staff nensive person-centered Resident 100's diagnosis of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	095024 B. W		B. WING		C 09/16/2021	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	00/10/2021	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 656	6 Continued From page 58		F 65	6		
	During a face-to-face Employee #42 (Unit Notes that Present Pr	interview on 09/16/2021, Manager) stated that she is are plan. However, the lin why the resident's anxiety dress in the previosly s. ailed to update Resident ddress his needs for mental dmitted to the facility on iple diagnoses including, Ribs, Acute Chronic ith Hypoxia, Unspecified d of Right Femur, and cral Region. g progress notes dated from 2021 revealed the following: M- "Refused wound care, th my wounds they are nt was educated the s being done but refused" M- "Resident refused to (a type of therapy to help to decreases air pressure on elp the wound heal more er made attempts to do the d care as well as therapy.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP (4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 656	07/26/2021 at 9:25 P [finger stick] check ar explained to resident' 07/27/2021 at 7:35 A morning care he said cleaned" 07/27/2021 at 6:58 P stated I do not need a [Oxycodone (opioid p tablet via G (gastroste night shift for Prior to Review of Resident # plan lacked documen 's staff developed a p address his refusal of During a face-to-face 09/16/2021 at approx Employee #14 (U she was not sure if th a Psychiatrist to addr 7. The facility's staff f comprehensive, persaddress Resident #10	M - "resident refused fs and insulin. risk and benefit" M - "patient refused it is too early for him to get M - " Resident refused, any pain medication ain reliever)5 MG Give 1 cmy)-Tube every day and wound care]" #102 's comprehensive care sted evidence that the facility person-centered care plan to it care. interview conducted on imately 3:15 PM, Unit Manager) stated that the resident was evaluated by the eresident was evaluated by the eresident of care. ailed to develop a con-centered care plan to	F	656		
	Chronic Pain Syndron Disorder and Bipolar Review of the Signific	iple diagnoses that included: me, Polyneuropathy, Anxiety Disorder. cant Change MDS dated that facility staff coded the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 656	In Section J (Health of in the last 5 days, ha scheduled pain medi documented "Yes", "pain medications or w facility staff document time have you experi the last 5 days" facilit "Frequently" In Section N (Medica of days the resident medications by pharmduring the last 7 da "Opioid (Dilaudid)", Device the physicial following: 05/26/2021- "Pain as 05/26/2021- "Pain as 05/26/2021- "Dilaudid 2 MG (milligram) of hours as needed for pain" During a review of Rethere was no document staff developed a base hours of admission) to During a face-to-face 08/30/2021 at 10:35	Conditions), " At any time is the resident: received cation regimen facility staff received PRN (as needed) was offered and declined" ited "Yes", "How much of the enced pain or hurting over the staff documented tions), "Indicate the number received the following macological classification ys Medication received: Days: "6". an's orders revealed the sessment every shift" inophen (pain reliever) tablet give 1 tablet by mouth every or mild pain" d (opioid pain reliever) tablet by mouth every 6 hours as resident #105's care plan, ented evidence that facility seline care plan (within 48 to address her pain. e interview conducted on AM, Employee #2 (Director provide any comments to the		657		
SS=D	Č					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COI AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COI A. BUILDING		COM		SURVEY			
		095024	B. WING	B. WING		C 09/16/2021	
NAME OF PE	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2021
	.07.52.1.01.001.1.2.2.1				501 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR			/ASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac the resident and the re An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by th (iii)Reviewed and revi team after each asse comprehensive and c assessments. This REQUIREMENT by: Based on record revi three (3) of 44 sample staff failed to revise th plan to address reside (Residents' #56 #78,	ensive Care Plans rehensive care plan must days after completion of ssessment. erdisciplinary team, that ited to sician. with responsibility for the responsibility for the and nutrition services staff. cticable, the participation of esident's representative(s). be included in a resident's carticipation of the resident resentative is determined development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary ssment, including both the quarterly review is not met as evidenced ew and staff interview for ed residents, the facility's ne person-centered care ent needs and diagnoses.	F	657	Residents #56 and #78 have had their comprehensive care plans reviewed and updated. Resident #87 no longer resider facility. 2. Identify other residents An audit of all current residents care place conducted and all current residents have their care plans reviewed and updated. Were no additional findings related to the citation. 3. Systemic changes IDT team has been educated on the improfensuring that comprehensive care place created for each resident and updated/reneeded. The Director of Reimbursement responsible for ensuring that all resident updated/revised comprehensive care place. 4. Monitor corrective actions The MDS nurses will complete monthly of comprehensive care plans to ensure the residents have updated/revised comprehensive care plans. Audits will be completed duresident MDS completion. The results we reported to the QAPI Committee monthly months for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance.	ns was had There is ortance ns are vised as t will be s have ns. audits nat all ensive ring vill be y x 3 s.	11/02/2021
	The findings include:						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095024	B. WING				C 1 6/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		4	TREET ADDRESS, CITY, STATE, ZIP CODE 601 MARTIN LUTHER KING JR AVENUE SW VASHINGTON, DC 20032	1 55,	10/2021
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	1A. The facility's staff the comprehensive of Resident's #56 discourinary catheter. Resident #56 was ac 06/01/2021 with the file Peripheral Vascular In Acquired Absence of Dependence, Cirrhos Chronic Viral Hepatit Review of the Quarter 07/19/2021 revealed Patterns), that Reside having a Brief Interving Summary Score of "In was intact cognitively Bladder), the resident of an indwelling urinary cathering television. In observations, the resident was induced to the physic 06/02/2021, directed	f failed to revise and update are plan to address ntinued use of an indwelling distributed to the facility on following diagnoses: Disease , Diabetes Mellitus, Right Foot, Opioid Sis, Chronic Pancreatitis, is C, and Depression. The Minimum Data Set dated in Section C (Cognitive ent #56 was documented as ew for Mental Status 15" indicating the resident of the use ary catheter. The Section H (Bowel and the was not coded for the use ary catheter. The Section of the ident did not have an enterty of the identity of t	F	657	5. Date correction action complet		
	" The resident has ur presence of foley cat 06/03/2021. At the tir (08/26/2021) Reside indwelling urinary cat						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095024	B. WING _				C 16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 657	4:01 PM, Resident # [indwelling urinary captul it was removed." During a face-to-face 1:07 PM, Employee that she would removed related to presence from the resident's capture a fall/accident of the comprehensive of a face and the comprehensive of the care face and the comprehensive of the care face and the comprehensive of the care face and the capture of the care face of	e interview on 08/24/2021 at 256 stated, "I had "one" atheter] a few months ago, e interview on 08/26/2021 at #23 (Unit Manager) stated ve it (urinary retention of foley catheter care plan) omprehensive care plan. failed to revise and update care plan for Resident #56 on 08/03/2021. progress note dated (3:36 PM), documented, " It [Resident's name] fell out of	F6	,			
	#23 at 9:22 AM, ackind had a fall on 08/03/2	e interview with Employee nowledged that Resident #56 021 and that the care plan I not been updated to include					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 657	Continued From page	e 64	F 65	7		
	2. Facility staff failed Resident #78's care p diagnoses.	to update and revise plan to include all of the				
	04/14/2020, with mult Depression, Bipolar D	mitted to the facility on iple diagnoses including, Disorder, Anoxic Brain and Chronic Respiratory				
	(MDS) dated 08/22/20 C (Cognitive Patterns brief interview for me facility staff coded "0" (Active Diagnosis) Re	rly Minimum Data Set 021, showed that in Section s), C0100 asked, "should a ntal status be conducted" indicating "no". In Section I esident #78, was coded as polar Disorder and Anoxic				
	Review of the docume Physical" revealed the	ent entitled "History and e following:				
	H/O (history of)B	ry of present illness", " ipolar Disorder, Depression ine or Phenylcyclohexyl logenic drug] use"				
		y of present illness", "h/o Anoxic Brain Damage"				
	Plan" dated 08/18/20	78's "Comprehensive Care 21, failed to have focus the resident 's diagnoses oxic Brain Damage.				
	09/16/2021, Employe	interview conducted on e #42 (Unit Manager) stated e for updating the care plan.				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COL 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 657	Continued From pag	e 65	F 6	957			
		failed to revise Resident new interventions to address tegrity issues.					
	02/26/2021. The me resident had several 4 Sacral Pressure U Pressure Ulcer, Stag Ulcer Unstageable F and a Stage 2 Left F Dependency on Res						
	Manager) and Employere observed proving #87's Stage 4 sacral Stage 4 Right Calf properties Right Heel Deep Tiss	PM, Employee #16 (Unit byee #20 (Registered Nurse) ding wound care for Resident pressure injury/wound, ressure injury/wound, and					
	buttocks blister, leng 1.1 cm, depth not ap applicable, tunneling	nouse acquired, right th 4.2cm (centimeters),width plicable, undermining not					
	this wound as a Stag tissue loss) pressure 05/04/2021 -new, in- pressure injury to left	ge 4 (full thickness skin and injury. house acquired, Stage 4 tear, length 0.9cm, width 0.9 able, undermining not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CIT 4601 MARTIN LUTHE WASHINGTON, DO	ER KING JR AVENUE SW	33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	(IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD I EFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 657	Continued From page	e 66	F	557		
	blister, length 4.1cm, applicable, undermining not applicable. It should be noted that this wound [right hee (persistent non-bland purple discoloration). 07/06/2021- new, inunstageable (obscure tissue loss) pressure width 2.0 cm, depth rot applicable, tunne	house acquired, right calf ed full-thickness skin and ulcer/injury, length 3.0 cm, not applicable, undermining ling not applicable, and				
	mass of dead tissue) Review of physicians following:					
	gently with wound cle	, "Cleanse blister right heel eanser spray, pat dry, apply to protectEvery day and care."				
	with wound cleanser Exuderm RCD (Regu	I, "Cleanse wound left ear spray, pat dry, apply lated Colloidal Dispersion), ays every nightfor wound				
	with Anasept wound of apply Anasept gel, co secure with coversite	l, "Cleanse wound to sacrum cleanser spray, pat dry, ver with 4X4's and pad, and [stratasorb] dressing daily every night shift for wound				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	337.133.22	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 657	Continued From pag	e 67	F 65	57		
	calf with Anasept wor apply Anasept gel, co (abdominal) pad, wraneeded)." Review of the June 2 Treatment Administrathat nursing staff initi 06/01/2021 to 07/29/were providing woun Review of the Quarte (MDS) dated 06/02/2 In Section C (Brief In the resident was cod the resident was more in Section G (Function Coded as total dependant of the resident was cod on Respirator [Ventil Gastrostomy, and Goweakness. In Section resident was coded fulcers/injuries and has a and one Stage 4 president was also cowound(s). Review of the Signific Set (MDS) dated 07/following:	2021 and July 2021 tion Record (TAR) revealed aled the TAR from '2021indicating that they d care as prescribed. erly Minimum Data Set '2021 revealed the following: atterview for Mental Status) led as an "11" indicating that derately impaired cognitively. onal Status) the resident was adent on staff and requiring of one or two staff members essing, eating, toileting, and ection I (Active Diagnoses) ed for Aphasia, Dependency ator] Status, Tracheostomy,				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		095024	B. WING			C 09/16/2021		
	NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 657	the area was blank. I Status) the resident was dependent on staff and assistance with one of mobility, dressing, ear hygiene. Section I (Adwas coded for Stage Dependency on Resp. Tracheostomy, Gastr. Muscle Weakness. In the resident was code pressure ulcers/injuring Stage 4 Pressure Ulc. Wound, one Unstage and surgical wound (stage Assessment Supressure ulcer care assessment. Review of the care pl. 02/26/2021 with the firm the resident has Stage sacrum New pressight lateral calf". Ti documented evidence updated it with new (deach assessment (06 to address Resident including pressure ulcer care approximately 1:30 P. Manager) stated that Resident #87's care provided address the reside to address the reside.	n Section G (Functional was coded as total and requiring physical or two staff members for bed ting, toileting, and personal ctive Diagnoses) the resident 4 Pressure Ulcer, Aphasia, pirator [Ventilator] Status, costomy, and Generalized a Section M (Skin Condition) and for: being at risk for eas, one Stage 3 and one ear/Injury, one Unstageable table Deep Tissue Injury, and In Section V (Care mmary) indicated that trea was triggered for this an with an initial date of ocus area of: age 4 (pressure injury) to ure injury unstageable to be care plan lacked at that the facility's staff current) interventions after (702/2021 and 07/26/2021) #87's skin integrity issues cers/injuries.	F	557				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	5 111115		C 09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021	
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
				F 677	11/02/2021	
F 677	Continued From page	e 69	F 67			
F 677 SS=D		or Dependent Residents	F 67	7 1. Corrective action for resident		
SS=D	out activities of daily I services to maintain gersonal and oral hyg. This REQUIREMENT by: Based on observation resident interview, for residents, facility staff who are unable to cartiving (ADL) received hygiene. (Residents of The findings include: Review of the facility Daily Living (ADLs), adate of 03/2018 documents and services will be preserved.	dent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced in, record review, staff and in two (2) of 44 sampled if failed to ensure residents from the necessary personal in #25 and #37) s policy entitled, "Activities of Supporting" with a revision imented, "Appropriate care provided for residents who		Resident #25 has been having his urinal emptied regularly. Resident # 37 has be offered a shower 3 x week and has given bath with a wash cloth water and body when she declines her shower. Her fing and toenails have been cleaned and trim She has been put on the list to be seen b podiatrist on the next scheduled visit. 2. Identify other residents An audit of other residents have been contone that ADLs are being addressed Resident shower/bath preferences have been reviewed and documented. There were readditional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that resident's A	een n a bed vash eernails med. y the onducted h. been no n.	
	including appropriate	at ADLs independently support and assistance ng, dressing, grooming, and		addressed appropriately. The Director of Nursing will be responsible for ensuring resident's ADL needs are being met.	of	
	The facility's staff f (urine collection device)	ailed to empty the urinal ce) for Resident #25.		4. Monitor corrective actions The Director of Nursing/Designee will of		
	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." 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.		ident urinals vill be ly x 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		095024	B. WING _		0	9/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIDGER	OINT SUBACUTE AND	REHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE	SW		
DIVIDUEL	SINT GODAGOTE AND	KEIIAB NATIONAL HARBOR		WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			
				The QAPI Committee is respons	sible for the on	-	
F 677	Continued From pa	ge 70	F6	going monitoring for complianc			
		ion on Unit 3 West on		5. Date correction action	completed		
		AM, three (3) full urinals that		The facility's date of alleged co	mpliance is		
		ately 1000 milliliters of clear, bserved at Resident #25's		November 2, 2021.	inpinunce is		
		servation on 08/25/2021 at e three (3) full urinals ent #25's bedside.					
	Review of the Annual Minimum Data Set (MDS) dated 07/21/2021 showed that facility staff coded the following:						
	g.						
		itive Patterns), a Brief I Status (BIMS) score of "15", gnitive response.					
	In Section G (Functional Status), Mobility devices, "wheelchair", toilet use, "limited assist, one-person physical assist"						
	In Section H (Bowel continence, "always	l and Bladder), urinary s continent"					
	[Resident #25] has (related to) right eye 07/16/2019 reveale	plan with the focus area of: impaired visual function r/t e blindness" revised on d the interventions, " Provide n the appropriate staff support					
	"[Resident #25] has performance deficit on 09/25/2019, reve interventions, "pe	r/t limited mobility" revised					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE CORRECTION OF TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	and encouragement During a face-to-face 08/25/2021 at approx #21 (Registered Nur them (urinals) now." 2. The facility's staff oral and nail care for Resident #37 was re 09/01/2020, with the Weakness (Generali: Mellitus, Hyperlipide: Accident (CVA), Hern Depression, Schizop Personality Disorder During an observation approximately 9:30 A Nurse Aide) was observation approximately 9:30 A Nurse Aide) was observation to the second to t	e interview conducted on kimately 11:20 AM, Employee se) stated, "I will go empty failed to bath and provide Resident #37. -admitted to the facility on following diagnoses: Muscle zed), Hypertension, Diabetes mia, Cerebral Vascular niplegia, Seizure Disorder, whrenia, and Paranoid on on 08/25/2021 at AM, Employee #21 (Certified erved providing a bed bath e employee washed the ment care wipes". The loyee #21, "I want a bath with ash, and water, not a wipe." on revealed Resident #37's halls were long and dirty. Also, was dry and scaly. e interview on 08/25/2021 at AM, Resident #37 stated that both most days and she had care in the past three days. at podiatry comes once a ot remember seeing them	F	677		
		erly Minimum Data Set 2021 revealed the following:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pa	ge 72	F 6	677			
	Interview for Menta Score of "15" indica cognitively intact. In Section G (Functives and personal Interview of a physical use, and personal Interview of a physical following: 09/02/2020, directed week, one time a discrete we	an orders revealed the ad, "Oral care two times a day" ad, "Shower resident 3 times a ay every Mon, Thu, and Sun. plan with a focus of area of: had an ADL self-care deficit at-side) Status Post (s/p) CVA, Muscle Weakness", revised on d the following interventions: g: Check nail length and trim day and as necessary Report rse Provide sponge bath shower cannot be tolerated Illy dependent on 1 staff"					
	shows that facility s been giving Reside Monday, Thursday been providing mon a day.	08/01/2021 to 08/31/2021, staff signed off that they had ent #37 a shower every and Sunday and that they had uth care to Resident #37 twice					
	However, review of	the shower book revealed a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL A. BUILDING (X3) DATE S COMPL							
		095024	B. WING			09/ ⁻	C 16/2021
NAME OF PROVIDE		REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		(X5) COMPLETION DATE
docu Com Show that: two (Durin 2:52 givin note: show on the Show on the Show on the Show one Show one Show one Show on the Show one Show	orehensive Certiver" dated from showed Resider 2) occasions 07 ag a face-to-face PM, Employee gresidents a basit on the skin rer/bath book lose unit. Ing a face-to-face per/bath book lose unit.	Skin Monitoring: fied Nurse Aide (CNA) 07/01/2021 to 08/31/2021 nt#37 received a bed bath on //31/2021 and 08/28/2021. e interview on 08/31/2021 at #22 (CNA) stated that after th, bed bath, or shower, she nonitoring sheets in the cated at the nurse 's station e interview conducted on PM, Employee #2 (Director that Resident #37 had only d bath for August 2021 and d bath for July 2021.	F 68	Resident #68 is being turned ar prescribed. Resident #68's heabeing elevated during and at le after tube feedings (only lower care). Resident #76's mattress changed and is being monitore per shift). Resident #87 no lon facility. Resident #100 was as and deemed inappropriate for t program. Resident #372 no lon facility.	nd reposition and of the bast 30-40 and to prove has been d 2 x day ager reside sessed by the restoral	oned as ed is minutes ide (once s in the therapy tive	11/02/2021

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095024	B. WING			C 1 6/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2021
TO THE OT TH	TO VIDER OR OUT FEET			4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
				2. Identify other residents		
F 684	Continued From page	e 74	F 6			
	by: facility staff failed to turn and reposition two (2) residents as prescribed for wound prevention;			An observation audit of other resident		
				turning and repositioning, residents or		
	failed to elevate head	of bed at a 45-degree angle		feeding, and residents who require the		
	while one (1) resident	t's tube (enteral) feeding was		drug monitoring did not reveal any ad		
	infusing; failed to ens			concerns. All mattresses were observ		
		r contracture management;		audited and were in good repair. The additional findings related to this citat		
		ysician's orders to obtain		additional findings related to this citat	1011.	
		ugh levels (lab value). s, #87, #100 and #372)		3. Systemic changes		
				Nursing staff have been educated on t	he	
	The findings include:			importance of ensuring that residents		
	The initiality include.			and repositioned appropriately, the Ho	OB is	
				raised during tube feedings/30-40 mir	utes after	
	1. The facility 's staff	failed to turn and reposition		feedings, and that therapeutic drugs an	e	
	Residents #68, as pre			monitored per physician orders. The		
	prevention.			engineering department was educated		
				ensuring that resident equipment is ke		
				repair. The Director of Nursing will		
	Review of the Compr			responsible for ensuring that residents	receive	
		a of: Activity of Daily Living		quality care.		
		mobility with a revision date		4. Monitor corrective actions		
		care plan outlined multiple		4. Monitor corrective actions		
		t needs total assistance to		The Unit Managers and Supervisors/I)ecianee	
	turn/reposition at leas	blevery 2 nours.		will complete daily audits of turning a	_	
	Resident #68 was ad	mitted to the facility on		repositioning. Dietician/Designee wil		
		lical record revealed that the		25% of tube feeding residents weekly		
	resident had several			that the head of the bed is properly rai		
		Iriplegia, Respiratory Failure,		during/after feedings. The Director of		
	Dependence on Resp			Nursing/Designee will audit therapeut		
	Tracheostomy and G			medications weekly to ensure that		
	,	-		corresponding laboratory tests are cor		
				and results addressed. Materials Man	_	
	Review of a physician	n order dated 04/20/2021		will audit 25% of resident beds month		
	directed, "Turn and re	eposition every 2 hrs (hours)		signs of disrepair and address any issu		
	to prevent skin break	down."		results will be reported to the QAPI C	ommittee	
				monthly x 3 months for review and recommendations.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		205004			С		
		095024	B. WING		09/1	6/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DDIDOED	NAT CURACUTE AND D	FUAD NATIONAL HARROR		4601 MARTIN LUTHER KING JR AVENUE SW			
BRIDGEP	DINI SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
				DEFICIENCY)			
				The QAPI Committee is responsible for	the on-		
F 684	Continued From page	e 75	F 68	going monitoring for compliance.			
	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.				_		
				5. Date correction action complet	ed		
				The facility's data of alleged countings	_ :_		
				The facility's date of alleged compliance November 2, 2021.	e is		
	In section G (Function	nal Status - Bed mobility) the					
	resident was coded a	s a"4" and "2" indicating that					
		lly dependent on the staff					
	and required one-person physical assist for bed						
	mobility.						
	In section I (Active Diagnoses), the resident was						
	coded for Cerebral Pa						
		Dependence on Respirator acheostomy and Weakness.					
		ndition), the resident was					
	_	ounds (gastrostomy and					
	tracheostomy) and us device for bed.	sing a pressure reducing					
	-	n on 08/30/2021 from 7:55 ours) the following was					
	noted:	ours) the following was					
	At 7:55 AM, Resident her back.	#68 was in bed, lying on					
	At 10:30 AM, Resider on her back.	nt #68 remained in bed, lying					
	and at 11:57 AM, Res	sident #68 was observed to ack.					
	• ,	ours of the observation, eposition Resident #68.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEI WASHINGTON, DC 20032		00/10/2021	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page	e 76	F 6	884			
	approximately 12:40 stated that the reside the certified nursing a #17]. During a face-to-face approximately 12:45 stated, "I have not pr	interview on 08/30/2021 at PM, Employee #20 (RN) ent had been reposition by assistant (CNA) [Employee interview on 08/30/2021 at PM, Employee #17 (CNA) ovided any care or resident (Resident #68)					
	#68's Head of Bed (H	failed to elevate Resident IOB) at a 45-degree angle ube (enteral) feeding was					
	04/19/2021. The me the resident had seve Gastrostomy, Gastro	ficulties, Quadriplegia, and Dependence on					
	PM, Resident #68 wa	0/2021 at approximately 2:30 as observed lying flat in bed g (Glucerna 1.5 at 45 as infusing.					
	Review of the medica following physician o	al record revealed the rders:					
	45 degrees at all time	ate HOB (head of bed) 30 to es during feeding and for at s after the feeding stopped."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIES/CL

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	COMPLETED	
		095024	B. WING _				C 1 6/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		460	REET ADDRESS, CITY, STATE, ZIP CODE 11 MARTIN LUTHER KING JR AVENUE SW ASHINGTON, DC 20032	<u> </u>	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 77	F 6	84			
		feed order every shift /hr (milliliters/hour) X (times)					
	Gastrostomy Tube (E 04/01/21 revealed mu	an with a focus area of: Enteral) Feeding dated Ultiple interventions including s the HOB elevated 45 be (enteral) feeding.					
	approximately 2:30 F (Registered Nurse) s	tated that the nursing vided care for the resident					
	<u> </u>	to assess Resident #76 's y shift, as ordered by the					
	03/27/2020 with the formal Respiratory Failure, A	Imitted to the facility on ollowing diagnoses: Anemia, Atrial Fibrillation, Colostomy Obstructive Sleep Apnea.					
	(MDS) dated 06/27/2 In Section C (Cogniti had a Brief Interview Summary Score is, " resident was mildly in Section G (Functional coded as, "total depe	assist," for dressing, toilet					
		n on 08/25/2021 at 11:08 as lying in her bed. The					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	her mattress, and se back in February of observation, there in the middle of Reservation, there in the middle of Reservation, there in the middle of Reservation, there in the middle of Reservation of Reservation (Proceedings of Reservation) and the middle of Reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress for the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the reservation (Proceedings of Reservation) and the mattress of the	it felt like there was a hole in the had reported it to the staff or March. Upon further appeared to be a raised area sident #76 's mattress. Resident #76 's clinical record 's order dated 03/28/2020 that PS (Digital Pump System) ery shift." Imment Administration Record 2021 to 08/31/2021, showed itialed the TAR twice a day ing that they had been ent's mattress. The er #27 (Registered she had not checked Resident fore today. However, she did in the resident's mattress ident complained of her nole. The employee then said in a request for another sident. The er and reposition escribed for wound prevention. The eradmitted to the facility on edical record showed the al diagnoses including accident, Dependency on	F6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COE 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	Right Calf Pressure Ulcer, Heel Pressure Ulcer, Pressure Ulcer. Revi	e 79 Jicer Unstageable Right and a Stage 2 Left Heel ew of the resident weight /02/2021 she weighed 265.9	Fé	584			
	directed, "Turn and re and as needed to pre	n 's order dated 02/26/2021 eposition every 2 hrs (hours) event pressure injury. Every Facility had 12-hour shifts)."					
	4 left ear, Stage 4 sa Unstageable right lat on 07/30/2021. The c interventions including	a of: Pressure Injury (Stage crum, Stage 2 right heel, and eral calf) with a revision date care plan outlined several ag, the resident needs total position at least every 2 need (with an					
	Set (MDS) dated 07/following: In section of this section was blan Status - Bed mobility "4" and "2" indicating dependent on the staphysical assist for be (Active Diagnoses), the Anemia, Hypertensin Cerebrovascular Accir Respirator [Ventilato Ulcer- Stage4. In section of the s						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	(X3) DATE SURVEY COMPLETED			
		095024	B. WING _				C 1 6/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032			10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 684	one (1) Unstageable Unstageable Deep	(1) Stage 4 pressure ulcer, pressure ulcer and one (1)	F6	584			
	_	and a half hours) the following					
	At 8:10 AM, Resider room, in bed, laying	at #87 was observed in her on her right side.					
	At 10:46 AM, Reside on her right side.	ent #87 remained in bed, lying					
	At 12:40 PM, Reside be lying on her right	ent #87 was observed to still side in the bed.					
		half hours of the observation, turn and reposition Resident					
	approximately 12:40 (Registered Nurse) and been turned and because the certified	stated that the resident had repositioned every two hours d nursing assistance was wn to Resident #87 's room to					
	_	failed to ensure Resident rative nursing for contracture					
		admitted to the facility on Itiple diagnoses ' that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	095024	B. WING _				C 16/2021
	REHAB NATIONAL HARBOR					10/2021
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION	SHOULD BI		(X5) COMPLETION DATE
included Cerebral Pa and Neuritis. On 08/24/2021 at ap Resident #100, was removed by staff and both Residents hand Resident# 100 's lim difficulty moving resident# 100 's lim difficulty moving resident# 100 's lim difficulty moving resident# 100's lim difficulty moving resident doubt on 06/29/202 Status) G0400, facili "1" for upper extrem impairment on one sthe resident as a "2" there is impairment of Cocupational TID Discharge Summary and 06/29/2021 for I resident #100 was to services for contract discharge from OT at During a face-to-face 08/31/2021 at 10:50 (Director of Rehabili Resident #100 is not discharged (06/29/2 program. During a face-to-face	proximately 12:30 PM observed having his mittens d the writer observed that ds were closed tightly and obs appear stiff and staff had dents arms. arterly Minimum Data Set 2021, Resident#100 received at started on 04/27/2021 and 1. In section G (Functional dty staff coded resident as a dity meaning there is side and facility staff coded for lower extremity meaning on both sides. all record revealed a derapy) Progress & dated 06/24/2021 for OT etc. which stipulated that or receive Restorative Nursing our management upon and PT case load. at interview conducted on AM with Employee #13 tation Services) she stated " a on case load and had been output for the storative nursing at interview conducted on and end of the storative nursing at interview conducted on	F	584			
	Continued From pagincluded Cerebral Paand Neuritis. On 08/24/2021 at ap Resident #100, was removed by staff and both Residents hand Resident# 100 's lim difficulty moving resident# 100 (Cocupational Timpairment on one side resident as a "2" there is impairment on the resident #100 was to services for contract documents entitled "OT (Occupational Timpischarge Summary and 06/29/2021 for Fresident #100 was to services for contract discharge from OT at During a face-to-face 08/31/2021 at 10:50 (Director of Rehabili Resident #100 is not discharged (06/29/20) program. During a face-to-face 08/31/2021 at 11:37	ROVIDER OR SUPPLIER DINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	ROVIDER OR SUPPLIER DINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 81 included Cerebral Palsy, Quadriplegia, Neuralgia and Neuritis. 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WING STREET ADDRESS, CITY, STATE, 2IP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEPICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) FROM PREFIX TAG 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 is 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) GOMO, facility staff coded resident as a "1" for upper extremity meaning there is impairment on noe side and facility staff coded the resident as a "2" for lower extremity meaning there is impairment on both sides. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		33.10.202.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 684	Continued From page not have one [Restore		F 684	1		
		to follow the physician ' s dent #372's Trough levels				
	08/10/2021, with diag Metabolic Encephalo Gastrostomy, Chronic Hypoxia, Bacteremia to inhalation of food a	dmitted to the facility on gnoses that included pathy, Tracheostomy, c Respiratory Failure with , Epilepsy, Pneumonitis due and vomit, Schizophrenia, d Restlessness and Agitation.				
	Review of Resident # showed the following	372 's physician 's orders :				
	HCI (hydrochloride) S	nycin (antibiotic medication) Solution 750 mg (milligrams) 2 hours for Bacteremia for 8				
	08/17/2021-"Hold var trough- 42"	ncomycin on 8/17. High				
		[order category-laboratory], trough daily for 3 days"				
	Review of the Medica for August 2021 reve	ation Administration Record aled the following:				
	On 08/11/2021, 08/12 08/14/2021, 08/15/20 Vancomycin HCI Soli administered twice da PM.	21 and 08/16/2021				
	On 08/17/2021, Vand	comycin HCl Solution 750				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	CON		TE SURVEY MPLETED	
		095024	B. WING _			C)/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	mg was administered 10:00 PM as ordered 10:00 PM as ordered On 08/18/2021, Vandwas held at 10:00 AM physician. On 08/18/2021 at 10: solution 750 mg was Review of the laboration reference range 10.0 the laboratory values physician was notified. There was no evident levels were drawn or (08/18/2021 and 8/19 the physician 's order 108/26/2021 at 2:52 PM Manager) acknowled trough levels were not Treatment/Svcs to Pt CFR(s): 483.25(b)(1) \$483.25(b)(1) Pressure Based on the compressional standard pressure ulcers and of ulcers unless the indidemonstrates that the	d at 10:00 AM and held at by the physician. comycin HCI Solution 750 mg as ordered by the 00 PM, Vancomycin HCI administered. cory results for 08/17/2021 in trough results 42.6 -20.0, Flag-HH (indicating are out of range) and the dat 13:52 [1:52 PM]." ce that vancomycin trough two additional days 1/2021) in accordance with res. c interview conducted on M, Employee #14 (Unit ged that three vancomycin of drawn. event/Heal Pressure Ulcer (i)(ii) grity gri	F6	86 F 686 1. Corrective action for resider Residents #87, #83, #73, #62, and #4 assessed on 9/8/2021 to ensure that a in skin condition were identified and appropriately. Resident #87 no longe the facility. Staff were educated on i and reporting changes in skin conditi	2 were ny changes treated er resides in dentifying		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION		SURVEY
			A. BUILDIN	NG		0
		095024	B. WING _			C / 16/2021
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	110/2021
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	REHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686	Continued From pag		F 6	2. Identify other residents		
		and services, consistent		Facility completed house wide skin	S	
		ndards of practice, to		assessments by 9-09-2021, going	3	
		vent infection and prevent		forward skin assessments will be		
	new ulcers from deve					
	This REQUIREMENT is not met as evidenced			performed twice a week by the Lic	ense	
	by:			Nursing staff during the residents		
	Based on observation, record reviews and staff			showers/bed baths to document an		
	_	aff failed to ensure that staff		changes in the resident's skin cond	tion.	
	resident skin condition	locumenting changes in				
		5) of five (5) residents		3. Systemic changes		
		ity as high risk for developing				
	-	pressure ulcers/injuries first		The assessments will be document		
		an advance stage (Stage 3,		stored in the departmental shower		
		eable). (Residents' #87, #83,		and the DON/Designee will audit	or	
	#73, #62, and #42)	, , ,		completion twice a week for two		
	,			months. The corporate wound nurs		
	Due to these failures	an immediate jeopardy		designee will in-serviceAll Nursing	staff	
	situation was identifie	ed on September 8, 2021 at		including registry on the process o	1	
		submitted a plan of action		reporting head and toe assessment	and	
	to the survey team o			reporting documenting changes in		
		and the plan was accepted.		residents skin condition to the Phy	sician	
		urned on September 16,		and wound team as soon as identif		
		facility's plan, and the		An in-service including a sign-in s		
		was lifted on September 16,		will be provided to track Nursing s		
	2021 at 7:52 PM. Aft			All Nursing Staff including registry		
		ient practice remained at a cope and severity was		be in-serviced on Wound Policy an		
	lowered to an H.	cope and seventy was		procedures. The Corporate wound		
	iowered to all I i.			will educate the Director of Nursin		
	The findings include:				3 011	
	o mango moiddo.			the Wound policy and procedures.		
	Review of the facility	policy entitled, "Prevention		4. Monitor corrective actions		
	=	juries" with a revision date of		4. Monitor corrective actions		
		e policy instructed staff to, "		Turning and repositioning will be m	onitored	
	Inspect the skin on			every two hours by the nursing supe		
		ng with personal care or		ensure proper turning and reposition		
		aily Living) turn and		conducted. A turning and reposition		
	reposition bedbound	resident at least every two		will be used to monitor turning and		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ULTIPLE CONSTRUCTION (X3) DATE LDING (X9) DATE COMI	
			7. BOILDING	·	С
		095024	B. WING		09/16/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BDIDGEDO	NINT SUBACUTE AND D	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGER	JINI SUBACUTE AND RI	EHAD NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 686	02/26/2021. The med resident had several of Cerebral Vascular Acc Respirator [Ventilator Gastrostomy, Obesity Ulcer, Stage 4 Left Earlight Calf Pressure Ulcer a Pressure Ulcer. Review of the Care Pl focus: "Anti-coagulandate of 11/20/2020. In inspections" Review of the medical following: -02/26/2021 Physicial reposition every 2 hrs prevent pressure injur [Facility staff worked shin assessments Q ((medical doctor/nurse abnormalities and doctor).	re-admitted to the facility on ical record showed the diagnoses including: ident, Dependency on J. Tracheostomy, v. Stage 4 Sacral Pressure ar Pressure Ulcer, Stage 4 Ulcer, Unstageable Right and a Stage 2 Left Heel an revealed the following to Therapy" with a revision intervention: " daily skin. I record revealed the in's order- Turn and is (hours) and as needed to be every day and night shift. 12-hour shifts]. In's order- Daily head to toe every) shift. Notify MD/NP is practitioner) of any cument your assessment. Scale - [Resident #87] ing that the resident was at veloping pressure	F 68	Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staf 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 staf with over3 violations will be taken off the floor immediatelyfor training and a weekly Quality Audit will be conducte 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 ensur 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 going monitoring for compliance. 5. Date correction action complete The facility's date of alleged compliance September 15, 2021.	the on-
	"Pressure (injury), Sta	age 4 (full-thickness skin ear, new, in-house acquired,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		095024	B. WING			C 09/16/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	wound measuremen (centimeters), width (undermining not app applicable, wound be exudate - light, seros Resident seen by wo assessment. Stage 4" -06/19/2021 Braden scored an "8" indicat "very high risk" for de ulcers/injuries. -07/02/2021 weight rough the continuous skin and lateral, new, in-house measurements - lengwidth 2.9 cm, depth rough not applicable, tunner bed-100% slough (a cast out from, living to Resident seen by wo assessment Noted lateral calf, unit managements are signed their in conducted head to to Resident #87 twice as Review of all progress dietary) from 04/19/206/21/2021 to 07/05/	ts - length 0.9 cm 0.9 cm, depth not applicable, licable, tunneling not ed-100% granulation, anguineous, no odor ound care staff for weekly pressure injury to left ear Scale - [Resident #87] ng that the resident was at eveloping pressure ecord: "265.9 [pounds]". Vound Evaluation - nstageable (Obscured d tissue loss), Right calf e acquired, wound outh 3.0 cm (centimeters), not applicable, undermining ling not applicable, wound mass of dead tissue in, or sissue), exudate - none ound care staff for weekly new pressure injury to right	F6	86		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIF 4601 MARTIN LUTHER KING JR A WASHINGTON, DC 20032		33,13,202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B O THE APPROPRIA	
F 686	pressure (injury) and pressure (injury) were the assessments core on 05/04/2021 and 07 were first observed at Review of the Signific Set (MDS) dated 07/following: In Section BIMS (Brief Interview Score was blank. In Section BIMS (Brief Interview Score Was Bed Interview Score Was Bed Interview Score Injury. Further review of the focus: "Pressure Injury. Further review of the Signific Interview Injury. Further review of the Signific Interview Injury. Further review of the Signific Interview Injury.	the Unstageable Right Calf e observed by staff prior to ducted by the wound team 7/06/2021 [when the wounds t an advanced stage]. cant Change Minimum Data 29/2021 revealed the C (Cognitive Patterns) the of or Mental Status) summary Section G (Functional Status esident was coded as "4" and e resident was totally aff and required one-person d mobility. In section M (Skin ent was coded for have one ulcer, one (1) Stage 4 1) unstageable pressure stageable Deep Tissue care revealed the following ry (Stage 4 left ear, Stage 4 t heel, and Unstageable right vision date of 07/30/2021. resident needs total position at least every 2	F	586		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			(3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 686	noted: -At 8:10 AM, Resider room, in bed, laying of the right side lying on her right side lying on her right side lying on her right side be lying on her right side be lying on her right side be lying on her right side lying on her right staff failed to resident daily, the facility staff identified skin condition and fa approaches identified (turn and reposition). #87 developed in-hor ear and Right Calf Lainjuries/ulcers. During a face-to-face 08/26/2021 at 12:45 (Registered Nurse) so be turned and repositioned. The CNA (coworking her way down to provide care."	at #87 was observed in her on her right side. ent #87 remained in bed, e. ent #87 was observed to still side in the bed. alf hours of the observation, eposition Resident #87. a nursing staff documented head-to-toe assessments on ere was no evidence that changes in the residents 'filed to implement do in the resident's care plan Subsequently, Resident use acquired wounds (Left exteral) Stage 4 pressure e interview conducted on PM, Employee #16 tated, "The resident should tioned every 2 hours and as ertified nurse's aide) is in to the resident's room now at Resident #87"s left calf rry/ulcer required bedside	F	686		
	to provide care." It should be noted that Stage 4 pressure injuserial excisional debi	at Resident #87"s left calf rry/ulcer required bedside ridement (the use of a vitalized [slough/necrotic]				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		PLETED
		095024	B. WING _			C / 16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		 10,2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI	(X5) COMPLETION DATE
F 686	During a face-to-face 09/08/2021 at appr Employee #2 (Direct how did residents' to advanced stages observed them, Emfor nursing staff to believe that there is When asked how consider that nursing staff at twice-a-week during. During a face-to-face 09/08/2021 at appr #15 (Registered Nursing staff at twice asked if she notice with Resident #87 in July 2021, the emp During a face-to-face approximately 5:30 Manager/RN) was	ce interview conducted on oximately 10:00 AM, ctor of Nursing) was asked wounds (pressure injuries) get is before staff (wound team) inployee #2 stated, "I'm looking have good assessment skills. I sa need for (nursing) training." Iften IS residents' skin ing staff, Employee #2 stated issess residents' skin at least go bathing times. The interview conducted on oximately 5:30 PM, Employee inselected as a head-to-toe interview conducted on oximately 5:30 PM, Employee inselected and interview conducted on oximately 5:30 PM, Employee inselected and interview on (1) to two (2) including on her workload. When indigent interview on 09/08/2021 and loyee stated, "No". The interview on 09/08/2021 at PM, Employee #14 (Unit asked how often she assess'	F 6	86		
	she is assigned a to head-to-toe assess shift. When asked i integrity issues with of May 2021 and Ju "No". 2. Resident #83 wa 07/20/2021 with dia and Chronic Respin	e employee stated that when eam, she conducts a ament of the residents every f she noticed any new skin a Resident #87 in the months ally 2021, the employee stated, as re-admitted to the facility on agnoses that included: Acute ratory Failure with Hypoxia, estrostomy, Hypertension,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE COMF	SURVEY PLETED
		095024	B. WING _				C / 16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032			10,202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
F 686	and Pressure Ulcer's According to the Adr 07/20/2021, Resider "rarely/never unders (Cognitive Patterns). Status), G0400, the dependence" on stateoilet use, and perso "Functional Limitation resident was coded and lower extremitie Conditions), the resippressure ulcer/injury pressure ulcer/injury pressure ulcer that was the facility. According to the Brate the resident was assindicating that the resident was assinded to the resident was	ffecting Right Dominant Side, Stage 4. mission MDS dated at #83 was coded as tood" under Section C Under Section G (Functional resident was coded as "total ff for bed mobility, eating	F	586			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			09/1	6/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 M	ADDRESS, CITY, STATE, ZIP CODE ARTIN LUTHER KING JR AVENUE SW IINGTON, DC 20032	<u> </u>	3/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 91	F 6	886			
	Review of the physic following:	ian's orders show the					
	(every) shift. Notify N	ad-to-toe skin assessment q /ID/NP for any abnormalities assessment two times a day"					
		and reposition every 2 hours event pressure injury"					
	Anasept wound clear Anasept wound gel o	e wound right shoulder with nser spray then apply cover with 4x4 and secure ally every night shift for te"					
	they: "performed dail assessment Q shift (MD/NP of any abnor assessment and turn	that facility staff signed that y head to toe skin twice daily), would notify malities and document the led and repositioned the burs and as needed to					
	However, review of the following:	he Skin and Wound dated 08/17/2021 showed					
	skin and tissue loss; In-house acquired; E Wound Measuremen cm x width 2.4 cm x slough- 100%,P Resident seen on wo pressure injury to right	ole: obscured full thickness 22. Location: right shoulder; xact Date- [left blank]; ats= Area-7.8 cm, length 4.3 depth not applicable rogress -NewNotes: bund rounds, noted new at shoulder, wound is 100% iwound area has intact					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
	095024	B. WING			C 09/16/2021
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REI	HAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
that they were assessing daily and turned and revery two hours. Howe developed an in-house noted at an advanced a pressure injury to his risobservation and assess. During a face-to-face in 09/08/2021 at approxime Employee #9 (Director asked how do resident injuries) evolve to an accobserved them? Employee speak to why the (pressadvanced stages. I speateam) see issues with a that over the last coupl bringing up in our Performance Meetings that nursing stresidents." 3. Resident #73 was accomply a consider the medical following: Review of the medical following:	ing in the medical recording Resident #83's skin epositioned the resident ever, Resident #83 acquired pressure injury stage (unstageable ght shoulder at the first sment). Interview conducted on mately 10:15 AM, of Wound Care) was so wounds (pressure dvanced stage before staff ever #9 stated, "I can't sure injuries) are found at eak up when we (wound a resident's skin. I know the of months, I have been entered to be a filler, and the staff is not bathing the diagnoses that included: a fillure, Anoxic Brain (sidney Disease. The resident #73 scored the staff of the staff is not bathing the	F 6	86		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		095024	B. WING			C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP 4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		09/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	
F 686	MD (medical doctor)/ 04/28/2020 [Physicial with hydroguard (skin) 04/28/2020 [Physicial reposition q (every) the state of	n Order]-"Moisturize skin n lotion) every shift" n Order]- "Turn and wo hours." n Order]- "Administer bed to resident daily and as Scale] - Resident #73 scored he resident was at "very high ressure ulcers/injuries. an Order] - "Apply skin prep Injury) left heel twice a day, any redness or drainage	F	686			
	lateral malleolus R staff for weekly asse	Wound Evaluation] -"Right esident seen by wound care ssment. New unstageable nt malleolus noted. wound is					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE	
F 686	dry eschar, with no re edges" Review of all progres physician, dietary) fro lacked documented as Stage 4 Left Malled Unstageable Right Mobserved by staff pricassessment on 08/18 Review of the Treatme (TAR) from 08/01/20 that facility staff docureceived a bed or spobilateral heels were cat night, skin was moverning and night shand repositioned ever 2:00 AM, 4:00 AM, 6:12:00 PM, 2:00 PM, and 10:00 PM. Review of Resident #Living (ADL) Notes 10/08/18/2021 revealed "No" to the question skin condition?" Review of the Admiss revealed that facility in Section G (Function total dependence to assist"	edness or drainage noted at as notes (such as, nursing, om 07/01/2020 to 08/17/2020 evidence that Resident #73 blus pressure injury and the dalleolus pressure injury was or to the wound team 's 8/2020. The Administration Record 20 to 08/18/2020 revealed amented that Resident #73; onge during the day shift, off loaded during the day and disturized during the day, ifts, and was being turned ary two hours at 12:00 AM, 00 AM, 8:00 AM, 10:00 AM, 4:00 PM, 6:00 PM, 8:00 PM	F	686			
	continence bowel incontinent"						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE : COMP	SURVEY LETED
		095024	B. WING _			09/·) 16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	n should be E appropria		(X5) COMPLETION DATE
F 686	pressure ulcersye pressure ulcer/injury prominence, or a nono", "is this re pressure ulcers/injur esident have one of ulcers/injuries? no Review of the Care Focus: "Activities of Performance Deficit several intervention bath when a full bat toleratedbed mobidependent on staff fibed every 2 hour." Focus: "Alteration in 03/12/2020 revealed including " skin instindings to the nurse Although the facility identified in the resi reposition and inspersed that the stage 4 Left Malleo Unstageable Right 108/18/2020. During a face-to-fact 09/08/2021 at approximation in the resi reposition and inspersed that the stage 4 Left Malleo Unstageable Right 108/18/2020.	Conditions), " risk of es"; " resident has a y, a scar over bony n-removable dressing/ device esident at risk of developing ries? yes", " does this or more unhealed pressure." Plan revealed the following: Daily Living Self-care dated 03/11/2020 revealed including, "provide sponge h or shower cannot be sility, and the resident is totally or repositioning and turning in a Neurological Status" dated diseveral interventions spections daily and report any	F	586			
	During a face-to-fac 09/08/2021 at appro Employee #9 (Direc "The wound team hamultiple times on as	oximately at 9:35 AM, tor of Wound Care) stated,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING			(X3) DATE SURVEY COMPLETED			
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 686	issue of the nursing making the wound to an early stage to the Nursing and the Adm 4. Resident #62 was 07/31/2021. The me resident had several Dependency on Res Tracheostomy, Diab Malnutrition, Stage 4 Stage 4 Scapula Pre Trochanter Pressure Pressure Ulcer, Left Surgical Sacral Wound During an observation 12:12 PM, the wound care for Resident #6 left leg, back and sac Review of the medicate following: 05/07/2021 [Braden a "10" indicating that high risk" for develop 05/08/2021 [Physicia reposition every 2hrs help prevent pressure 05/08/2021 at 4:15 A Summary Note) - "Resident has a sac (centimeters) X 5(cm amount of serosa (serosa sac serosa serosa serosa sac serosa	staff not documenting or am aware of skin issues at attention of the Director of ninistrator." re-admitted to the facility on dical record showed the diagnoses including: pirator [Ventilator], etes Mellitus, Protein-Calorie Left Calf Pressure Ulcer, essure Ulcer, Stage 4 Left Ulcer, Stage 3 Left Heel Foot Deep Tissue Injury, and and. on on 08/24/2021 starting at dicare team provided wound 2's wounds for the left hip, crum. all record revealed the Scale] - Resident #62 scored of the resident was at "very bing pressure ulcers/injuries. an Order] - Turn and control of the component of the com	F	586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODI 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	scattered wound. Mullower extremities. Oldabdomen." 05/09/2021 at 2:16 A "Resident alert and rereadmissionskin wand wound cares (spreposition (sp) every prevent pressure ulcomobility of the control of the contro	Itiple scars noted to bilateral disurgical sites to chest and M (Nursing Progress Note)-esponsive, 2nd day of arm and dry to touchADL provided turn (sp) and two hours and as needed to er" M (Nursing Progress Note) - I responsive, skin warm and are provided, turning, and wo hours as needed to er (sp)" (Skin & Wound Evaluation)-red, Left calf, Stage 3 less), pressure (injury), length width 2.7 cm, depth 0.1 cm, icable, tunneling not did 100% granulation -pink or repurulent" ent Administration Records did the following: their initials indicating that repositioned Resident #62 05/08/2021 to 05/10/2021. Ilans revealed the following:	F	586		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED			
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Review of the Minim 04/21/2021 revealed Patterns), Brief Intersummary score was (Functional Status - was coded as a "4" was totally depende section was left blan Condition), the resid (4) Stage 3 pressure pressure ulcers, one ulcer and one (1) un Injury. Although the facility identified in the resided in the resided eveloped in-house Stage 3 pressure injure-admission date of During a face-to-face approximately 10:30 Team Nurse) stated assessed Resident in-house acquired Sthe resident 's left composition's left composition of Wound Care) was wounds (pressure in stage before staff of stated, "I can't speal injuries) are found a up when we (wound resident's skin. I knownths, I have been	um Data Set dated I, In section C (Cognitive view for Mental Status blank. In section G Bed mobility) the resident indicating that the resident into on the staff. The support k. In section M (Skin ent was coded to having four e ulcers, three (3) Stage 4 (1) unstageable pressure stageable Deep Tissue implemented approaches dent care plan (turn and uently, Resident #62 acquired wound (Left Calf) tury within 48 hours of his fo5/08/2021. ie interview on 09/08/2021 at AM, Employee #10 (Wound that on 05/10/2021 she #62 's skin and observed an tage #3 pressure injury on alf. ie interview on 09/08/2021 at AM, Employee #9 (Director asked how do residents' juries) evolve to an advanced served them? Employee #9 (a to why the (pressure advanced stages. I speak team) see issues with a withat over the last couple of	F6	86		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		095024	B. WING _				C 1 6/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B E APPROPRIA		(X5) COMPLETION DATE
F 686	09/12/2020 with diag and Chronic Respira Mellitus, Tracheosto Hypertension, Contre Elbow), and Pressure According to the Qui 06/30/2021 the residerarely/never unders (Cognitive Patterns) Status), G0400, the dependence" on stationariation in Range coded for "impairmed extremities". Section resident was coded and one (1) unhealed According to the Bracessed and score was "very high risk" 04/03/2021 and was "10" indicating "high 07/03/2021. Review of the care prevaled the following needs assistance to	esidents." The re-admitted to the facility on gnoses that included Acute atory Failure, Type 2 Diabetes army, Gastrostomy, actures (Right and Left re Ulcer Left Heel Stage 4. The under Section C grace and a stood" under Section C grace and section and resident was coded as "total for bed mobility, eating, and hygiene; Functional of Motion the resident was at risk for pressure ulcers and pressure ulcers are at risk for pressure ulcers and at a "9" indicating that she for skin breakdown on assessed and scored at a risk" for skin breakdown on the scale, Resident #42 was a strick for skin breakdown on the scale and scored at a risk" for skin breakdown on the scale and scored at a risk" for skin breakdown on the scale and scored at a risk" for skin breakdown on the scale and scored at a risk" for skin breakdown on the scale and scored at a risk" for skin breakdown on the scale and scored at a risk for skin breakdown on the	F	586			
	dated 07/23/2021, "policies/protocols fo skin breakdown" init	r the prevention/treatment of					

PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	C 09/16/2021
STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	33/13/2321
,	
	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		095024	B. WING _				C 16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		00/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 686	wound filled; exudat Notes: Resident see noted development lateral malleolus (sp thickness with palpa description and pictu" Facility staff were s wound treatments to daily, were assessin floated the resident turned and repositio hours. However, Rein-house acquired p advanced stage (state Lateral Malleolus During a face-to-face 09/08/2021 at approximately approximately evolve to an observed them? Emspeak to why the (produced stages. I steam) see issues withat over the last cobringing up in our Polymeters."	igning that they: conducted of the residents left heel twice go the resident skin daily, and need the resident #42 developed an areasure injury noted at an age 4 pressure ulcer to the eis).	F	886			
	was identified.	ediate jeopardy (IJ) situation 21 at 7:31 PM, the facility's					
	on september 6, 20	Z rac r.o r r w, the lacility S					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CC 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		09/10/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	administrator provide the State Agency Sur "1. Facility will complassessments by 9-0s assessments will be the License Nursing showers to documen 's skin condition. The documented and sto shower books and the for completion twice corporate wound nur All Nursing staff inclusof reporting head and reporting documentirs skin condition to the as soon as identified sign-in sheet will be staff. 2. All Nursing Staff in in-serviced on Wound The Corporate woun Director of Nursing or procedures. 3. Turning and repose every two hours by the ensure proper turning conducted. A turning be used to monitor to Wounds found during RCA (Root Cause An Nursing staff response documenting skin as turning and reposition as turning and reposition as turning and reposition in the staff of the staff o	ete house wide skins 0-2021, going forward skin performed twice a week by staff during the resident 's t any changes in the resident e assessments will be red in the departmental e DON/Designee will audit a week for two months. The se or designee will in-service iding registry on the process d toe assessment and ng changes in resident 's Physician and wound team . An in-service including a provided to track Nursing cluding registry will be d Policy and procedures. d nurse will educate the n the Wound policy and itioning will be monitored the nursing supervisor to g and reposition audit tool will arning and reposition. g the skin assessments a alaysis) to investigate the sible for not properly sessments, and conducting	F	586		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 686 F 688 SS=D	Nursing and Nursing violation card" will be any staff found not do repositioning of resid 3 violations will be talfor training and a west conducted by the QA addressed at the west months. 5. QA Audits of skin and done weekly for two assessments will be and appropriately. The Administrator, Director Director and addressed meetings. All Items to 9-15-2021." The State Agency Suffacility and verified the immediate jeopar Increase/Prevent Dec CFR(s): 483.25(c)(1) The far resident who enters to range of motion does range of motion demonstration of motion is unavoidal \$483.25(c)(2) A resident motion receives appropriately.	Supervisors. A "skin tag implemented to address bing proper turning and ents. Nursing staff with over ken off the floor immediately ekly Quality Audit will be a PI team. All finding will be ekly QAPI meeting for two sesessment documentation months to ensure skin completed to ensure timely his will be monitored by the for of Nursing and the Quality and in the weekly QAPI be completed by Arvey team returned to the at the plan of correction was fer 16, 2021 at 7:52 PM, and dry was removed. Crease in ROM/Mobility—(3) cility must ensure that a the facility without limited anot experience reduction in ses the resident's clinical tes that a reduction in range	F 68	F 688	ducted chotics on the ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		095024	B. WING _		09	/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
				4601 MARTIN LUTHER KING JR AVENUE	SW		
BRIDGEP	DINT SUBACUTE AND	REHAB NATIONAL HARBOR		WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
				3 Systemic changes			
F 688	§483.25(c)(3) A resi receives appropriate assistance to mainta the maximum practi reduction in mobility This REQUIREMEN by: Based on observati interview for one (1) facility staff failed to orthotics to prevent and mobility. Resident mand mobility. Resident #48 was a 04/19/2019, with mu Paraplegia, Muscle Spasm, Pain Unsper Respiratory Failure. Resident #48 was of approximately 9:05 Employee #43 (Lice was noted that Resiculasped in a fist like were stiff and difficulate Review of Resident Data Set (MDS) dat Section C (Cognitive coded resident as a "rarely/never unders (Functional Status) resident a "4" for beis totally dependent	ident with limited mobility e services, equipment, and ain or improve mobility with cable independence unless a is demonstrably unavoidable. IT is not met as evidenced ion, record review and staff of 44, sampled residents, implement the use of decrease in range of motion ent #48 c: dmitted to the facility on altiple diagnoses including: Weakness, Other Muscle ecified, Aphasia and abserved on 08/23/2021 at AM receiving care from ensed Practical Nurse) and it dent #48's hands were tightly position and residents arms alt for staff to move. #48's Quarterly Minimum ed 06/13/2021, revealed: In the Patterns) C0100 facility staff "0" meaning resident is estood". In Section G G0110 facility staff coded and mobility meaning resident on staff to perform this	F 6	3. Systemic changes Nursing and Administrative stafeducated on the importance of eresidents receive appropriate res. The Director of Rehabilitation wresponsible for maintaining the program with assistance from the Nursing. The IDT team will refet therapy for the restorative program. 4. Monitor corrective active active the Director of Rehabilitation/Ecomplete weekly audits of 10% ensure that ordered orthotics are appropriately. The results will be the QAPI Committee monthly a review and recommendations. The QAPI Committee is responsing going monitoring for compliance. 5. Date correction action of The facility's date of alleged con November 2, 2021.	nsuring that storative care. vill be restorative end prector of er residents to am as needed. Ons Designee will residents to being used be reported to 3 months for sible for the onee.		
		during a seven day period. In all Limitation Range of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SE COMPLETION
F 688	"0" for Upper extremi and coded resident a meaning impairment (Special Treatments, Programs), under "Refor "Range of Motion (active) and Splint Br coded all three as "0" not performed. Review of the Comprevealed with a focus name] has limited ph Contractures of the brevised on 02/07/201 including: "Apply roll times remove every 2 check" Review of nursing producing a face-to-face 11:30 AM, Employee Rehabilitation) stated that applies rolled tow During a face-to-face 11:37 AM, Employee	y staff coded resident as a ty meaning no impairment "2" for lower extremity to both sides. In Section O Procedures, and estorative nursing programs" (passive), Range of motion ace assistance", facility staff meaning the activities were rehensive Care Plan area of: "[Resident ' s ysical mobility r/t (related to) ilateral hand and legs" 9 had multiple interventions towel to bilateral hands at all 2 hours for hygiene and skin orgress noted and Treatment d dated from 07/01/2021 to ocumented evidence that towel to both hands the	F 68	8	
	Nursing]."	rds/Supervision/Devices	F 68	9	

		(X3) DATE S COMPL				
		095024	B. WING		09/1	; 6/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
				F 689	1	1/02/2021
F 689	Continued From page	e 106	F 68	1. Corrective action for resident		
	§483.25(d) Accidents	3.				
	The facility must ensu			Resident #93 was educated on signing o		
				leaving the facility. The heater was rem		
	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			from room 335. The resident was educa such devices are a safety hazard and not		
	§483.25(d)(2)Each re	esident receives adequate		permitted.		
		stance devices to prevent		2. Identify other residents		
	This REQUIREMENT	Γ is not met as evidenced				
by: An audit		An audit of other resident LOAs was co	mpleted.			
	•	n and record review for one		An audit of resident rooms did not yield	any	
		sidents, facility staff failed to		additional heaters. There were no additi	ional	
		pervision to monitor the		findings related to this citation.		
		t in and out of the facility for				
		t the facility without the staff		3. Systemic changes		
		ty staff failed to provide an				
		n accident hazards as		Nursing and security staff have been edu	ucated	
		ble space heater that was		on the importance of ensuring that resid	ents are	
	seen in one (1) of 76			signed out appropriately and accounted	for and	
				no heaters are present. Nursing staff ha	ve been	
	The findings include:			educated on the importance of accurate		
	J			documentation and validation of residen	ıt	
	1.Resident #93 was a	admitted to the facility on		whereabouts throughout the shift. The I	Director	
	01/07/2021 with diag	-		of Security will be responsible for ensur	ing that	
		r End of Right Tibia, Anemia,		residents are engaged upon exit of the fa	acility to	
	Unsteadiness on Fee			ensure that they have notified nursing st	aff of	
		der, and Bipolar Type.		their whereabouts.		
		arterly Minimum Data Set 021 the resident's Brief		4. Monitor corrective actions		
		Status (BIMS) Score was		The Director of Nursing/Designee will of	complete	
		ne resident was cognitively		weekly audits of all residents who go ou		
		Functional Status), the		LOAs to ensure that their absence and re		
		as requiring supervision and		documentation is accurate. The Engineer		
		ed mobility; he was coded as		department will audit 25% of resident's		
		ferring, eating, toilet use,		monthly for unauthorized appliances. T		
		d dressing. He required set		results will be reported to the QAPI Cor		
		h dressing, eating and		monthly x 3 months for review and	minuce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		095024	B. WING		09/16	6/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEP	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 689	having impairment to both sides and was conformobility. Review of the progress 08/30/2021 at 4:28 A round, resident was rounded that the did not sign himself or room untouched. Us another floor to visit, medication pass, resident was number showed up would responsible party) work message left on the atto call the unit, super was on the floor to as of phone calls was monther without success, 08/30/2021 at 6:46 A writer at 06:00 that the back to the facility. Reference of the did not [have] times supervisor made awas to [assess] the situation instead asking for his will continue to monition. Review of the security 08/31/2021 at 4:18 Please of the security of the security of the security of the security 08/31/2021 at 4:18 Please of the security of the securi	e resident was coded as his lower extremities on oded as using a wheelchair as notes showed: M "Upon change of shift not in his room, off going resident is in the facility and out, his dinner tray was in the ually resident goes to but up to the end of the dent did not come back to so call on his cell phone, the grong number, R/R as also called no answer, answering service for them wisor made aware and she assessed the situation, couple adde to his family member by resident still out at this time." M "Security informed this e resident had just returned esident arrived on the unit at he had a family emergency came and took him home at (Sunday, 8/29/21) and that the time to sign himself out, are and she was on the unit on, refused to be assess a sleeping medication, staff or the resident status."	F 68	recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance November 2, 2021.	red	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		03/10/2021		
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	Review of the Treat for 08/29/2021 show they were turning, an every two hours as 18:00 PM (0000, 0200 1200, 1400, 1600, 1500 During a face-to-faction 08/31/2021 at 100 fault." And made not review of the clinical documenting that the Resident #93 on 08/8:00 PM. However, facility. The facility's resident did not eat 1 check/verify Resident building. Subsequently, the rebuilding for approximal facility staff discover longer present in the search for him. During a face-to-face 8:45 AM, Employee documentation and in the findings. 2. Facility staff failed free from accident him portable space heater (1) of 76 resident's reduction and walkthrough a walkthr	ment Administration Record as that facility staff signed that and repositioning Resident #93 aneeded from 12:00 AM to 0, 0400, 0600, 0800, 1000, 800, 2000). The interview with Resident #93 and AM he stated, "It was my a other statements. The record, facility staff were an ey were providing care to 129/2021 from 1:00 PM to a the resident was not in the astaff noticed that the and dinner, but they failed to an the yas's location in the antely seven (7) hours before and that the resident was no are building and began to The interview on 09/01/2021 at a the reviewed the anade no comments on about The to provide an environment azards as evidenced by a are that was observed in one a comments.	F	589				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		LETED
		095024	B. WING		09/	C 16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 691 SS=D	resident room #335 [west. The space hea electrical outlet, read Employee #1 (Admir findings during a face 09/01/2021, at appro Colostomy, Urostomy CFR(s): 483.25(f) §483.25(f) Colostomy care. The facility must ens require colostomy, ur services, receive suc professional standard comprehensive perso the resident's goals a This REQUIREMENT by: Based on observatio and staff interview, for residents, facility staf #76's colostomy bag the abdomen that co digestive tract throug abdominal wall called full, in accordance wi professional scope a The findings include: According to The Am Society,"Change th to avoid leaks and sk have a regular sched	r was stored on the floor in private room] on the unit 3 ter was plugged in an y for use. Inistrator) acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, or ileostomy Care Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistrator, acknowledged the e-to-face interview on ximately 4:00 PM. Inistra	F 68	F 691 1. Corrective action for resident Resident #76's colostomy was changed/ at the time of the observation. Resident having her colostomy bag changed/emp' prescribed and as needed. 2. Identify other residents An audit of other residents with coloston not reveal any other residents that were. There were no additional findings relate citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that resident's colostomy bags are being emptied/chang prescribed. The Director of Nursing wil responsible for ensuring that residents as having their colostomy bags emptied/cle regularly.	demptied #76 is tied as mies did affected. d to this ged as II be re	11/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095024	B. WING			C 09/16/2021	
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE S WASHINGTON, DC 20032	SW SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 691	in the day. It's easies system during these early morning before https://www.cancer.coside-effects/treatment ostomy/management Resident #76 was accomy/management Resident #76 was accomy/management Resident #76 was accomply grant of the Quarter (MDS) dated 06/29/2 coded Resident #76 In Section C (Cognitian Brief Interview for Summary Score of Cognitively impaired. Status), facility staff staff for dressing, to hygiene and require assist. In Section H Appliance, facility staff staff for dressing, to hygiene and require assist. In Section H Appliance, facility staff staff for dressing, to hygiene and require assist. In Section H Appliance, facility staff staff for dressing, to hygiene and require assist. In Section H Appliance, facility staff in the colostomy buring an observation 08/23/2021 at 6:5 that two days ago should be accompleted because metals. I'm afraid to lead activities because metals and the colostomy bag) gleak. I'm afraid to lead activities because metals and the colostomy bag of the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy because metals and the colostomy bag of leak. I'm afraid to lead activities because metals and the colostomy because metals and the colosto	owel activity at certain times at to change the pouching times. You may find that you eat or drink is best" org/treatment/treatments-and-in-types/surgery/ostomies/col t.html dmitted to the facility on tiple diagnoses including: sophageal Reflux Disease alized Muscle Weakness. orly Minimum Data Set 2021 revealed the facility staff as followed: ve Patterns) the resident had Mental Status (BIMS) 12" indicating she is mildly In Section G (Functional coded "totally dependent on let use, and personal ad "one-person physical (Bowel and Bladder),	F 6	4. Monitor corrective action The Director of Nursing/Designe weekly audits of residents with consure that they are being emptie prescribed and as needed. The reservoired to the QAPI Committee months for review and recommer The QAPI Committee is responsing going monitoring for compliance 5. Date correction action of the facility's date of alleged commonwealth November 2, 2021.	e will compolostomies to deleaned as esults will be monthly x 3 additions.	0 6 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION (X3) D. BUILDING		
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 691	On further observation pressed the call light colostomy bag is full 7:05 AM (11 minutes (Registered Nurse) of the resident wanted. Employee #44 that sl bag changed. Employ resident and surveyo (colostomy) because scissors, they were on now they are not." Er resident's room and contains the colostomy of the colo	n, at 6:54 AM, Resident #76 in order to tell the nurse her and in need of changing. At later), Employee #44 ame in the room to see what Resident #76 stated to the needed her colostomy yee #44 then stated to the r,"I did not change the bag I was looking for my in the medication cart and inployee #44 then left the came back at 7:15 AM to bag. Employee #44 pulled sess the colostomy bag and	F 6	91		
F 692 SS=D	the necessary care a #76 when her colosto of changing. Nutrition/Hydration St CFR(s): 483.25(g)(1) §483.25(g) Assisted (Includes naso-gastri both percutaneous endosc enteral fluids). Based comprehensive assesensure that a resident §483.25(g)(1) Maintal	nutrition and hydration. c and gastrostomy tubes, doscopic gastrostomy and copic jejunostomy, and on a resident's esment, the facility must	F6	1. Corrective action for resident Residents #37 and #95 have been weightheir physician's orders. 2. Identify other residents An audit of other residents with orders weights has be completed and all reside been weighed and their weights docum verified. There were no additional find related to this citation.	for ents have ented and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
		EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	33/13/2321	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 692	desirable body weigh balance, unless the redemonstrates that this preferences indicate of \$483.25(g)(2) Is offer maintain proper hydrates \$483.25(g)(3) Is offer there is a nutritional provider orders a their This REQUIREMENT by: Based on observation (2) of 44 sampled resweigh a resident ever verify accurate weigh Residents' #37 and # The findings include: Review of the facility's and Documentation in the objective (not opinion complete, and accurate the complete of the c	trange and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care rapeutic diet. is not met as evidenced and record review, for two idents, facility staff failed to ry 30 days as ordered and its were being obtained. spolicy entitled, "Charting revised 07/2017, revealed," he medical record will be ated or speculative), ite" so weigh Resident #37 every by the physician. admitted to the facility on rid showed resident had the Anemia, Hypertension, perlipidemia, Cerebral A), Hemiplegia, Seizure	F 692	Nursing staff and the Dietician have bee educated on the importance of ensuring residents are weighed and weights documer physician orders. The Dietician will responsible for ensuring that residents at weighed and weights documented and weighted and residents with orders to be weighted to a light residents with orders to be weighted and verified. The results were ported to the QAPI Committee monthly months for review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	that mented be re erified. eekly veighed rill be y x 3 s. the on-	
	Vascular Accident (CV Disorder, Depression Paranoid Personality	, Schizophrenia, and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		33,13,22
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA	
F 692	(MDS) dated 08/12 In Section C (Cogn had a Brief Intervie Summary Score of cognition. In Section Resident #37 was cone-person physical use, and personal Interview of the clinical following: 09/08/2020 at 10:00-"Weekly weight on 07/13/2021 at 11:31 167.2 lbs. (pounds) Review of the nursing Treatment Administration 07/14/2021 to documented evider Resident #37 weekly buring a face-to-fact 12:15 PM, Employed Manager) stated the documented in the 2. Facility staff failed were being documented for Gast Respiratory Failure,	arterly Minimum Data Set //2021 revealed the following: itive Patterns), Resident #37 w for Mental Status (BIMS) "15", indicating intact n G (Functional Status), coded as, "total dependence, al assist," for dressing, toilet hygiene. D AM [physician order] e time a day every Tuesday." AM - recorded weight of Ing progress notes and the ration Record (TAR) dated 08/31/2021 lacked nee that facility staff weighed	F6	592		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021	
(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 CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 692	revealed that facility In Section C (Cogniti was coded as being impaired. In Section resident was coded to calorie)" Review of the physical colories of the care particles of the physical colories of the	staff coded the following: ve Patterns), the resident severely cognitively I (Active Diagnoses), the for "Malnutrition (protein, dian's orders revealed: consult as needed" weight one time a day and ending on the 3rd every documented weights for ed: bs (pounds), 05/12/2021 21 129.0 Lbs, 05/21/2021 21 156.4 Lbs, 06/10/2021 21 146.2 Lbs". lan with a focus area of: as nutritional problem" with a 6/2021 revealed the following nitor/record/report to MD N (as needed) s/sx (signs alnutrition significant	F	592			

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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			095024	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 692 F 692 F 693			EHAB NATIONAL HARBOR	4	601 MARTIN LUTHER KING JR AVENUE SW	03/10/2021	
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.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION	
Respiratory/Tracheostomy Care and Suctioning SS=E 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 1. Corrective action for resident Resident #21 currently has an order for oxygen that matches his oxygen delivery. 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.	F 695	PO (by mouth) inta (percutaneous endose PO intake: 50-100° assistance with meals weight): 150.6 (pound Will continue to monit tolerance, weights Although Employee # reviewed and recorded the residents nutrition evidence that she revidence that the weight [2021] were not accurate that the weight [2021] were not accurate Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirato tracheostomy care and tracheal succare, consistent with practice, the compression and 483.65 of this sull This REQUIREMENT by: Based on observatio resident interview, for resident interview, for	ke S/p (status post) PEG copic gastrostomy) removal % of meals - requires s Current BW (body ds) - 6/10, 156 (pounds) or PO intake/TF (tube feed) 28 (Registered Dietician) d clinical notes regarding hal status, there was no riewed the weights to acy or if the resident at weight loss. Interview conducted on AM, when asked about the cumented on 05/12/2021, 1/2021, Employee #28 as on those days in May rate. Istomy Care and Suctioning and tracheal suctioning. The cord review staff and a one (1) of 44 sampled,		F 695 1. Corrective action for resident Resident #21 currently has an order for of that matches his oxygen delivery. 2. Identify other residents An audit of other residents on oxygen direveal any other residents that were missorders. There were no additional finding	d not sing	

F 695 Continued From page care consistent with the practice as evidenced (1) resident receiving physician's orders to to be delivered to the The findings include: Resident #21 was rea 06/29/2021, with multing Respiratory Failure, E Tracheostomy and Design Review of the Admission revealed that facility so In Section I (Active Discontinued).	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	S	С
		095024	B. WING		09/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021
DDID 0 ED 0	NINT OUD A QUITE AND D	FUAD MATIONAL MADDOD		4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEP	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032	
PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	BE COMPLETION
				3. Systemic changes	
F 695	N. I.D.				
	practice as evidenced (1) resident receiving physician's orders to to be delivered to the	direct the amount of oxygen resident. Resident #21.		Nursing and Respiratory Therapy staff been educated on the importance of ensthat residents have oxygen orders that corresponds with what they are receiving Director of Nursing will be responsible ensuring that residents have orders for a modalities received.	uring ag. The for
	06/29/2021, with multi Respiratory Failure, E Tracheostomy and D Review of the Admiss revealed that facility s In Section I (Active D supplemental oxygen	admitted to the facility on tiple diagnoses that included: Encounter for Attention to egenerative Joint Disease. sion MDS dated 07/07/2021 staff coded the following: diagnoses), "dependence in". In Section O (Special ares and Programs), Oxygen,		4. Monitor corrective actions The Director of Nursing/Designee will weekly audits of residents on oxygen to that they have orders that match what the receiving. The results will be reported QAPI Committee monthly x 3 months are review and recommendations. The QAPI Committee is responsible for going monitoring for compliance.	ensure ney are to the For
	"Yes".	approximately 09:45 AM the ed in bed with a		5. Date correction action comple The facility's date of alleged compliance November 2, 2021.	
	documented evidence to specify how much required to be on.	ian's orders revealed no e of oxygen orders in place oxygen Resident #21 was e interview conducted on M, Employee #26			
F 697 SS=E	(Respiratory Therapis #21] should have an the pulmonologist no	st) stated, "He [Resident oxygen order. I will message	F 69	07	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		095024	B. WING _				C 1 6/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2021
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR			601 MARTIN LUTHER KING JR AVENUE SW VASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	§483.25(k) Pain Man The facility must ens provided to residents consistent with profes the comprehensive p and the residents' go This REQUIREMENT by: Based on record rev two (2) of 44 sample failed to accurately re resident pain after ac medication. Resident The findings include: Review of the facility Assessment and Mar 2015, documented: "Assessing Pain 1. During the compre [staff is to] gather the indicated from the re representative): a. History of pain (as standardized pain so b. Characteristics of p (1) Intensity of pain (s standardized pain so (2) Descriptors of pair (3) Pattern of pain (e (4) Location and radi (5) Frequency, timing c. Impact of pain on c	agement. ure that pain management is a who require such services, asional standards of practice, erson-centered care plan, als and preferences. T is not met as evidenced iew and staff interview for diresidents, facility staff eassess and evaluate the diministering her pain as #56 and #87. Is policy entitled: "Pain magement" revised March thensive pain assessment efollowing information as sident (or legal a measured on a ale); pain: as measured on a ale); pain:	F	697	1. Corrective action for resident Resident #56 is currently out of the facil upon readmission the resident's orders f medication will be reviewed to ensure of indicators for administration. The reside also be assessed pre/post medication del Resident #87 no longer resides in the face 2. Identify other residents An audit of other residents with orders f medications was completed and resident assessed for indications and effectivenes. There were no additional findings relate citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are pain medication as ordered and assessed indications and effectiveness of pain me and administration as prescribed prior to care treatments. The Director of Nursin responsible for ensuring that residents are assessed for effectiveness of pain medic 4. Monitor corrective actions The Director of Nursing/Designee will comp weekly audits of 10% of residents receiv medication to ensure that the medication given per physician orders and has been effective. The results will be reported to QAPI Committee monthly x 3 months for review and recommendations.	or pain lear ent will ivery. cility. or pain es were es. d to this e given for dication o wound g will be reation.	
	c. Impact of pain on o	·			review and recommendations.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		SURVEY PLETED
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		095024	B. WING _			/16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2021
				4601 MARTIN LUTHER KING JR AVENUE S	sw .	
BRIDGEPO	DINI SUBACUTE AND	REHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
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				The QAPI Committee is responsi		
F 697	F 697 Continued From page 118		F6	going monitoring for compliance.		
	e. Factors and strategies to reduce pain; and f. Symptoms that accompany pain (e.g., nausea, anxiety)			5. Date correction action co	ompleted	
	anxiety)			The facility's date of alleged com	pliance is	
	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."			November 2, 2021.	phance is	
According to the factoring Management policy		cility's Pain Assessment and last reviewed May 2016 the as follows: 0= none; 1-3= , 7-10=severe				
	<u> </u>	d to reassess Resident #56's administration of ordered pain				
	06/01/2021 with the Dependence, Periph Diabetes Mellitus, A Foot, Cirrhosis, Chr Viral Hepatitis C, an	•				
		t #56's clinical record				

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	095024	B. WING _				
ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032	sw	33,13,2021	
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE		N
revealed the following of the following	In physician's orders: In ment every shift and prn (as Idone (opioid pain reliever) Itablet 5 mg (milligram), "Inouth every 12 hours as (Moderate)." In adol (opioid pain reliever) Isive 1 tablet by mouth every 6 In pain Itablet by mouth two times Itablet by mouth every 6 Itallet by mo	F 6	97			
pain level 0/10	-					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENC REGULATORY OF Continued From page revealed the following 06/01/2021 "Methad HCL (hydrochloride) Give one tablet by medded for Pain 4-6 07/08/2021 for Tram HCL tablet 50 mg" Generated for 09/02/2021 for Oxyo HCL tablet 5 mg Give a day for pain Review of the Medic for September 2021 On 08/12/2021 and Generated for the medded for the medded for the medical form of	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 119 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 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for	ROVIDER OR SUPPLIER DINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 119 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	ROWIDER OR SUPPLIER DINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 119 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 on tablet by mouth every 12 hours as needed for pain 09/02/2021 for Tramadol (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 3 out of 10 and 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 facility staff administered made 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	A BUILDING B. WIND STREET ADDRESS, CITY, STATE, 2P CODE 4601 MARTIN LUTHER KING. JR AVENUE SW WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY WISE TE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 119 revealed the following physician's orders: 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 09/02/2021 for Tramadol (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 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 5 out of 10. The tramadol was administered approximately 3 hours apart, however the physician's order dated 07/08/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 0/10 On 09/11/2021 and 09/12/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 0/10	OSONECTION DESCRIPTION DESCRIPTION NUMBER: 095024 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 409 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032 SUMMARY STATEMENT OF DEPOIENCES EACH DEPOIENCY MUST BE PRECIDED BY PUIL REGULATORY OR LISC DEPHTPHING INFORMATION) Continued From page 119 revealed the following physician's orders: 06/01/2021 "Methadone (opicid 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 Tranadol (opicid 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 08/11/2021 facility 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 to 10 for 10. On 09/11/2021 facility staff administered Tramadol at 9:17 AM for a pain level of 5 out of 10. The tramadol was administered Tramadol was administered paproximately 3 hours again thowever the physician's order dated 07/08/2021 tincets 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 01 out of 0. On 09/11/2021 and 09/12/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 01 to thou seem to the control of the co

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		
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F 697	9:45 AM for a pain I Continued review of Administration Recordshowed Resident #15 mg every 12 hourn however there were listed to direct staff Tramadol 50 mg, are example for mild, more applied to the staff Tramadol 50 mg, are example for mild, more applied to the staff Tramadol 50 mg, are example for mild, more applied to the staff performed a production of the painth of the performed before administered to resident painth of the pa	evel 5 out of 10 and again at evel of 4 out of 10. If the Medication ord for September 2021 If was to receive Methadone is for pain 4-6 (moderate); in no pain level parameters when to administer the ind Oxycodone 5 mg, for oderate or severe pain. It is sident #56's Medication is sident #56's Medication in August and September ented evidence that facility is pain assessment to in medication administered to rective and what was the	F	697		
	medication for Resident	dent #87 prior to providing				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	wound care. Resident #87 was re 02/26/2021. The meresident had several Cerebral Vascular Ac Respirator [Ventilato Gastrostomy, Obesit Ulcer, Stage 4 Left E Right Calf Pressure Heel Pressure Ulcer. During an observation approximately 11:20 (Registered Nurse) was to Resident #87 via to tube. When asked wadministering, the eradministering pain in provides wound care. Observation of the reher right leg and sacclean, dry and intact signed and dated by Team Nurse) "08/24/indicating that wound care to the residual	e-admitted to the facility on dical record showed the diagnoses including cident, Dependency on r], Tracheostomy, y, Stage 4 Sacral Pressure ar Pressure Ulcer, Stage 4 Ulcer Unstageable Right, and a Stage 2 Left Heel on on 08/24/2021 at AM, Employee #16 vas administering medication the resident's gastrostomy hat medication she was inployee stated that she was included in the resident. esident's wound dressings to ral area revealed they were in the dressings were also in Employee #10 (Wound 1/2021 at 7:00 am to 7:00 PM" in the care had been provided attion of the pain medications	F	697		
	5-325 milligram (Hyo give 1 tablet via PEG	(opioid pain reliever) Tablet drocodone-Acetaminophen) i (percutaneous endoscopic very day shiftprior to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STAT 4601 MARTIN LUTHER KING WASHINGTON, DC 20032	JR AVENUE SW	33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD B SED TO THE APPROPRIA FICIENCY)	
F 697	Continued From pa	nge 122	F 6	97		
	wound with Dankin dry dankin 's solut (abdominal) pad ar [stratasorb] dressir needed)." Review of the Narchydrocodone/Acet Employee #16 sign administered the madministered pain raccordance with the During a face-to-fa approximately 11:2 that she was unaw care had been provadministered the p (Hydrocodone-Acet During a face-to-fa approximately 11:4 Team Nurse) state care to the residen because she was thanager) Residen	medication to Resident #87 in e physician's order. ce interview on 08/24/2021 at 25 AM, Employee #16 stated are that Resident #87's wound vided. She then stated that she				
	approximately 11:4 Manger) stated tha Employee #10. Em	ce interview on 08/24/2021 at 14 AM, Employee #14 (Unit 15 the misunderstood 16 aployee 14 then stated that 16 ot receive pain medication 16 on 08/24/2021.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL		
		095024	B. WING		C 09/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021
				4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 725 SS=F	the appropriate comp provide nursing and r resident safety and a	Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest	F 72	1. Corrective action for resident Resident #37 has received baths and ora appropriate. Resident #68 is being turne repositioned as ordered. Resident #87 n resides in the facility. Residents #83, #7 and #42 have been assessed and are bein	d and o longer 73, #62, ng
	well-being of each re resident assessments and considering the r diagnoses of the facil	mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required		turned and repositioned per physician or their wounds are being monitored by the team. The organization has been using a number of strategies to increase facility care staffing to include but not limited to licensed managerial support, job fairs, a schedule adjustments.	e wound a patient
	by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not		 Identify other residents An observation audit related to baths, or and turning and repositioning of other rewas conducted. There were no additional findings related to this citation. Systemic changes 	esidents l
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observation interview, facility staff nursing staff to provid turn and reposition two residents as prescrib and failed to ensure the documenting change	section, the facility must nurse to serve as a charge duty. is not met as evidenced in, record review and staff failed to maintain sufficient e a shower to resident; to		Nursing staff have been educated on the importance of ensuring that residents are and repositioned per physician orders are care is provided to residents per physicial orders and as needed. The Director of N will be responsible for ensuring that residente provided care per physician orders.	e turned ad ADL an Jursing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		095024	B. WING			C /16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SV WASHINGTON, DC 20032	I	710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	residents identified by developing pressure ulcers/injuries first ob advance stage (Stage Unstageable). The findings include: Review of the facility Daily Living (ADLs), S date of 03/2018 docu and services will be pare unable to carry or including appropriate with hygiene (bathir oral care)" 1. Facility staff failed nail care to Resident Resident #37 was re-09/01/2020, with the Weakness (Generaliz Mellitus, Hyperlipider	policy entitled, "Activities of Supporting" with a revision mented, "Appropriate care provided for residents who at ADLs independently support and assistance and, dressing, grooming, and to bathe, provide oral and #37. admitted to the facility on following diagnoses: Muscle and, Hypertension, Diabetes and, Cerebral Vascular applegia, Seizure Disorder,	F7	4. Monitor corrective action The Unit Managers and Nursing Supervisors/Designee will comple of all residents with turning and products to ensure that residents are and repositioned per physician ord Managers and Nursing Supervisor will also audit 10% residents depe ADLs to ensure that they receive aphysician orders weekly. The resurported to the QAPI Committee months for review and recomment QAPI Committee is responsible for monitoring for compliance. 5. Date correction action country The facility's date of alleged comply November 2, 2021.	te daily audits ostitioning being turned ers. The Units/Designee ndent for ADL care per lits will be nonthly x 3 lations. The r the on-going	
	Personality Disorder. Review of a physiciar following:					
	09/02/2020, directed,	"Oral care two times a day"				
	Review of the Admiss	ion Minimum Data Set				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP (4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		09/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 725	(MDS) dated 08/12/2 In Section C (Cogniti Interview for Mental Score of "15" indicati cognitively intact. In Section G (Function was coded as total of one-person physical use, and personal hy Review of the care person the care personal form of the car	ive Patterns),had a Brief Status (BIMS) Summary ing that the resident was onal Status), the resident dependence and requiring assist with dressing, toilet	F	725		
	an order dated 08/02	physician orders revealed 2/2021, which directed, mes a week, one time a day I Sun."				
	was providing Reside employee washed th care wipes. The reside want a bath with a w water, not a wipe." C	on on 08/25/2021 at AM, Employee #21 (CNA) ent # 37 with a bed bath. The se resident with incontinent dent said to Employee #21, "I ashcloth, bodywash, and continued observation 87's fingernails and toenails				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032	sw	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	were long and dirty. A resident's feet was di	Also, the skin on the ry and scaly.	F 7	725		
	approximately 9:45 A she is given a wipe b not received mouth of She also reported that	interview on 08/25/2021 at M, Resident #37 stated that ath most days and she had are in the past three days. at podiatry comes once a ot remember seeing them				
	(TAR) dated from 08, showed that facility s been giving Resident Monday, Thursday an	ent Administration Record /01/2021 to 08/31/2021, taff signed off that they had #37 a shower every nd Sunday and that they had n care to Resident #37 twice				
	document entitled, "S Comprehensive Certif Shower" dated from that showed Residen					
	2:52 PM, Employee # giving residents a bat notes it on the skin m	interview on 08/31/2021 at #22 (CNA) stated that after th, bed bath, or shower, she nonitoring sheets in the cated at the nurse 's station				
	09/01/2021 at 12:15 of Nursing), admitted	interview conducted on PM, Employee #2 (Director that Resident #37 had only bath for August 2021 and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	·	С
		095024	B. WING		09/16/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 725	Continued From page	e 127	F 72	5	
	one documented bed	bath for July 2021.			
	that two Registered N nurse aides, and one	edule for 8/25/21 showed Jurses (RN), one certified certified nurse aide in gned to care 29 residents on			
		CFR§ 483.24(a)(2), F677 or Dependent residents			
	2A. The facility 's stareposition Residents wound prevention.	ff failed to turn and #68, as prescribed for			
	Deficit related to Im on 04/01/2021. The o	n of: Activity of Daily Living mobility with a revision date are plan outlined multiple t needs total assistance to			
	04/01/2021. The med resident had several	riplegia, Respiratory Failure, birator [Ventilator],			
		n order dated 04/20/2021 eposition every 2 hrs (hours) down."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE COMPLETION
F 725	Continued From page	e 128	F 72	5	
	(MDS) dated 07/6/20 section C (Brief Inter Summary Score) this In section G (Functio resident was coded at the resident was total and required one-permobility. In section I (Active Dicoded for Cerebral Pickerspiratory Failure, I [Ventilator] Status Truin section M (Skin Cocoded for surgical work tracheostomy) and used device for bed. During an observation AM to 11:57 AM (3 hinoted: At 7:55 AM, Resident her back. At 10:30 AM, Resident on her back. and at 11:57 AM, Resident on her back.	nal Status - Bed mobility) the is a"4" and "2" indicating that lly dependent on the staff son physical assist for bed iagnoses), the resident was alsy, Quadriplegia, Dependence on Respirator acheostomy and Weakness. andition), the resident was bunds (gastrostomy and sing a pressure reducing in on 08/30/2021 from 7:55 ours) the following was at #68 was in bed, lying on the matter of the matte			
		ours of the observation, eposition Resident #68.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pag	e 129	F 7	25		
	approximately 12:40 stated that the reside	e interview on 08/30/2021 at PM, Employee #20 (RN) ent had been reposition by assistant (CNA) [Employee				
	approximately 12:45 stated, "I have not pro-	e interview on 08/30/2021 at PM, Employee #17 (CNA) rovided any care or resident (Resident #68)				
	certified nurse's aide	is day 8/30/21 was two (2) , one of which was on e (3) registered nurse to care				
	2B. The facility 's stareposition Resident # prevention.	aff failed to turn and #87 as prescribed for wound				
	02/26/2021. The me resident had several Cerebral Vascular Ac Respirator [Ventilato Gastrostomy, Obesit Ulcer, Stage 4 Left E Right Calf Pressure Heel Pressure Ulcer. Rev	r-admitted to the facility on dical record showed the diagnoses including cident, Dependency on r], Tracheostomy, ry, Stage 4 Sacral Pressure ar Pressure Ulcer, Stage 4 Ulcer Unstageable Right, and a Stage 2 Left Heel iew of the resident weight 1/02/2021 she weighed 265.9				
	Review of a physicia	n ' s order dated 02/26/2021				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	directed, "Turn and rand as needed to proday and night shift. (I	e 130 eposition every 2 hrs (hours) event pressure injury. Every Facility had 12-hour shifts)." rehensive Care Plan	F	725		
	4 left ear, Stage 4 sa Unstageable right lat on 07/30/2021. The interventions includir	•				
	Set (MDS) dated 07/following: In section this section was blar Status - Bed mobility "4" and "2" indicating dependent on the staphysical assist for be (Active Diagnoses), Anemia, Hypertensir Cerebrovascular Acci Respirator [Ventilato Ulcer- Stage4. In secresident was coded a pressure ulcer, one (1)	dent, Dependence on r] Status, and Pressure ction M (Skin Condition), the for have one (1) Stage 3 (1) Stage 4 pressure ulcer, pressure ulcer and one (1)				
	_	on on 08/26/2021 from 8:10 nd a half hours) the following				

	OF DEFICIENCIES CORRECTION			(X3)) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP C 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From page	e 131	F7	725		
	At 8:10 AM, Resident room, in bed, laying of	#87 was observed in her on her right side.				
	At 10:46 AM, Resider on her right side.	nt #87 remained in bed, lying				
	At 12:40 PM, Reside be lying on her right s	nt #87 was observed to still side in the bed.				
	_	alf hours of the observation, eurn and reposition Resident				
	approximately 12:40 (Registered Nurse) s not been turned and because the certified	tated that the resident had repositioned every two hours nursing assistance was n to Resident #87 's room to				
		s day 8/26/21 was two (2) and three (3) registered esidents.				
	Cross reference 42 C Ulcers (F684)	CFR §483.25(b)(1) Pressure				
	reporting and docum skin condition as so i (5) of five (5) residen high risk for developi	to ensure that staff were enting changes in resident dentified. Subsequently, five ts identified by the facility as ng pressure ulcers had es first observed by staff at tage 3, Stage 4 and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Unstageable). (Resi and #42). A. Resident #42 - dia Mellitus, Contractor abnormal posture. Fron 07/14/2021, obse acquired left lateral reconstruction of the contract of the	gnoses: Type 2 Diabetes Left and Right elbow, acility staff first documented rving/finding an in-house nalleolus at Stage 4. ons in place- Monitoring/ e to turn and reposition at or more often as needed. The resident had multiple Dependency on Respirator reostomy, Gastrostomy iabetes Mellitus, and 7/13/2021 stage 3 left calf esident also multiple surgical cluding sacrum, left and left heel. on in place- Turn and wo hours.	F 7			
	on 08/18/2021 obser acquired Stage 4 left ulcer and an unstage unstageable pressur had a Stage 4 pressur Care Plan intervention reposition q (every) to	Facility staff first documented rying/finding an in-house tateral malleolus pressure eable right lateral malleolus e ulcer. The resident also ure injury to the sacrum. In place- Turn and wo hours. Jiagnoses: Hemiplegia,				
		g Cerebral Infarction, and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) (CROSS-REFERENCED TO THE CORRECTION OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 725	Weakness. Facility s 08/17/2021 observin acquired right should ulcer. Care plan interventic reminding/ assistand least every 2 hours of E. Resident #87 - The multiple diagnoses in Respirator [Ventilate Gastrostomy, Insulin Mellitus and Anemial documented on 5/4/in-house acquired pr and on 07/06/2021, injury of left calf. The resident also ha ulcer; Stage 2 right ha the right heel. Care Plan interventic resident needs total at least every 2 hour requested. On 8/26/21 the state Resident #87's posit PM. During this time lying on her right sid reposition the reside (4) hour observation Facility staff were do administration recommentioned residents	staff first documented on a g/finding an in-house der unstageable pressure der unstageable pressure der unstageable pressure der to turn and reposition at or more often as needed. The medical record had including Dependency on orly, Tracheostomy, Obesity, in Dependent Diabetes. The facility's staff first 2021 observing finding an ressure ulcer on the left ear an unstageable pressure des Stage 4 sacrum pressure des Pressure ulcer; DTI of the dated 02/26/2021- The assistance to turn/reposition is, more often as needed or the resident was observed e. At no time did the staff int for the duration of the four occumenting in the treatment decumenting in the treatment.	F7	725		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	33/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
F 725	day); and they were to nurse practitioner of a was no documented or the nurse practition resident's skin impair aforementioned date: ulcers/injuries were fit team (who conduct wat an advanced stage). Facility staffing on this certified nurse aides a to care for 32 resident receiving ventilator through the competent Nursing SCFR(s): 483.35 (a)(3)(3) §483.35 Nursing Send The facility must have the appropriate competent provide nursing and resident safety and a practicable physical, well-being of each reresident assessments and considering their diagnoses of the faciliaccordance with the state \$483.70(e). §483.35(a)(3) The facilicensed nurses have and skill sets necessioneeds, as identified to	co notify the physician/ or any abnormalities. There evidence that the physician mer were notified of the ment prior to the s when the pressure arst observed by the wound evekly visits to the residents) and three registered nurses arts, with 14 residents eatment. FR §483.25(b)(1) Pressure Staff (4)(c) Vices The sufficient nursing staff with everencies and skills sets to related services to assure that or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and lity's resident population in facility assessment required Cility must ensure that the specific competencies ary to care for residents'	F 72	1. Corrective action for resident Staff #36, #23, #33, #34, and #35 were prome their assignments and educated immediately on Infection Control and Prevention Practices to include enhanced precautions, appropriate medication pass practices, ensuring that soap and sanitized dispensers are filled and working proper proper disposal of soiled linen. Resident not affected by these practices. 2. Identify other residents All residents could have been affected by practice. Random observations to observam/pm care and medication passes on all were completed. There were no addition findings related to this citation.	d barrier ser ly, and ts were y this ve l shifts	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE S COMPL	
		095024	B. WING		09/1	; 6/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/1	0/2021
	.07.52.1 01. 001 1 2.2.1			4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND RI	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	Continued From page	135	F 72	6 3. Systemic changes		
	§483.35(a)(4) Providi limited to assessing, implementing resident to resident's needs. §483.35(c) Proficience The facility must ensut to demonstrate comptechniques necessary needs, as identified the assessments, and de This REQUIREMENT by: Based on observation interviews, for one (1) the facility staff failed staff with the approprisets to provide nursing assure resident safety maintain Infection Conadministering medical. The findings include: 1.Employee #36 failed Control Standards of medications for Resident Staff to "to follow estaff to "t	ng care includes but is not evaluating, planning and t care plans and responding by of nurse aides. It to that nurse aides are able etency in skills and to care for residents' brough resident scribed in the plan of care. It is not met as evidenced by a sevidenced services and skills and related services to the plan of care are competencies and skills and related services to the plan of care. It is not met as evidenced by: failure to have sufficient nursing attentions and skills and related services to the plan of care. It is not met as evidenced by: failure to have sufficient nursing attentions are evidence by: failure to have sufficient #47. It is to maintain Infections Practice when administering lent #47. It is tering Medication policy December 2012 instructed stablished facility infection and an antiseptic technique)		Nursing, Respiratory, Rehabilitation, Therapeutic Recreation, Housekeeping, Maintenance staff have been educated o Infection Control and enhanced barrier precautions. Random medication pass observations will be completed. The Inf Preventionist will be responsible for ens that staff are adequately trained on Infec Control and Prevention practices. 4. Monitor corrective actions The Infection Preventionist/Designee wi complete weekly random audits on all u ensure that infection prevention practice being used by all staff. Audits (Environ Services) will include validation that soa dispensers and hand sanitizer dispensers filled and in working order daily. Any o will be addressed immediately. The rest be reported to the QAPI Committee mor months for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete The facility's date of alleged compliance November 2, 2021.	fection uring stion fill nits to s are mental ap are concerns alts will nthly x 3 s. the on-	
	•	on 08/23/21 starting at				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032	sw	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	9:28 AM, Employee Infection Control Sta administering Reside evidenced below: The employee remormedication packets a placed them on top that was in the reside placed the 30cc cup, on top of the "dirty of #36 opened the meditime and administering Employee #36 was a touching the top of the multiple times. The picking up the straw and removing all the #36 was also observed mixing the Miralax are employee attempted to administer the Mirals and the employee speak with her in the It should be noted the door had signage from Prevention and Conferesident was on Enhalm (are intended to proving the Mirals of Compount of the Mirals of Conferesident was on Enhalm (are intended to proving the Mirals of Compount of Co	#36 (RN) failed to maintain indards of Practice while ent #47 's medications, as wed the resident 's 10 AM from the medication cart, the "dirty clothes hamper" ent 's room. Employee also a straw and a cup of water othes hamper". Employee dications packets one at a ed them. the resident 's medications, observed wearing gloves and the "dirty clothes hamper" employee was then observed off the "dirty clothes hamper" paper covering. Employee red touching the straw while and water. When the to walk towards the resident relax, the state surveyor to step out the room and thallway. at Resident #47 's room of the Center for Disease to (CDC) indicating that the anced Barrier Precautions	F7	726		

			(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 726	1 3		F 72	6	
	And the unit had six (Aureus (classified by	6) residents with Candia CDC as a MDRO).			
	04/12/21. The medicaresident had the follow	Imitted to the facility on al record revealed the wing diagnoses Respiratory Tracheostomy, Dysphonia, Anemia.			
	Review of the physici following:	an's orders revealed the			
	by mouth one time a Ascorbic Acid tablet g mouth one time a day Docusate Sodium table every 12 hours for lax every 12 hours for lax escitalopram Oxalate one time a day for an Lisinopril tablet 5mg g time a day for hyperte Nephro-vite tablet 0.8 a day for multivitamin	yive 500 mg (milligrams) by y for supplement. blet give 100 mg by mouth kative. tablet give 10 mg by mouth tidepressants. give 1 tablet by mouth one ension Brug give by mouth one time			
	2021 at approximatel was asked, if she was Miralax after touching hand that touched the stated that she was gishe did not realize shis straw. The employed discard the Miralax arwas then asked if it wadminister medication	interview on August 23, by 9:40 AM, Employee #36 is going the administer the gothe straw with her gloved be "dirty clothes hamper". She going to administer because the had touched the resident be then stated that she would and start over. The employee was the facility is policy to the straw of the stated, "I cleaned"			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVENI WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 726	it when I came in this asked, how could sh	s morning at 8:00 AM." When e ensure the "dirty clothes an at 9:40 AM, Employee	F	726		
	maintain Infection Co providing direct resid linen, as evident belo					
	of Patients & Healtho 10/09/2020, docume protective equipment	es for Quarantine and Testing care Providers" revised on ented, "PPE (personal t) requirements eye shield eld) at all times when working				
	08/23/2021 at 5:40 A Nurse 's Aide) was o patient care on a res should be noted that his door that directed	vation on Unit 3 West on M, Employee #33 (Certified observed providing direct oident without an eye field. It is the resident had a sign at d, "Droplet Precautions ovear eye protection if likely"				
	08/23/2021 at 11: 00 (Administrator) state	e interview conducted on O AM, Employee #1 d, "All staff are required to hen they are doing any direct				
	08/24/2021 at 11:52 soap dispenser in roo	vation on Unit 3 West on AM, it was noted that the om 337 was not functioning. functioning soap dispenser				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVENI WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 726 F 732 SS=D	was a bottle of "soot and body wash". It sl had a sign on the do Barrier Precautions hands, including befileaving the room" During a face-to-face time of the observati (Environmental Serva aware that the soap it and it only needs not 2C. During an obser 08/24/2021 at 1:11 Finoted sitting on top of 207. During a face-to-face time of the observati Manager) acknowled "I know, I should've liplace the dirty linens 2D. During an obser 08/31/2021 at 11:58 (Registered Nurse) wo of the resident to drink, wearing a gown or groom 333 had a sign "Enhanced Barrier P staff must wear gown During a face-to-face time of the observati he should've been were staff to the observation of the observation	the & cool cleanse shampoo hould be noted that room 337 for that directed, "Enhanced Everyone must clean their ore entering and when e interview conducted at the on, Employee #34 fices) stated, "I was not made dispenser was out. I checked new batteries." vation on Unit 2 East on PM, a pile of soiled linens was of the sink in resident's room e interview conducted at the on, Employee #23 (Unit dged the findings and stated, brought a dirty linen bin to sin." vation on Unit 3 West on AM, Employee #35 was observed leaning on bed m 333 bed A while assisting. The employee was not loves. It should be noted that in on the door that directed, Precautions providers and in and gloves" e interview conducted at the on, Employee #35 stated that the on the door that directed that the on, Employee #35 stated that the on the one of the order that the one of the order than the order that the order than the order		732		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021
				4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEPC	DINI SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				F 732	11/02/2021
F 732	Continued From page	140	F 73		
	CFR(s): 483.35(g)(1)-	-(4)		1. Corrective action for resident	
	§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily			Daily Nurse Staffing is now posted as reon each unit.	quired
	basis:	ig information on a daily		2. Identify other residents	
	(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.			All residents could have been affected. Swere no additional findings related to the citation. 3. Systemic changes	
				Nursing staff have been educated on the importance of ensuring that the daily nu staffing information is posted on each un Director of Nursing will be responsible ensuring that the information is posted a	rse nit. The for
				required. 4. Monitor corrective actions The Director of Nursing/Designee will or random weekly audits of each unit to en the required daily nurse staffing information posted as required. The results will be reto the QAPI Committee monthly x 3 months.	sure that tion is eported
	staffing data. The fac written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fac posted daily nurse sta	for review at a cost not to y standard.		review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	ed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	33/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLÉTION
	This REQUIREMENT by: Based on observation determined that the father required daily numbered. The findings include: An observation on ur [08/22/2021 night ship posted daily nurse staboard across from the south that was dated. However, Employee provided the surveyor assignment sheet for 08/22/2021). During a face-to-face time for the observation provide a comment to current daily nurse staposted (08/22/2021). Behavioral Health Se CFR(s): 483.40 §483.40 Behavioral heach resident must reprovide the necessar services to attain or repracticable physical, well-being, in accordant assessment and plar encompasses a resident multiple in the provide well-being, will-being, w	is not met as evidenced n and staff interview, it was acility failed to ensure that see staffing information was at 1 south on 08/23/2021 ft] at 6:00 AM, revealed the affing information on the wall enurse's station on unit 1 08/20/2021. #48 (Night Supervisor) If with a "written" daily the current shift (night dated) interview conducted at the on, Employee #48 failed to address why the most affing information was not rvices ealth services. eceive and the facility must y behavioral health care and	F 74	F 740 1. Corrective action for resident Residents #100 and #102 are currently be assessed for the effectiveness of their psetropic medications. They have also bee evaluated by a psychiatrist.	sycho

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	СОМ	
		205004				С
		095024	B. WING _		09	/16/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW		
				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
				2. Identify other residents		
F 740	Continued From page	e 142	F 7			
	and substance use di			An audit of other residents on psych		
		「 is not met as evidenced		medications and orders for psychiat	ric	
	by:	To not mot do ovidencoa		evaluations has been completed. Re		
	•	iew and staff interview, for		been evaluated as needed and are be		
		d residents facility, staff		for effectiveness of their psychotrop		
	failed to: monitor for			medications. There were no addition	nal findings	
	effectiveness of the r			related to this citation.		
		tions for depression and				
		a resident was evaluated by		3. Systemic changes		
	a psychiatrist, as orde	ered by the physician.				
	Residents' #100 and #102.			Nursing staff have been educated or		
				importance of ensuring that resident		
	The findings include:			ordered medical evaluations and are		
				for the effectiveness of their medica		
	1. The facility's staff facility	ailed to monitor Resident		Director of Social Services will be a		
	#100 for side effects	and effectiveness of his		for ensuring that residents are evalu		
	prescribed psychotro	opics medications.		psychiatrist per physician orders and effectiveness of the psychotropic me		
	Resident #100 was a	dmitted to the facility on		assessed.		
	04/26/2021 with mult Anxiety and Depress	iple diagnoses including ion.		4. Monitor corrective actions		
	Review of physician of	orders revealed the		The Director of Social Services/Des	ignee will	
	following:	orders revealed the		complete weekly audits of Behavior		
	Tollowing.			sheets of all residents on psychotrop	_	
	04/26/2021- " Diazen	oam (antianxiety) 5 mg		medications to ensure that they are		
		a G(Gastrostomy) tube		the effectiveness of their medication		
	every twelve hours for			they have been evaluated by a psycl		
	,			ordered. The results will be reporte	d to the	
	04/27/2021- "Antipsy	chotic medication-monitor		QAPI Committee monthly x 3 month		
	for dry mouth, constit			review and recommendations.		
	disorientation/confusion difficulty urinating, hypotension, dark urine, yellow skin"					
				The QAPI Committee is responsible	for the on-	
				going monitoring for compliance.		
	07/09/2021-"Quetiapi	ne Fumarate (antipsychotic)				
	25 mg Give 3 tablet depression."	via G-tube every 8 hours for		5. Date correction action com	pleted	
	•	in (Antianxiety) Tablet 1 mg		The facility's date of alleged compl November 2, 2021.	ance is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		095024	B. WING _			09/) 16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) (EACH CORRECTIVE ACTIVE) (EACH CORRECTIVE ACTIVE) (EACH CORRECTION OF THE	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 740	a day for anxiety" Review of the Quarte 08/02/2021 showed following: In Section "Should a brief Intervenducted", "0" mean understood". In Sect E (Behavior), potenti "Z", "none of the about Review of the care pure "[Resident's name] understood interventions including and effectiveness Quarter of 05/04/2021. The content of the care pure of the care pure of 05/04/2021 and effectiveness Quarter of the care pure stated that the last times are conducted for the care pure of the care pure o	erly Minimum Data Set dated facility staff coded the C (Cognitive Patterns), view for Mental status be ning "Resident is rarely/never ion D (Mood). "0". In Section al indicators of psychosis, ove". Dan revealed a focus area of: isses psychotropic ession with a revision dated eare plan outlined multiple ing monitor for side effects eshift (Every shift)". Existerview on 08/30/2021 at #11 (Registered Nurse) me a Behavioral Assessment in resident was in June of failed to ensure Resident by a mental health as ordered by the physician. Readmitted to the facility on tiple diagnoses including: Ribs, Acute Chronic with Hypoxia, Unspecified d of right Femur, and	F7	740			

PRINTED: 11/15/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		095024	B. WING		C 09/1	6/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 740	agitation and refusal 08/9/2021- "Psych coagitation and refusal 08/10/2021- "Psych coagitation 08/26/2021-"Psych Copossible) and PRN Review of the Quarte (MDS) dated 08/17/2 In Section C (Brief Inthe resident was give that the resident intact In Section D (Mood) -a "01" indicating minimal In Section E (Rejecti Frequency) the resident indicating this behavior less than daily. Review of the medical was no documented of 09/16/2021 that Residental puring a face-to-face	consult" consult one time only for of medication" consult one time only for of medication " consult one time only for onsult one time only for consult asap (as soon as " crly Minimum Data Set 021 revealed the following: terview for Mental Status) - in a score of "15: indicating of cognitively. The resident was coded as mal depression. on of Care-Presence & ent was coded as "2" or occurred 4 to 6 days but all record revealed that there evidence from 06/26/2021 to	F 740		1	1/02/2021
F 755 SS=D	Manager) stated, "I' n (psychiatric) consult (done." Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b) §483.45 Pharmacy Sc	n not sure if a psych evaluation/assessment) was cedures/Pharmacist/Records (1)-(3) ervices	F 755	F 755 1. Corrective action for resident The nurse signed out the medication that been previously given and all counts were reconciled and correct. Nursing staff hareducated on the importance of accurate	t had	1/02/2021
	The facility must prov	ide routine and emergency to its residents, or obtain		accounting of narcotic medications and documentation of medication administra	tion.	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED		(X3) DATE SURVEY COMPLETED	
	095024	B. WING		C 09/16/2021
	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		
them under an agree §483.70(g). The facil personnel to adminis permits, but only unda licensed nurse. §483.45(a) Procedure pharmaceutical servithat assure the accur dispensing, and adm biologicals) to meet the same that assure the accur dispensing, and adm biologicals) to meet the same that assure the accur dispensing, and adm biologicals) to meet the same that assure the accur dispensing, and adm biologicals) to meet the same that assure the accur dispensing, and adm biologicals) to meet the same that assure the accur dispension, and same that assure the accur dispension, and same that an accurate that a same that an accurate that a supplier that a	ment described in ty may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident. Consultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of in of all controlled drugs in able an accurate Inines that drug records are in count of all controlled drugs riodically reconciled. To is not met as evidenced and, record review and staff and failed to accurately en narcotic storage box on	F 75	All other narcotic books were reviewed. 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 na medications and documentation of mediadministration. The Director of Nursing responsible for ensuring that nurses accurate account and document narcotic medication. 4. Monitor corrective actions The Director of Nursing/Designee will or random weekly audits of 10 % of narcot sheets to ensure that medication counts at the medication on hand correctly and are documented when given. The results we reported to the QAPI Committee monthly months for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete.	rcotic cation g will be arately as. complete ic count match e ill be dy x 3 s. the on-
08/23/2021 at 6:51 A	M on Unit 3 West, it was			
	SUMMARY ST (EACH DEFICIENCY REGULATORY OR I Continued From page them under an agreet §483.70(g). The facilit personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accurr dispensing, and admit biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility. §483.45(b)(2) Establic receipt and dispositio sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on observatio interview, facility staff reconcile narcotics. The findings include: During a review of the 08/23/2021 at 6:51 A	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	ROVIDER OR SUPPLIER DINT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	NOVIDER OR SUPPLIER INT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY) EACH DEPICIENCY MISS TEREST ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20322 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 accupining, 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 Ouriga review of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 755	(milligram) tab (table	ge 146 zepam (antianxiety) 2 mg et) 1 tab by mouth at maining tablets. However, the	F 75	5		
	narcotic book documeremaining. During a face-to-factime of the observat (Registered Nurse) one tablet last night sign it off in the book	e interview conducted at the ion, Employee #31 stated, "I gave the resident at 10:00 PM but I forgot to k."		E 757	11/02/2021	
F 757 SS=D	CFR(s): 483.45(d)(1 §483.45(d) Unnecess Each resident's drug unnecessary drugs. drug when used-	sary Drugs-General. g regimen must be free from An unnecessary drug is any sessive dose (including	F 75	1. Corrective action for resident Resident #56 has had their medication rereviewed by the Pharmacist with recommendations given to the physician their regimen with parameters. Resident currently being assessed pre and post medication administration. Resident #8' longer resides in the facility.	egimen for t #56 is	
	§483.45(d)(3) Witho	ut adequate monitoring; or ut adequate indications for its		2. Identify other residents An audit of other resident's medication regimens was completed. There were no additional findings related to this citation		
	consequences which reduced or disconting \$483.45(d)(6) Any constated in paragraphs section.	presence of adverse h indicate the dose should be nued; or ombinations of the reasons s (d)(1) through (5) of this T is not met as evidenced		3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents do receive unnecessary medications and that medications are given per physician order Pharmacist will complete a pharmacy rethe facility. The Director of Nursing wiresponsible for ensuring that residents are given unnecessary medications.	not at ers. The view for Il be	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	<u> </u>	(X3) DATE COMP	
		095024	B. WING _			() ()	C 16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, 4601 MARTIN LUTHER M WASHINGTON, DC 20	KING JR AVENUE SW	03/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Based on record rev facility staff failed to e residents were free fr medications. Resider The findings include: Review of the facility Assessment and Mar 2015, documented: "Assessing Pain 1. During the compre [staff is to] gather the indicated from the reserversentative): a. History of pain (as standardized pain scale) b. Characteristics of pain (as standardized pain scale) b. Characteristics of pain (as standardized pain scale) c) Descriptors of pain (as standardized pain scale) (2) Descriptors of pain (as standardized pain scale) (3) Pattern of pain (as standardized pain scale) (4) Location and radia (5) Frequency, timing color factors that precipe and strates for symptoms that account in the standard pain Market for symptoms that account in the standard pain Market for symptoms that account in the standard pain Market for symptoms that account in the standard pain Market for symptoms that account in the symptoms tha	iew and staff interview, ensure two (2) of 44 sampled from unnecessary pain int #56 and #87. Is policy entitled: "Pain hagement" revised March The hensive pain assessment is following information as isident (or legal Is measured on a hale); hain: has measured on a hale); hain: hain hale hale hale hale hale hale hale hale	F	The Director of Noweekly audits of 1 medication adminithey are not received and are given per partial be reported to monthly x 3 month recommendations. The QAPI Commingoing monitoring in the correction of the	ittee is responsible for for compliance. rection action complete of alleged compliance	and sure that cations results	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021	
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032		03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE	
F 757	Monitoring and Modii2. Monitor the follo the resident 's pain i controlled: a. The resident's resplevel of comfort over b. The status of the u identified previously; c. The presence of a treatment." According to the faci Management policy I pain scale rating is a mild; 4-6=moderate, 1. Resident #56 was 06/01/2021 with the Dependence, Periph Diabetes Mellitus, Ac	fying Approaches: wing factors to determine if is being adequately ponse to interventions and time; underlying cause(s) of pain, if and dverse consequences to lity's Pain Assessment and ast reviewed May 2016 the s follows: 0= none; 1-3= 7-10=severe admitted to the facility on following diagnoses: Opioid eral Vascular Disease (PVD), cquired Absence of Right onic Pancreatitis, Chronic d Depression.	F7	757			
	06/01/2021 "assessn needed)	nent every shift and prn (as					
	HCL (hydrochloride)	one (opioid pain reliever) tablet 5 mg (milligram), " outh every 12 hours as (Moderate)."					
		adol (opioid pain reliever) ive 1 tablet by mouth every 6 pain					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATI	(X5) COMPLETION DATE
F 757	Continued From page	ge 149	F 7	57		
		codone (opioid pain reliever) ve 1 tablet by mouth two times				
	Review of the Medi for September 2021	cation Administration Record showed:				
	Methadone for a pa	08/15/2021 staff administered in level of 3 out of 10 and on stered Methadone for a pain				
	Tramadol at 9:17 Al and again at 12:00 l 10. The tramadol w approximately 3 hou physician's order da	ity staff administered M for a pain level 4 out of 10 PM for a pain level of 5 out of as administered urs apart, however the ted 07/08/2021 directs staff to y 6 hours as needed for pain.				
		09/12/2021 at 10:00 AM, staff odone HCL tablet 5 mg for				
		f administered Tramadol at evel 5 out of 10 and again at evel of 4 out of 10.				
	showed Resident #5 5 mg every 12 hour however there were listed to direct staff Tramadol 50 mg, ar example for mild, m	ord for September 2021 56 was to receive Methadone s for pain 4-6 (moderate); no pain level parameters when to administer the nd Oxycodone 5 mg, for oderate or severe pain.				
	Lastiy, review of Re	sident #56's Medication				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER OINT SUBACUTE AND F	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 757	2021 lacked docume staff performed a podetermine if the pain the resident was efferesident's pain level administration. During a face-to-face 08/26/2021 at 9:22 A Manager) stated that be performed before administered to resident pain was not connotes nor on the merecord, for Resident nurses cannot e-sign administered without assessment, however provide documented	d for August and September ented evidence that facility st pain assessment to medication administered to ective and what was the post medication e interview conducted on MM, Employee #23 (Unit to pain assessments should and after pain medication is dents. She acknowledged ensistently noted the progress dication administration #56. She reported that in that a pain medication was to performing a post er she was not able to	F 75	57	
	02/26/2021. The me resident had several Cerebral Vascular Ac Respirator [Ventilato Gastrostomy, Obesid Ulcer, Stage 4 Left E Right Calf Pressure Heel Pressure Ulcer Pressure Ulcer. During an observation approximately 11:20 (Registered Nurse) ventage of the several control o	cy, Stage 4 Sacral Pressure Ear Pressure Ulcer, Stage 4 Ulcer Unstageable Right , and a Stage 2 Left Heel on on 08/24/2021 at			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED) DATE SURVEY COMPLETED				
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COD 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 757	tube. When asked w administering, the en administering pain m provides wound care. Observation of the reher right leg and sacclean, dry and intact. signed and dated by Team Nurse) "08/24/indicating that wound prior to the administration by Employee #16. Review of physician's following: 05/10/2021- "Norco of 5-325 milligram (Hyogive 1 tablet via PEG gastrostomy) tube exwound care for pain. 07/23/2021 - " Cleawound with Dankin's dry dankin's solutio (abdominal) pad and [stratasorb] dressing needed)." Review of the Narcot Hydrocodone/Acetar Employee #16 signe administered the med 11:20 AM.	hat medication she was imployee stated that she was nedication before she for the resident. Sesident's wound dressings to ral area revealed they were in the dressings were also in Employee #10 (Wound 1/2021 at 7:00 am to 7:00 PM" in dicare had been provided attion of the pain medications in sorders revealed the indications in the pain medications in the pain medications in the pain medication in the pain medi	F7	757		
		that facilty staff administerd esident #87 in accordance order.				

	OF DEFICIENCIES F CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL				
		095024	B. WING _			C / 16/2021
	ROVIDER OR SUPPLIER OINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 757	Continued From page		F 79	57		
F 761 SS=E	approximately 11:25 that she was unaward care had been provid administered the pair (Hydrocodone-Acetar) During a face-to-face approximately 11:40 Team Nurse) stated to care to the resident abecause she was told Manager) Resident # medication. During a face-to-face approximately 11:41 Manger) stated that is Employee #10.	interview on 08/24/2021 at AM, Employee #10 (Wound hat she had provided wound round 8:00 AM or 9:00 AM of by Employee #14 (Unit 87 had received pain interview on 08/24/2021 at AM, Employee #14 (Unit she misunderstood by ee 14 then stated that receive pain medication in 08/24/2021. d Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be se with currently accepted so, and include the y and cautionary	F 70	1. Corrective action for residents Medication carts and rooms are free medications. 2. Identify other residents An audit of all medication carts and rooms was completed. There were findings related to this citation.	ent e of expired I medication	11/02/2021

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
NAME OF PR	OVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2021
				4601 MARTIN LUTHER KING JR AVENUE SW	
BRIDGEPC	DINT SUBACUTE AND RI	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 761	Continued From page	: 153	F 76		
	personnel to have according	·		Nursing staff have been educated on the importance of ensuring that no expired medications are left on medication carts medication rooms. The Director of Nur	or in
	locked, permanently a storage of controlled the Comprehensive Dr	cility must provide separately affixed compartments for drugs listed in Schedule II of any Abuse Prevention and and other drugs subject to		be responsible for ensuring that no expirate medications are left in medication carts medication rooms.	red
	package drug distribut quantity stored is min be readily detected. This REQUIREMENT by:	he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced in and staff interview, facility tore medications.		4. Monitor corrective actions The Unit Managers and Supervisors/Deswill complete random weekly audits of ensure that no expired medications are p. The results will be reported to the QAPI Committee monthly x 3 months for revierecommendations.	1 unit to present.
	The findings include: During an observation	n of 3 west, Team 2		The QAPI Committee is responsible for going monitoring for compliance.	
	(3) resident's Glucago	/25/2021 at 10:50 AM, three		 Date correction action complet The facility's date of alleged compliance 	
	"01/2021". During a face-to-face time of the observatio (Registered Nurse) st	interview conducted at the on, Employee #21 ated that she would remove pens from the medication		November 2, 2021.	5 15
F 812 SS=E	cart.	ore/Prepare/Serve-Sanitary	F 81		11/02/2021
	§483.60(i) Food safet The facility must - §483.60(i)(1) - Procui	y requirements.		Cooling fan has been removed and food temperatures have been consistently wit required range.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ILTIPLE CONSTRUCTION (X3) DATE : COMPI		SURVEY LETED	
		095024	B. WING				C
NAME OF D	DOVIDED OD CLIDDLIED	033024		CTREET ADDRESS OITY STATE 71D OF	ODE .	09/	16/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
BRIDGEPO	DINT SUBACUTE AND R	REHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVEN	NUE SW		
				WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
				Identify other reside	nts		
F 812	Continued From pag	e 154	F 8	12			
	state or local authorit			All residents could have been	ı affected. T	There	
		ood items obtained directly		were no additional findings re	elated to thi	is	
		, subject to applicable State		citation.			
	and local laws or reg						
		es not prohibit or prevent		Systemic changes			
	. ,	produce grown in facility					
		ompliance with applicable		Dietary and Engineering staff	f have been		
		od-handling practices.		educated on the importance of			
		es not preclude residents		cooling fans are not used in the			
		ds not procured by the facility.		Dietary staff was also educate			
	morn consuming look	as not produced by the lacinty.		include proper food temperat			
	8/18/3 60(i)(2) - Store	, prepare, distribute and		of Dietary will be responsible			
		ance with professional		food safety requirements are		Ü	
	standards for food se	•					
		T is not met as evidenced		4. Monitor corrective a	actions		
	by:	1 13 Hot met as evidenced					
	-	ons and staff interview, the		The Director of Dietary/Desi	gnee will co	omplete	
		are, serve, and distribute		daily audits of food temperate			
		conditions, as evidenced by		food temperatures are within			
	_	is in use in the kitchenh and		In addition, the Director of D			
		nat were below 135 degrees		will complete random test tra			
	Fahrenheit (F) on thr			The Director of Facility Man			
	observations.	66 (6) 61 111116 (6)		weekly audits of the kitchen			
				cooling fans are in use. The			
	The findings include:			reported to the QAPI Commi			
	2			months for review and recom			
	1. During an observa	ation on 08/23/2021 at					
		AM, a cooling fan was noted		The QAPI Committee is resp	onsible for	the on-	
	being used in the kito			going monitoring for complia	ance.		
	J						
	2. During food test tr	ay assessment on		Date correction action	on complete	ed	
		eximately 1:15 PM, and on			•		
		eximately 1:30 PM, hot foods		The facility's date of alleged	compliance	eis	
		0 F), spinach (120 F), and		November 2, 2021.	-		
		sted below the required 135					
	degrees Fahrenheit	•					
		· <i>,</i>					
	These observations	were acknowledged by					
	Employee #46 (Food	l Service Employee) on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE 3 COMPL						
		095024	B. WING		09/1) 16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			4	4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR	١,	WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 835 SS=F	09/01/2021 at approx Administration		F 812	F 835		11/02/2021
SS=F	enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on staff intervensure that action plaimplemented to ensure that action as so it census was 122. Findings include: 1.In the area of 42 Ci Abuse, Neglect, and Administration failed were developed and it provide a safe environ the likelihood of one (1) resident was restraint. Based on the Immediate Jeopardy	ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. Tis not met as evidenced riew, Administration failed to ans were developed and re freedom from abuse, on, to ensure a resident was ough investigate all failed to implement a resident involved in the and to ensure that staff were enting changes in resident dentified. The resident FR§ 483.12, Freedom from Exploitation, the to ensure that action plans implemented to protect and nment for one (1) resident abuse and failed to ensure		1. Corrective action for resident The Administrator and Director of Nursithe time of the survey are no longer with organization. 2. Identify other residents All residents could have been affected. Twere no additional findings related to the citation. 3. Systemic changes A new Administrator and Regional Dire Operations for Skilled Nursing Services been hired. The Administrative team had educated on the QAPI process (including and metrics) and all areas of concern from survey. The findings of this survey will monitored through the new QAPI command the results will be shared with the Governing Board monthly. The Administrative and add appropriately in accordance with state and federal regulations. 4. Monitor corrective actions The Administrator/Designee will completed to the insurve of all findings of this sand other issues identified to ensure app follow up and interventions are in placed results will be reported to the QAPI committee and and other issues identified to ensure app follow up and interventions are in placed results will be reported to the QAPI committee and and other issues identified to ensure app follow up and interventions are in placed results will be reported to the QAPI committee.	Ctor of have is been g goals om this be nittee distrator findings are dressed in dressed in dressed in the control of the cont	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		C
		095024	B. WING			C /16/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PRÉFIX TAG				(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
				and Governing Board monthly x 3 r	nonths for	
F 835	Continued From page	e 156	F 83	35 review and recommendations.		
	and Exploitation on 0	9/08/2021 at 1:55 PM.			.	
				The QAPI Committee and Governing	-	
		ew was conducted with		responsible for the on-going monito compliance.	ing for	
	Employee #1 on 8/30 employee acknowled			r		
	employee acknowled	ged the illidings.		5. Date correction action com	pleted	
	Cross reference 42 C	FR§ 483.12, Freedom from				
	Abuse, Neglect, and	Exploitation, F600.		The facility's date of alleged compliance is November 2, 2021.		
	2. In the area of 42 C	FR §483.12(c)(2) Have				
		ged violations are thoroughly				
		ninistration failed to ensure				
	that action plans were	e developed and				
		re facility staff failed to				
		n investigation: for one (1)				
		staff member hit her; for				
		nily who complained that her				
		tronic device) was missing, found under her mother; for				
		se hand mitten was found				
		one (1) resident who				
		ched his leg and slung it				
		over and made a negative				
	verbal comment; and	one (1) resident who				
		ember stuffed her brief with				
		(incontinence pad) and				
	made a negative verb	oal comment.				
	A face-to-face intervie	ew was conducted with				
	Employee #1 on 8/30					
	employee acknowled	ged the findings.				
	Cross reference 42 C	FR§ 483.12, Freedom from				
	Abuse, Neglect, and					
	3.In the area of 42 CF	FR§483.25 Quality of Care-				
	Treatment/Services to	o Prevent/Heal Pressure				

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	095024 B. WING		C 09/16/2021		
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND R	EHAB NATIONAL HARBOR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SV WASHINGTON, DC 20032	•	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
staff were reporting a resident skin condition Subsequently, five (5 identified by the facility pressure ulcers had probserved by staff at a Stage 4 and Unstage failures, and an immer identified at 42 CFR§ Treatment/Services the Ulcers, F686 on Septon Cross reference 42 Contract the Treatment/Services Ulcers, F686. F 837 Governing Body CFR(s): 483.70(d)(1) The fact body, or designated properties and implementation of the management and set stablishing and implementation of the management and set of the set of t	ation failed to ensure that and documenting changes in an as so identified. b) of five (5) residents ty as high risk for developing pressure ulcers/injuries first an advance stage (Stage 3, table). Based on the facility's ediate jeopardy (IJ) was ediate jeopardy (IJ) wa	F 83	F 837	Nursing at er with the eted. There I to this I Director of evices have has been eluding goals ern from this y will be	

MAKE OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR PRETIX GRAND SUBMAIN STATEMENT OF REFLICACIONES (EACH DECORDER NATIONAL HARBOR) F 837 Continued From page 158 and implemented to ensure freedom from abuse, neglect and exploitation, to ensure a resident was restraint free, to through 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. F 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 mignement or protect an provided a safe environment for 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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR STREET ADDRESS. CITY, STATE, ZIP CODE 4609 MARTIN LUTHER KIND JR AVENUE SW WASHINGTON, DC. 2032 FROUDER'S PLAN OF CORRECTION PRIETY TAG FROUDER'S PLAN OF CORRECTION PRIETY TAG Continued From page 158 and implemented to ensure freedom from abuse, neglect and exploitation, or ensure a resident was restraint free, to thorough investigate all allegations of abuse, failed to implement measures to protect ar 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 for provide a safe environment for 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 9096/2021 at 1:55 PM. A face-to-face interview was conducted with Employee at 1 on 8/30/21 at 9:06 AM. The employee acknowledget, and Exploitation, F600.		095024 B.		B. WING			_	
Residence Summary statement of deficiencies Summary statement of deficiencies Summary statement of deficiencies Summary statement of deficiency Summary statement of	NAME OF DE	POVIDED OD SLIDDLIED			STREET ADDRESS CITY STATE ZID CODE	09/	10/2021	
ID (MA) ID (MA	NAME OF T	COVIDER OR SOLT LIER						
SUMMANY EXPLIBENT OF DEFICIENCES. REGULATORY ONLS DENTIFYMEN BYFORMATION) 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 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 at no 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.	BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR					
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 actions to developed and implemented actions to developed and implemented by a facility's failures, an Immediate Jeopardy (IJ)-"K" in 42 CFR (Code of Federal Regulations), 94. A face-to-face interview was conducted with Employee #1 on 8/30/21 at 1:55 PM. A face-to-face interview was conducted with Employee acknowledged the findings. Cross reference 42 CFR§ 483.12, Freedom from Abuse, Neglect, and Exploitation, F600.					WASHINGTON, DC 20032			
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 to protect and provide a safe environment for one (1) resident was free from a physical restraint. Based on the facility's failures, an Immediate Jeopardy (IJ)-"fix' 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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	COMPLETION		
evidence that all alleged violations are thoroughly investigated, the governing body failed to ensure that administration developed and implemented	F 837	and implemented to eneglect and exploitating restraint free, to thore allegations of abuse, measures to protect abuse investigation, a reporting and docume skin condition as so it census was 122. Findings include: 1. In the area of 42 Cl Abuse, Neglect, and body failed to ensure developed and implemented to penvironment for one likelihood of abuse and resident was free from Based on the facility's Jeopardy (IJ)-"K" in 4 Regulations) § 483.1 Exploitation on 09/08 A face-to-face interview Employee #1 on 8/30 employee acknowled Cross reference 42 Cl Abuse, Neglect, and	ensure freedom from abuse, on, to ensure a resident was ough investigate all failed to implement a resident involved in the and to ensure that staff were enting changes in resident dentified. The resident dentified. The resident FR§ 483.12, Freedom from Exploitation, the governing that administration mented actions to developed protect and provide a safe (1) resident from the failed to ensure one (1) in a physical restraint. In a failures, an Immediate 2 CFR (Code of Federal Of Abuse, Neglect, and 1/2021 at 1:55 PM. FR§ 483.12, Freedom from Exploitation, F600. FR§ 483.12, Freedom from Exploitation, F600.	F 83	will be responsible for ensuring that the of this survey and other issues identificated to the QAPI committee and a appropriately in accordance with state federal regulations. 4. Monitor corrective actions The Administrator/Designee will common Monthly reviews of all findings of this and other issues identified to ensure a follow up and interventions are in placed results will be reported to the QAPI Cand Governing Board monthly x 3 more review and recommendations. The QAPI Committee and Governing responsible for the on-going monitoring compliance. 5. Date correction action compliance. The facility's date of alleged compliance.	plete survey oppropriate se. The ommittee on this for Board are ag for eted		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COL 4601 MARTIN LUTHER KING JR AVENI WASHINGTON, DC 20032		09/10/2021
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 837	actions to thoroughly one (1) resident who her; for one (1) reside that her mother 's IP missing, and then whother; for one (1) rewas found tied to the who shared that staff it requesting he [turn verbal comment; and shared that a staff mipieces from a chuck made a negative verbal comment; and employee acknowled. A face-to-face intervice Employee #1 on 8/30 employee acknowled. Cross reference 42 C Abuse, Neglect, and 3.In the area of 42 C Treatment/Services to Ulcers, the governing administration develoactions to ensure that documenting change as so identified. Substresidents identified be developing pressure ulcers/injuries first obtation and an immediate jed 42 CFR§483.25 Qual Treatment/Services to the sidentification of	conduct an investigation: for stated a staff member hit ent's family who complained AD (electronic device) was een it was found under her esident whose hand mitten bedrail; for one (1) resident snatched his leg and slung over and made a negative one (1) resident who ember stuffed her brief with (incontinence pad) and on comment. Ew was conducted with 0/21 at 9:06 AM. The open deviation, F610. ER§483.25 Quality of Care-to Prevent/Heal Pressure of body failed to ensure that oped and implemented to staff were reporting and so in resident skin condition sequently, five (5) of five (5) by the facility as high risk for ulcers had pressure eserved by staff at an ear, Stage 4 and do on the facility's failures, oppardy (IJ) was identified at	F	337		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COME	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021		
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE S' WASHINGTON, DC 20032	I	110/2021	
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F 837	Cross reference 42 C	e 160 FR§ 483.25, Quality of Care to Prevent/Heal Pressure	F 8				
	Facility Assessment CFR(s): 483.70(e)(1): §483.70(e) Facility as The facility must confacility-wide assessment resources are necess competently during by and emergencies. The update that assessment least annually. The facility plans for, any substantial modification assessment. The facility plans for, any substantial modification assessment. The facility plans for any substantial modification (i) Both the number of resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fact that population; (iii) The staff competer provide the level and resident population; (iv) The physical enviservices, and other pertinent fact are necessary to (v) Any ethnic, culture may potentially affect.	seessment. duct and document a tent to determine what sary to care for its residents oth day-to-day operations the facility must review and tent, as necessary, and at acility must also review and tent whenever there is, or the change that would require a on to any part of this tility assessment must cility's resident population, ted to, f residents and the facility's by the resident population to of diseases, conditions, the disabilities, overall acuity, that are present within tencies that are necessary to types of care needed for the	F8	1. Corrective action for resi The Facility Assessment has been reflect current average census, bee staffing, and changes in leadership 2. Identify other residents All residents could have been affe were no additional findings related citation. 3. Systemic changes The leadership team has been educimportance of ensuring that the Fa Assessment is accurate and kept uf acility characteristics change. The Administrator will be responsible that the Facility Assessment is upout 4. Monitor corrective action The Administrator/Designee will amonthly audits of the Facility Assensure that it is accurate. The restreported to the QAPI Committee months for review and recommend. The QAPI Committee is responsible going monitoring for compliance.	updated to d capacity, p. ected. There d to this cated on the acility apdated as a for ensuring dated. as complete essment to alts will be monthly x 3 dations. ble for the on-	11/02/2021	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			SURVEY LETED		
			A. BUILDII	A. BUILDING			С	
	095024 B. V		B. WING	B. WING			09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				46	01 MARTIN LUTHER KING JR AVENUE SW			
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		W	ASHINGTON, DC 20032			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)	
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17.0		,			DEFICIENCY)			
				5	 Date correction action complet 	od		
F 838	р		F 8	338	5. Date correction action complet	eu		
	food and nutrition ser	vices.		7	The facility's date of alleged compliance	e is		
	\$492.70(a)(2).The for	cilitula raccuraca including			November 2, 2021.			
	but not limited to,	cility's resources, including						
		r other physical structures						
	and vehicles;	. ,						
		cal and non- medical);						
	•	d, such as physical therapy,						
		fic rehabilitation therapies; cluding managers, staff (both						
		who provide services under						
	contract), and volunte							
	education and/or train	ning and any competencies						
	related to resident ca							
		randums of understanding,						
	_	with third parties to provide nt to the facility during both						
	normal operations an	, ,						
	=	n technology resources,						
		electronically managing						
	patient records and e	, ,						
	information with othe	r organizations.						
	§483.70(e)(3) A facili	ty-based and						
	•	k assessment, utilizing an						
	all-hazards approach							
	_	Γ is not met as evidenced						
	by: Based on record rev	iew and staff interview,						
	facility staff failed to							
		t the facility's current						
		gencies. The resident						
	census on the first da	ay of survey was 122.						
	The findings include:							
		e Point Sub-Acute and						
	Rehabilitation Nation							
	Assessment docume	nt revealed the following:						

AND DI AN OF CODDECTION IDENTIFICATION NUMBER.			TIPLE CONSTRUCTION NG	(X3	OMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP 4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		007.107202.
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 838	Continued From pag	e 162	F 8	338		
	Administrators Nar NursingName of M Dates of assessmen (leadership changes Date(s) assessment assessment and ass 12/3/2020 Part 1: Our Resident - average Daily Cens 3 West-29 beds, 1 beds; Part 3: 3.2 staffing-li direct care- 14; nurs	t or update11/26/2018 conly) reviewed with QAA (quality surance)/QAPI committee Profile lists 1.1 94 beds; 1.2 sus:100-105. 3 East- 33 beds South 16 beds, 2 South 16				
	interview with Employer current medical direct Review of the resided day of survey, 8/23/2 house and lists the rawest, 1 South, 2 Sto Employee #1 resides since February 2021	oyee #1, he stated that the ctor started in March 2021. ent alpha census on the first 2021-lists 122 residents in esidents in rooms on 3East, outh and 2 East. According dents have resided on 2 East.				
	9/8/2021, showed the staff and nurse aided residing unit 2 East of the staff and nurse aided residing unit 2 East of the staff and nurse aided residing unit 2 East of the staff and staff	e staffing from 8/2021 to e facility had licensed nursing s to care for residents with a bed capacity of 31. Ince that staff updated the o include the change in the reflect that the facility now dent care unit and to reflect umber of license nurses and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED				
		095024	B. WING		C 09/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 838 F 842	certified nurse aides working on 2 East. Resident Records - Identifiable Information		F 838 F 842 ^{F 842}		11/02/2021		
	certified nurse aides working on 2 East.		F 842	1. Corrective action for resident Resident #3 has been re-weighed and the current weight has been documented and verified by the Dietician. Resident #5 he evaluated by a psychiatrist and assessed effectiveness of their psychotherapeutic medications. Resident #119 has receive ordered respiratory medications and treat and they are being signed off as appropring the Treatment Administration Record and Respiratory Medication Administration 2. Identify other residents An audit of other residents was completed There were no additional findings related citation. 3. Systemic changes Nursing staff and Dietician have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Social Services staff have been expended accurately and weights document Nursing and Services staff have been expended accurately and weights document Nursing and Services accurately	eir d as been for the d the atments iate on ad Record. ed. d to this ducated ents are ented. been that and		
	operations, as permi with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and	ayment, or health care tted by and in compliance 5; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation		Respiratory Therapists were educated or importance of documenting respiratory medications and treatments are document the Treatment Administration Record and Respiratory Medication Administration The Director of Nursing, Dietician, Director Cardiopulmonary Services, and Director	n the nted on ad record.		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			WASHINGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE COMPLETION	
F 842	medical examiners, for a serious threat to he by and in compliance \$483.70(i)(3) The fact record information agunauthorized use. §483.70(i)(4) Medicat for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yealegal age under State §483.70(i)(5) The medical ground of the results of the results of the results of any and resident review of determinations conductively The results of any and resident review of determinations conductively Physician's, nurse professional's progrectively Laboratory, radio services reports as real three (3) of 44 samp failed to: accurately of the side effects as or as directed in the car	curposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512. Idility must safeguard medical painst loss, destruction, or a records must be retained required by State law; or e date of discharge when ent in State law; or ears after a resident reaches e law. Idical record must containation to identify the resident; sident's assessments; we plan of care and services or preadmission screening evaluations and fucted by the State; ets, and other licensed es notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced evaluations and staff interview, for led residents, facility's staff locument the resident's ident; accurately document dered by the physician and	F 8-	Social Services will be responsible for a that medical records are complete for the respective disciplines. 4. Monitor corrective actions The Unit Managers and Nursing Supervisors/Designee will complete we audits of 10% of residents to ensure that records are complete and accurate. The will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	ekly t medical results e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		095024	B. WING			C 09/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		09/10/2021		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 842	resident receiving Sy trach care on the Tr Record and Respirat Administration for on #5 and #119. The findings include: 1. Resident #3 was a 07/10/2021 with mult Morbid Obesity, Cellic Review of the medical discharge summary documented Resider kilogram (396 pound). Review of Resident revealed that the reson 07/10/2021 and 4 which was difference weight gain) in 25 da. During a face-to-fact at approximately 10: (Registered Dieticiar the weight discrepanter-weight the resider which weight was the stated, "The 497.5 praccurate rate." 2. Resident #5 was a 02/22/2017 with mult Anxiety Disorder, De Status.	dmitted to the facility on tiple diagnoses including ulitis, and Lymphedema al record showed a hospital from a local hospital that int #3 's weight as 179.7 s) on 07/02/2021. #3 's Weight Summary List ident weighed 285 pounds 97.5 pounds on 08/04/2021, e of 212.5 pounds (72.15%	F8	342				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095024	B. WING _	B. WING		C 09/16/2021	
	NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			40	TREET ADDRESS, CITY, STATE, ZIP CODE 601 MARTIN LUTHER KING JR AVENUE SW VASHINGTON, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TION SHOULD BE COM THE APPROPRIATE	
F 842	Continued From page	e 166	F 8	342			
	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 (Cognitively	ve Patterns), cognitive skills, '] impaired"					
		staff assessment of resident rescree 00" (indicating the gn of depression)					
		or), psychosis, behavioral behavior not exhibited"					
	In Section I (Active D Dementia, Restlessn	Diagnosis), "Non Alzheimer's ess and Agitation"					
	In Section N (Medicon received, "antipsychological")						
	Review of the care pl	an 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) MULT A. BUILDII	TIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED			
	095024 B. WING		B. WING _			C 09/16/2021		
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEN WASHINGTON, DC 20032		03/10/2021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 842	medicines, interver possible signs and sign reaction: falls, weight agitation, lethargy, condepression, poor appropriate to the Treatment (TAR) revealed a sect from side effects of predications (if no, do every shift". In this sect dates 08/01/2021 to documented nine (9) Resident #5 was not side effects. Review of the progres 08/25/2021 lacked do facility staff document chotherapeutic side of the progres 08/26/2021 at 11:11 of Nursing) had no condepred to the progres of the pr	2018 [Resident #5] is on 9+ intions: "Monitor for ymptoms of adverse drug is loss, fatigue, incontinence, confusion, agitation, petite, constipation, gastric ent Administration Record ction labeled, "Is resident free esychotherapeutic ocument side effects in PN) ection, it was noted that from 08/25/2021, facility staff times, "N (no)", indicating free of psychotherapeutic ess notes from 08/01/2021 to ocumented evidence that the inted Resident #5's effects. e interview conducted on AM, Employee #2 (Director omments about the findings. es admitted to the facility on nosis that included Chronic ary Disease (Acute) ic Respiratory Failure with	F	342				
	Hypoxia, and Encour							

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVEI WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	According to the Adm 08/10/2021, the resid Brief Interview for Me indicating she had no under Section O (Sp Programs) she was of	e 168 ission MDS completed on lent was coded as having a lental Status (BIMS) of "15" to cognitive impairment and lecial Treatments and lecoded as "While a Resident" therapy, suctioning and tach	F 8	342		
	and Respiratory Med	ent Administration Record lication Administration 021 showed the following:				
	control asthma and utreatment of chronic disease) puff inhale not signed as being 8/14/2021, 8/16/2022	60-4.5 Mcg/ACT 2 (helps to used for maintenance obstructive pulmonary orally two times a day was administered on 8/12/2021, 1, 8/18/2021 at 2200 (10:00 and 08/22/2021 at 1000 AM.				
	gauze every (unable was not signed as be 08/06/2021, 08/16/20	n normal saline, pat dry apply to read) care and as needed eing completed on day 021, and 08/22/2021; and on 18/12/2021, and 08/18/2021."				
	Assessment for the a showed that a respira	ratory Treatment Care aforementioned dates atory therapist administered and performed Peri trach he physician.				
		tion and treatment were Respiratory Therapist, the				

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE		(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	3371312321
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
F 842 F 867 SS=F	staff failed to record to resident receiving Syntrach care on the Treat Record and the Resp. Administration record. During a face-to-face 8:36 AM, Employee 4 Services) made no confindings. QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by: Based on observation and staff interview, the and implement an eff quality assurance and (QAPI) program incluevidenced by failing to developed plans of a deficiencies. The ressurvey was 122. Findings include:	the administration of the mbicort Aerosol and Peri trent Administration biratory Medication l. interview on 09/01/2021 at the 2 (Director of Nursing trent and assurance of the ent Activities (iii) assessment and assurance. ality assessment and assurance of the ent appropriate plans of the ent appropria	F 84	F 867	ctor of have s been g goals m this be ittee
	the following deficien	hat the facility was cited for cies: e/Discontinue/Treatment;		of this survey and other issues identified reported to the QAPI committee and add appropriately in accordance with state ar federal regulations.	are Iressed

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 867	Plan F600 Free from Abuse F610 Investigate/Previous Violation F641- Accuracy of Ass F655 -Baseline Care F656 Develop/Implem Plan F657 Care Plan Timin F677- ADL care Provi Residents F684 - Quality of Care F686- Treatment/Sem Pressure Ulcer F732- Posted Nurse S F812- Food Procurem F880- Infection Previous The aforementioned of in this current survey 2021. Based on the repeate evidence that the faci monitored their defici survey and implement they indicated in their recertification survey compliance date of 1/2 In addition, the facility Develop and implement	pirective infortable/Homelike inent Comprehensive Care and Neglect ent/Correct Alleged is essments in Plan inent Comprehensive Care ing and Revision ided for Dependent inent, Store/Prepare/Serve ention & Control ideficiencies were again cited ending September 16, and deficiencies, there is no illity staff continuously ent practices from the prior ted the corrective actions as in Plan of Correction from the of 11/19/2019 with a 110/2020.	F 86'	The Administrator/Designee will complementally reviews of all findings of this sand other issues identified to ensure approach follow up and interventions are in placed results will be reported to the QAPI Corand Governing Board monthly x 3 montreview and recommendations. The QAPI Committee and Governing Boards responsible for the on-going monitoring compliance. 5. Date correction action complete. The facility's date of alleged compliance. November 2, 2021.	urvey ropriate The nmittee hs for pard are for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3)) DATE SURVEY COMPLETED		
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COE 4601 MARTIN LUTHER KING JR AVENU WASHINGTON, DC 20032		03/10/2021
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F 867	Under F600 Free fro staff failed to thoroug corrective action for accused of abusing a F610 Investigate/Pre Violation- Failed to the investigate allegation. A face-to-face interve Employee #1 on 9/8/PM, at the time of the abuse weekly. No furnade. Under F686- Treatme Pressure Ulceresure Ulceresure Ulceresure ulceresuring that staff rechanges in residents identified. A face-to-face interve Employee #2 on 9/8/PM at the time of the westarted doing hud no formal plan. Under F880- Infection 9/8/2021 at approximate QAPI interview, sof staff protocols, we (infection control train	m Abuse and Neglect-facility ghly investigate and provide one male Employee who was a female resident; and Under event/Correct Alleged noroughly conduct and	F	367		
		ssurance and Performance meeting on 09/01/2021 at				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 867	the facility's staff had Directives for most of employee then state Orders for Scope of The Advanced Direct requirement."	#1 (Administrator) stated that not looked at Advanced of their residents. The d, "We used the Medical Treatment (M.O.S.T) forms.	F 86	57	
F 880 SS=E	Employee #2 on 9/8 PM at the time of the Assurance review, it facility has no proce performance, no est thresholds for perfor failed to develop and	/2021 at approximately 2:36 e Quality Assessment and was determined that the ess to track and measure its ablished goals and mance measurement(s) and d implement action plans to ality deficiencies in the ed above. & Control	F 88	To F 880 1. Corrective action for resident	11/02/2021
	infection prevention designed to provide comfortable environ development and tradiseases and infection \$483.80(a) Infection program. The facility must estand control program a minimum, the follows \$483.80(a)(1) A system	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at		The cooling fan has been removed from kitchen. The air handler is being addres The architects are preparing plans to be submitted for permitting prior to beginning project. Resident #87 no longer resides facility. Residents #47 and #100 have be observed receiving medications and pati with proper infection control practices. batteries in the soap dispenser in room 3 been replaced. Random room audits havyielded any soiled linen on clean surface. Audits of rooms with enhanced barrier precautions are being conducted. Staff #36, #33, #34, #23, and #47 were educated proper infection control and prevention practices.	sed. ing in the een ent care The 37 have we not es.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
				·	С	
		095024	B. WING _		09/1	6/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW		
				WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page and communicable of staff, volunteers, visit providing services un arrangement based us conducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveit possible communication infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trant to be followed to prevectively (iv) When and how is resident; including but (A) The type and dur depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstances	iseases for all residents, tors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and ogram, which must include, allance designed to identify tole diseases or a can spread to other are infections should be assessingly provided in the contraction of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the assumer which the facility	F 8	2. Identify other residents	ance of affection at the distribution and and and and arithmetical arithme	
	disease or infected s contact with resident contact will transmit t (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste	e procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the		 The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action comple The facility's date of alleged compliance November 2, 2021. 	ted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)) DATE SURVEY COMPLETED			
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F 880	Continued From pag	e 174	F 8	880		
		dle, store, process, and s to prevent the spread of view.				
	The facility will condu IPCP and update the This REQUIREMEN' by: Based on observation	uct an annual review of its bir program, as necessary. T is not met as evidenced on, record review, and				
	the facility's staff faile Control Practices wh distributing foods undevidenced by using a while providing woun administering medica and not sanitizing the	3) of 44 sampled residents, ed to maintain Infection en: preparing, serving, and der sanitary conditions, as a cooling fan in the kitchen; ad care for one (1) resident, eations to one (1) resident; eir hands before entering a ovide care. (Residents' #87				
	The findings include:					
	distribute foods unde	to prepare, serve, and er sanitary conditions, as ng fan that was in use, in the				
	08/23/2021, at approcooling fans were be preparation area. The	n of dietary services on eximately 6:45 AM, three sing used in the food the temperature in the main of the observation was 86				
	During a face-to-face	e interview with Employee #1				

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F 880	(Administrator) and E #1 stated "The air is The air handler that s and 3 West is not we been down prior to 5. This deficient practic dust and/or foreign st the kitchen and conta the kitchen and cont	Employee # 37, Employee not sufficient in the kitchen. Services the kitchen, 2 West rking. The air handler has (25/2021". The could potentially cause substances to spread through aminate food items. The acknowledged by ptember 1, 2021, at m. The distriction of the providing wound care for the care policy with a revision of instructed staff to: place to resident (under the barrier to protect the bed sitesloosen tape and scard into appropriate and the care policy with a revision of the care and the car	F	380		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			DATE SURVEY COMPLETED		
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F 880	Review of physician directed, "cleanse solution, then apply of dressing, cover with secure with cover sit 12 hours [and] prn (a 12 hours [and] prn (a 13:30 PM, Employee failed to maintain Information of the providing wound care evidenced below: 1st -While setting up care supplies, the er 4X4's (used internall the packaging and p set up on the bedsid 2nd - After removing 4X4's from the reside pressure wound), Er soiled packing on an at the foot of the residence (bowel) care. However sident's sacral wou incontinent care. 4th- The employee proposed in the foot of Reside then removed her gliphand hygiene before gloves. 5th -Employee #20 files.	order dated 07/23/2021 wound with Dankin's moist to dry Dankin's solution abd (abdominal) pad and e [Stratasorb] dressing every as needed)." on on 08/25/2021 starting at # 20 (Registered Nurse) ection Control Practices while e for Resident #87, as the clean field with wound imployee removed sterile y in the sacral wound) from laced them on the clean field e table. the wound packing including ent's sacral wound (Stage #4 incontinent pad that she set ident's bed. then provided incontinent er, she failed to recover the	F&			

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		095024	B. WING		09/16/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW	
DIVIDUEL	SINT CODACOTE AND IN	ENAB NATIONAL HANDON		WASHINGTON, DC 20032	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE SALE
				,	
F 880	Continued From page	<u> 177</u>	F 88	0	
	1 - 3	tinent care) at the foot of the	1 00		
		providing wound care to			
	Resident #87's Stage	. •			
	resident #01 3 Stage	4 Sacial Woulid.			
	6th - Additionally, Em	ployee #20 failed to place a			
		resident's sacral area before			
		e. The employee provided			
	wound care on top of				
	•				
	During a face-to-face	interview on 08/25/21 at			
	approximately 4:00 P	M, Employee #20 stated that			
		ormed hand hygiene after			
	removing her gloves				
		employee also said that she			
		ed the dirty supplies at the			
		bed before providing wound			
	care.				
		d to maintain Infections			
		Practice when administering			
	medications for Resid	dent #47.			
	Dovious of the Admin	istoring Madigation !:-:			
		istering Medication policy			
		December 2012 instructed			
		ablished facility infection			
	for the administration	.g antiseptic technique)			
	applicable."	of medications, as			
	αρριιοασίο.				
	During an observation	n on 08/23/2021 starting at			
		#36 (RN) failed to maintain			
		ndards of Practice while			
		nt #47 's medications, as			
	evidenced below:	·			
		ed the resident's 10 AM			
		om the medication cart,			
	placed them on top th	e "Soiled Clothes Hamper"			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		095024	B. WING		09/16/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW	
DIVIDUEL	AND IN	ENAB NATIONAL HARBOR		WASHINGTON, DC 20032	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORTORE	LOCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NIE .
F 880	Continued From page	e 178	F 88	0	
	that was in the reside	nt ' s room. Employee also			
		c centimeters) cup, a straw			
		top of the "dirty clothes			
		36 opened the medications			
	packets one at a time	and administered them.			
	Mbila administaring t	he resident 's medications,			
		bserved wearing gloves and			
		e "Solied Clothes Hamper"			
	-	mployee was then observed			
		off the "dirty clothes hamper"			
		paper covering. Employee			
	#36 was also observe	ed touching the straw while			
	mixing the Miralax an				
		to walk towards the resident			
		alax, the state surveyor			
		to step out the room and			
	speak with her in the	naliway.			
	It should be noted the	at Resident #47 's room			
		m the Center for Disease			
		ol (CDC) indicating that the			
		anced Barrier Precautions			
	(are intended to provi				
		s based on resident risk			
	-	are, rather than based on			
		istant organism) status,			
	especially for residen	ts at risk for acquisition (i.e.,			
	presence of indwellin	g medical devices or			
	wounds).				
	https://www.sels.es//	aci/containment/DDF Number			
	nttps://www.cac.gov/r g-Homes.html	nai/containment/PPE-Nursin			
	9-11011163.1111111				
	Additionally, the unit I	had six (6) residents with			
		fied by CDC as a MDRO).			
	Resident #47 was add	mitted to the facility on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X:	3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 880	04/12/2021. The meresident had the follo Failure with Hypoxia, Kidney Disease and Review of the physic following: Review of the hysic following: Review of the Augus Adminstration Record administered the following previously mentioned. Polyethylene Glycol by mouth one time a day for Acid tablet of mouth one time a day be a day for art Lisinopril tablet 5mg time a day for multivitamin Sennoside Tablet given a day for multivitamin Sennoside Tablet given asked, if she was go Miralax after touchin hand that touched the She stated that she would discard the Employee #36 was the stated with the stated was the moule of the stated that she would discard the Employee #36 was the stated with the stated was the stated was the multiple of the stated was the stated was the multiple of the stated was	dical record revealed the wing diagnoses Respiratory Tracheostomy, Dysphonia, Anemia. cian's orders revealed the st 2021 Medication do revealed Employee #36 owing medication during the dobservation. (Miralax)3350 Kit give 17 mg day for laxative. give 500 mg (milligrams) by y for supplement. Tolet give 100 mg by mouth exative. The example the stablet give 10 mg by mouth exative. The stablet give 10 mg by mouth entidepressants. Give 1 tablet by mouth one time sing give by mouth one time	F	380		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _			C 09/16/2021
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CO 4601 MARTIN LUTHER KING JR AVE WASHINGTON, DC 20032		007.107202.
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	of the "dirty clothes I stated, "I cleaned it vat 8:00 AM." When a the "dirty clothes har AM, Employee #36 f. 4. Review of the faci "COVID-19 Guideling of Patients & Health 10/09/2020, docume protective equipmen (goggles or face shie with the patients/resi Facility signage for Estipulated the followi "Enhanced Barrier P Everyone Must: Clean their hands, in when leaving the root Providers and Staff r Wear gloves and a ghigh-Contact Resider Bathing/Showering, Linens, Providing Hy assisting with toiletin Device care or use: Central line, urinary of tracheostomy Wound Care: any sk dressing	namper", the employee when I came in this morning isked, how could she ensure imper" was still clean at 9:40 ailed to provide an answer. Ity 's policy entitled, es for Quarantine and Testing care Providers" revised on ented, "PPE (personal t) requirements eye shield eld) at all times when working idents" Enhanced Barrier Precautions ing: recautions cluding before entering and om. must also: lown for the following: int Care Activities. Dressing, Transferring, Changing regiene, Changing briefs or ing catheter, feeding tube, in opening requiring a lie gown and gloves for the	F	380		
		vation on Unit 3 West on M, Employee #33 (Certified				

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	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP COI 4601 MARTIN LUTHER KING JR AVENI WASHINGTON, DC 20032		03/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Nurse 's Aide) was of care on a resident when noted that the resident directed, "Droplemust wear eye professes likely" During a face-to-face 08/23/2021 at 11: 00 (Administrator) state wear a face shield with patient care." 4B. During an obsero 08/24/2021 at 11:52 soap dispenser in rowing a bottle of "soot and body wash". It is had a sign on the domain as a bottle of "soot and body wash". It is had a sign on the domain as a bottle of "soot and body wash". It is had a sign on the domain as a bottle of "soot and body wash". It is had a sign on the domain arier Precautions hands, including before a bottle of the observation (Environmental Serva ware that the soap it and it only needs in the control of the observation of	bbserved doing direct patient ithout an eye field. It should sident had a sign at his door et Precautionseveryone otection if splash/spray to e interview conducted on AM, Employee #1 d, "All staff are required to hen they are doing any direct vation on Unit 3 West on AM, it was noted that the om 337 was not functioning. -functioning soap dispenser he & cool cleanse shampoo hould be noted that room 337 for that directed, "Enhanced Everyone must clean their ore entering and when e interview conducted at the on, Employee #34 rices) stated, "I was not made dispenser was out. I checked	F				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095024	B. WING			C 9/16/2021		
	ROVIDER OR SUPPLIER	REHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE WASHINGTON, DC 20032	I			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 880		brought a dirty linen bin to	F 88	80				
	08/31/2021 at 11:58 (Registered Nurse) bed of the resident i assisting the resider not wearing a gown that room 333 had a directed, "Enhanced	rvation on Unit 3 West on 3 AM, Employee #35 was observed leaning on the in room 333 Bed A while not to drink. The employee was or gloves. It should be noted a sign on the door that d Barrier Precautions must wear gown and gloves						
	_	re interview conducted at the ion, Employee #35 stated that vearing a gown.						
		to sanitize her hands prior to sroom to provide care.						
	Employee # 47 was #100 in room #159- door to room 159 st Precautions" Everyo	oroximately 5:50 AM, observed caring for Resident A. The signage outside the ated, "Enhanced Barrier one must: Clean their hands ering and when leaving the						
	medication cart and first sanitizing/clean an enteral feeding b Employee #47 then the room and proce #100's tracheostom	observed leaving her entered room #159 without ing her hands. She then hung ottle for Resident #100. changed her gloves while in eded to suction Resident y. Employee #47 then and sanitized her hands						

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED		
		095024	B. WING		C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 880	acknowledged being policy and offered no not perform hand hygresidents room. There was no eveider her hands prior to ent provide care.		F 886	F 883	11/02/2021
SS=E	policies and procedur (i) Before offering the each resident or the receives education re potential side effects (ii) Each resident is o immunization Octobe annually, unless the ic contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that in following: (A) That the resident of was provided educati and potential side effei immunization; and (B) That the resident of	and pneumococcal za. The facility must develop es to ensure that- influenza immunization, resident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically resident has already been stime period; e resident's representative or refuse immunization; and dical record includes dicates, at a minimum, the		1. Corrective action for resident Residents #21 and #95 have been offered Influenza and Pneumonia vaccines and v have been administered as appropriate. Resident #105 no longer resides in the fa 2. Identify other residents An audit of all current residents has been completed. There were no additional fine related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are vaccines and ensuring that the residents a their responsible party are given information/education regarding the bene and risks of immunization. The Directo Nursing will be responsible for ensuring vaccines are offered with information/ed regarding the benefits and risks of immunization.	raccines acility. In dings coffered and/or efits or of that

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		LETED
		095024	B. WING _			C 1 6/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE S WASHINGTON, DC 20032	·	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 883	immunization due to refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the immunization, each representative receive benefits and potential immunization; (ii) Each resident is communization, unless medically contraindical already been immunication that in following: (A) The resident or the has the opportunity to the resident was provided educated and potential side effit immunization; and (B) That the resident pneumococcal immunication or resident or resident pneumococcal immunication pneumococcal	medical contraindications or nococcal disease. The facility is and procedures to ensure responding to the resident's responding the solution regarding the solution regarding the solution is resident's representative to refuse immunization; and redical record includes andicates, at a minimum, the resident's representative for resident's representative regarding the benefits rects of pneumococcal reither received the mization or did not receive remunization due to medical	F	The MDS Nurse/Designee will co audits of vaccination reports to en vaccines are being offered and the records of residents with new vaccensure that information/education benefits and risks of immunization will be reported to the QAPI Commonthly x 3 months for review an recommendations. The QAPI Committee is responsil going monitoring for compliance. 5. Date correction action control for the facility's date of alleged common November 2, 2021.	omplete weekly issure that a medical cinations to regarding the in. The results imittee in the completed is the completed in the completed issues that the completed is the completed is the completed in the completed is the completed in the completed in the completed is the completed in the complete in the complet	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP 4601 MARTIN LUTHER KING JR AV WASHINGTON, DC 20032		33/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 883	Continued From page	e 185	F	883		
	Vaccine" revised 07/2 and employees who contraindications to the influenza vaccine and of the vaccine shall be informed Consent for placed in the resident's medical red. 1. Resident #21 was 06/29/2021, with multiple Degenerative Joint Degen	ne vaccine will be offered the hually A resident's refusal e documented on the Influenza Vaccine and cord" readmitted to the facility on iple diagnoses that included: isease, Respiratory Failure, oral Vascular Accident. sion Minimum Data Set 021, revealed that the facility ent as follows: re Patterns), "Severely" Treatments, Procedures the resident receive the his facility for this year's season?" Facility staff not received, state reason" ted, "Not offered"; umococcal vaccination up to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095024	B. WING			C 09/16/2021
	ROVIDER OR SUPPLIER	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIF 4601 MARTIN LUTHER KING JR A WASHINGTON, DC 20032		03/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 883	benefits and risks of opportunity to receive 2. Resident #95 was 01/19/2021, with mul Cerebral Infarc due to Cerebral Artery, Resident and Programs of the Admissive revealed that facility. In Section C (Brief In "Severely cognitively. In Section O (Special and Programs), "Didinfluenza vaccine in Influenza vaccine facility staff documented "No"; "If influenza vaccine facility staff documented "Is the resident's Programs of the resident's Programs of the resident of the residence of the recipies and paper health received of the resident of the resident of the resident of the resident of the residence of the received of the residence of the received of the received of the resident and risks of opportunity to receive 3. Resident #105 was 05/26/2021, with mul Polyneuropathy, And the received of the received	admitted to the facility on tiple diagnoses that included: o Embolism of Left Middle dessness and Agitation, ter Gastrostomy and ter Tracheostomy. Sion MDS dated 01/26/2021, staff coded the following: Treatments, Procedures the resident receive the disinguity for this year's a season?" facility staff Interceived, state reason" ted, "Not offered"; sumococcal vaccination up to occumented, "No", coination not received, state documented, "Not offered". Resident #95's electronic ord lacked documented staff provided the resident's information regarding the immunizations or the	F	383		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		X3) DATE SURVEY COMPLETED
		095024	B. WING _		C 09/16/2021
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 908 SS=E	Chronic Pain Syndron Review of the Signific 07/13/2021, revealed following: In Section C (Brief Insummary score of "15 response. In Section O (Special and Programs), " Is Pneumococcal vaccinstaff documented, "N" If pneumococcal vaccinstaff documented, "N" is pneumococcal vaccinstaf	rant Change MDS dated facility staff coded the sterview for Mental Status) 5", indicating intact cognitive Treatments, Procedures the resident's nation up to date?" facility oo", cination not received, state locumented, "Not offered". Resident #105's electronic ord lacked documented staff provided the resident rding the benefits and risks the opportunity to receive interview conducted on M, Employee #2 (Director of the would follow-up about Safe Operating Condition in all mechanical, electrical,	F8	08 F 908 1. Corrective action for resident	11/02/2021
	condition. This REQUIREMENT by: Based on observatio	pment in safe operating is not met as evidenced ns and staff interview, facility mechanical/electrical		No areas are greater than 81°F. Resident low-air pressure mattress has been replace. The air handler is being addressed. Resid were checked with no concerns raised abound individual room temperatures.	ed. lents

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				URVEY ETED
			A. BUILDING	<u> </u>	C	
		095024	B. WING		09/16/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
				2. Identify other residents		
F 908	Continued From page	e 188	F 90			
	equipment in safe op	erating condition as		An audit of resident rooms and commo		
	evidenced by: failure	to ensure the air handler		did not reveal any areas at or greater that		
	was working as intend	ded, and failed to ensure a		An audit of resident beds was complete		
	-	essure bed was operating		were no additional findings related to the	118	
	as intended. Resider	nt # 68.		citation.		
				3. Systemic changes		
	The findings include:			Staff have been educated on the import	ance of	
	1 During a walkthrou	igh of distant continue on		ensuring that mechanical, electrical, and		
	1. During a walkthrough of dietary services on August 23, 2021, at approximately 6:45 AM, a			care equipment are in safe working con		
	cooling fans were bei			include initiating service requests for ed		
	· ·	e temperature in the main		in need of repair/servicing). The Direct		
		the observation was 86		Engineering, Materials, and Biomedica	l	
	degrees Farenheit.			Engineering Technician will be respons		
	J			ensuring that mechanical, electrical, and		
		interview on 8/23/2021 at		care equipment are in safe working con	dition.	
	Employee #37, Employee	M, with Employee #1 and oyee #1 stated, "The air is		4. Monitor corrective actions		
		tchen." Employee #37		Engineering/Designee will complete we		
	2 West and 3 West is	ler that services the kitchen,		audits of mechanical, electrical, and par		
		wn prior to 5/25/2021. We		equipment service requests to ensure th		
		the air from the unit"		are in safe working condition. The resu		
	are losing 20 40 /0 01	the an normale arm		be reported to the QAPI Committee mo		
	During a walkthrough	of unit 3 west on		months for review and recommendation	ıs.	
		kimately 8:30 AM resident		The CADI Committee is 11.1.6		
		rith Employee #37 (Director		The QAPI Committee is responsible for	the on-	
		using the facility's infrared		going monitoring for compliance.		
	thermometer, temper	ature levels registered		5. Date correction action comple	ted	
	_	hrenheit in five (5) out of		Date correction action comple	icu	
		room 337, 81.9 degrees		The facility's date of alleged compliance	e is	
		6, 85.5 degrees Fahrenheit;		November 2, 2021.	15	
		ees Fahrenheit; room 335,				
	_	heit and room 334, 81.7				
	degrees Fahrenheit.					
	At the time of the obs acknowledged the fin	ervation, Employee #37 dings.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPION DEFICIENCY)) BE COMPLETION
F 908	Continued From page	e 189	F 90	8	
		to ensure Resident #68's was operating as intended.			
	Resident #68 was re multiple diagnoses in	al record revealed that -admitted to the facility with cluding Chronic Respiratory on Respirator [Ventilator], Spastic Quadriplegic			
	an Assessment Refer revealed in Section (Status) the section w (Functional Status) - "4" and "2" indicating dependent on the ph staff person for bed r Diagnoses)- the resid Palsy, Quadriplegia, Dependence on Res Weakness. In Sectio and Skin Problems)	erly Minimum Data Set with ence Date of 07/06/21 C (Brief Interview for Mental vas blank. In Section G the resident was coded as a that the resident was totally ysical assistance of one (1) mobility. In Section I (Active dent was coded for Cerebral Respiratory Failure, pirator [Ventilator], and n M (Other Ulcers, Wounds the resident was coded for using pressure reducing			
	11:00 AM to 1:00 PM pressure mattress pu	vations on 08/26/2021 from I, Resident #68's low-air ump?alarm was beeping ure and power failure."			
	1:05 PM, Employee stated that she had to	e interview on 08/25/2021 at #38 (Registered Nurse) o unplug the bed and then ound alarm would stop			
	During several obser	vations on 08/30/2021 from			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		095024	B. WING _		C 09/16/2021	
	ROVIDER OR SUPPLIER DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 943 SS=E	1:00 PM to 3:00 PM, pressure mattress puindicating "low pressure mattress puindicating "low pressure mattress puindicating "low pressure mattress puindicating a prong. The he would change the During several observations as the would change the During several observations are mattress puindicating "low pressure mattress puindicating "low pressure mattress puindicating "low pressure maintenance) was as department was awa continues to alarm, the mattress that was in resident's room and separtment had broughted to be changed help to switch out the Abuse, Neglect, and CFR(s): 483.95(c) Abuse, near landidition to the free and exploitation requirement at a minimum editorial mattress must also protest and an information of the free and exploitation requirement at a minimum editorial mattress must also protest and a minimum editorial mattress puinters and a minimum editori	Resident #68's low-air mp alarm was beeping are and power failure." interview on 08/30/2021 at #39 (Maintenance) stated and because the three-prong arong, three-prong plug was employee then stated that "cord and pump". // wations on 09/01/2021 from Resident #68's low-air mp alarm was beeping are and power failure." interview on 08/30/2021 at #40 (put in work request for ked if the maintenance are that the resident bed are employee pointed to a generate that the maintenance got the hallway in front of the stated that the maintenance got the new mattress up to the alarming. Employee #40 (whole mattress and pump end all staff would need to mattress. Exploitation Training and all staff would need to mattress. Exploitation Training to their staff would their staff	F9	F 943	e. De affected.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		-1	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2021
				4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGEP	DINT SUBACUTE AND R	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
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F 040	0 " 15	404		3. Systemic changes		
F 943	1.3		F 94	Staff have been educated on Abuse, Ne	alaat	
	neglect, exploitation, resident property as s	and misappropriation of set forth at § 483.12.		and Exploitation. The Director of Educ will be responsible for ensuring that em	ation	
		ures for reporting incidents		participate in annual required trainings.		
	of abuse, neglect, expension of respective of respective of the control of the co			4. Monitor corrective actions		
	by: Based on record rev facility staff failed to e an abuse, neglect, ar training program and place to track attenda first day of survey wa The findings include: Review of the "2020 s included training and	ntion. is not met as evidenced iew and staff interview, insure all staff participated in and exploitation prevention failed to have a process in ance. The census on the s 122. Skills Competency Packet" skills check-off on subjects		The Director of Education/Designee wi complete weekly audits of all required t and reconcile attendance with work schensure that all staff receive the education results will be reported to the QAPI Commonthly x 3 months for review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete The facility's date of alleged compliance November 2, 2021.	rainings edules to on. The mmittee	
	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,					

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	095024	B. WING		C 09/16/2021		
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032			
ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION		
she stated, "The eduroster, then tracks ar those individuals contrainings." During a face-to-face 09/08/2021 at 11:35 documented evidence received/participated	cator reconciles the sign- in and follows up to make sure applete and receive the einterview conducted on AM, when asked to provide that all staff in the mandatory the	F 94	3			
Required In-Service T CFR(s): 483.95(g)(1) §483.95(g) Required aides. In-service training must \$483.95(g)(1) Be sufficient to less than 12 how services than	in-service training for nurse ust- ficient to ensure the ce of nurse aides, but must burs per year. de dementia management abuse prevention training. ss areas of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as cility staff. rse aides providing services gnitive impairments, also ne cognitively impaired.	F 94	1. Corrective action for resident Staff have been trained on restraints. 2. Identify other residents All residents have the potential to be There were no additional findings relicitation. 3. Systemic changes Staff have been educated on Restrain Director of Education will be responsensuring that employees participate in required trainings. 4. Monitor corrective actions The Director of Education/Designee complete weekly audits of all require	affected. ated to this ts. The sible for annual will d trainings		
	CORRECTION DVIDER OR SUPPLIER NT SUBACUTE AND R SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page she stated, "The eductoster, then tracks ar those individuals contrainings." During a face-to-face 09/08/2021 at 11:35 of the documented evidence received/participated trainings, Employee of the any documentation. Required In-Service T CFR(s): 483.95(g)(1) §483.95(g) Required the aides. In-service training mutually and resident training and resident training and resident the shall be and facility assessment address the special redetermined by the face of the shall be and the shall be and the shall be and the shall be the shall be and the shall be	DUTING A FACE TO THE TRANSPORT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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:	DOVIDER OR SUPPLIER NT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §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:	DOUBTER OR SUPPLIER NT SUBACUTE AND REHAB NATIONAL HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 192 she stated, "The educator reconciles the sign-in roster, then tracks and follows up to make sure throse individuals complete and receive the trainings." During a face-to-face interview conducted on 09/09/2021 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. Required in-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) S483.95(g) Required in-service training for nurse aides. In-service training must-service training must-service training and resident abuse prevention training. S483.95(g)(2) Include dementia management training and resident abuse prevention training. S483.95(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. S483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REOUIREMENT is not met as evidenced		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN		С	
		095024	B. WING		09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRINCER	NINT CUDACUTE AND D	EHAB NATIONAL HARBOR		4601 MARTIN LUTHER KING JR AVENUE SW		
BRIDGER	JINI SUBACUTE AND K	EHAB NATIONAL HARBOR		WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)) BE COMPLETION	
F 947	F 947 Continued From page 193		F 94	The QAPI Committee is responsible for going monitoring for compliance.	the on-	
	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.			5. Date correction action complet The facility's date of alleged complianc November 2, 2021.		
	The findings include:					
	that showed, " This within the week wher care to residents in a instructed to [Employ the residents. The typ [Employee #5] to the	cument dated 07/20/2020 s is the second occurrence e [Employee #5] provided manner previously ee #5] should not provide to be of care provided by residents isActing in sidered abuse or neglect or cient/resident either				
	file lacked documente additional training wa	s conducted after these yet he was allowed to return				
	09/08/2021 at approx Employee #7 (Directo stated, "No additional	interview conducted on kimately 12:15 PM, or of Human Resources) education was provided, he of the verbal warning."				
	equipment to prevent considered restraints	rision date of 04/2017 es that inappropriately utilize resident mobility are and are not permitted "				
	Review of a facility re	ported incident (FRI) on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095024	B. WING		C 09/16/2021	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 947	01/27/2021 document 1-27-2021 her (Residited to the rail. It was the patient was assess ongoing" During a face-to-face 08/31/2021 at 9:45 A (Administrator) stated the allegation. Based could not determine a bed rail. It could have family member. We anot find any other resito the bed." Review of the facility's Sheet Title/Subject: R (conducted 36 days at the signatures of 22 CLPNs CNAs), indicating received the training. During a face-to-face 09/08/2021 at 11:35 appreviously mentioned (Educator) stated tha and was done on diffiprovide documented	lent #95) mitten was found immediately released, and immediately released on M, Employee #1 d., "We couldn't substantiate on the staff interviews, we who tied the resident to the impediately and did ident with hand mittens tied in items in the incident immediately revealed of 127 staff members (RN, ing only 22 staff members (RN, ing only 22 staff members interview conducted on AM, when asked about the interview interview the interview efficiency interview interview efficiency interview the interview and interview was ongoing in the training, Employee #8 in the training was ongoing interview that all the nurse's straints training, Employee	F 94	7		