ATEMENT	gulation & Licensing A OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
			A. BUILDING		C	;
		HFD02-0023	B. WING		09/1	6/2021
ME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	DINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW		
			IGTON, DC 200	032		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLE DATE
	at Bridge Point Nation dates- August 23, 202 The survey team con- survey onsite at the fa 30, 2021 and Septern Survey activities cons sampled residents. T the survey was 122. The following compla incidences were inve DC00010058, DC000 DC00010199, DC000 DC00010198, DC000 DC00010198, DC000 DC00010198, DC000 DC00010240. After analysis of the f that the facility is not requirements of 22B Municipal Regulation It should be noted tha Federal survey the fa immediate jeopardy (42 CFR§483.12 Free and Exploitation, F60 1:55 PM. The facility plan of corrective acti concerns on Septem	indings, it was determined in compliance with the District of Columbia s Chapter 32. at during the joint State and cility was cited at an IJ) under: dom from Abuse, Neglect, 00 on September 8, 2021 at 's Administrator provided a ion to address the identified ber 8, 2021 at 7:32 PM. rified the IJ was removed on	L 000	L 000-Preparation and/or execution plan of correction do not constitute or agreement by provider of the transference of transferen	e admission cuth of the th in the n of cuted solely and state	
	42 CFR§483.25 Qual Treatment/Services t Ulcers, F686 on Sep	lity of Care- o Prevent/Heal Pressure tember 8, 2021 at 2:01 PM. rator provided a plan of				
RATORYD	RECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE Interim Administrator		(X6) DATE 1/02/20

STATE FORM

If continuation sheet 1 of 149

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		• • •	E SURVEY PLETED
			A. BUILDING:			
		HFD02-0023	B. WING		09	C 0/16/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	DINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
BRIDGER			NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 000	Continued From page	e 1	L 000			
	After the team verifie	ddress the identified ber 8, 2021 at 7:31 PM. d that the plan of correction ember 16, 2021 at 7:52 PM,				
	The following deficient observation, record reinterviews.	ncies are based on eview, and resident and staff				
	-	ectory of abbreviations t may be utilized in the				
	AV-ArteriovenousBID -Twice-a-dB/P -Blood Prescm -CentimeCFR-Code of	nt Reference Date s ay ssure ters Federal Regulations				
	ServicesCNA-CertifiedCRF -CommunitCRNP-Certified FD.CDistrict of	or Medicare and Medicaid Nurse Aide y Residential Facility Registered Nurse Practitioner Columbia Columbia Municipal				
	Regulations D/C- Disconti DI- Deciliter DMH - Department	nue of Mental Health				
	DOH-DepartmenEKG -12 lead ElectEMS -EmergencyF -FahrenheitFRFrench					
	G-tube- Gastrostor HR- Hour HSC - Health Se	my tube rvice Center				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		HFD02-0023	B. WING		09	C 9/16/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
RIDGEP	DINT SUBACUTE AND R		NGTON, DC 20032			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
L 000	Continued From page	e 2	L 000			
	HVAC - Heating ven	tilation/Air conditioning				
	ID - Intellectua	÷				
	IDT - Interdiscipl					
	•	revention and Control				
	Program					
	-	Practical Nurse				
	L- Liter					
	Lbs - Pounds (u	nit of mass)				
	MAR - Medication	Administration Record				
	MD- Medical Do					
	MDS - Minimum D	Data Set				
	Mg - milligrams	(metric system unit of mass)				
	M- minute					
	mL - milliliters (metric system measure of				
	volume)					
		ns per deciliter				
	mm/Hg - millimeters	of mercury				
	MN midnight					
	N/C- nasal ca					
	Neuro - Neurologica					
		e Protection Association				
	NP - Nurse Prac	ctitioner				
	O2- Oxygen					
		ion screen and Resident				
	Review	F adasaania				
	Peg tube - Percutane	eous Endoscopic				
	Gastrostomy PO- by mouth					
	•	Attornov				
	Prn - As neede	's order sheet				
	Pt - Patient	ŭ				
	Q- Every					
		dicator Survey				
	RD- Registered					
	RN- Registered N					
	-	of Motion				
	RP R/P - Responsibl					
	-	ckground, Assessment,				
	Recommendation					

STATE FORM

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	eted
		HFD02-0023	B. WING		09/1	6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW 032		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
L 000	Continued From page	e 3	L 000			
	SCC Special C	are Center				
	Sol- Solution					
	TAR - Treatment	Administration Record				
	Ug - Microgram	า				
L 001	3200.1 Nursing Facili	ties	L 001	L 001		
	J					
		shall comply with the Act,		A. Under 42 CFR §483.12, F600,		09/15/202
		equirements of 42 CFR Part		Freedom from Abuse, Neglect, a	ind	
	483, Subpart B, Sect			Exploitation		
		483.150 to 483.158; and		1. Corrective action for resid	lent	
	-	33.200 to 483.206, all of				
		licensing standards for		Identified resident #105 (no longer		
	-	e District of Columbia.		facility) was interviewed 9-8-2021	U	
	This Statute is not me	-		their statement. The identified Aide	e was	
	Based on observation			terminated on 9-01-2021.		
		or facility documents and		2 Identify other residents		
		lity staff failed to comply with		2. Identify other residents		
		nd the requirements of 42		An audit of all other resident's con	mlatad	
		art B, Sections 483.1 to ections 483.150 to 483.158;		There were no additional findings		
		on 483.200 to 483.206, all of		citation.		
	-	licensing standards for		chaton.		
				3. Systemic changes		
		e District of Columbia. The g the survey was 122.		5. Systemic changes		
	Tacinty 5 census durin			All FRIs from January 2021 to pres	sent were	
	The findings include:			reviewed to ensure that they were		
				investigated. Education files of an		
	Immediate Jeopardv	(IJ) represents a situation in		involved in the FRIs were reviewed		
		bliance has placed the health		that appropriate actions were taken		
		nts in its care at risk for		their involvement. Education/Desi		
		s harm, serious impairment		service all staff on the Abuse Policy		
		tions must be accurately		procedures. New Administrator and		
		rs, thoroughly investigated,		Board will in-service leadership on the		
		entity as quickly as possible.		Policy and procedures. In the future,		
		liance cited at IJ is the most		employees involved in allegations		
		be, and carries the most		neglect, exploitation, or mistreatme		
		providers, suppliers, or		receive immediate in-servicing on		
	laboratories (entities)	. An immediate jeopardy		Abuse Policies and Procedures. Al	l future FRIs/	

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	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	:	с
		HFD02-0023	B. WING		09/16/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (X
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP
L 001	Continued From page		L 001	allegations conclusions will be forwar email/writing the	-
	situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be			LNHA/HR/DON/Departmental Super [Licensed Nursing Home Administrate	
				Resource/Director of Nursing] with th	
	corrected to avoid fur	ther or future serious harm.		and preventative measures that have b place to protect the resident.	
	https://www.cms.gov/Regulations-and-guidance/			place to protect the resident.	
	Guidance/Manuals/dovelogical edjeopardy.pdf	wnloads/som107ap_q_imm		4. Monitor corrective actions	
	A Under 42 CFR 848	3.12, F600, Freedom from		Administrator/ Designee will conduct	an
	Abuse, Neglect, and			audit all FRIs weekly for 2 months to ensure the facility has completed a	
				thorough investigation of the alleged	
		clinical records, facility y policies, and resident and		violation; prevented further abuse,	
	staff interviews, for or			neglect, exploitation and mistreatment	t
	residents, the facility	s staff failed to prevent and		from occurring while the investigation	1
		5 from psychological and		was in progress; and took appropriate	
		nployee #5 and because of oyment history, there is a		corrective action, as a result of investigation findings. Results of findi	ing
	likelihood of the empl			will be forward to QAPI for review an	-
	residents.			recommendations.	
	situation was identifie	, an immediate jeopardy ed on September 8, 2021 at submitted a plan of action		The QAPI Committee is responsible for going monitoring for compliance.	or the on-
	to the survey team the on September 8, 202	at was on onsite at 7:32 PM 1, and the plan was		5. Date correction action compl	eted
	accepted. The survey September 16, 2021 and the immediate je	to validate the facility's plan,		The facility's date of alleged complian September 15, 2021.	nce is
		at 7:52 PM. After removal			
	of the immediacy, the	deficient practice remained			
	•	e than minimal harm for all at a scope and severity of H.			
	The findings include:				
	Investigation and Rep	s policy entitled, "Abuse porting" with a review date of			
	08/2020 revealed, "	The administrator will			

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		HFD02-0023	B. WING		C 09/1	; 6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW 32		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	NC	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLET DATE
L 001		otential abuse, neglect	L 001	B. Under 42 CFR §483.25, F686, Treatment/Services to Prevent/Heal PressureUlcers		09/15/2021
	exploitation or mistrea	atment is prevented"		1 Compative estion for residen		
	Neglect- Clinical Prot 08/2020 revealed, " and staff will institute	s policy entitled, "Abuse and ocol" with a review date of The facility management measures to address the ad minimize the possibility of		1. Corrective action for residen Residents #87, #83, #73, #62, and #42 assessed on 9/8/2021 to ensure that an in skin condition were identified and appropriately. Resident #87 no longe the facility. Staff were educated on ic and reporting changes in skin condition	2 were ny changes treated er resides in dentifying	
		provide a safe environment of Resident #105 from the fom Employee #5.		2. Identify other residents		
		essive Disorder, and		Facility completed house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the Licen Nursing staff during the residents showers/bed baths to document any		
		nplaint was received by the cumented, "[Resident #105		changes in the resident's skin condit	tion.	
	reported to the Ombu August 18th [2021] the	udsman on the night of e nursing Aide stuffed		3. Systemic changes		
		ef with pieces from a chuck nd said 'I am not changing		The assessments will be documented stored in the departmental shower be and the DON/Designee will audit fo	ooks	
		08/24/2021, documented, " e staff and other residents on g with examining the		completion twice a week for two months. The corporate wound nurse designee will in-serviceAll Nursing s including registry on the process of reporting head and toe assessment an	staff	
	investigation has con determined from the i evidence presented to was committed towar	cluded, and it was investigation there was no o prove abuse and neglect ds the resident [Resident		reporting documenting changes in residents skin condition to the Physi and wound team as soon as identifie An in-service including a sign-in sho	ician d. eet	
	#105] in question. In unsubstantiated due	erefore, the case has been to these findings."		will be provided to track Nursing sta All Nursing Staff including registry		

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TATEMENT	OF DEFICIENCIES DF CORRECTION	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		HFD02-0023	B. WING		09/16/2021
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
	OINT SUBACUTE AND R	4601 MA	RTIN LUTHER	KING JR AVENUE SW	
		WASHIN	IGTON, DC 200	32	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DPRIATE DATE
L 001	Continued From page	e 6	L 001	be in-serviced on Wound Policy an	
				procedures. The Corporate wound i	
	On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]The residents daughter reported to the Ombudsman C.N.A. (Certified Nurse's Aide) told the resident 'she caused him three days of pay, and that she talks too much."			will educate the Director of Nursin	ig on
				the Wound policy and procedures.	
				4. Monitor corrective actions	
	pay, and that she talk	s too much."		Turning and repositioning will be m	
	Deview of Desident #	105's Significant Change		every two hours by the nursing supe	
	Review of Resident #105's Significant Change Minimum Data Set (MDS) dated 07/13/2021,			ensure proper turning and reposition	
		staff coded the following:		conducted. A turning and reposition	
	Tevealed that facility s	stall coded the following.		will be used to monitor turning and	reposition.
	In Section C (Cognitiv	ve Patterns), Brief Interview		Wounds found during the skin	
		MS) score "15", indicating		assessments a RCA (Root Cause	
	intact cognitive respo	· •		Analysis) to investigate the Nursing	, staff
	indet obginare roope			responsible for not properly	
	In Section E (Behavio	or), Hallucinations		documenting skin assessments, and	1
		ces in the absence of real		conducting turning and repositioning	ng.
	external sensory stim			This will be monitored by The Dire	-
		eliefs that are firmly held,		of Nursing and Nursing Supervisor	
	contrary to reality) "N	o"; and in Section GG		"skin tag violation card" will be	
	(Functional Abilities a	nd Goals), Toileting hygiene		implemented to address any staff f	ound
	" total dependence	one-person physical		not doing proper turning and	ound
	assist".			repositioning of residents. Nursing	atoff
		interview conducted on		with over3 violations will be taken	
	08/30/2021 at 9:06 A			the floor immediately for training a	
	(Administrator) stated			weekly Quality Audit will be cond	
		e Nurse Supervisor knew		by the QAPI team. All finding will	
		vork with the resident		addressed at the weekly QAPI mee	eting
	(Resident #105). The			for 2 months. QA Audits of skin	
		tem. The involved CNA was		assessment documentation done wee	ekly
		ere Resident #105 resided).		for two months to ensure skin	
		assigned to that unit. He ed that he did not say		assessments will be completed to e	ensure
	anything to [Resident	-		timely and appropriately. This will	
	providing care. The s			monitored by the Administrator,	
	reprimanded, and the			Director of Nursing and the Quality	J
	suspended (on 08/27			Director and addressed in the week	
	terminated as of toda				цу
	isininaleu as ul luua	·y·		QAPI meetings.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY PLETED
			B. WING		C
		HFD02-0023	5. 11110		0/16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST		
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	ARTIN LUTHER NGTON, DC 200	KING JR AVENUE SW 032	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE ⁻ DATE
L 001	Continued From page	e 7	L 001	The QAPI Committee is responsible for the on going monitoring for compliance.	-
	08/30/2021 at 9:17 A			5. Date correction action completed	
		she stated, "We don't and-off (transfer of patient		The facility's date of alleged compliance is	
	care and responsibility from one healthcare provider to another) communication with the			September 15, 2021.	
		e week. The supervisors		C. Under 42 CFR §483.10(c)(6), F578,	11/02/202
	were made aware that to work on the third fle	at the CNA involved was not oor at all."		Request/Refuse/Discontinue Treatment;Formulate	11/02/202
		nterview conducted on		Advance Directive:	
	Supervisor) stated, "T	AM, Employee #6 (Nurse The CNA [Employee #5] was		1. Corrective action for resident	
	for that unit. I was tole	ause we didn't have a CNA d that the CNA shouldn't be		Resident #105 no longer resides in the facility. Residents' #3, #5, #21, #37, #76, and #95 and/	
	issues on 3 west."	is not made aware about the		their representatives have been given the opportunity to exercise their rights to formulate	
	•	nterview conducted on		Advance Directives and Staff have validated corresponding orders.	
		AM, Employee #5 stated, "I st and was pulled to 3 West			
	because they were sl investigation was res	hort. I was told the olved and no issues were		2. Identify other residents	
	found, so I went to th	e unit (3 west). I was taking		An audit of all resident's Advance Directives was completed. There were no additional	
	[Resident #105] state	e (room 333 bed B) when ed that she was wet and		findings related to this citation.	
	she made a report or	s well. I reminded her that in me and that I didn't want		3. Systemic changes	
		esident stated that she er and so I did. There were		Social Services staff have been educated on the	2
		ADL (activities of daily living) ing this for 17 years. I have		importance of resident's/responsible party's rights to formulate an Advance Directive and	
		to her nor intimidate her in		their responsibility to ensure that there is a corresponding order and armband. The Direct of Social Services will be responsible for	or
		#5's personnel file on a form entitled; "[Facility's		validating that all residents have been offered	
	Name] Employee Wa 07/29/2020. The form				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
			B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	HFD02-0023 STREET A	DDRESS, CITY, STA		09/1	6/2021
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	RTIN LUTHER P	(ING JR AVENUE SW 32		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
L 001	policy/procedure". Attached to the previnotice was a docume Director of Nursing the "On the morning of J to the attention of the Wound Care Team r resided on unit 3 east filled incontinence br Ultrasorb (under pads CNA (Employee #5) of the under pads ins [Employee #5] said [wetter" "On the morning of J #105] had a urine stat taped together to for was taped to the res roommate] was obse makeshift incontinen 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 patient/resident either verbally."	7/20/2020) for "violation of fously mentioned warning ent written by the (previous) hat revealed the following: uly16, 2020, it was brought e Director of Nursing by nember a resident [that st] was observed with a urine ief on and a urine saturated is) in the incontinence Brief. was asked about the use side of the resident 's diaper. Resident's Name] is a heavy uly 20 [2020] [Resident ained Ultrasorb under pad m a incontinence brief and ident's skin[Resident 105's erved with the same ce brief and in addition urine und between the resident's cond occurrence within one ree #5] provided care to er The type of care ee #5] to the residents is a sting in a way that can be neglect, or mistreatment of a er physically, mentally or	L 001	 the opportunity to formulate an Adva Directive and have corresponding phorders. 4. Monitor corrective actions The Director of Social Services/Design complete audits of all Advance Directive actions weekly and monthly other residents to assess compliance aup on any subsequent findings. The pie reported to the QAPI Committee rimonths for review and recommendation The QAPI Committee is responsible going monitoring for compliance. 5. Date correction action complete facility's date of alleged compliand November 2, 2021. D. Under 42 CFR §483.15, F622 Transfer andDischarge 1. Corrective action for resider Residents #97 and #103 are currently in the facility. We are unable to retrocomplete the documents. The Acute Transfer Document Checklist has beet to include Comprehensive Care Plan 2. Identify other residents with trans the facility was conducted. Moving for the section of the section for the section for the section for the facility was conducted. Moving for the facility was conducted. Moving for the section for the facility was conducted. Moving for the facility was conducted. Moving for the section for the section for the section for the section for the facility was conducted. Moving for the section for t	ysician gnee will tives on all on all and follow results will nonthly x 3 ions. for the on- oleted unce is nt residents ospectively care en updated Goals.	
	revealed there was n the facility's staff revi personnel record or i	o documented evidence that iewed Employee #5's implemented measures to including Resident #105, "abuse or neglect, or		the documents will be included in tra packets. An audit of the Acute Care Document Checklist noted that the Comprehensive Care Plan Goals was included in the list of documents auto	nsfer Transfer not	

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
			A. BUILDING		С
		HFD02-0023	B. WING		09/16/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER	KING JR AVENUE SW	
			IGTON, DC 200	032	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE
L 001	Continued From page	e 9	L 001	to include in the transfer packet (this has b	
	mistreatment of a pat			corrected). There were no additional findin related to this citation.	igs
	physically, mentally o	or verbally." Additionally,			
		nnel record failed to outline		3. Systemic changes	
	unit 3 East.	as not allowed to work on		Nursing staff and Unit Secretaries have been	en
				educated on the updated Transfer Docume	
		interview on 09/08/2021 at		Checklist and the need to include the	
		AM, Employee #7 (Director		Comprehensive Care Plan Goals in the tran	
		s) stated, "The previous hat occurred in 07/2020)		packet. The Acute Care Transfer Checklis been updated to include the Comprehensiv	
		to the Director of Nursing		Care Plan Goals. The Shift Supervisors wi	
		ccurred on 08/31/2021 when		responsible for ensuring that Comprehensi	
	termination (of Emplo	oyee #5) was discussed."		Care Plan Goals are included in the transfe	r
	During a face-to-face	interview on 09/08/2021 at		packets.	
	-	AM, Employee #2 (Director		4. Monitor corrective actions	
		was not aware of any			
	(CNA) until the meeti	made for Employee #5		The Director of Social Services/Designee	will
		ng 011 00/3 1/2021.		complete weekly audits of all residents transferred out of the facility to ensure that	the
	During a face-to-face	interview on 09/08/2021 at		Comprehensive Care Plan Goals were included	
	approximately 10:30			in the transfer packet. The results will be	
		d, "I was not aware of any		reported to the QAPI Committee monthly	x 3
		or disciplinary actions for the #5). I did not review his		months for review and recommendations.	
	personnel file as part			The QAPI Committee is responsible for the going monitoring for compliance.	e on-
		21, at 1:55 PM an Immediate			
		ation was identified. On		5. Date correction action completed	
		t 7:32 PM, the facility's ad a corrective action plan to		The facility's date of alleged compliance is	5
		vey Team, which included:		November 2, 2021.	
		t #105 was interviewed			
	9-8-2021 and signed				
	identified Aide was te	rminated on 9-01-2021.			
		nducted on all SNF [Skilled			
		connel files to identify if any			
	have been under inve tion & Licensing Administration	estigation for allegations of			

	OF DEFICIENCIES OF CORRECTION	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		HFD02-0023	B. WING		C	6/2021
					09/10	0/2021
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, S	rate, zip code KING JR AVENUE SW		
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H	IGTON, DC 200			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLET DATE
L 001	Continued From page	e 10	L 001	E. Under 42 CFR §483.20, F641, Accuracy of Assessments	1	1/02/2021
	abuse, neglect, explo	pitation, or mistreatment to		Accuracy of Assessments		
	ensure all identified of	corrective disciplinary and and investigations were		1. Corrective action for residen	nt	
		t and protect residents from		Resident #87's MDS was corrected.	The	
	further abuse, negled	•		resident is no longer residing in the fa	acility.	
	audit all IRF's [Incide	nces Reported by the grievances from January of		2. Identify other residents		
		ertinent staff and residents		An audit of all current residents MDS		
	were interviewed to r	eevaluate the complaint or		that cognitive statuses were correct.		
	incident.			no additional findings related to this	citation.	
		ee will in-service all staff and se Policy and procedures .		3. Systemic changes		
	-	with allegations of abuse,		IDT team has been educated on the in	mportance	
		or mistreatment will receive		of ensuring that resident's cognitive		
	÷ .	g on the facilities Abuse		correctly documented in the MDS. T		
		ire. All future IRF allegations		of Reimbursement will be responsibl		
		orwarded by email/writing the		ensuring that resident's MDSs accura	ately reflect	
	LNHA/HR/DON/Depa			their cognitive status.		
	Resource/Director of	ome Administrator/Human Nursing] with the results and		4. Monitor corrective actions		
	place to protect the re	es that have been put in		The Director of Reimbursement/Desi	ignee will	
		esident.		complete random weekly audits of 10	0	
	4. LNHA/ Designee v	vill conduct an audit all IRF's		resident's MDSs to ensure that menta		
	•	is to ensure the facility has		documented correctly. The results w		
		h investigation of the alleged		reported to the QAPI Committee more		
	· •	urther abuse, neglect,		months for review and recommendat	ions.	
		reatment from occurring			6 (1	
	-	n was in progress; and took		The QAPI Committee is responsible	for the on-	
		e action, as a result of		going monitoring for compliance.		
		 Results of finding will be eview and recommendations. 		5. Date correction action comp	oleted	
	5. All actions to be co	ompleted by 9-15-2021"		The facility's date of alleged complia November 2, 2021.	ance is	
	The State Agency Su	Irvey Team returned to the				
	facility and verified th	at the plan of correction was				
	in place on 09/16/202	21, at 7:52 PM, and the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	STREET A 4601 MA	I DDRESS, CITY, ST IRTIN LUTHER IGTON, DC 200	KING JR AVENUE SW		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
L 001	Continued From pag Immediate Jeopardy		L 001	F. 42 CFR §483.35 (g)(1)-(4) F732, Poste Nurse Staffing Information	ed 11/02/2021	
		3.25, F686, o Prevent/Heal Pressure		 Corrective action for resident Daily Nurse Staffing is now posted as requore each unit. 	uired	
	reviews and staff interest ensure that sufficient ensure that nursing s documenting change as so identified. Subs residents identified b developing pressure ulcers/injuries first of advance stage (Stag Unstageable). (Residentiation advance stage (Stag Unstageable). (Residentiation advance stage (Stag Unstageable). (Residentiation advance stage (Stag Unstageable). (Residentiation 2:01 PM. The facility to the survey team reture 2021 to validate the facility to validate the facility 2021 at 7:52 PM. Affirmediacy, the defice potential for more that remaining residents at The findings include: Review of the facility of Pressure Ulcers/In	poserved by staff at an e 3, Stage 4 and dents' #87, #83, #73, #62, an immediate jeopardy ed on September 8, 2021 at y submitted a plan of action in site at 7:31 PM on and the plan was accepted. urned on September 16, facility's plan, and the was lifted on September 16, ter removal of the ient practice remained at a an minimal harm for all at a scope and severity of H. policy entitled, "Prevention juries" with a revision date of a policy instructed staff to, "		 Identify other residents All residents could have been affected. The were no additional findings related to this citation. Systemic changes Nursing staff have been educated on the importance of ensuring that the daily nurse staffing information is posted on each unit Director of Nursing will be responsible for ensuring that the information is posted as required. Monitor corrective actions The Director of Nursing/Designee will conrandom weekly audits of each unit to ensut the required daily nurse staffing information is posted as required. The results will be rep to the QAPI Committee monthly x 3 mont review and recommendations. The QAPI Committee is responsible for the going monitoring for compliance. Date correction action completed The facility's date of alleged compliance in November 2, 2021. 	e The mplete re that on is orted hs for e on-	

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (>	X3) DATE SU COMPLE	
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		1			09/10	5/2021
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(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 APPROPRIAT DEFICIENCY)		(X5) COMPLET DATE
L 001	Continued From page	a 12	L 001	G. 42 CFR §483.80 (d) (1)(2) F883,	1	1/02/2021
2001	ADLs (Activities of Daily Living) turn and		2001	Influenza andPneumococcal Immunizations		
	reposition bedbound hours"	edbound resident at least every two		1. Corrective action for resident		
	 hours" 1. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer, Unstageable Right Heel Pressure Ulcer and a Stage 2 Left Heel Pressure Ulcer. Review of the Care Plan revealed the following focus: "Anti-coagulant Therapy" with a revision date of 11/20/2020. Intervention: " daily skin inspections" 			 Residents #21 and #95 have been offered Influenza and Pneumonia vaccines and va- have been administered as appropriate. Resident #105 no longer resides in the face 2. Identify other residents An audit of all current residents has been completed. There were no additional find 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 	accines cility. dings offered and/or efits	
		s (hours) and as needed to ry. Every day and night shift.		and risks of immunization. The Director Nursing will be responsible for ensuring vaccines are offered with information/edu regarding the benefits and risks of immunization.	that	
	skin assessments Q (medical doctor/nurse abnormalities and do	n's order- Daily head to toe (every) shift. Notify MD/NP e practitioner) of any cument your assessment Scale - [Resident #87]		 Monitor corrective actions The MDS Nurse/Designee will complete audits of vaccination reports to ensure the vaccines are being offered and the medic records of residents with new vaccination 	at al	
	scored an "8" indicati "very high risk" for de ulcers/injuries.	ng that the resident was at eveloping pressure		ensure that information/education regardi benefits and risks of immunization. The will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	ing the	
alth Pogulat	-05/04/2021 Skin & V "Pressure (injury), Station & Licensing Administration	age 4 (full-thickness skin		recommendations.		

	OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLI		
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(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE	
L 001	Continued From page		L 001	The QAPI Committee is responsible going monitoring for complia			
	and tissue loss), Left ear, new, in-house acquired, wound measurements - length 0.9 cm (centimeters), width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% granulation, exudate - light, serosanguineous, no odor Resident seen by wound care staff for weekly assessment. Stage 4 pressure injury to left ear "			5. Date correction action The facility's date of alleged of November 2, 2021.			
		Scale - [Resident #87] ng that the resident was at eveloping pressure					
	-07/06/2021 Skin & V						
	full-thickness skin and lateral, new, in-house measurements - leng width 2.9 cm, depth n	th 3.0 cm (centimeters), ot applicable, undermining					
	bed-100% slough (a cast out from, living ti Resident seen by wo assessment Noted	ling not applicable, wound mass of dead tissue in, or ssue), exudate - none und care staff for weekly new pressure injury to right					
	(TAR) for May, June nurses signed their in conducted head to to	Iger made aware" ent Administration Record and July 2021 showed itials indicating that they had e skin assessments for day (day and night shift).					
	dietary) from 04/19/2 06/21/2021 to 07/05/2	s notes (nursing, physician, 021 to 05/03/2021 and 2021 lacked documented nt #87's Stage 4 Left Ear					

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
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		HFD02-0023	B. WING	09	09/16/2021	
	ROVIDER OR SUPPLIER	4601 MA REHAB NATIONAL H	NDDRESS, CITY, STATE, ARTIN LUTHER KING NGTON, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From page 14 pressure (injury) and the Unstageable Right Calf pressure (injury) were observed by staff prior to the assessments conducted by the wound team on 05/04/2021 and 07/06/2021 [when the wounds were first observed at an advanced stage]. Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In Section C (Cognitive Patterns) the BIMS (Brief Interview for Mental Status) summary Score was blank. In Section G (Functional Status - Bed mobility), the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section M (Skin Condition), the resident was coded for have one (1) Stage 3 pressure ulcer, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury.		L 001			
	focus: "Pressure Inju sacrum, Stage 2 righ lateral calf)" with a re Interventions: " the	position at least every 2				
	Employee #16 (Unit I (Registered Nurse) v wound care for Resid pressure injury/wound	proximately 3:30 PM, Manager) and Employee #20 vere observed providing dent #87's Stage 4 sacral d, Stage 4 Right Calf d, and Right Heel Deep				
		n on 08/26/2021 from 8:10 2 hours) the following was				

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY IPLETED
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			NGTON, DC 20032			
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L 001	Continued From page	e 15	L 001			
	-At 8:10 AM, Resider room, in bed, laying o	nt #87 was observed in her on her right side.				
	-At 10:46 AM, Reside	ent #87 remained in bed, e.				
	-At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed.					
		alf hours of the observation, reposition Resident #87.				
	that they conducted h the resident daily, the facility staff identified skin condition and fa approaches identified (turn and reposition). #87 developed in-ho	a nursing staff documented nead-to-toe assessments on ere was no evidence that changes in the residents ' iled to implement d in the resident's care plan Subsequently, Resident use acquired wounds (Left ateral) Stage 4 pressure				
	08/26/2021 at 12:45 (Registered Nurse) s be turned and reposi needed. The CNA (c	e interview conducted on PM, Employee #16 tated, "The resident should tioned every 2 hours and as ertified nurse's aide) is n to the resident's room now				
	Stage 4 pressure inju serial excisional deb	at Resident #87"s left calf ıry/ulcer required bedside ridement (the use of a vitalized [slough/necrotic] 1.				
	During a face-to-face 09/08/2021 at approx	interview conducted on kimately 10:00 AM,				

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		• • •	E SURVEY IPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CON	
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	·····	WASHIN	IGTON, DC 20032			
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L 001	Continued From page	e 16	L 001			
	Employee #2 (Direct how did residents' we to advanced stages to observed them, Emp for nursing staff to ha believe that there is a When asked how oft assessed by nursing that nursing staff ass twice-a-week during During a face-to-face 09/08/2021 at approx #15 (Registered Nurs does she assess res stated that she condu assessment of the re times per shift depen asked if she noticed with Resident #87 in July 2021, the emplo During a face-to-face approximately 5:30 F Manager/ RN) was as residents' skin. The e she is assigned a tea head-to-toe assessm shift. When asked if s integrity issues with f of May 2021 and July "No". 2. Resident #83 was 07/20/2021 with diag and Chronic Respira	or of Nursing) was asked bunds (pressure injuries) get before staff (wound team) bloyee #2 stated, "I'm looking we good assessment skills. I a need for (nursing) training." en IS residents' skin staff, Employee #2 stated sess residents' skin at least bathing times. e interview conducted on kimately 5:30 PM, Employee se) was asked how often idents' skin, the employee ucts a head-to-toe esidents one (1) to two (2) bding on her workload. When any new skin integrity issues the months of May 2021 and yee stated, "No". e interview on 09/08/2021 at PM, Employee #14 (Unit sked how often she assess' employee stated that when am, she conducts a nent of the residents every she noticed any new skin Resident #87 in the months y 2021, the employee stated, re-admitted to the facility on noses that included: Acute tory Failure with Hypoxia,				
		rostomy, Hypertension, ffecting Right Dominant Side, Stage 4.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED		
ND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CON	IPLETED	
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RIDGEP	OINT SUBACUTE AND R		NGTON, DC 20032				
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L 001	Continued From page	e 17	L 001				
	(Cognitive Patterns). Status), G0400, the r dependence" on staff toilet use, and persor "Functional Limitation resident was coded for and lower extremities Conditions), the reside pressure ulcer/injury pressure ulcer that w the facility. According to the Brace the resident was asso	t #83 was coded as ood" under Section C Under Section G (Functional esident was coded as "total f for bed mobility, eating nal hygiene, G0400, n in Range of Motion" the or "no impairment to upper					
	Review of the care pl	ans showed the following:					
	sacrum"; Intervention assistance to turn/rep	e 4 pressure injury to the as: "the resident needs position at least every 2 needed or requested dated					
	deficit r/t (related to) (accident), MI (myoca cognition" Interven residents skin require observe for redness,	self-care performance CVA (cerebral vascular rdial infarction), Impaired tions: "Skin Inspection: the es skin inspection q shift, open areas, scratches, cuts, hanges to the nurse initiated					
	Review of the physici following:	an's orders show the					

STATEMENT	egulation & Licensing / OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		• •	E SURVEY PLETED
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L 001	Continued From page 18		L 001			
	(every) shift. Notify N	ead-to-toe skin assessment q MD/NP for any abnormalities assessment two times a day"				
	07/21/2021 "Turned and reposition every 2 hours and as needed to prevent pressure injury"					
	08/17/2021 "Cleanse wound right shoulder with Anasept wound cleanser spray then apply Anasept wound gel cover with 4x4 and secure with border gauze daily every night shift for wound care- start date"					
	they: "performed dail assessment Q shift (MD/NP of any abnor assessment and turr	that facility staff signed that ly head to toe skin twice daily), would notify malities and document the ned and repositioned the burs and as needed to				
	However, review of t Evaluation V5.0 form the following:	he Skin and Wound dated 08/17/2021 showed				
	skin and tissue loss; In-house acquired; E Wound Measuremer cm x width 2.4 cm x slough- 100%,P Resident seen on wo pressure injury to rigi	rogress -NewNotes: bund rounds, noted new ht shoulder, wound is 100% wound area has intact				
	that they were asses	ning in the medical record sing Resident #83's skin repositioned the resident				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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L 001	Continued From page 19 every two hours. However, Resident #83 developed an in-house acquired pressure injury noted at an advanced stage (unstageable pressure injury to his right shoulder at the first observation and assessment). During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."		L 001			
	03/11/2020 with mult	admitted to the facility on iple diagnoses that included: Failure, Anoxic Brain c Kidney Disease.				
	Review of the medica following:	al record revealed the				
	a "9" indicating that t	Scale] - Resident #73 scored he resident was at "very high pressure ulcers/injuries.				
	assessment and repo	an Order]- "Weekly skin ort any abnormality to the /NP (nurse practitioner)"				
	04/28/2020 [Physicia with hydroguard (skir	n Order]-"Moisturize skin n lotion) every shift"				
	04/28/2020 [Physicia	on Orderl- "Turn and				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From pag	e 20	L 001			
	reposition q (every) t	wo hours."				
	04/29/2020 [Physician Order]- "Administer bed bath or sponge bath to resident daily and as needed"					
	a "9" indicating that t	Scale] - Resident #73 scored he resident was at "very high pressure ulcers/injuries.				
	to DTI (Deep Tissue	an Order] - "Apply skin prep Injury) left heel twice a day, any redness or drainage shift for wound care."				
	wounds with Anesept dry then apply Anese	an Order] - Cleanse right heel spray (wound cleanser) pat pt gel (antimicrobial skin eels with pillows continuously				
	lateral malleolus R staff for weekly asse pressure injury notec 0.5 cm (centimeters)	Vound Evaluation]- "Left tesident seen by wound care ssment. New Stage 4 It to left malleolus area has area of slough also able to and bed. Unit manager made				
	lateral malleolus R staff for weekly asse pressure injury to rigl	Wound Evaluation] -"Right tesident seen by wound care ssment. New unstageable ht malleolus noted. wound is edness or drainage noted at				
	physician, dietary) fro	ss notes (such as, nursing, om 07/01/2020 to 08/17/2020 evidence that Resident #73 ' olus pressure injury and the				

STATEMENT	egulation & Licensing A	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED		
		HFD02-0023	B. WING		C 09/16/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE					
		4601 MA	RTIN LUTHER KIN	G JR AVENUE SW				
BRIDGEP	OINT SUBACUTE AND R		IGTON, DC 20032					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	HE APPROPRIATE	COMPLET DATE		
	2			DEFICIENC	f)			
L 001	Continued From page	e 21	L 001					
		alleolus pressure injury was						
		or to the wound team 's						
	assessment on 08/18	3/2020.						
	Review of the Treatme	ent Administration Record						
		20 to 08/18/2020 revealed						
		Imented that Resident #73;						
		onge during the day shift,						
		off loaded during the day and						
	U	isturized during the day,						
		ifts, and was being turned						
	-	ry two hours at 12:00 AM, :00 AM, 8:00 AM, 10:00 AM,						
		4:00 PM, 6:00 PM, 8:00 PM						
	and 10:00 PM.							
	Review of Resident #	73's "CNA Activity of Daily						
	Living (ADL) Notes" 1							
	• • •	that facility staff documented						
		that asked, "Is there a new						
	skin condition?"							
	Review of the Admiss	sion MDS dated 03/18/2021						
	revealed that facility	staff coded the following:						
	In Section G (Function	onal Status), "bed mobility						
	•	wo+ (plus) persons physical						
	assist"							
	In Section H (Bowel a	and Bladder), "urinary						
	continence bowel							
	incontinent"							
	In Section M (Skin C	onditions), " risk of						
	pressure ulcersyes	s"; " resident has a						
	pressure ulcer/injury,							
		-removable dressing/ device						
		sident at risk of developing						
		es? yes", " does this						
	tion & Licensing Administrati	more unhealed pressure						

	egulation & Licensing / OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		с	
		HFD02-0023	B. WING		09/16/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW			
	1		IGTON, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
L 001	Continued From pag	e 22	L 001				
	ulcers/injuries? no'	1					
	Review of the Care F	Plan revealed the following:					
		Daily Living Self-care dated 03/11/2020 revealed					
		s including, "provide sponge					
		or shower cannot be					
		lity, and the resident is totally or repositioning and turning in					
		Neurological Status" dated several interventions					
		pections daily and report any					
	identified in the resid reposition and inspect Resident #73 develo Stage 4 Left Malleol	implemented approaches lent care plan (turn and ct skin daily). Subsequently, ped an in-house acquired us pressure injury and a falleolus pressure on					
	09/08/2021 at appro- Employee #9 (Direct "The wound team ha multiple times on ass reporting of resident issue of the nursing making the wound te	or of Wound Care) stated, s educated the nursing staff sessment, documenting and ' s skin. I have brought this staff not documenting or eam aware of skin issues at					
	Nursing and the Adm						
	07/31/2021. The me	re-admitted to the facility on dical record showed the diagnoses including: pirator [Ventilator]					

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		· · · ·	E SURVEY IPLETED
					С	
		HFD02-0023	B. WING		09/16/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, 2	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
	Γ	WASHIN	IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT 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)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From page 23		L 001			
	Malnutrition, Stage 4 Stage 4 Scapula Pre Trochanter Pressure Pressure Ulcer, Left Surgical Sacral Wou During an observatio 12:12 PM, the wound care for Resident #60 left leg, back and sac Review of the medica following: 05/07/2021 [Braden 4 a "10" indicating that high risk" for develop 05/08/2021 [Physicia reposition every 2hrs help prevent pressur	on on 08/24/2021 starting at d care team provided wound 2's wounds for the left hip, crum. al record revealed the Scale] - Resident #62 scored the resident was at "very ing pressure ulcers/injuries. an Order] - Turn and c (hours) for comfort and to e injury every shift.				
	Summary Note) - "Re Resident has a sac (centimeters) X 5(cm amount of serosa (se noted. (Left lower leg (Left buttock pressur scattered wound. Mu lower extremities. Of abdomen."	M (Nursing Admission esidentadmitted at 7pm eral wound stage IV (4), (6cm erosanguinous) drainage g wound 0.6cm X 1.0cm). e 0.1cm)with multiple litiple scars noted to bilateral d surgical sites to chest and				
	"Resident alert and r readmissionskin w and wound cares (sp	M (Nursing Progress Note)- esponsive, 2nd day of varm and dry to touchADL o) provided turn (sp) and two hours and as needed to er"				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			•
		HFD02-0023	B. WING		09	C 9/16/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA	RTIN LUTHER KING	G JR AVENUE SW		
_			IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
L 001	Continued From pag	e 24	L 001			
	"Resident is alert and dry to touchADL c	M (Nursing Progress Note) - d responsive, skin warm and are provided, turning, and wo hours as needed to er (sp)"				
	"new, in-house acqui (Full-thickness skin k 3.2 cm (centimeters) undermining not app	(Skin & Wound Evaluation)- ired, Left calf, Stage 3 oss), pressure(injury), length , width 2.7 cm, depth 0.1 cm, licable, tunneling not ed 100% granulation -pink or eropurulent"				
	Review of the Treatme for May 2021 reveale	ent Administration Records ed the following:				
	they had turned and	their initials indicating that repositioned Resident #62 05/08/2021 to 05/10/2021.				
	Review of the Care F	Plans revealed the following:				
	with am initial date of multiple interventions	nent related to Immobility" f 05/07/2021, outlined s including turn and prevent pressure injuries.				
		, In section C (Cognitive view for Mental Status				
	(Functional Status - I was coded as a "4" in	Bed mobility) the resident ndicating that the resident nt on the staff. The support				
	section was left blan Condition), the reside					
		(1) unstageable pressure				

Health Regulation & Licensing Administration STATE FORM

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CWPH11

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURV COMPLETE	
					с	
		HFD02-0023	B. WING		09/16/2	021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		3 JR AVENUE SW		
0(0)15	CLIMMA DV C		NGTON, DC 20032	PROVIDER'S PLAN OF C	ODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE C	(X5) COMPLE DATE
L 001	Continued From pag	e 25	L 001			
	ulcer and one (1) uns Injury.	stageable Deep Tissue				
	identified in the resid reposition). Subsequ developed in-house	acquired wound (Left Calf) ury within 48 hours of his				
	approximately 10:30 Team Nurse) stated assessed Resident #	e interview on 09/08/2021 at AM, Employee #10 (Wound that on 05/10/2021 she #62 ' s skin and observed an cage #3 pressure injury on alf.				
	approximately 10:15 of Wound Care) was wounds (pressure inj stage before staff ob stated, "I can't speak injuries) are found at up when we (wound resident's skin. I kno months, I have been	ement Meetings that nursing				
	09/12/2020 with diag and Chronic Respira Mellitus, Tracheosto Hypertension, Contra	re-admitted to the facility on noses that included Acute tory Failure, Type 2 Diabetes my, Gastrostomy, actures (Right and Left e Ulcer Left Heel Stage 4.				
	According to the Qua 06/30/2021 the resid "rarely/never unders					

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		• •	E SURVEY IPLETED
			A. BUILDING.			С
		HFD02-0023	B. WING		0	9/16/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	OINT SUBACUTE AND F	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From page	e 26	L 001			
	Status), G0400, the in dependence" on staft toilet use, and person Limitation in Range of coded for "impairment extremities". Section resident was coded at and one (1) unhealed According to the Brad assessed and scored was "very high risk" fo 04/03/2021 and was "10" indicating "high 07/03/2021.	den Scale, Resident #42 was d at a "9" indicating that she for skin breakdown on assessed and scored at a risk" for skin breakdown on				
	"Stage 4 pressure in revealed the followin needs assistance to 2 hours, more often a dated 07/23/2021, "F	the prevention/treatment of				
	Review of the physic following:	ian 's orders revealed the				
	Anasept wound clear PRN (as needed). Pl	e left medial heel wound with nser spray every day and lease float heels ent pressure every night shift				
		els while in bed with a pillow down and pressure every night)"				
	00/12/2020 "Daily bo	ad to skin assessments per				

STATEMENT	egulation & Licensing / OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			С
		HFD02-0023	B. WING		09	0/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
			IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT 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)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From pag	e 27	L 001			
	protocol every shift a would notify MD (me abnormality every da	· ·				
		d reposition every 2 hours lieving and redistribution"				
	from 07/01/2021 to 0 facility staff signed th care to the resident	ent Administration Record 7/14/2021 showed that hat they: performed wound s left heel, floated the				
	abnormality every da and repositioned the	ce daily, performed D (medical doctor) for any y and night shift, and turned resident every two hours living and retribution.				
	However, review of t Evaluation V5.0 form the following:	he Skin and Wound dated 07/14/2021 showed				
	Location: Left Latera Acquired; In-house a 7/14/21; Wound Mea length 2.2cm x width undermining 1.0 cm;	ness and tissue loss I Malleolus (ankle) Icquired Exact Date- Isurements= Area-2.5 cm, 1.8 cm x 0.5 depth, Wound bed -slough 100% of e-light; type seropurulent;				
	noted development of lateral malleolus (sp) thickness with palpal	en by wound care team, of new pressure injury to left . Wound is stage 4, full ole bone in wound bed full res in PPC (point click care)				
	wound treatments to daily, were assessing floated the resident '	gning that they: conducted the residents left heel twice g the residents skin daily, s heels twice daily, and hed the resident every two				

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			С
		HFD02-0023	B. WING		09/16/202	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From page	e 28	L 001			
	in-house acquired pr	ident #42 developed an essure injury noted at an ge 4 pressure ulcer to the s).				
	09/08/2021 at approx Employee #9 (Direct asked how do reside injuries) evolve to an observed them? Emp speak to why the (pre advanced stages. I s team) see issues with that over the last cour	or of Wound Care) was nts' wounds (pressure advanced stage before staff bloyee #9 stated, "I can't essure injuries) are found at peak up when we (wound h a resident's skin. I know ple of months, I have been rformance Improvement				
	•	n September 8, 2021 at 2:01 opardy (IJ) situation was				
	administrator provide	21 at 7:31 PM, the facility's d a corrective action plan to rvey team which included:				
	assessments by 9-09 assessments will be the License Nursing showers to documen	ete house wide skins 9-2021, going forward skin performed twice a week by staff during the resident ' s t any changes in the resident e assessments will be				
	shower books and th for completion twice corporate wound nurs All Nursing staff inclu	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				
	reporting documenting	toe assessment and				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			C
		HFD02-0023	B. WING		09	0/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA	RTIN LUTHER KING	G JR AVENUE SW		
	1		IGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
L 001	Continued From page	e 29	L 001			
	as soon as identified	Physician and wound team . An in-service including a provided to track Nursing				
	in-serviced on Woun The Corporate woun	cluding registry will be d Policy and procedures. d nurse will educate the n the Wound policy and				
	every two hours by the ensure proper turning conducted. A turning be used to monitor tu Wounds found during RCA (Root Cause An Nursing staff response	sessments, and conducting				
	Nursing and Nursing violation card" will be any staff found not d repositioning of resid 3 violations will be ta for training and a we conducted by the QA	bred by The Director of Supervisors. A "skin tag implemented to address oing proper turning and lents. Nursing staff with over ken off the floor immediately ekly Quality Audit will be API team. All finding will be ekly QAPI meeting for two				
	done weekly for two assessments will be and appropriately. Th Administrator, Directo					

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		• •	E SURVEY PLETED
			A. BUILDING:			
		HFD02-0023	B. WING		09	C 9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA	RTIN LUTHER KINC	G JR AVENUE SW		
		WASHIN	IGTON, 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 ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From page	e 30	L 001			
	9-15-2021."					
	facility and verified th	83.10(c)(6), F578, continue Treatment;				
	staff interview for sev residents, the facility residents or their rep formulate Advance Di and failed to confirm	ased on record review and ven (7) of 44 sampled 's staff failed to inform presentatives of their rights to irectives for six (6) residents one (1) resident's code 3, #5, #21, #37, #76, #95 and				
	The findings include:					
	07/10/2021 with mult Morbid Obesity, Obs	admitted to the facility on iple diagnoses that included: tructive Sleep Apnea, jia, and Lymphedema.				
	(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 vely intact.				
	Review of the resider was her own response	nt's face sheet revealed she sible party.				
	lacked documented e staff provided the res	ode". However, the record evidence that the facility's sident with verbal or written g Advance Directives.				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:		с	
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
			IGTON, DC 20032			1
(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 THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 001	Continued From pag	e 31	L 001			
	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 rev	facility staff coded Resident				
	(EHR) and paper me documented evidenc 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 Advanced Directives	e interview conducted on AM, Employee #3 (Director tated, "Advance Directives but it is not documented. have not been discussed illy members much during emic."				
	06/29/2021, with mul Degenerative Joint D	re-admitted to the facility on tiple diagnoses that included: Disease, Respiratory Failure, bral Vascular Accident.				
		ximately 10:00 AM, Resident a "DNR (Do Not Resuscitate)"				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			С
		HFD02-0023	B. WING		09	0/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From pag	e 32	L 001			
	bracelet on his left w	rist.				
	dated 07/07/2021, re	facility staff coded Resident				
	area of: [Resident ' s to remain a full code documented the follo (interdisciplinary tear	#21's care plan with the focus name] end of life wishes are " revised on 05/18/2021 owing interventions: "IDT m) will review residents code ocument wishes in medical xisting wishes".				
	and paper medical re	Resident #21 ' s electronic ecord revealed that facility and confirm the resident ' s representative .				
	08/30/2021 at 11:32 of Social Services) st are offered quarterly Advanced Directives	e interview conducted on AM, Employee #3 (Director tated, "Advanced Directives but it is not documented. have not been discussed ily members much during emic. "				
	09/01/2020 with mult Anemia, Hypertensic	re admitted to the facility iple diagnoses that included: on, Diabetes Mellitus, erebral Vascular Accident				
	A review of the Admi (MDS) dated 08/12/2	ssion Minimum Data Set 2021 revealed:				
		ve Patterns), Resident #37 for Mental Status (BIMS) 15" indicating intact				

	egulation & Licensing OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		· · ·	E SURVEY IPLETED	
			A. BUILDING:			с	
		HFD02-0023	B. WING		09	9/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW			
			NGTON, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
L 001	Continued From pag	e 33	L 001				
	cognition.						
	Review of the medic physician's order dat "Full Code."	al record revealed a ed 11/21/2020 that directed,					
	07/24/2021, noted, " wishes will be honor "full code". The goal (interdisciplinary tea	f Life Care Plan revised on Resident #37's end-of-life ed. Her desire is to remain a documented that the IDT m) will review the resident's or if there is a change in					
	that the facility's staf	acked documented evidence f provided Resident #37 with mation regarding Advance					
	08/30/2021 at 11:22 of Social Services) s the resident an Advar complete the Five W document of residen	e interview conducted on AM, Employee #3 (Director tated that she did not offer nce Directive, but she did lishes document (facility's t's end of life wishes). The that she would ask Resident Directive.					
	03/27/2020 with the	admitted to the facility on following diagnoses: Anemia, Atrial Fibrillation, Colostomy ive Sleep Apnea.					
	A review of the Admi (MDS) dated 03/27/2	ssion Minimum Data Set 2020 revealed:					
	the resident was give	nterview for Mental Status), en a summary score of "12" ¢76 was mildly impaired					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HFD02-0023 B. WING COMPLETED C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW BRIDGEPOINT SUBACUTE AND REHAB NATIONALH MASHINGTON, DC 20032 4601 MARTIN LUTHER KING JR AVENUE SW VAME IN ILL CALL DEPICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x0) C(4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x0) REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (x0) L 001 Continued From page 34 L 001 L 001 ID I		egulation & Licensing A	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	• •	E SURVEY
HFD02-0023 B. WING	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	IPLETED
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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL H WASHINGTON, DC 20032 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET UNTE L 001 Continued From page 34 L 001 L 001 Review of the medical record revealed a physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)". L 001 Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, "[Resident's name] end-of-life wishes are to remain DNR/DNI." One goal documented that the IDT will review the resident's goal status quarterly or if there is a change in condition. There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident did not have an Advance Directive, but I think she has a	NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
WASHINGTON, DC 20032 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE L 001 Continued From page 34 L 001 Review of the medical record revealed a physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)". L 001 Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, "[Resident's name] end-of-life wishes are to remain DNR/DNI." One goal documented that the IDT will review the resident's goal status quarterly or if there is a change in condition. There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident did not have an Advance Directive, but I think she has a			4601 MA				
PAGE TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET TAG L 001 Continued From page 34 L 001 Enview of the medical record revealed a physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)". Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, the IDT will review the resident's goal status quarterly or if there is a change in condition. There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident directive, but I think she has a	BRIDGEP	UINT SUBACUTE AND R		NGTON, DC 20032			
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physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)". Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, "[Resident's name] end-of-life wishes are to remain DNR/DNI." One goal documented that the IDT will review the resident's goal status quarterly or if there is a change in condition. There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident did not have an Advance Directive, but I think she has a	L 001	Continued From page	e 34	L 001			
,		physician's order data "Code status is: DNR Resuscitate/Do Not I Review of the End of revised date of 07/25 "[Resident's name] e remain DNR/DNI." C the IDT will review th quarterly or if there is There was no docum medical record that th Resident #76 with ve regarding Advance D During a face-to-face 08/30/2021 at 11:28 of Social Services) st	ed 03/29/2021 that directed, R/DNI (Do Not ntubate)". This Life Care Plan with a 5/2021, noted that, nd-of-life wishes are to Due goal documented that e resident's goal status a change in condition. The facility's staff provided rbal or written information Directives.				
Cerebral Artery, Restlessness and Agitation.		Review of the Admiss (MDS) dated 01/26/2 (Cognitive Patterns),	sion Minimum Data Set 021, revealed in Section C facility staff coded Resident				
Review of the Admission Minimum Data Set (MDS) dated 01/26/2021, revealed in Section C (Cognitive Patterns), facility staff coded Resident #95 as "Severely [cognitively] impaired".		Record (EHR) and pa documented evidenc	#95's Electronic Health aper medical record lacked e that facility staff provided entative with information				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		. ,	E SURVEY PLETED
			A. BUILDING:			С
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	RTIN LUTHER KINC	G JR AVENUE SW		
		WASHIN	IGTON, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 001	Continued From pag	e 35	L 001			
	08/30/2021 at 11:32 of Social Services) st are offered quarterly Advanced Directives with residents or fam the COVID-19 Pande 7. Resident #105 wa 05/26/2021, with mul Polyneuropathy, Anx Disorder, Major Depi Chronic Pain Syndro	s admitted to the facility on tiple diagnoses that included: kiety Disorder, Bipolar ressive Disorder, and				
	07/13/2021, revealed Patterns), the facility with a Brief Interview	d in Section C (Cognitive 's staff coded the resident of Mental Status (BIMS) ing that the resident was				
	medical record lacke facility staff provided	#105's EHR and paper d documented evidence that the resident with information g Advance Directives.				
	08/30/2021 at 11:32 of Social Services) s are offered quarterly Advance Directives h	e interview conducted on AM, Employee #3 (Director tated, "Advance Directives but it is not documented. have not been discussed with hembers much during the c."				
	Improvement (QAPI) 2:33 PM, Employee	surance and Performance meeting on 09/01/2021 at #1 (Administrator) stated that I not looked at Advance f their residents. The				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		• • •	SURVEY PLETED
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		HFD02-0023	B. WING		09	/16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
RIDGEP	OINT SUBACUTE AND I	REHAB NATIONAL H	ARTIN LUTHER KINO NGTON, DC 20032	G JR AVENUE SW		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE
L 001	Continued From pag	ie 36	L 001			
		"We used the Medical Treatment (M.O.S.T) forms. tives is a federal				
	D. Under 42 CFR §4 Discharge	83.15, F622 Transfer and				
	interview, facility's st required documents receiving health care	ed on record review and staff taff failed to ensure all the were conveyed to the e provider for two (2) of 44 that were transferred from the #97, and #103)				
	The findings include	:				
	07/27/2021 with mult	admitted to the facility on tiple diagnoses that included: Respiratory Failure and eostomy.				
		tian's order dated 08/17/2021 d, "Transfer to hospital to a 911".				
	dated 08/17/2021, la	#97's transfer documents acked documented evidence f included the care plan goals ansfer packet.				
	08/26/2021 at appro Employee #2 (Direct	tor of Nursing) stated that a not part of the documents				
	07/21/2021 with diag	as admitted to the facility on gnoses that included ute and Chronic Respiratory				

TATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY IPLETED
			A. DOILDING.			С
		HFD02-0023	B. WING		09	9/16/2021
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		G JR AVENUE SW		
	SUMMARY S		ID ID ID	PROVIDER'S PLAN OF ((XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From pag	e 37	L 001			
		, Chronic Obstructive Type 2 Diabetes, and ase.				
	Review of the reside	nt's progress notes revealed:				
	make arrangements LTACH (Long Term A	[4:07 PM] " new order to for resident to be transfer to cute Care Hospital). I they will give us a call when				
		[9:46 PM] "resident left the ACH I/C (Intensive Care)				
		's "Acute Care Transfer ' last updated June 2018 g:				
	"Copies of Documen	ts Sent with Resident/Patient				
	Documents Recomm Resident/Patient	ended to Accompany				
	Resident /Patient Tra	ansfer Form				
	Personal belongings Resident/Patient Tra	identified on nsfer Form are enclosed				
	Face Sheet					
	Current Medication L (Medication Administ					
		ckground, Assessment and nd/or other Change in Note (if completed)				
	Advance Directives (Durable Power of Attorney				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS A. BUILDING:		X3) DATE SURVEY COMPLETED
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		HFD02-0023	B. WING		09/16/2021
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIF	° CODE	
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING J	IR AVENUE SW	
	CLIMMA DV C		NGTON, 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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
L 001	Continued From pag	e 38	L 001		
	for Health Care, Livin	ng Will)			
	Advance Care Order	S			
	Send These Docume	ents if available:			
	Most Recent History	and Physical			
	Recent Hospital Disc	charge Summary			
	Recent MD/NP (Nurs (Physician 's Assista	se Practitioner) /PA ant) 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	had the aforementioned omplete a checklist before s, the form does not list re Plan Goals" as a to the receiving facilities.			
	to the LTACH with Re was conducted. The resident's comprehe	ments [transfer packet] sent esident #103 on 07/13/2021 re was no evidence that the nsive care plan goals were ments sent to the hospital			
	#45 (Unit Secretary 1 12:48 PM, and with E	e interview with Employee I South) on 08/30/2021 at Employee #2 (Director of 021 at 8:26 AM, they both			

TATEMENT	egulation & Licensing / OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		· · · ·	E SURVEY IPLETED
			A. BUILDING.		С	
		HFD02-0023	B. WING		09	9/16/2021
	ROVIDER OR SUPPLIER	4601 MA	ADDRESS, CITY, STATE, ARTIN LUTHER KING NGTON, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE ⁻ DATE
L 001	Continued From pag	e 39	L 001			
		comprehensive care plans the hospital with residents rerred.				
	E. Under 42 CFR §4 Assessments	83.20, F641, Accuracy of				
	review and interview ensure a Minimum D accurately reflected a	ed on observation, record , the facility's staff failed to Data Set Assessment a resident's mental status for d residents. (Resident #87)				
	The findings include:					
	02/26/2021. The mean resident had several Dependency on Res	pirator [Ventilator], sity, Gastrostomy and Stage				
	03/01/2021, the phys February 2nd 2021 s cardiopulmonary arr	y and Physical dated sician documented, "On she (Resident #87) suffered a estCurrently, the patient egetative state and on full (Ventilator)"				
	06/02/2021 revealed of Mental Status) [Bl	ly Minimum Data Set dated I, In Section C (Brief Interview IMS] the resident was given "11" for the indicating that oderately impaired				
	09/16/2021 at approx	e interview conducted on ximately 12:30 PM, or of Social Services) stated				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
						С
		HFD02-0023	B. WING		09	9/16/2021
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING NGTON, DC 20032	G JR AVENUE SW		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
L 001	Continued From page	e 40	L 001			
	that she incorrectly c score.	oded the resident's BIMS				
	F. 42 CFR §483.35 (Staffing Information	g)(1)-(4) F732, Posted Nurse				
	interview, it was dete	d on observation and staff rmined that the facility failed quired daily nurse staffing ed.				
	The findings include:					
	[08/22/2021 night shi posted daily nurse sta	hit 1 south on 08/23/2021 ift] at 6:00 AM, revealed the affing information on the wall e nurse's station on unit 1 08/20/2021.				
	provided the surveyo	#48 (Night Supervisor) or with a "written" daily the current shift (night dated				
	time for the observation provide a comment to	interview conducted at the ion, Employee #48 failed to o address why the most affing information was not				
	G. 42 CFR §483.80 (Pneumococcal Immu	d) (1)(2) F883, Influenza and inizations				
	interview, for three (3 facility staff failed to: resident's medical re					

STATE FORM

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STATEMENT	egulation & Licensing / OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		• • •	E SURVEY PLETED
		BERNI IO, HIGH HOMBER.	A. BUILDING:			
		HFD02-0023	B. WING		09	C 0/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KIN	G JR AVENUE SW		
(X4) ID	SUMMARY S		NGTON, DC 20032	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLET
L 001	Continued From pag	e 41	L 001			
		immunization. (2) ensure eived their immunizations. and #105.				
	The findings include:					
	Vaccine" revised 07/ and employees who contraindications to t influenza vaccine an of the vaccine shall t Informed Consent fo placed in the resident's medical re 1. Resident #21 was	the vaccine will be offered the nually A resident's refusal be documented on the r Influenza Vaccine and cord" readmitted to the facility on				
	Degenerative Joint E	tiple diagnoses that included: Disease, Respiratory Failure, bral Vascular Accident.				
		sion Minimum Data Set 2021, revealed that the facility ent as follows:				
	In Section C (Cogniti [cognitively] impaired	ve Patterns), "Severely j"				
	and Programs), "Did influenza vaccine in Influenza vaccination documented "No";	I Treatments, Procedures the resident receive the this facility for this year's n season?" Facility staff				
	facility staff documer "Is the resident's Pne date?" facility staff de	eumococcal vaccination up to ocumented, "No",				
	date?" facility staff de "If pneumococcal vac	-				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		• •	E SURVEY PLETED
			A. BUILDING:			С
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
	SI IMMARY S		NGTON, DC 20032	PROVIDER'S PLAN OF C		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 001	Continued From pag	e 42	L 001			
	and paper health rec evidence that facility representative with in	Resident #21's electronic ord lacked documented staff provided the resident's nformation regarding the immunizations or the				
	2. Resident #95 was 01/19/2021, with mul Cerebral Infarc due t	admitted to the facility on tiple diagnoses that included: o Embolism of Left Middle tlessness and Agitation, ter Gastrostomy and				
	revealed that facility	sion MDS dated 01/26/2021, staff coded the following:				
	"Severely cognitively	terview for Mental Status), r impaired"				
	and Programs), "Did influenza vaccine in	I Treatments, Procedures the resident receive the this facility for this year's n season?" facility staff				
	facility staff documer "Is the resident's Pne date?" facility staff do	eumococcal vaccination up to				
	-	documented, "Not offered".				
	and paper health rec evidence that facility representative with in	Resident #95's electronic ord lacked documented staff provided the resident's nformation regarding the immunizations or the e immunizations.				
	3. Resident #105 wa					

	gulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STA		03/10/2021	
		4601 MA		ING JR AVENUE SW		
BRIDGEP	DINT SUBACUTE AND F	REHAB NATIONAL H WASHIN	NGTON, DC 2003	2		
(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 APPROPRI DEFICIENCY)	BE COMPLET	
L 001	Continued From pag	e 43	L 001			
	Polyneuropathy, Any	Itiple diagnoses that included: kiety Disorder, Bipolar ressive Disorder, and me.				
	07/13/2021, revealed following:	cant Change MDS dated d facility staff coded the				
	summary score of "1 response.	nterview for Mental Status) 5", indicating intact cognitive				
	and Programs), " Is Pneumococcal vacci staff documented, "N "If pneumococcal vac	nation up to date?" facility				
	and paper health rec evidence that facility with information rega	Resident #105's electronic cord lacked documented staff provided the resident arding the benefits and risks the opportunity to receive				
	08/30/2021 at 3:39 F	e interview conducted on PM, Employee #2 (Director of she would follow-up about				
L 051	3210.4 Nursing Facil	ities	L 051	L 051	11/02/20	
	following:	be responsible for the		The charge nurse failed to develop and implement a baseline care plan within 48 hours ofadmission for thre		
		lent visits to assess physical and implementing any		(3) residents.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PF	ROVIDER OR SUPPLIER	1	ADDRESS, CITY, ST	ATE, ZIP CODE	00,10,202	
		4601 MA		KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND F		NGTON, DC 200	32		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMF	
L 051	Continued From pag	ie 44	L 051	1. Corrective action for reside	ent	
	-	ation records for racy in the transcription of d adherences to stop-order		The baseline Care Plans cannot be r retrospectively. However, compreh plans are in place for Resident #95, #372. Resident #95 has a care plan address the use of a hand mitten. Re #105 and #372 no longer reside in th 2. Identify other residents	ensive care #105, and in place to esidents	
	appropriate goals an them as needed; (d) Delegating respor direct resident nursin	d approaches, and revising nsibility to the nursing staff for ng care of specific residents; evaluating each nursing		An audit of all new admissions base plans was conducted and all current have had their baseline care plans in address pertinent resident specific co There were no additional findings re citation.	residents place to oncerns.	
	or her designee infor residents. This Statute is not m Based on record revi nine (9) of 44, sampl nurse failed to develo care plan within 48 h (3) residents; failed t comprehensive perso seven (7) residents; person-centered care needs and diagnose failed to monitor for s of the resident's preso	iew and staff interview, for ed residents, the charge op and implement a baseline ours of admission for three to develop and implement on-centered care plans for failed to revise the e plan to address resident s for three (3) residents; and side effects and effectiveness scribed psychotropic ression and anxiety for one nts' #56, #68, #78, #87,		 3. Systemic changes IDT team has been educated on the of ensuring that baseline care plans for each resident within 48 hours of The Director of Reimbursement will responsible for ensuring that all resi interim care plans within 48 hours of 4. Monitor corrective actions The Director of Reimbursement/Descomplete daily audits of all new admensure that all residents have interim within 48 hours (weekend/holiday a will be audited the next business day results will be reported to the QAPI monthly x 3 months for review and recommendations. 	are created admission. I be dents have f admission. signee will nissions to n care plans dmissions y). The	
	The findings include:			The QAPI Committee is responsible going monitoring for compliance.	e for the on-	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
					С	
		HFD02-0023			09/	16/2021
ME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	ARTIN LUTHER KING NGTON, DC 20032	J JR AVENUE SW		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLE DATE
L 051	Continued From page	e 45	L 051 5.	Date correction action co	ompleted	
	The charge nurse fai implement a baseline admission for three (e care plan within 48 hours of		ne facility's date of alleged com ovember 2, 2021.	pliance is	
		ny and Attention for				
	Review of the physici following:	an's orders revealed the				
		left wrist restraint q (every) 2 any findings every 2 hours"				
	prevent patient from	ft wrist restraint in place to pulling on her trach (gastrostomy)- Tube q shift"				
		95's Admission Minimum d 01/26/2021 revealed that e following:				
	In Section P (Restrain mitten] Used daily	nt), "Limb restraint [hand '				
	there was no docume staff developed a bas	esident #95's care plan, ented evidence that facility seline care plan (within 48 o address her use of a hand				
	08/30/2021 at 10:35	interview conducted on AM, Employee #2 (Director provide any comments to				
	2. Resident #105 was	s admitted to the facility on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL		
						С	
		HFD02-0023	B. WING		09/1	9/16/2021	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	OINT SUBACUTE AND F		RTIN LUTHER	KING JR AVENUE SW			
RIDGEF	OINT SUBACUTE AND I	WASHIN	IGTON, DC 200)32			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T		COMPLE ⁻ DATE	
IAG			TAG	DEFICIE			
L 051	Continued From page	o 46	L 051	The charge nurse faile	d to develop	11/02/2021	
L 051	Continued From pag	e 46	L 051	and implement compre			
		tiple diagnoses that included:		person -centered carep	olans.		
	Chronic Pain Syndro	me, Polyneuropathy, Anxiety		(Residents' #56, #68, #	87, #95, #100,		
	Disorder and Bipolar	Disorder.		#102 and #105)			
	Review of the physic	ian's orders revealed:		1. Corrective action	n for resident		
					1 11 100 1		
	05/26/2021 "Pain as	sessment every shift"		Residents #56, #68, #87,			
				had their comprehensive			
		inophen (pain reliever) tablet		and updated. Resident #1	05 no longer resides in		
		give 1 tablet by mouth every 6		the facility.			
	hours as needed for	mild pain"		2. Identify other res	sidents		
	00/00/0004 """ "	(opioid poin reliever) to blot C		2. Identify other res	SIUCIIIS		
		l (opioid pain reliever) tablet 2		An audit of all current res	ident's care plans was		
		mouth every 6 hours as		conducted and all current			
	needed for pain"			their care plans reviewed			
	Review of the Signifi	cant Change Minimum Data		were no additional finding			
		1, revealed that facility staff		citation.	So refuted to this		
	coded the following:	r, revealed that idenity star					
	coucu ino renorming.			3. Systemic change	S		
	In Section J (Health (Conditions), " At any time					
		is the resident: received		IDT team has been education	ted on the importance		
		cation regimen facility staff		of ensuring that comprehe	ensive care plans are		
	documented "Yes",			created for each resident a			
				The Director of Reimburs			
		needed) pain medications or		responsible for ensuring t			
	was offered and dec	lined Facility staff		comprehensive care plans	5.		
	documented "Yes",						
				4. Monitor correcti	ve actions		
		ne have you experienced					
		he last 5 days" facility staff		The MDS nurses will con			
	documented "Freque	entiy"		of comprehensive care pla			
	In Conting N//Mar			residents have comprehen			
		tions), "Indicate the number		Audits will be completed			
		received the following		completion. The results v			
		macological classification		QAPI Committee monthly			
	"Opioid (Dilaudid)", E	iys Medication received:		review and recommendation	ions.		
		Jays. U.		The QAPI Committee is r	esponsible for the on-		
	During a review of P	esident #105's Care Plan,		going monitoring for com			
	tion & Licensing Administrati			some monitoring for com	rriance.		

If continuation sheet 47 of 149

STATEMENT	egulation & Licensing A r OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	·		
		HFD02-0023	B. WING			C 16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 M	ARTIN LUTHER	KING JR AVENUE SW		
		WASHI	NGTON, DC 200	32		
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
L 051	Continued From page	e 47	L 051	5. Date correction action	completed	
	there was no docume	ented evidence that facility			-	
	staff developed a bashours of admission) t	seline care plan (within 48 to address her pain.		The facility's date of alleged co November 2, 2021.	mpliance is	
		e interview conducted on AM, Employee #2 (Director				
	of Nursing) failed to p address the findings.	provide any comments to				
	3. Resident #372 wa 08/10/2021, with diag	s admitted to the facility on gnoses that included				
	Metabolic Encephalo Gastrostomy, Chroni	pathy, Tracheostomy, c Respiratory Failure with				
		, Epilepsy, Pneumonitis due				
		and Vomit, Schizophrenia,				
	Anxiety Disorder, and Agitation.	a Restlessness and				
	Review of the nursing	g progress notes revealed:				
		[6:26 PM] (Admission Note) ted from [Hospital ' s name]				
	with vent in place due	e to respiratory failure PEG				
		scopic Gastrostomy) tube on				
		enJevity 1.5 is continuous				
	for 24 hours at 55 ml	in place and draining clear				
	yellow urine"	in place and draining clour				
		lan section of the electronic ed there was no Baseline				
		d including a focus area,				
		to address Resident #372's				
	needs for Respirator					
		are and Enteral Feeding,				
	and diagnoses of Sc					
		ss or Agitation. Also, there				
		t the facility's staff provided				
		r representative with a				
	summary of the Base tion & Licensing Administrati					

ND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 09/16/2021	
		HFD02-0023	B. WING			
		1			9/10/2021	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, DC 200			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
L 051	08/30/2021 at 10:35	e interview conducted on AM, Employee #2 (Director provide any comments to	L 051	 The charge nurse failed to revise the person-centered care plan to address resident needs and diagnoses. (Residents' #56 #78, #87) 1. Corrective action for resident Residents #56 and #78 have had their comprehensive care plans reviewed and updated. Resident #87 no longer resides in the facility. 	e	
	plans. (Residents' # #102 and #105) 1.The charge nurse implement a compre	iled to develop and ensive person -centered care 56, #68, #87, #95, #100, failed to develop and hensive person-centered ed Resident #56's smoking		 Identify other residents An audit of all current residents care plans wa conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. Systemic changes 		
	06/01/2021 with the Peripheral Vascular Mellitus, Acquired Ab Dependence, Cirrho	dmitted to the facility on following diagnoses: Disease (PVD), Diabetes osence of Right Foot, Opioid sis, Chronic Pancreatitis, tis C, and Depression.		 IDT team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated/revised needed. The Director of Reimbursement will responsible for ensuring that all residents have updated/revised comprehensive care plans. 4. Monitor corrective actions 	as be	
	approximately 9:00 A (Administrator) state residents that smoke Review of the care p	d that the facility did not have e. Ian revealed it was last		The MDS nurses will complete monthly audit of comprehensive care plans to ensure that all residents have updated/revised comprehensive care plans. Audits will be completed during resident MDS completion. The results will be		
	evidence the facility' comprehensive, pers	son-centered care plan with ons to address the resident's		reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the or going monitoring for compliance.		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPI	
			B. WING			C
		HFD02-0023			09/	16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ARTIN LUTHER KING			
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	NGTON, DC 20032	SIR AVENUE SW		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLE DATE
L 051	Continued From page	e 49	L 051 5.	Date correction action co	ompleted	
	-	interview on 08/24/2021 at 56 said that she smokes.	Th	e facility's date of alleged com	-	
	08/26/2021 at 9:22 A Manager) stated that	interview conducted on M, Employee #23 (Unit Resident #56 is a smoker he care plan to reflect the to smoke.				
	#68's Head of Bed (H	failed to elevate Resident IOB) at a 45-degree angle ube (enteral) feeding was				
	04/19/2021. The mean the resident had sever 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."				
		feed order every shift /hr (milliliters/hour) X (times)				
		an with a focus area of: Interal) Feeding dated				

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU COMPLE	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	IED
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		4601 MA		KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND R		IGTON, DC 200)32		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLE DATE
			1110	DEFICIENCY)		
L 051	Continued From page	e 50	L 051	The charge nurse failed to monitor		1/02/2021
				side effectsand effectiveness of the		
		ultiple interventions including		resident's prescribed psychotropic	;	
		s the HOB elevated 45		medications for depression and		
	degrees duringtub	e (enteral) feeding.		anxiety Resident #100		
	During a face-to-face	interview on 08/30/21 at		1. Corrective action for resident		
	approximately 2:30 P					
		tated that the nursing		Residents #100 is currently being asse	ssed for	
	, ,	vided care for the resident		the effectiveness of their psycho tropic		
	and forgot to elevate			medications. They have also been eva		
	5			a psychiatrist.	induced by	
	3. The charge nurse	failed to develop a				
		on-centered care plan to		2. Identify other residents		
		7's use of a urinary catheter				
	and PICC (Periphera			An audit of other residents on psychot	ropic	
	Line)/mid-line (intrave	enous access).		medications and orders for psychiatric		
	, ,	,		evaluations has been completed. Resid		
	Resident #87 was re-	admitted to the facility on		been evaluated as needed and are bein		
		lical record showed that the		for effectiveness of their psychotropic	5 4000000	
	resident had several	diagnoses including		medications. There were no additiona	l findings	
	Dependency on Resp			related to this citation.	i iiiiaiiigs	
	Tracheostomy, Obes	ity, Gastrostomy and Stage				
	4 Sacral Pressure Ul	cer		3. Systemic changes		
	During an observatio			Nursing staff have been educated on the	ne	
		imately 3:30PM, the resident		importance of ensuring that residents r	received	
	was noted to have a	urinary catheter and right		ordered medical evaluations and are ev		
	upper arm PICC/MID	-line.		for the effectiveness of their medication	ons. The	
				Director of Social Services will be res	ponsible	
		an orders showed the		for ensuring that residents are evaluate		
	following:			psychiatrist per physician orders and the		
				effectiveness of the psychotropic medi		
		Foley (urinary) catheter		assessed.		
	every month"					
	08/05/2021 "Chases	PICC/MID line dragging		4. Monitor corrective actions		
		PICC/MID line dressing				
	once a week"			The Director of Social Services/Design		
	The medical second l			complete weekly audits of Behavior M	Ionitoring	
		acked documented evidence		sheets of all residents on psychotropic		
		developed care plans to		medications to ensure that they are ass		
	address the resident'	s use of a urinary catheter		the effectiveness of their medications a	and that	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING		С	
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IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
RIDGEP	OINT SUBACUTE AND R	4601 MA REHAB NATIONAL H	ARTIN LUTHER	KING JR AVENUE SW		
			NGTON, DC 200	32		
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
L 051	Continued From page	e 51	L 051	they have been evaluated by a p		
	and a PICC/MID-line			ordered. The results will be rep QAPI Committee monthly x 3 n		
	During a face to face	inter inv on 00/01/2021 at		review and recommendations.		
	U	interview on 09/01/2021 at AM, Employee #14 (Unit		The QAPI Committee is response	sible for the on-	
		she would develop a care		going monitoring for complianc		
	C <i>i</i>	dent #87's use of a urinary				
	catheter and a PICC/	/MID line.		5. Date correction action	completed	
				The facility's date of alleged con	mpliance is	
	4. The charge nurse	failed to develop a on-centered care plan to		November 2, 2021.		
		5's use of a hand mitten.				
		lmitted to the facility on				
		tiple diagnoses that included:				
	Restlessness and Ag Encounter Gastroston					
	Encounter Tracheost	•				
		95's Admission Minimum d 01/26/2021, revealed that				
		no following.				
	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 "				
	•	eft wrist restraint in place to				
	prevent patient from (tracheostomy) or G	pulling on her trach (gastrostomy)- Tube q shift"				
		95's care plan revealed				
		ented evidence that the				
	person-centered care	bed a comprehensive,				
	tion & Licensing Administrati					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		C	
		HFD02-0023			09	/16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ARTIN LUTHER KING			
RIDGEP	OINT SUBACUTE AND	REHAB NATIONAL H	NGTON, DC 20032	00000000		
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
L 051	Continued From pag	je 52	L 051			
	interventions to addr hand mitten.	ress the resident's use of a				
	10:35 AM, Employee	e interview on 08/30/2021 at e #2 (Director of Nursing) comments to address				
	-	failed to develop a care plan #100's diagnosis of Anxiety.				
	04/26/2021, with mu	admitted to the facility on Itiple diagnoses that and Depression				
	Review of physician following:	orders revealed the				
		oam (antianxiety) Tablet 5 mg blet via G (gastrostomy) tube or anxiety"				
	for dry mouth, const	ychotic medication-monitor ipation, blurred vision, sion, difficulty urinating, rine, yellow skin.				
		pine Fumarate (antipsychotic) tablet via G (Gastrostomy) for Depression"				
		in (antianxiety) give 1 tablet a day for Anxiety"				
	showed that in Secti C0100 "Should a Bri be conducted" facilit	erly MDS dated 08/02/2021 on C (Cognitive Patterns), ef Interview for Mental Status y staff coded, "0" meaning ever understood". Section D				

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY IPLETED
					С	
		HFD02-0023	B. WING		0	9/16/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
		WASHIN	NGTON, 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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From page	e 53	L 051			
	(Mood) Facility staff coded "0"(meaning no symptoms present). In Section E (Behavior - Potential Indicators of Psychosis) facility staff coded, "Z" indicating none of the above. In Section "I" (Active Diagnosis) facility staff coded Anxiety Disorder and Depression.					
	documented evidence developed a compre	#100's care plans lacked the the facility's staff hensive person-centered Resident 100's diagnosis of				
	Employee #42 (Unit responsible for the ca employee failed expla	e interview on 09/16/2021, Manager) stated that she is are plan. However, the ain why the resident's anxiety dress in the previously s.				
		failed to update Resident ddress his needs for mental				
	05/12/2021, with mul Multiple Fractures of Respiratory Failure v	vith Hypoxia, Unspecified nd of Right Femur, and				
		g progress notes dated from 2021 revealed the following:				
	stated "don't you tou already done" reside	M- "Refused wound care, ch my wounds they are nt was educated the Is being done but refused"				
	07/07/2021 at 6:14 F					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:		C	
		HFD02-0023	B. WING		09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT 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)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From page	e 54	L 051			
	wounds healdevice the wound this can h quickly)" done writ	c (a type of therapy to help e decreases air pressure on elp the wound heal more er made attempts to do the ed care as well as therapy. does not want to be				
		nedicine.org/health/treatmen vacuumassisted-closure-of- a-				
		PM -"resident refused fs nd insulin. risk and benefit "				
		M - "patient refused I it is too early for him to get				
	stated I do not need [Oxycodone (opioid p	pain reliever)5 MG Give 1 comy)-Tube every day and				
	plan lacked docume	#102 ' s comprehensive care nted evidence that the facility person-centered care plan to f care.				
	09/16/2021 at approx Employee #14 (she was not sure if th	e interview conducted on kimately 3:15 PM, Unit Manager) stated that he resident was evaluated by ress his refusal of care.				
	7. The charge nurse comprehensive, pers	failed to develop a on-centered care plan to				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
		HFD02-0023	B. WING		09	09/16/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
	OINT SUBACUTE AND F	REHAB NATIONAL H		3 JR AVENUE SW			
a			NGTON, 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 ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
L 051	Continued From page 55		L 051				
	address Resident #1	05's pain.					
	05/26/2021, with mul	admitted to the facility on tiple diagnoses that included: me, Polyneuropathy, Anxiety Disorder.					
	Review of the Significant Change MDS dated 07/13/2021, revealed that facility staff coded the following:						
	in the last 5 days, ha scheduled pain medi documented "Yes", " pain medications or v facility staff documen	Conditions), " At any time is the resident: received ication regimen facility staff received PRN (as needed) was offered and declined" inted "Yes", "How much of the ienced pain or hurting over ty staff documented					
	of days the resident medications by phare	tions), "Indicate the number received the following macological classification ays Medication received: Days: "6".					
	Review of the physic following:	ian's orders revealed the					
	05/26/2021- "Pain as	sessment every shift"					
		ninophen (pain reliever) tablet Give 1 tablet by mouth every or mild pain"					
	2 MG Give 1 tablet b needed for pain"	d (opioid pain reliever) tablet y mouth every 6 hours as esident #105's care plan,					

STATE FORM

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		. ,	E SURVEY PLETED
					С	
		HFD02-0023	B. WING		09	/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		G JR AVENUE SW		
			IGTON, 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) COMPLET DATE
L 051	Continued From pag	e 56	L 051			
		ented evidence that facility seline care plan (within 48 to address her pain.				
	08/30/2021 at 10:35	e interview conducted on AM, Employee #2 (Director provide any comments to the				
	needs and diagnoses 1A. The charge nurs the comprehensive of	e plan to address resident s. (Residents' #56 #78, #87) e failed to revise and update				
	06/01/2021 with the Peripheral Vascular Acquired Absence of Dependence, Cirrho	Disease, Diabetes Mellitus,				
	07/19/2021 revealed Patterns), that Resid having a Brief Intervi Summary Score of " was intact cognitively	erly Minimum Data Set dated I in Section C (Cognitive lent #56 was documented as iew for Mental Status 15" indicating the resident y. In Section H (Bowel and ht was not coded for the use ary catheter.				
		acility on 08/23/2021 at 9:04 as observed lying in bed,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		• •	E SURVEY PLETED	
			A. BUILDING:		С		
		HFD02-0023	B. WING		09	09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
BRIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	JR AVENUE SW			
-		WASHIN	NGTON, 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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
L 051	Continued From page	e 57	L 051				
	watching television. A observations, the res indwelling urinary cat	ident did not have an					
		, "Change foley catheter, "q as needed." This order was					
	" The resident has ur presence of foley cat 06/03/2021. At the tir (08/26/2021) Resider indwelling urinary cat	ne of this review, nt #56 no longer had the theter in place. However, the dated to reflect the resident's					
	4:01 PM, Resident #	interview on 08/24/2021 at 56 stated, "I had "one" theter] a few months ago,					
	1:07 PM, Employee # that she would remove related to presence of	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 are plan for Resident #56 n 08/03/2021.					
	was reportedthat [her wc (wheelchair) [propertyresident wa	(3:36 PM), documented, " It Resident's name] fell out of					

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		HFD02-0023	B. WING		09	0/16/2021
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		G JR AVENUE SW		
	SIIMMARY ST		IGTON, DC 20032	PROVIDER'S PLAN OF C		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From page	e 58	L 051			
	access driver helped	rson walking by and a metro l her up[resident] states I y arm refusedmedical				
	Review of the care plan with a revision date of 08/24/2021 with the focus area: "at risk for fall" However, the last update on 08/24/2021 failed to address Resident #56's fall on 08/03/21.					
	#23 at 9:22 AM, ackr 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				
	-	failed to update and revise plan to include all of the				
	04/14/2020, with mul Depression, Bipolar	dmitted to the facility on tiple diagnoses including, Disorder, Anoxic Brain nd Chronic Respiratory				
	(MDS) dated 08/22/2 C (Cognitive Patterns brief interview for me facility staff coded "0 (Active Diagnosis) R	erly Minimum Data Set 2021, showed that in Section s), C0100 asked, "should a ental status be conducted" " indicating "no". In Section I esident #78, was coded as ipolar Disorder and Anoxic				
	Review of the docum Physical" revealed th	ent entitled "History and ne following:				
	04/15/2020 - " histo	ory of present illness", "				

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		• •	E SURVEY PLETED
			B. WING		С	
		HFD02-0023			09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, RTIN LUTHER KING			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	IGTON, 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From page	e 59	L 051			
	and PCP (Phencyclic	lipolar Disorder, Depression dine or Phenylcyclohexyl nogenic drug] use"				
	05/17/2021- " history of present illness", "h/o Depression, Bipolar, Anoxic Brain Damage" Review of Resident #78's "Comprehensive Care Plan" dated 08/18/2021, failed to have focus areas that addressed the resident 's diagnoses of Depression and Anoxic Brain Damage.					
	09/16/2021, Employe	e interview conducted on ee #42 (Unit Manager) stated le for updating the care plan.				
	-	failed to revise Resident new interventions to address tegrity issues.				
	02/26/2021. The med resident had several Sacral Pressure Ulce Ulcer, Stage 4 Right Unstageable Right H	leel Pressure Ulcer, and a essure Ulcer, Dependency ator], Tracheostomy,				
	Manager) and Emplo were observed provid #87's Stage 4 sacral	PM, Employee #16 (Unit byee #20 (Registered Nurse) ding wound care for Resident pressure injury/wound, ressure injury/wound, and				
	Review of Skin &Wo					

TATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING.		С	
		HFD02-0023	B. WING	09	09/16/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
(V.A) ID	STINWARY S		NGTON, DC 20032	PROVIDER'S PLAN OF C		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From pag	e 60	L 051			
	revealed the followin	g:				
	buttocks blister, leng	nouse acquired, right th 4.2cm (centimeters),width plicable, undermining not not applicable.				
		at staff is currently classifying ge 4 (full thickness skin and injury.				
	pressure injury to left	house acquired, Stage 4 t ear, length 0.9cm, width 0.9 able, undermining not not applicable.				
	blister, length 4.1cm	-house acquired, right heel , width 4.3 cm, depth not ing not applicable, tunneling				
	this wound [right hee	at staff is currently classifying I] as a Deep Tissue Injury chable deep red, maroon, or				
	unstageable (obscur tissue loss) pressure width 2.0 cm, depth not applicable, tunne	house acquired, right calf ed full-thickness skin and e ulcer/injury, length 3.0 cm, not applicable, undermining eling not applicable, and f wound filled with slough (a).				
	Review of physicians following:	orders revealed the				
	gently with wound cle	l, "Cleanse blister right heel eanser spray, pat dry, apply / to protectEvery day and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		E SURVEY PLETED
		HFD02-0023	B. WING		C 09/16/2021	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		4601 MA	RTIN LUTHER KING	G JR AVENUE SW		
SRIDGEPO	DINT SUBACUTE AND F		IGTON, DC 20032			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLET DATE
		,		DEFICIENC	Y)	
L 051	Continued From pag	e 61	L 051			
	night shift for wound	care."				
	05/21/2021 - directed	d, "Cleanse wound left ear				
		spray, pat dry, apply				
		ulated Colloidal Dispersion),				
		days every nightfor wound				
	care."					
	05/21/2021 - directed	d, "Cleanse wound to sacrum				
	with Anasept wound	cleanser spray, pat dry,				
	apply Anasept gel, co	over with 4X4's and pad, and				
		e [stratasorb] dressing daily				
	and prn (as needed) care".	every night shift for wound				
	07/07/2021 - directed	d," Cleanse wound to right				
	calf with Anasept wound cleanser spray, pat dry,					
	apply Anasept gel, co					
	(abdominal) pad, wra needed)."	ap with kling daily and prn (as				
	·					
	Review of the June 2					
		tion Record (TAR) revealed				
	that nursing staff initi	2021 indicating that they				
		d care as prescribed.				
	₋					
		erly Minimum Data Set				
	(MDS) dated 06/02/2	2021 revealed the following:				
	In Section C (Brief In	terview for Mental Status)				
	•	led as an "11" indicating that				
		derately impaired cognitively.				
		onal Status) the resident was				
		ident on staff and requiring				
		of one or two staff members				
		ssing, eating, toileting, and				
		ection I (Active Diagnoses) led for Aphasia, Dependency				
	on Respirator [Ventila					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		HFD02-0023	B. WING		09	C 9/16/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
RIDGEP	OINT SUBACUTE AND R		ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
L 051	Continued From page	e 62	L 051			
	Gastrostomy, and Generalized Muscle Weakness. In Section M (Skin Condition) the resident was coded for being at risk for pressure ulcers/injuries and having one Stage 2, one Stage 3 and one Stage 4 pressure ulcer/injury. The resident was also coded for having surgical wound(s).					
	Review of the Signific Set (MDS) dated 07/2 following:	cant Change Minimum Data 29/2021 revealed the				
	the area was blank. I Status) the resident w dependent on staff and assistance with one of mobility, dressing, ea hygiene. Section I (Ad was coded for Stage Dependency on Resp Tracheostomy, Gastr Muscle Weakness. In the resident was code pressure ulcers/injuri Stage 4 Pressure Ulc Wound, one Unstage and surgical wound (s					
	02/26/2021 with the f	an with an initial date of ocus area of: age 4 (pressure injury) to sure injury unstageable to				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		HFD02-0023	B. WING		09	9/16/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, 2	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H	ARTIN LUTHER KING	JR AVENUE SW		
0(0)5			NGTON, DC 20032	PROVIDER'S PLAN OF (
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
L 051	Continued From page	e 63	L 051			
	updated it with new (current) interventions each assessment (06/02/2021 and 07/26/2 to address Resident #87's skin integrity is including pressure ulcers/injuries.					
	approximately 1:30 F Manager) stated that Resident #87's care to address the reside	e interview on 09/01/2021 at PM, Employee #14 (Unit s she had not revised plan with new interventions nt's skin integrity issues, but e care plan moving forward.				
	and effectiveness of	led to monitor for side effects the resident's prescribed tions for depression and 00				
		ailed to monitor Resident and effectiveness of his opics medications.				
		idmitted to the facility on iple diagnoses including ion.				
	Review of physician of following:	orders revealed the				
		oam (antianxiety) 5 mg a G(Gastrostomy) tube or anxiety."				
	for dry mouth, consti	chotic medication-monitor pation, blurred vision, ion difficulty urinating, ine, vellow skin"				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
RIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KI	NG JR AVENUE SW		
		WASHIN	NGTON, DC 2003	2		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
L 051	Continued From page	9 64	L 051			
		ne Fumarate (antipsychotic) <i>r</i> ia G-tube every 8 hours for				
		n (Antianxiety) Tablet 1 mg tablet via G- tube two times				
	08/02/2021 showed f following: In Section 0 "Should a brief Interv conducted", "0" mean understood". In Section	C (Cognitive Patterns), iew for Mental status be ing "Resident is rarely/never on D (Mood). "0". In Section al indicators of psychosis,				
	"[Resident's name] us medications r/t depre of 05/04/2021. The ca	ssionwith a revision dated are plan outlined multiple g monitor for side effects				
	3:31 PM, Employee # stated that the last tir	interview on 08/30/2021 at 411 (Registered Nurse) ne a Behavioral Assessment e resident was in June of				
L 052	3211.1 Nursing Facili	ties	L 052	L 052	11/02/2021	
	resident to ensure the receives the following	: itions, diet and nutritional		A.Facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were reporting and documenting change inresident skin condition as so identified.	0	

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STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BOILDING		С
		HFD02-0023	B. WING		09/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H		KING JR AVENUE SW	
			IGTON, DC 200	32 PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLE
L 052	Continued From page	e 65	L 052	residents identified by the facility as high risk for developingpressure ulcers had pressure ulcers/injuries	3
	(b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:			first observed by staff at an advanc stage (Stage 3, Stage 4 and Unstageable). (Residents' #87, #83,	
		personal grooming so that		#73, #62, and #42)	
		rtable, clean, and neat as m from body odor, cleaned nd clean, neat and		1. Corrective action for resident	
	well-groomed hair;			Residents #87, #83, #73, #62, and #42 assessed on 9/8/2021 to ensure that any	v changes
		ccident, injury, and infection;		in skin condition were identified and tr appropriately. Resident #87 no longer	resides in
	(e) Encouragement, a self-care and group a	assistance, and training in activities;		the facility. Staff were educated on ide and reporting changes in skin condition	
	(f) Encouragement ar	nd assistance to:		2. Identify other residents	
		and dress or be dressed in ng; and shoes or slippers,		Facility completed house wide skins assessments by 9-09-2021, going	
	which shall be clean	•		forward skin assessments will be performed twice a week by the Licens	20
	(2) Use the dining roo	om if he or she is able; and		Nursing staff during the residents showers/bed baths to document any	
	(3) Participate in mea recreational activities	0		changes in the resident's skin condition	on.
	(g) Prompt, unhurried requires or request h	assistance if he or she elp with eating:		3. Systemic changes	
				The assessments will be documented a stored in the departmental shower boo	
	(h) Prescribed adaptive him or her in eating	ve self-help devices to assist		and the DON/Designee will audit for	
	independently;			completion twice a week for two months. The corporate wound nurse of	r l
	(i) Assistance, if need	ed, with daily hygiene,		designee will in-serviceAll Nursing st	
	including oral acre; a	nd		including registry on the process of	
		an activated call bell or call		reporting head and toe assessment and reporting documenting changes in	1
	for help.			residents skin condition to the Physic	
	This Statute is not m	et as evidenced by:		and wound team as soon as identified.	

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PRINTED: 10/29/2021 FORM APPROVED

	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		00/1	0/2021
	NOVIDER OR GOLT EIER			KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	IGTON, DC 200			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE
L 052	Continued From page	9 66	L 052	An in-service including a sign-in sh		
				will be provided to track Nursing s	taff.	
	Based on observation, record reviews Resident and staff interviews, 12 of 44 sampled residents, facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were			All Nursing Staff including registry	' will	
				be in-serviced on Wound Policy and	d	
				procedures. The Corporate wound n	urse	
		enting changes in resident	will educate the Director of Nursing on			
	skin condition as so identified. Subsequently, five			the Wound policy and procedures.		
		s identified by the facility as				
		ng pressure ulcers had		4. Monitor corrective actions		
		es first observed by staff at		Transien and searching in 111		
	an advance stage (St			Turning and repositioning will be m		
	÷ .	ed to ensure that sufficient		every two hours by the nursing supe ensure proper turning and reposition		
		en to: provide adequate		conducted. A turning and reposition		
		r the residents whereabout		will be used to monitor turning and reposition		
		ity for one (1) resident who		Wounds found during the skin	eposition.	
		the staff knowledge; weigh		assessments a RCA (Root Cause		
	a resident every 30 days as ordered and verify accurate weights were being obtained for two (2) residents'; provide respiratory care consistent			Analysis) to investigate the Nursing	staff	
				responsible for not properly	50001	
	with the professional standards of practice as		documenting skin assessments, and	I		
	evidenced by failure to ensure one (1) resident			conducting turning and repositionin		
	receiving oxygen the	receiving oxygen therapy had physician's orders		This will be monitored by The Dire		
	to direct the amount of oxygen to be delivered to			of Nursing and Nursing Supervisor		
		esident; change one (1) resident's		"skin tag violation card" will be		
		stic bag attached to the		implemented to address any staff for	ound	
		s fecal matter from the		not doing proper turning and	Junu	
	digestive tract throug	h an opening in the I a stoma), when it was		repositioning of residents. Nursing	staff	
		th the physician's order and		with over3 violations will be taken		
		nd standards of practice;		the floor immediatelyfor training an		
		and evaluate the resident		weekly Quality Audit will be condu		
	-	ng pain medication for two		by the QAPI team. All finding will		
		ensure one (1) resident was		addressed at the weekly QAPI mee		
		iatrist, as ordered by the		for 2 months. QA Audits of skin	ung	
		s' #21, #37, #42, #56, #62,		assessment documentation done wee	kly	
	#73, #76, #83, #87, #	#93, #95 and #102)		for two months to ensure skin	лту	
					0.1170	
				assessments will be completed to entire timely and appropriately. This will		
	The findings include:			timely and appropriately. This will	be	
	The findings include:			monitored by the Administrator,		
			1	Director of Nursing and the Quality		

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	STREET A 4601 MA	ADDRESS, CITY, ST	KING JR AVENUE SW	03/1	0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	WASHII TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	32 PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
L 052	Continued From page	e 67	L 052	Director and addressed in the w QAPI meetings.	eekly	
	nursing time was give staff were reporting a resident skin condition Subsequently, five (5 identified by the facility observed by staff at a Stage 4 and Unstage #73, #62, and #42) Review of the facility of Pressure Ulcers/In 07/2017 revealed the Inspect the skin on performing or assistin ADLs (Activities of D reposition bedbound hours" 1. Resident #87 was 02/26/2021. The med resident had several Cerebral Vascular Act Respirator [Ventilato Gastrostomy, Obesit Ulcer, Stage 4 Left E Right Calf Pressure Ulcer Pressure Ulcer. Review of the Care F focus: "Anti-coagular date of 11/20/2020. I inspections"	 i) of five (5) residents ty as high risk for developing pressure ulcers/injuries first an advance stage (Stage 3, eable). (Residents' #87, #83, policy entitled, "Prevention ujuries" with a revision date of policy instructed staff to, " a daily basis when ng with personal care or aily Living) turn and resident at least every two re-admitted to the facility on dical record showed the diagnoses including: cident, Dependency on		The QAPI Committee is respons going monitoring for compliance 5. Date correction action of The facility's date of alleged com September 15, 2021.	e. ompleted	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER OINT SUBACUTE AND R	EHAB NATIONAL H	ADDRESS, CITY, S ARTIN LUTHER NGTON, DC 20	KING JR AVENUE SW		
(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)	D BE	(X5) COMPLE DATE
L 052	prevent pressure inju [Facility staff worked -02/26/2021 Physicia skin assessments Q (medical doctor/nurse abnormalities and doc -03/19/2021 Braden S scored an "8" indicati "very high risk" for de ulcers/injuries. -05/04/2021 Skin & V "Pressure (injury), St and tissue loss), Left wound measurement (centimeters), width C undermining not appl applicable, wound be exudate - light, serost Resident seen by wo assessment. Stage 4 " -06/19/2021 Braden S scored an "8" indicati "very high risk" for de ulcers/injuries. -07/02/2021 weight re -07/06/2021 Skin & W "Pressure (injury), Un	n's order- Turn and s (hours) and as needed to ry. Every day and night shift. 12-hour shifts]. n's order- Daily head to toe (every) shift. Notify MD/NP e practitioner) of any cument your assessment Scale - [Resident #87] ng that the resident was at eveloping pressure Vound Evaluation - age 4 (full-thickness skin ear, new, in-house acquired, s - length 0.9 cm 0.9 cm, depth not applicable, icable, tunneling not ed-100% granulation, anguineous, no odor und care staff for weekly pressure injury to left ear Scale - [Resident #87] ng that the resident was at eveloping pressure ecord: "265.9 [pounds]".	L 052	 B.Facility staff failed to ensure that nursing time was given to provide a supervision to monitor the resident whereaboutin and out of the facility with staff knowledge Corrective action for resident Resident #93 was educated on signing leaving the facility. Identify other residents An audit of other resident LOAs was There were no additional findings relicitation. Systemic changes Nursing and security staff have been on the importance of ensuring that resigned out appropriately and accounter no heaters are present. Nursing staff educated on the importance of accura documentation and validation of reside whereabouts throughout the shift. The of Security will be responsible for ensure that they have notified nursing their whereabouts. Monitor corrective actions The Director of Nursing/Designee wi weekly audits of all residents who go LOAs to ensure that their absence and documentation is accurate. The 	adequate ts / for thout the at g out when completed. ated to this educated sidents are ed for and have been te lent te Director suring that e facility to g staff of	11/02/2021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL		
					С		
		HFD02-0023			09/1	9/16/2021	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE KING JR AVENUE SW			
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	NGTON, DC 200				
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE	
L 052	not applicable, tunne bed-100% slough (a cast out from, living ti Resident seen by w assessment Noted n lateral calf, unit mana Review of the Treatme (TAR) for May, June nurses signed their in conducted head to to Resident #87 twice a Review of all progress dietary) from 04/19/2 06/21/2021 to 07/05/2 evidence that Reside pressure (injury) and pressure (injury) and pressure (injury) were the assessments corr on 05/04/2021 and 07/2 following: In Section BIMS (Brief Interview Score was blank. In S - Bed mobility), the re "2" indicating that the dependent on the stap physical assist for be	ling not applicable, wound mass of dead tissue in, or ssue), exudate - none ound care staff for weekly ew pressure injury to right ager made aware " ent Administration Record and July 2021 showed itials indicating that they had e skin assessments for day (day and night shift). s notes (nursing, physician, 021 to 05/03/2021 and 2021 lacked documented nt #87's Stage 4 Left Ear 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 for Mental Status) summary Section G (Functional Status esident was coded as "4" and e resident was totally ff and required one-person d mobility. In section M (Skin	L 052	results will be reported to the Q. monthly x 3 months for review a recommendations. The QAPI Committee is respon- going monitoring for complianc 5. Date correction action The facility's date of alleged co November 2, 2021.	and sible for the on- e. completed		
	physical assist for be Condition), the reside (1) Stage 3 pressure pressure ulcer, one (1)						
		care revealed the following ry (Stage 4 left ear, Stage 4					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		HFD02-0023	B. WING	(09/1) 6/2021	
	ROVIDER OR SUPPLIER OINT SUBACUTE AND R	4601 MA EHAB NATIONAL H	DDRESS, CITY, ST RTIN LUTHER IGTON, DC 200	KING JR AVENUE SW		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
L 052	lateral calf)" with a rev Interventions: " the assistance to turn/rep hours, more often as On 08/25/2021 at app Employee #16 (Unit M (Registered Nurse) w wound care for Reside pressure injury/wound pressure injury/wound Tissue Injury. During an observation AM to 12:40 PM (4 ½ noted: -At 8:10 AM, Residen room, in bed, laying of -At 10:46 AM, Reside lying on her right side -At 12:40 PM, Reside be lying on her right side During the four and h facility staff failed to r Although the facility's that they conducted h the resident daily, the facility staff identified of skin condition and fai approaches identified (turn and reposition). #87 developed in-hou	 theel, and Unstageable right vision date of 07/30/2021. resident needs total position at least every 2 need" proximately 3:30 PM, Manager) and Employee #20 rere observed providing lent #87's Stage 4 sacral d, Stage 4 Right Calf d, and Right Heel Deep n on 08/26/2021 from 8:10 h our 08/26/2021 from 8:10 h ours) the following was t #87 was observed in her on her right side. ant #87 remained in bed, e. ant #87 was observed to still side in the bed. alf hours of the observation, eposition Resident #87. n ursing staff documented read-to-toe assessments on ere was no evidence that changes in the residents ' 	L 052	 C. Facility staff failed to e sufficient nursing time w weigh a resident every30 ordered and verify accurate were being obtained. Residents and #95. 1. Corrective action for Residents #37 and #95 have their physician's orders. 2. Identify other residents weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights has be completed at been weighed and their weights are weighed and weighed and weighed and weights docum 3. Systemic changes Nursing staff and the Dietic educated on the importance residents are weighed and weighed and weighed and weighed and weighed and weights docum 4. Monitor corrective The Dietician/Designee wilf audits of all residents with ot to ensure that weights are of documented, and verified. Treported to the QAPI Comm months for review and recommon the for review and recommon the for complete the part of the par	ensure that as given to days as ate weights sidents' #37 For resident been weighed per lents with orders for nd all residents have ghts documented and ditional findings ian have been of ensuring that veights documented Dietician will be t residents are mented and verified. actions I complete weekly orders to be weighed btained, The results will be nittee monthly x 3 mmendations.	11/02/2021

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	E SURVEY PLETED	
						С	
		HFD02-0023	B. WING		09	/16/2021	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H		KING JR AVENUE SW			
		WASHIN	IGTON, DC 200				
(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 ⁻ DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
L 052	Continued From page	e 71	L 052	5. Date correction	action completed		
	During a face-to-face 08/26/2021 at 12:45 (Registered Nurse) s be turned and reposi needed. The CNA (c working her way dow to provide care." It should be noted tha Stage 4 pressure inju serial excisional deb scalpel to remove de tissue) on 08/31/202 During a face-to-face 09/08/2021 at approx Employee #2 (Direct how did residents' we to advanced stages to observed them, Emp for nursing staff to ha believe that there is a When asked how oft assessed by nursing that nursing staff ass twice-a-week during During a face-to-face 09/08/2021 at approx	e interview conducted on PM, Employee #16 stated, "The resident should itioned every 2 hours and as ertified nurse's aide) is in to the resident's room now at Resident #87"s left calf iry/ulcer required bedside ridement (the use of a vitalized [slough/necrotic] 1. e interview conducted on kimately 10:00 AM, or of Nursing) was asked bunds (pressure injuries) get before staff (wound team) bloyee #2 stated, "I'm looking ave good assessment skills. I a need for (nursing) training." en IS residents' skin staff, Employee #2 stated sess residents' skin at least bathing times. e interview conducted on kimately 5:30 PM, Employee se) was asked how often idents' skin, the employee		The facility's date of alle November 2, 2021.	ged compliance is		
	times per shift depen asked if she noticed	esidents one (1) to two (2) nding on her workload. When any new skin integrity issues the months of May 2021 and byee stated, "No".					
	During a face-to-face	e interview on 09/08/2021 at					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL		
		HFD02-0023	B. WING			C 09/16/2021	
	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
	ROVIDER OR SUPPLIER			KING JR AVENUE SW			
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	IGTON, DC 200				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE	
L 052	Continued From page	e 72	L 052	D. Facility staff failed to e		11/02/2021	
				sufficient nursing time wa	-		
		PM, Employee #14 (Unit		provide respiratory carec with the professional star			
		sked how often she assess' employee stated that when		practice as evidenced by			
	she is assigned a tea			ensure one			
	-	ent of the residents every		(1) resident receiving oxy	gen therany		
		she noticed any new skin		had physician's orders to			
		Resident #87 in the months		amount of oxygento be de			
	0.	2021, the employee stated,		the resident. Resident #2			
				1. Corrective action for	or resident		
		re-admitted to the facility on					
		noses that included: Acute		Resident #21 currently has a			
		tory Failure with Hypoxia,		that matches his oxygen deli	very.		
		ostomy, Hypertension,					
	and Pressure Ulcer S	ffecting Right Dominant Side, Stage 4.		2. Identify other resid	ents		
		-		An audit of other residents o	on oxygen did not		
	According to the Adn	nission MDS dated		reveal any other residents th			
	07/20/2021, Residen			orders. There were no additi			
		ood" under Section C Under Section G (Functional		related to this citation.			
	Status), G0400, the r	esident was coded as "total		3. Systemic changes			
	-	f for bed mobility, eating		_			
	toilet use, and person			Nursing and Respiratory The			
		n in Range of Motion" the		been educated on the import			
		or "no impairment to upper		that residents have oxygen o			
	and lower extremities	dent was coded as at risk for		corresponds with what they			
		and one (1) unhealed		Director of Nursing will be a			
		as present on admission to		ensuring that residents have	orders for all		
	the facility.			modalities received.			
	According to the Brow	den Scale, on 07/21/2021		4. Monitor corrective	actions		
		essed and scored at a "10"					
		sident was "high risk" for skin		The Director of Nursing/Des			
	breakdown.			weekly audits of residents of			
				that they have orders that ma			
	Review of the care pl	ans showed the following:		receiving. The results will b QAPI Committee monthly x			
		-		review and recommendation			
	Focus area. " Stad	e 4 pressure injury to the		it view and recommendation			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPLI	
					C 09/16/2021	
		HFD02-0023			09/1	6/2021
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST.			
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, DC 200	KING JR AVENUE SW 32		
(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 THE DEFICIENCY)	SHOULD BE	(X5) COMPLE ⁻ DATE
L 052	Continued From page 73		L 052	The QAPI Committee is respor going monitoring for compliance		
		ns: "the resident needs		Bound montoring for combination		
		position at least every 2 needed or requested dated		5. Date correction action The facility's date of alleged co		
				November 2, 2021.	I	
	Focus area, " ADL self-care performance deficit r/t (related to) CVA (cerebral vascular accident), MI (myocardial infarction), Impaired					
	residents skin require	ntions: "Skin Inspection: the es skin inspection q shift,				
		open areas, scratches, cuts, nanges to the nurse initiated				
	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 c	e wound right shoulder with nser spray then apply cover with 4x4 and secure aily every night shift for to"				
	Review of the TAR fr					
	they: "performed dail assessment Q shift (MD/NP of any abnor	y head to toe skin twice daily), would notify malities and document the				
		ned and repositioned the ours and as needed to iry"				
	However, review of the	he Skin and Wound				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	· · · · · · · · · · · · · · · · · · ·	(3) DATE SURVEY COMPLETED
			A. BUILDING	·	C
		HFD02-0023	B. WING		C 09/16/2021
ME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	ARTIN LUTHER NGTON, DC 200	KING JR AVENUE SW 32	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLE
L 052	Continued From page	e 74	L 052	E. Facility staff failed to ensure that	11/02/2021
	Evaluation V5.0 form	dated 08/17/2021 showed		sufficient nursing time was given to change Resident #76'scolostomy bag	
	the following:			(a plastic bag attached to the	
	C C			abdomen that collects fecal matter	
		le: obscured full thickness		from the digestive tract through an	
	,	22. Location: right shoulder;		opening in the abdominal wall called	
		xact Date- [left blank]; ts= Area-7.8 cm, length 4.3		a stoma), when it was full, in accordance with the physician's	
	cm x width 2.4 cm x			order andprofessional scope and	
		ogress -NewNotes:		standards of practice.	
		und rounds, noted new		-	
	pressure injury to righ	nt shoulder, wound is 100%		1. Corrective action for resident	
	-	wound area has intact			
	blister and redness			Resident #76's colostomy was changed/e at the time of the observation. Resident #	
	Essility staff wars sig	ning in the medical record		having her colostomy bag changed/empti	
		ning in the medical record sing Resident #83's skin		prescribed and as needed.	icu as
		repositioned the resident			
	every two hours. How			2. Identify other residents	
	developed an in-hous	e acquired pressure injury			
	noted at an advanced			An audit of other residents with coloston	
		right shoulder at the first		not reveal any other residents that were a	
	observation and asse	essment).		There were no additional findings related citation.	to this
		interview conducted on			
	09/08/2021 at approx			3. Systemic changes	
		or of Wound Care) was		Nursing staff have been advested on the	
		nts' wounds (pressure advanced stage before staff		Nursing staff have been educated on the importance of ensuring that resident's	
		bloyee #9 stated, "I can't		colostomy bags are being emptied/chang	ed as
		essure injuries) are found at		prescribed. The Director of Nursing will	
	advanced stages. I s	peak up when we (wound		responsible for ensuring that residents are	e
	-	n a resident's skin. I know		having their colostomy bags emptied/clea	aned
		ple of months, I have been		regularly.	
	bringing up in our Pe Meetings that nursing residents."	rformance Improvement g staff is not bathing		4. Monitor corrective actions	
	าธิอเนิยาเอ.			The Director of Nursing/Designee will co	omplete
	3. Resident #73 was	admitted to the facility on		weekly audits of residents with colostom	
		ple diagnoses that included:		ensure that they are being emptied/cleaned	ed as
	Chronic Respiratory I			prescribed and as needed. The results wi	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
		HFD02-0023			C 09/16/2021	
RIDGEP	ROVIDER OR SUPPLIER	4601 MA	NGTON, DC 200	KING JR AVENUE SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
L 052	Damage and Chronic Review of the medica following: 03/11/2020 [Braden 3 a "9" indicating that the risk" for developing p 04/28/2020 [Physicia assessment and repor MD (medical doctor)/ 04/28/2020 [Physicia with hydroguard (skin 04/28/2020 [Physicia reposition q (every) the 04/29/2020 [Physicia reposition q (every) the 04/29/2020 [Physicia bath or sponge bath needed" 07/19/2020 [Braden 3 a "9" indicating that the risk" for developing p 07/30/2020- [Physicia wounds with Anesept dry then apply Anesept gel) off load both he every 12 hours"	c Kidney Disease. al record revealed the Scale] - Resident #73 scored he resident was at "very high pressure ulcers/injuries. an Order]- "Weekly skin port any abnormality to the /NP (nurse practitioner)" an Order]- "Moisturize skin h lotion) every shift" an Order]- "Moisturize skin h lotion) every shift" an Order]- "Turn and wo hours." an Order]- "Administer bed to resident daily and as Scale] - Resident #73 scored he resident was at "very high pressure ulcers/injuries. an Order] - "Apply skin prep Injury) left heel twice a day, any redness or drainage	L 052	reported to the QAPI Committee months for review and recommon The QAPI Committee is respon- going monitoring for compliance 5. Date correction action The facility's date of alleged con November 2, 2021.	endations. sible for the on- ce. completed	

STATEMENT	egulation & Licensing A OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SI COMPLE	
					С	
		HFD02-0023	B. WING		09/1	6/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW 132		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLET DATE
L 052	Continued From page	e 76	L 052	F.Facility staff failed to ensure that s		11/02/2021
	staff for weekly ass pressure injury noted 0.5 cm (centimeters)	sessment. New Stage 4 to left malleolus area has area of slough also able to nd bed. Unit manager made		nursing time was given to accurately reassess and evaluate the resident p administeringher pain medication. R #56 and #87. 1. Corrective action for resident	ain after esidents'	
	lateral malleolus R staff for weekly asses pressure injury to righ	Wound Evaluation] -"Right esident seen by wound care ssment. New unstageable nt malleolus noted. wound is edness or drainage noted at		cliity, for pain clear dent will elivery. acility.		
	physician, dietary) fro lacked documented e s Stage 4 Left Malleo Unstageable Right M	is notes (such as, nursing, om 07/01/2020 to 08/17/2020 evidence that Resident #73 ' olus pressure injury and the calleolus pressure injury was or to the wound team ' s 8/2020.		2. Identify other residents An audit of other residents with orders medications was completed and reside assessed for indications and effectivened There were no additional findings relation.	ents were less.	
	(TAR) from 08/01/202 that facility staff docu received a bed or spo bilateral heels were o at night, skin was mo evening and night sh and repositioned eve 2:00 AM, 4:00 AM, 6:	ent Administration Record 20 to 08/18/2020 revealed mented that Resident #73; onge during the day shift, ff loaded during the day and isturized during the day, ifts, and was being turned ry two hours at 12:00 AM, 00 AM, 8:00 AM, 10:00 AM, 4:00 PM, 6:00 PM, 8:00 PM		3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents a pain medication as ordered and assesses indications and effectiveness of pain m and administration as prescribed prior care treatments. The Director of Nursi be responsible for ensuring that resident assessed for effectiveness of pain medi	re given ed for hedication to wound ng will hts are	
	Review of Resident # Living (ADL) Notes" f 08/18/2021 revealed "No" to the question t skin condition?"	73's "CNA Activity of Daily from 08/01/2021 to that facility staff documented that asked, "Is there a new sion MDS dated 03/18/2021		4. Monitor corrective actions The Director of Nursing/Designee will corrective audits of 10% of residents recepain medication to ensure that the med was given per physician orders and has effective. The results will be reported QAPI Committee monthly x 3 months review and recommendations.	nplete iving ication s been to the	

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER OINT SUBACUTE AND F	STREET / A601 M/	ADDRESS, CITY, ST ARTIN LUTHER NGTON, DC 200	KING JR AVENUE SW		0/2021
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
L 052	In Section G (Function total dependence tr assist" In Section H (Bowel at continence bowel incontinent" In Section M (Skin C pressure ulcersyee pressure ulcersyee pressure ulcersyee pressure ulcers/injury prominence, or a nor no", "is this re pressure ulcers/injur resident have one or ulcers/injuries? no' Review of the Care F Focus: "Activities of Performance Deficit" several interventions bath when a full bath toleratedbed mobi dependent on staff for bed every 2 hour." Focus: "Alteration in 03/12/2020 revealed including " skin insp findings to the nurse Although the facility if identified in the resid reposition and inspect Resident #73 develo	staff coded the following: onal Status), "bed mobility wo+ (plus) persons physical and Bladder), "urinary continence always onditions), " risk of s"; " resident has a , a scar over bony n-removable dressing/ device sident at risk of developing ies? yes", " does this " more unhealed pressure " Plan revealed the following: Daily Living Self-care dated 03/11/2020 revealed including, "provide sponge or shower cannot be lity, and the resident is totally pr repositioning and turning in Neurological Status" dated several interventions pections daily and report any	L 052	The QAPI Committee is response going monitoring for compliance 5. Date correction action of The facility's date of alleged com November 2, 2021.	e. completed	

TATEMENT	egulation & Licensing A OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
	JF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	S:		
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
		4601 MA		KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND R		NGTON, DC 20	032		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLET DATE
				DEFICIENCY)		
L 052	Continued From page	e 78	L 052	G.Facility, staff failed to ensure tha		1/02/2021
	08/18/2020.			sufficientnursing time was given to have a resident evaluated by a	5	
	00/10/2020.			psychiatrist, as ordered by the		
	During a face-to-face	interview conducted on		physician. Residents' #102.		
	09/08/2021 at approx	kimately at 9:35 AM,				
	"The wound team has	or of Wound Care) stated, s educated the nursing staff		1. Corrective action for resident		
		essment, documenting and		Resident #102 is currently being asses		
		's skin. I have brought this		the effectiveness of their psycho tropic		
	-	staff not documenting or am aware of skin issues at		medications. They have also been eva	luated by	
		attention of the Director of		a psychiatrist.		
	Nursing and the Adm			2. Identify other residents		
	4. Resident #62 was	re-admitted to the facility on		An audit of other residents on psychot	ropic	
		dical record showed the		medications and orders for psychiatric		
	resident had several			evaluations has been completed. Resi		
	Dependency on Resp			been evaluated as needed and are bein		
		etes Mellitus, Protein-Calorie Left Calf Pressure Ulcer,		for effectiveness of their psychotropic		
		ssure Ulcer, Stage 4 Left		medications. There were no additionar related to this citation.	l findings	
		Ulcer, Stage 3 Left Heel		related to this citation.		
		Foot Deep Tissue Injury, and		3. Systemic changes		
	Surgical Sacral Wour	nd.				
		00/04/0004		Nursing staff have been educated on t		
		n on 08/24/2021 starting at		importance of ensuring that residents		
		l care team provided wound 2's wounds for the left hip,		ordered medical evaluations and are e		
	left leg, back and sac	• *		for the effectiveness of their medication		
				Director of Social Services will be res for ensuring that residents are evaluate		
	Review of the medica	al record revealed the		psychiatrist per physician orders and t		
	following:			effectiveness of the psychotropic med		
				assessed.		
	-	Scale] - Resident #62 scored				
		the resident was at "very ing pressure ulcers/injuries.		4. Monitor corrective actions		
	might isk tot develop	ng pressure uicers/injunes.				
	05/08/2021 [Physicia	n Order] - Turn and		The Director of Social Services/Desig		
		(hours) for comfort and to		complete weekly audits of Behavior M		
	help prevent pressure			sheets of all residents on psychotropic medications to ensure that they are ass		
				the effectiveness of their medications		
h Regula	tion & Licensing Administration	on		the effectiveness of their medications	una mai	

	OF DEFICIENCIES OF CORRECTION	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
			B. WING		C 09/16/2021	
		HFD02-0023		09/1	6/2021	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, DC 200			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE ⁻ DATE
L 052	Summary Note) - "Re Resident has a sac (centimeters) X 5(cm amount of serosa (se noted. (Left lower leg (Left buttock pressur scattered wound. Mu lower extremities. Oh abdomen." 05/09/2021 at 2:16 A "Resident alert and r readmissionskin w and wound cares (sp reposition (sp) every prevent pressure ulco 05/10/2021 at 1:06 P "Resident is alert and dry to touchADL ca repositioning every th prevent pressure ulco 05/10/2021 1:58 PM "new, in-house acqui (Full-thickness skin lo 3.2 cm (centimeters) undermining not app applicable. wound be red, exudate light, se	M (Nursing Admission esidentadmitted at 7pm eral wound stage IV (4), (6cm b) X 1 (cm) deep). Moderate erosanguinous) drainage g wound 0.6cm X 1.0cm). e 0.1cm)with multiple litiple scars noted to bilateral d surgical sites to chest and M (Nursing Progress Note)- esponsive, 2nd day of varm and dry to touchADL b) provided turn (sp) and two hours and as needed to er" M (Nursing Progress Note) - d responsive, skin warm and are provided, turning, and wo hours as needed to er (sp)" (Skin & Wound Evaluation)- ired, Left calf, Stage 3 pss), pressure(injury), length , width 2.7 cm, depth 0.1 cm, licable, tunneling not ed 100% granulation -pink or eropurulent"	L 052	they have been evaluated by a ps ordered. The results will be repo QAPI Committee monthly x 3 m review and recommendations. The QAPI Committee is respons going monitoring for compliance 5. Date correction action c The facility's date of alleged com November 2, 2021.	ible for the on- completed	
	they had turned and	their initials indicating that repositioned Resident #62 05/08/2021 to 05/10/2021.				
	Review of the Care F	Plans revealed the following:				

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		. ,	E SURVEY PLETED
			A. BUILDING:		С	
		HFD02-0023	B. WING		09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA	RTIN LUTHER KING	G JR AVENUE SW		
			IGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
L 052	Continued From pag	e 80	L 052			
	Focus: "Skin Impairment related to Immobility" with am initial date of 05/07/2021, outlined multiple interventions including turn and reposition resident to prevent pressure injuries.					
	Review of the Minimum Data Set dated 04/21/2021 revealed, In section C (Cognitive Patterns), Brief Interview for Mental Status summary score was blank. In section G (Functional Status - Bed mobility) the resident was coded as a "4" indicating that the resident was totally dependent on the staff. The support section was left blank. In section M (Skin Condition), the resident was coded to having four (4) Stage 3 pressure ulcers, three (3) Stage 4 pressure ulcers, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury.					
	identified in the resid reposition). Subsequ developed in-house a Stage 3 pressure inju re-admission date of During a face-to-face	acquired wound (Left Calf) ury within 48 hours of his 05/08/2021. e interview on 09/08/2021 at				
	Team Nurse) stated assessed Resident #	AM, Employee #10 (Wound that on 05/10/2021 she t62 ' s skin and observed an age #3 pressure injury on alf.				
	approximately 10:15 of Wound Care) was wounds (pressure inj stage before staff ob	e interview on 09/08/2021 at AM, Employee #9 (Director asked how do residents' uries) evolve to an advanced served them? Employee #9 to why the (pressure				

	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		. ,	E SURVEY IPLETED
	DI CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		HFD02-0023	B. WING	0	C 9/16/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
-		WASHIN	IGTON, 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 ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENC)	ON SHOULD BE TE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page	e 81	L 052			
	injuries) are found at up when we (wound resident's skin. I know months, I have been Performance Improve staff is not bathing re 5. Resident #42 was 09/12/2020 with diagr and Chronic Respirat Mellitus, Tracheostor Hypertension, Contra Elbow), and Pressure According to the Qua 06/30/2021 the reside "rarely/never underst (Cognitive Patterns); Status), G0400, the r dependence" on staff toilet use, and persor Limitation in Range of coded for "impairmer extremities". Section resident was coded a and one (1) unhealed According to the Brad assessed and scored was "very high risk" f 04/03/2021 and was "10" indicating "high 07/03/2021.	advanced stages. I speak team) see issues with a w that over the last couple of bringing up in our ement Meetings that nursing sidents." re-admitted to the facility on noses that included Acute tory Failure, Type 2 Diabetes my, Gastrostomy, actures (Right and Left e Ulcer Left Heel Stage 4. arterly MDS dated ent was coded as ood" under Section C Under Section G (Functional resident was coded as "total f for bed mobility, eating, nal hygiene; Functional of Motion the resident was at to upper and lower M (Skin Conditions), the as at risk for pressure ulcers d pressure ulcer. den Scale, Resident #42 was d at a "9" indicating that she or skin breakdown on assessed and scored at a risk" for skin breakdown on				
	"Stage 4 pressure inj revealed the following needs assistance to t	lan with the focus area, ury to left lateral malleolus" g interventions, "the resident urn/reposition at least every as needed or requested" follow facility				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
				A. BUILDING:		С	
		HFD02-0023	B. WING	09/16/2021			
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,				
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING NGTON, DC 20032	G JR AVENUE SW			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
L 052	Continued From page 82		L 052				
	policies/protocols for skin breakdown" initi	the prevention/treatment of ated 12/04/2020.					
	Review of the physician 's orders revealed the following: 06/11/2021 "Cleanse left medial heel wound with Anasept wound cleanser spray every day and PRN (as needed). Please float heels continuously to prevent pressure every night shift for wound care"						
		eels while in bed with a pillow kdown and pressure every night)"					
		, ,					
		d reposition every 2 hours lieving and redistribution"					
	from 07/01/2021 to 0 facility staff signed th care to the resident ' resident ' s heels twic head-to-toe notify MI abnormality every da and repositioned the	ent Administration Record 07/14/2021 showed that hat they: performed wound s left heel, floated the ce daily, performed D (medical doctor) for any and night shift, and turned resident every two hours living and retribution.					
	However, review of t Evaluation V5.0 form the following:	he Skin and Wound a dated 07/14/2021 showed					
	" Stage 4 full thickn Location: Left Latera	ness and tissue loss I Malleolus (ankle)					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	INSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		HFD02-0023	B. WING		C 09/16/2021	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND R		NGTON, 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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
L 052	Continued From page	e 83	L 052			
	7/14/21; Wound Mea length 2.2cm x width undermining 1.0 cm; ' wound filled; exudate Notes: Resident see noted development o lateral malleolus (sp) thickness with palpate description and pictur " Facility staff were sig wound treatments to daily, were assessing floated the resident ' turned and reposition hours. However, Res in-house acquired pr advanced stage (stag Left Lateral Malleolus During a face-to-face 09/08/2021 at approx Employee #9 (Directo asked how do resider injuries) evolve to an observed them? Emp speak to why the (pre advanced stages. I sp team) see issues with that over the last cou	Wound bed -slough 100% of e-light; type seropurulent; n by wound care team, f new pressure injury to left . Wound is stage 4, full ble bone in wound bed full res in PPC (point click care) gning that they: conducted the residents left heel twice g the residents skin daily, s heels twice daily, and hed the resident every two sident #42 developed an essure injury noted at an ge 4 pressure ulcer to the s). e interview conducted on kimately 10:15 AM, or of Wound Care) was nts' wounds (pressure advanced stage before staff ployee #9 stated, "I can't essure injuries) are found at peak up when we (wound n a resident's skin. I know ple of months, I have been rformance Improvement				

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		. ,	E SURVEY PLETED
			A. BUILDING:			
		HFD02-0023	B. WING		09	C 9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
BIGBOEI			NGTON, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page	e 84	L 052			
	nursing time was give supervision to monito	to ensure that sufficient en to provide adequate or the residents whereabout ity for Resident #93 who left e staff knowledge.				
	Resident #93 was admitted to the facility on 01/07/2021 with diagnoses that included: Fracture of the Lower End of Right Tibia, Anemia, Unsteadiness on Feet, Weakness, Schizoaffective Disorder, and Bipolar Type.					
	(MDS) dated 07/16/2 Interview for Mental S "15" indicating that the intact. In Section G (I resident was coded as set up help only for b independent in transf personal hygiene, and up help from staff witt personal hygiene. The having impairment to	arterly Minimum Data Set 2021 the resident's Brief Status (BIMS) Score was ne resident was cognitively Functional Status), the as requiring supervision and ed mobility; he was coded as ferring, eating, toilet use, ad dressing. He required set h dressing, eating and ne resident was coded as b his lower extremities on coded as using a wheelchair				
	round, resident was r nurse stated that the	M "Upon change of shift not in his room, off going resident is in the facility and put, his dinner tray was in the				
	another floor to visit, medication pass, res the floor, resident wa number showed up v	but up to the end of the ident did not come back to is call on his cell phone, the vrong number, R/R as also called no answer,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	• •	E SURVEY PLETED
ND FLAN C	of correction	IDENTIFICATION NOWBER.	A. BUILDING:		COM	
		HFD02-0023	B. WING	09	C /16/2021	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KIN NGTON, DC 20032	G JR AVENUE SW		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE
L 052	Continued From page	e 85	L 052			
	message left on the	answering service for them				
		visor made aware and she				
		ssessed the situation, couple				
	-	hade to his family member by				
	ner without success,	resident still out at this time."				
	08/30/2021 at 6:46 A	M "Security informed this				
		ne resident had just returned				
		Resident arrived on the unit at				
		he had a family emergency				
	-	came and took him home at				
		(Sunday, 8/29/21) and that				
		e the time to sign himself out,				
	-	are and she was on the unit ion, refused to be assess				
		s sleeping medication, staff				
	-	tor the resident status."				
		ty camera footage on				
		M showed that the resident				
	exited the building at	1:09 PM on 08/29/2021.				
	Review of the Treatm	nent Administration Record				
		s that facility staff signed that				
		d repositioning Resident #93				
	-	eeded from 12:00 AM to				
	8:00 PM (0000, 0200 1200, 1400, 1600, 18	0, 0400, 0600, 0800, 1000,				
	1200, 1400, 1000, 10	500, 2000).				
	During a face-to-face	e interview with Resident #93				
		00 AM he stated, "It was my				
	fault." And made no	other statements.				
	Review of the clinica	I record, facility staff were				
		ey were providing care to				
		29/2021 from 1:00 PM to				
		he resident was not in the				
	facility. The facility's					
		is dinner, but they failed to				
	CHECK/VEIIIY RESIDEN	t # 93's location in the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE S COMPL	
			2.1/10		С	
		HFD02-0023	B. WING		09/*	16/2021
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
RIDGEP	OINT SUBACUTE AND	REHAB NATIONAL H		G JR AVENUE SW		
			NGTON, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
L 052	Continued From pag	e 86	L 052			
	building.					
	Subsequently, the resident was gone from the building for approximately seven (7) hours before facility staff discovered that the resident was no longer present in the building and began to search for him.					
	8:45 AM, Employee	e interview on 09/01/2021 at #2 reviewed the made no comments on about				
	nursing time was giv 30 days as ordered	d to ensure that sufficient en to weigh a resident every and verify accurate weights . Residents' #37 and #95.				
	and Documentation"	r's policy entitled, "Charting revised 07/2017, revealed, " the medical record will be nated or speculative), rate"				
	1. Facility staff failed 30 days as ordered	to weigh Resident #37 every by the physician.				
	09/01/2020. The rec following diagnoses: Diabetes Mellitus, H Vascular Accident (C	e-admitted to the facility on ord showed resident had the Anemia, Hypertension, yperlipidemia, Cerebral VA), Hemiplegia, Seizure n, Schizophrenia, and y Disorder.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		• •	E SURVEY IPLETED	
					С		
		HFD02-0023	B. WING		09	09/16/2021	
AME OF PR	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE			
RIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW			
		WASHI	NGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
L 052	Continued From page	e 87	L 052				
	(MDS) dated 08/12/2 In Section C (Cogniti had a Brief Interview Summary Score of " cognition. In Section Resident #37 was co	G (Functional Status), ded as, "total dependence, assist," for dressing, toilet giene.					
	following: 09/08/2020 at 10:00	AM [physician order] time a day every Tuesday."					
	07/13/2021 at 11:36 AM - recorded weight of 167.2 lbs. (pounds)						
	Treatment Administration from 07/14/2021 to 0	e that facility staff weighed					
	12:15 PM, Employee Manager) stated that	e interview on 09/01/2021 at #2 (Director of Nursing/ Unit t residents' weights are AR and progress notes.					
	2. Facility staff failed were being documen	to ensure accurate weights ted for Resident #95.					
	01/19/2021 with mult Encounter for Gastro	Imitted to the facility on iple diagnoses that included: ostomy, Acute and Chronic Restlessness and Agitation.					
		rly MDS dated07/18/2021 staff coded the following:					

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION	· · ·	E SURVEY PLETED
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		HFD02-0023	B. WING		09/16/2021	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	JR AVENUE SW		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE
L 052	Continued From page	e 88	L 052			
	In Section C (Cognitive Patterns), the resident was coded as being severely cognitively impaired. In Section I (Active Diagnoses), the resident was coded for "Malnutrition (protein, calorie)" Review of the physician's orders revealed:					
	Review of the physic	ian's orders revealed:				
	05/21/2021 "Dietary	consult as needed"				
		weight one time a day nd ending on the 3rd every				
	Review of the facility Resident #95 reveale	documented weights for ed:				
	126.0 Lbs, 05/20/202	bs (pounds), 05/12/2021 1 129.0 Lbs, 05/21/2021 1 156.4 Lbs, 06/10/2021 1 146.2 Lbs".				
	"[Resident's name] h revision date of 05/16 interventions " mo (medical doctor) PRN	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				
	Review of the progre	ss notes revealed:				
	"Spoke to son about status. Writer [Regist	PM (Nutrition/Dietary Note) current nutrition and weight tered Dietician] discussed omy tube) removal"				
	PO (by mouth) inta	PM (Nutrition/Dietary Note) " ake S/p (status post) PEG copic gastrostomy) removal				

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION		E SURVEY IPLETED
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		HFD02-0023	B. WING		09	9/16/2021
	ROVIDER OR SUPPLIER	4601 MA	ADDRESS, CITY, STATE,			
		WASHI	NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page	e 89	L 052			
	assistance with meal weight): 150.6 (poun Will continue to moni tolerance, weights Although Employee a reviewed and record the residents nutrition evidence that she rev determine their accu sustained a significan During a face-to-face 08/30/2021 at 10:08 J weights that were do 05/20/2021 and 05/2	#28 (Registered Dietician) ed clinical notes regarding nal status, there was no viewed the weights to racy or if the resident nt weight loss. e interview conducted on AM, when asked about the cumented on 05/12/2021, 1/2021, Employee #28 ts on those days in May				
	nursing time was give consistent with the p practice as evidence (1) resident receiving physician's orders to to be delivered to the Resident #21 was re 06/29/2021, with mul	I to ensure that sufficient en to provide respiratory care rofessional standards of d by failure to ensure one g oxygen therapy had direct the amount of oxygen e resident. Resident #21. admitted to the facility on tiple diagnoses that included:				
	Respiratory Failure, I Tracheostomy and D	Encounter for Attention to legenerative Joint Disease.				
		staff coded the following:				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY PLETED
					С	
		HFD02-0023	B. WING		09	/16/2021
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
RIDGEP	DINT SUBACUTE AND	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
		WASHIN	NGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
L 052	Continued From pag	je 90	L 052			
	In Section I (Active Diagnoses), "dependence supplemental oxygen". In Section O (Special Treatments, Procedures and Programs), Oxygen, "Yes".					
	On 08/2520/2021 at resident was observ tracheostomy and or					
	documented evidence	cian's orders revealed no ce of oxygen orders in place n oxygen Resident #21 was				
	08/30/2021 at 9:42 / (Respiratory Therap	ist) stated, "He [Resident oxygen order. I will message				
	nursing time was giv colostomy bag (a pla abdomen that collec digestive tract throug abdominal wall calle full, in accordance w	d to ensure that sufficient ren to change Resident #76's astic bag attached to the ets fecal matter from the gh an opening in the ed a stoma), when it was with the physician's order and and standards of practice.				
	to avoid leaks and s have a regular schee Don't wait for leaks o	nerican Cancer he pouching system regularly kin irritation. It's important to dule for changing your pouch. or other signs of problems owel activity at certain times				

	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/16/2021	
		HFD02-0023	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H	RTIN LUTHER KINC	G JR AVENUE SW		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETI DATE
L 052	Continued From page	e 91	L 052			
	system during these	t to change the pouching times. You may find that you eat or drink is best"				
	•	rg/treatment/treatments-and- nt-types/surgery/ostomies/col t.html				
	03/27/2020 with mult Colostomy, Gastroes	Imitted to the facility on iple diagnoses including: ophageal Reflux Disease alized Muscle Weakness.				
		erly Minimum Data Set 021 revealed the facility staff as followed:				
	a Brief Interview for N Summary Score of "1 cognitively impaired. Status), facility staff of staff for dressing, toil hygiene" and require	d "one-person physical (Bowel and Bladder),				
		an's order dated 03/28/2020 care every shift as needed."				
	on 08/23/2021 at 6:5 that two days ago sh to change her colosto "It (colostomy bag) g leak. I'm afraid to lea activities because my	an and face-to-face interview 3 AM, Resident #76 stated e waited a long time for staff omy bag. She further stated, ot so full that it started to ve my room to participate in y bag (colostomy bag) might hen attempted to pull her ose to her body, but she				

	gulation & Licensing A OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY IPLETED
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		HFD02-0023	B. WING		09	9/16/2021
	OVIDER OR SUPPLIER	4601 MA	ADDRESS, CITY, STATE, ARTIN LUTHER KING			
(X4) ID PREFIX TAG	(EACH DEFICIENC	WASHI 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 THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page	e 92	L 052			
	pressed the call light colostomy bag is full 7:05 AM (11 minutes (Registered Nurse) c the resident wanted. Employee #44 that s bag changed. Emplo resident and surveyo (colostomy) because scissors, they were c now they are not." En resident's room and c change the resident's back the covers to as stated, "It is mostly a anyway."	on the medication cart and mployee #44 then left the came back at 7:15 AM to s bag. Employee #44 pulled ssess the colostomy bag and				
	nursing time was give and evaluate the resi	to ensure that sufficient en to accurately reassess dent pain after administering Residents' #56 and #87.				
	•	's policy entitled: "Pain nagement" revised March				
	"Assessing Pain 1. During the compre	hensive pain assessment				

STATEMENT	egulation & Licensing / OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	• • •	E SURVEY IPLETED
					C	
		HFD02-0023			09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, 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 ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page 93		L 052			
	[staff is to] gather the indicated from the re representative):	following information as sident (or legal				
	a. History of pain (as measured on a standardized pain scale);					
	 b. Characteristics of pain: (1) Intensity of pain (as measured on a standardized pain scale); (2) Descriptors of pain; (3) Pattern of pain (e.g. constant or intermittent); (4) Location and radiation of pain; and (5) Frequency, timing and duration of pain. 					
	e. Factors and strate	quality of life; bitate or exacerbate pain; gies to reduce pain; and company pain (e.g., nausea,				
	6. Implement the m	lanagement Strategies: nedication regimen as cumenting the results of the				
	Monitoring and Modit 2. Monitor the follo the resident 's pain i controlled:	wing factors to determine if				
	level of comfort over b. The status of the u identified previously;	underlying cause(s) of pain, if				
		lity's Pain Assessment and ast reviewed May 2016 the				

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STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		• •	E SURVEY PLETED
			B. WING		С	
		HFD02-0023			09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, RTIN LUTHER KING			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	IGTON, 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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page 94		L 052			
	pain scale rating is a mild; 4-6=moderate,	s follows: 0= none; 1-3= 7-10=severe				
	-	to reassess Resident #56's dministration of ordered pain				
	06/01/2021 with the to Dependence, Periphe Diabetes Mellitus, Ac	Imitted to the facility on following diagnoses: Opioid eral Vascular Disease (PVD), equired Absence of Right nic Pancreatitis, Chronic I Depression.				
	A review of Resident revealed the following					
	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				
	-	odone (opioid pain reliever) e 1 tablet by mouth two times				
	Review of the Medic for September 2021	ation Administration Record showed:				
	Methadone for a pair	8/15/2021 staff administered I level of 3 out of 10 and on tered Methadone for a pain				

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		· · ·	E SURVEY IPLETED
			A. BUILDING:		С	
		HFD02-0023	B. WING	0	09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 052	Continued From page	e 95	L 052			
	level of 0 out of 10.					
	and again at 12:00 P 10. The tramadol wa approximately 3 hour physician's order date	Í for a pain level 4 out of 10 M for a pain level of 5 out of				
		09/12/2021 at 10:00 AM, staff done HCL tablet 5 mg for				
		administered Tramadol at vel 5 out of 10 and again at vel of 4 out of 10.				
	showed Resident #50 5 mg every 12 hours however there were listed to direct staff w Tramadol 50 mg, and	the Medication rd for September 2021 6 was to receive Methadone for pain 4-6 (moderate); no pain level parameters when to administer the d Oxycodone 5 mg, for oderate or severe pain.				
	Administration Record 2021 lacked docume staff performed a posi determine if the pain	aident #56's Medication d for August and September ented evidence that facility st pain assessment to medication administered to ective and what was the post medication				
	08/26/2021 at 9:22 A Manager) stated that	e interview conducted on M, Employee #23 (Unit t pain assessments should and after pain medication is				

	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		· · ·	E SURVEY IPLETED	
ND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CON	IPLETED	
		HFD02-0023	B. WING		0	C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
		4601 MA	ARTIN LUTHER KING	G JR AVENUE SW			
RIDGEP	OINT SUBACUTE AND R		NGTON, DC 20032				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE	
L 052	Continued From page	e 96	L 052				
	administered to resid	ents. She acknowledged					
	that pain was not consistently noted the progress						
		lication administration					
		#56. She reported that					
		that a pain medication was					
	administered without	er she was not able to					
	provide documented						
		were done for Resident					
	<i>#</i> 56.						
	2. The facility's staff f	ciled to administer pain					
	•	ailed to administer pain ent #87 prior to providing					
	wound care.						
	Resident #87 was re-	admitted to the facility on					
		dical record showed the					
	resident had several						
	Respirator [Ventilator	cident, Dependency on					
		y, Stage 4 Sacral Pressure					
		ar Pressure Ulcer, Stage 4					
		JIcer Unstageable Right					
		and a Stage 2 Left Heel					
	Pressure Ulcer.						
	During an observatio	n on 0.8/21/2021 at					
	approximately 11:20						
		as administering medication					
		he resident's gastrostomy					
		hat medication she was					
		ployee stated that she was					
	administering pain m provides wound care						
	provides wound care						
	Observation of the re	sident's wound dressings to					
		ral area revealed they were					
	clean, dry and intact.	The dressings were also					
	signed and dated by	Employee #10 (Wound					

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING.		с	
		HFD02-0023	B. WING		09	/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		G JR AVENUE SW		
	SUMMARY ST		IGTON, DC 20032	PROVIDER'S PLAN OF C		(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE ⁻ DATE
L 052	Continued From page	e 97	L 052			
	Team Nurse) "08/24/2021 at 7:00 am to 7:00 PM" indicating that wound care had been provided prior to the administration of the pain medications by Employee #16.					
	Review of physician's following:	s orders revealed the				
	5-325 milligram (Hyd give 1 tablet via PEG	(opioid pain reliever) Tablet Irocodone-Acetaminophen) (percutaneous endoscopic very day shiftprior to				
	wound with Dankin's dry dankin ' s solution (abdominal) pad and	anse (sacral and left calf) solution then apply moist to n dressing covering with abd secure with coversite every 12 hours and PRN (as				
	Employee #16 signe	tic Count Sheet for ninophen revealed that d indicating that she had dication on 08/24/2021 at				
	There is no evidence administered pain me accordance with the	edication to Resident #87 in				
	approximately 11:25 that she was unawar					
		e interview on 08/24/2021 at AM, Employee #10 (Wound				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	. ,	E SURVEY PLETED
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		HFD02-0023	B. WING		09	/16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
RIDGEP	OINT SUBACUTE AND	REHAB NATIONAL H	ARTIN LUTHER KINO NGTON, DC 20032	G JR AVENUE SW		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLE DATE
		·		DEFICIEN		
L 052	Continued From page	je 98	L 052			
	care to the resident because she was to	that she had provided wound around 8:00 AM or 9:00 AM Id by Employee #14 (Unit #87 had received pain				
	approximately 11:41 Manger) stated that Employee #10. Emp	loyee 14 then stated that treceive pain medication				
	nursing time was giv	d to ensure that sufficient ven to have a resident hiatrist, as ordered by the s' #102.				
	06/25/2021 with mul Multiple Fractures o Respiratory Failure	readmitted to the facility on Itiple diagnoses including: f Ribs, Acute Chronic with Hypoxia, Unspecified d of right Femur, and acral region.				
	Review of the physic following:	cian's orders revealed the				
	agitation and refusa 08/9/2021- "Psych of agitation and refusa 08/10/2021- "Psych	consult one time only for l of medication" consult one time only for				
	agitation	Consult asap (as soon as				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD02-0023	B. WING		C 09/16/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•
RIDGEPO	DINT SUBACUTE AND R	EHAB NATIONAL H	ARTIN LUTHER I	KING JR AVENUE SW	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
L 052	Continued From page	99	L 052		
	possible) and PRN				
	(MDS) dated 08/17/2 In Section C (Brief In the resident was give that the resident intac In Section D (Mood) - a "01" indicating mini In Section E (Rejecti Frequency) the residu indicating this behavi less than daily. Review of the medica was no documented o 09/16/2021 that Resi	- the resident was coded as mal depression. fon of Care-Presence & ent was coded as "2" or occurred 4 to 6 days but al record revealed that there evidence from 06/26/2021 to			
	09/16/2021 at 3:15 P Manager) stated, "I' r	interview conducted on M, Employee #14 (Unit n not sure if a psych evaluation/assessment) was			
L 056	3211.5 Nursing Facili	ties	L 056	L 056	12/03/20
	provide a minimum d tenth (4.1) hours of d resident per day, of w hours shall be provid	hich at least six tenths (0.6) ed by an advanced practice egistered nurse, which shall		This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure a minimum dailyaverage of four and one tenth (4.1) hours ofdirect nursing care per resident.	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	ETED
		HFD02-0023	B. WING		C 09/1	; 6/2021
AME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		4601 MA		KING JR AVENUE SW		
RIDGEPO	DINT SUBACUTE AND R		NGTON, DC 200	32		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLE DATE
L 056	Continued From page	e 100	L 056	1. Corrective action for resident		
	This Statute is not me	et as evidenced by:		The staffing coordinator and Direct	or of Nursing have	
	Based on record review and staff interview,			been in-serviced on how to calculat		
		ensure a minimum daily		nursing care hours to ensure at least		
		one tenth (4.1) hours of		direct nursing care per resident per		
	direct nursing care pe	. ,		0.6 hours of those hours in RN hour day.	s per patient per	
	The findings included:			2. Identify other residents		
	Review of the facility'	s staffing revealed that for		All residents had the potential to be	affected by this	
	-	07/25/2021 to 08/31/2021,		alleged practice.	, i i i i i i i i i i i i i i i i i i i	
	-	e per resident was below the				
	regulatory requirement			3. Systemic changes		
	July 25, 2021- 2.5			The Director of Nursing will review		
	July 26, 2021-3.0			schedule prior to each weekend and		
	July 27, 2021-2.4			enough nursing coverage is available		
	July 28, 2021-2.7			hours of direct nursing care required nursing leadership will be on-call to		
	July 29, 2021- 3.3			work in the event staff call outs cau		
	July 30, 2021- 2.9			staffing to fall below 4.1 hours per		
	August 01, 2021- 3.9			resident per day. The Administrato		
	August 02, 2021- 3.3			by the Director of Nursing for addit		
	August 03, 2021- 3.9			needed to ensure appropriate staffin	g ratios.	
	August 06, 2021- 3.3					
	August 10, 2021- 3.9			4. Monitor corrective actions		
	August 11, 2021- 3.6			The Director of Nursing/Designee	vill complete	
	August 13, 2021- 3.8			audits of schedules as worked week		
	August 15, 2021- 3.7			The results will be reported to the Q		
	August 18, 2021- 3.4			monthly x 3 months for review and		
	August 24, 2021- 3.2			recommendations.		
	August 25, 2021- 3.0					
	August 26, 2021- 4.0			5. Date correction action completed		
	August 29, 2021- 3.3			The QAPI Committee is responsible	for the on going	
	August 30, 2021- 3.6			monitoring for compliance.	= for the on-going	
				The facility's date of alleged compl	iance is December	
		interview with Employee #1		3, 2021.		
	-	/08/2021 at approximately				
	8:45 AM, he acknowl	edged the finding.				

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG:	(X3) DATE S COMPL		
		HFD02-0023	B. WING			C)9/16/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
		4601 MA		R KING JR AVENUE SW			
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H WASHIN	IGTON, DC 20	0032			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET	
L 064	Continued From page	e 101	L 064	L 064		11/02/2021	
L 064	3213.1 Nursing Facil	ities	L 064				
	0_101110101.g1 001			The facility shall have a re			
	The facility shall have	e a restorative nursing care		nursing careprogram to a			
	•	maintaining the highest		maintaining the highest p			
	practicable level of p	hysical, mental and		level of physical, mental			
	psychosocial well-be			psychosocial well-being	of each		
	This Statute is not m	et as evidenced by:		resident.			
		n, record review and staff					
		of 44 sampled residents, the		1. Corrective action for	or resident		
	•	to ensure residents received		D 1	1 .1 . 1		
	treatment and care in			Resident #100 was assessed			
	professional standard	-		deemed inappropriate for the	e restorative		
	accordance with resid			program.			
	-	to ensure Resident #100		2 Identify other read	onto		
		nursing for contracture		2. Identify other resid	lents		
	management.			An observation audit of othe	ar residents was		
				completed and all residents			
	The findings include:			for the restorative program a			
	The infantys include.			management have been seen			
	Resident #100 was a	admitted to the facility on		inanagement nave been seen	1.		
		tiple diagnoses ' that		3. Systemic changes			
		Ilsy, Quadriplegia, Neuralgia					
	and Neuritis.			Nursing/Rehabilitation staff	have been educated		
				on the new restorative progr			
	On 08/24/2021 at ap	proximately 12:30 PM		Rehabilitation Director in co			
		observed having his mittens		Director of Nursing will be	5		
		the writer observed that		ensuring that residents recei			
		s were closed tightly and		_			
		bs appear stiff and staff had		4. Monitor corrective	actions		
	difficulty moving resid	dents arms.					
				The Rehabilitation Director			
	•	arterly Minimum Data Set		complete weekly audits of re			
		021, Resident#100 received		restorative program to ensur			
		t started on 04/27/2021 and		devices are being used per p			
		1. In section G (Functional		The results will be reported			
		ty staff coded resident as a		Committee monthly x 3 mon	nths for review and		
	"1" for upper extremi			recommendations.			
		ide and facility staff coded for lower extremity meaning					
	tion & Licensing Administrati						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
		HFD02-0023	B. WING		C 9/16/2021
	ROVIDER OR SUPPLIER OINT SUBACUTE AND R	4601 MA	DDRESS, CITY, ST ARTIN LUTHER IGTON, DC 200	KING JR AVENUE SW	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
L 064	OT (Occupational The Discharge Summary" and 06/29/2021 for P resident #100 was to services for contractu discharge from OT ar During a face-to-face 08/31/2021 at 10:50 / (Director of Rehabilita Resident #100 is not discharged (06/29/20) program. During a face-to-face 08/31/2021 at 11:37 /	h both sides. I record revealed a PT (Physical Therapy) and erapy) Progress & dated 06/24/2021 for OT T, which stipulated that receive Restorative Nursing ire management upon ad PT case load. interview conducted on AM with Employee #13 ation Services) she stated " on case load and had been 21) to restorative nursing interview conducted on AM with Employee # 2 she stated "Currently we do	L 064	 The QAPI Committee is responsible for the orgoing monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021. 	1-
L 065	nursing in his or her of of residents, which sh (a) Maintaining good b positioning of bedridd (b) Encouraging and a or those residents that change position at leas more often as the resident to stim	ee shall provide restorative laily care all include the following: body alignment and proper len residents; assisting bedridden residents at are confined to a chair to ast every two (2) hours or ident's condition warrants, ulate circulation; prevent ulcers and deformities; and	L 065	 Each nursing employee shall provide restorativenursing in his or her daily care of residents. 1. Corrective action for resident Resident #48 has been assessed by therapy and deemed not appropriate for restorative care at this time. We have an active Restorative program. 2. Identify other residents An audit of all current residents was conducte to determine if restorative care and/or orthotic 	d

	egulation & Licensing A	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLE	
		HFD02-0023	B. WING		C 09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	ATE, ZIP CODE		
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-			IGTON, DC 200			
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L 065	Continued From page	e 103	L 065	were needed. Residents were pic restorative case load and orthotic if indicated. There were no addit	s were ordered	
	of bed for reasonab	lents to be active and out le periods of time, except		related to this citation.	-	
	whencontraindicated	by physician's orders;		3. Systemic changes		
	activities of daily livin the importance of sel assisting with transfe by allowing sufficient the residents, and by resident's choices;	r and ambulating activities, time for task completion by encouraging and honoring		Nursing and Administrative staff educated on the importance of en residents receive appropriate resto The Director of Rehabilitation wi responsible for maintaining the re program with assistance from the Nursing. The IDT team will refer therapy for the restorative program	suring that orative care. Il be estorative Director of residents to m as needed.	
	(e) Assisting residents and to their use of pro	s to adjust to their condition osthetic devices;		4. Monitor corrective actio		
	residents who use m are properly designed supervision of a licen	dy alignment and balance for echanical supports, which d and applied under the sed nurse; ts who would benefit from a		The Director of Rehabilitation/De complete weekly audits of 10% re ensure that ordered orthotics are l appropriately. The results will be the QAPI Committee monthly x 3 review and recommendations.	esidents to being used e reported to	
		aining program and initiating acrease incontinence and catheters; and		The QAPI Committee is responsi going monitoring for compliance		
	(h) Assessing the natu behavioral disorienta implementing approp practices to improve	riate strategies and		5. Date correction action co The facility's date of alleged com November 2, 2021.	-	
	interview for one (1) of facility staff failed to in	n, record review and staff of 44, sampled residents, mplement the use of ecrease in range of motion				

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		. ,	E SURVEY IPLETED
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	OINT SUBACUTE AND F	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, DC 20032			
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L 065	Continued From pag	e 104	L 065			
	The findings include:					
	04/19/2019, with mul	dmitted to the facility on tiple diagnoses including: Weakness, Other Muscle cified, Aphasia and				
	approximately 9:05 A Employee #43 (Licer was noted that Resid	oserved on 08/23/2021 at AM receiving care from Insed Practical Nurse) and it Jent #48's hands were tightly position and residents arms t for staff to move.				
	Data Set (MDS) date Section C (Cognitive coded resident as a "rarely/never undersi (Functional Status) C resident a "4" for be is totally dependent of function every time d Section G (Functiona Motion) G0400 facilit "0" for Upper extrem and coded resident a meaning impairment (Special Treatments Programs), under "R for "Range of Motion (active) and Splint B	G0110 facility staff coded d mobility meaning resident on staff to perform this luring a seven day period. In al Limitation Range of ty staff coded resident as a ity meaning no impairment a "2" for lower extremity to both sides. In Section O				
	name] has limited ph	rehensive Care Plan s area of: "[Resident ' s ysical mobility r/t (related to) bilateral hand and legs"				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			
		HFD02-0023	B. WING	0	C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
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			IGTON, DC 200	32	1	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
L 065	Continued From page	9 105	L 065			
	including: "Apply roll	9 had multiple interventions towel to bilateral hands at all 2 hours for hygiene and skin				
	Administration Record 08/22/2021, lacked de	gress noted and Treatment d dated from 07/01/2021 to ocumented evidence that cowel to both hands the				
	11:30 AM, Employee Rehabilitation) stated #48) was discharged	interview on 08/31/2021 at #13 (Director of "The resident (Resident to restorative nursing (staff yels for hands and splints)".				
	11:37 AM, Employee	interview on 08/31/2021 at #2 (Director of Nursing) have one [Restorative				
L 080	3216.1 Nursing Facili	ties	L 080	L 080	11/02/202	
	Each resident has the physical and chemica			Each resident has the right to be free fromphysical and chemical restraints.		
		et as evidenced by: ew and staff interview, for I residents, facility staff		1. Corrective action for resident		
	• • •	ne resident was free from a		Resident #95 has a restraint for their safety that is being used appropriately.	t	
	The findings include:			2. Identify other residents		
	01/19/2021, with mult Cerebral Infarct due t	mitted to the facility on iple diagnoses that included: o Embolism of Left Middle essness and Agitation,		An audit of all residents with restraints did not reveal any residents whose restraints were not being used appropriately. There were no additional findings related to this citation.		

TATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0023			C 09/16/2021	
	ROVIDER OR SUPPLIER	STREET A 4601 MA	DDRESS, CITY, ST	ATE, ZIP CODE KING JR AVENUE SW	09/10/2021	
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L 080	Attention for Encount Attention for Encount Review of the facility' with a revision date of Practices that inappro- prevent resident mot restraints and are no Review of a facility re 01/27/2021 documer 1-27-2021 her (Resid tied to the rail. It was the patient was asse ongoing" Review of Resident # Data Set)dated 01/26 staff coded the follow In Section C (Cogniti- impaired" In Section E (Behavio behavioral symptoms (e.g., hitting, kicking, grabbing, abusing ot this type occurred 1 to In Section P (Restrai mitten]Used daily" Review of the physica following:	er Gastrostomy and ter Tracheostomy. s policy, "Use of Restraints" of 04/2017 revealed, " opriately utilize equipment to oblity are considered t permitted" eported incident (FRI) on need, " During rounds on dent #95) mitten was found immediately released, and ssedInvestigation is 495's Admission Minimum 6/2021, revealed that facility <i>r</i> ing: ve Patterns), "Severely oral Symptoms), " Physical a directed towards others pushing, scratching, hers sexually) Behavior of to 3 days" onal Status), "Bed mobility te-person physical assist" ent), "Limb restraint [hand	L 080	 Systemic changes Nursing staff have been educated on the importance of ensuring that restraints are appropriately. The Director of Nursin responsible for ensuring that residents in inappropriately restrained. Monitor corrective actions The Director of Nursing/Designee will weekly audits of all residents with ord restraints to ensure that no restraints are used in appropriately. The results will reported to the QAPI Committee month for review and recommendation The QAPI Committee is responsible for going monitoring for compliance. Date correction action compliance Date correction action compliance 	are used g will be are not l complete ers for re being be thly x 3 ons. or the on- eted	
		left wrist restraint q (every) 2 any findings every 2 hours"				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		· · · ·	E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
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L 080	Continued From pag	e 107	L 080			
	prevent patient from	eft wrist restraint in place to pulling on her trach (gastrostomy) - Tube q shift"				
	Review of the progre	ss notes revealed:				
	"[Resident's name] is who was admitted or on 1-27-2021 her mit It was immediately re assessed and not for fearful. Resident's ph and appropriate age wide sweep conduct found to have an ina Investigation is ongo	PM (Administrator note) is a 60 year old resident in 1-19-2021. During rounds itten was found tied to the rail. beleased and patient was und to be in distress, pain or hysician, RP (representative) incles were notified. House ed no other residents were ppropriate restraint. ing. Son was satisfied and e in communication with the				
	documents on 08/31, (6) staff members we investigation. There evidence of interview therapist who provide	vs from the respiratory ed Resident #95 with r from the environmental				
		asked, "Do you know the and procedure" as part of				
	investigator(s) follow members or is there	nented evidence that the ed up with those staff documented evidence that g/education was provided on				

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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
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L 080	Continued From pag	e 108	L 080			
	restraints or the facili and procedure.	ty's abuse reporting policy				
	Resident #95 was ph	istrator) acknowledged that hysically tied to the bedrail substantiate that abuse				
	08/31/2021 at 10:54 and Language Patho is nonverbal with righ to paralyses. Left sid for left [hand] mitten. 01/27/2021) and noti were wrapped aroun rail, fully restricting h of the left hand. I imm restraint, made the n the nurse that the mi	e interview conducted on AM, Employee #4 (Speech ologist) stated, "The resident at hemiparesis- pretty close e is intact. She had an order I walked into the room (on ided the straps to the mitten d and tied to the upper bed er (Resident #95) movement mediately removed the burse aware and educated tten was not to be used as a rted the incident to my dministrator."				
	08/31/2021 at 9:45 A Nursing) stated, "Mit who are a danger to incident, we interview resident and did aud the facility with hand	e interview conducted on M, Employee #2 (Director of tens are used for residents themselves. After the wed the staff, assessed the its of the other residents in mittens. We did not find any mittens tied to the bedrail."				
	08/31/2021 at 9:45 A (Administrator) state the allegation. Based could not determine bed rail. It could have family member. We a	e interview conducted on M, Employee #1 d, "We couldn't substantiate d on the staff interviews, we who tied the resident to the e been a staff, contractor or audited the facility and did sident with hand mittens tied				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
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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 APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
L 080	-	at a review of facility's /2021 at 10:00 AM revealed not have any visitors on	L 080		
L 091	The Infection Control that infection control implemented and sha services, including ho laundry, and linen sup the requirements of th This Statute is not m Based on observation interview, for three (3 the facility's staff faile Control Practices whe distributing foods und evidenced by using a while providing wound administering medica and not sanitizing the resident's room to pro #47 and #100). The findings include: 1.Facility staff failed to distribute foods under	Committee shall ensure policies and procedures are all ensure that environmental pusekeeping, pest control, pply are in accordance with his chapter. let as evidenced by:	L 091	 L 091 The Infection Control Committee shall ensure that infection control policies and procedures areimplemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. 1. Corrective action for resident The cooling fan has been removed from the kitchen. The air handler is being addressed. The architects are preparing plans to be submitted for permitting prior to beginning project. Resident #87 no longer resides in the facility. Residents #47 and #100 have been observed receiving medications and patient car with proper infection control practices. The batteries in the soap dispenser in room 337 hav been replaced. Random room audits have not yielded any soiled linen on clean surfaces. Audits of rooms with enhanced barrier precautions are being conducted. Staff #20, #36, #33, #34, #23, and #47 were educated on proper infection control and prevention 	
		of dietary services on kimately 6:45 AM, three ng used in the food		practices.	

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 091	Continued From page	e 110	L 091	2. Identify other residents	
	kitchen at the time of	e temperature in the main f the observation was 86		An initial audit of infection control pra-	
	degrees Fahrenheit.			was completed. All residents have the p to be affected. There were no addition	
	(Administrator) and	e interview with Employee #1 Employee # 37, Employee		findings related to this citation.	
	The air handler that	not sufficient in the kitchen. services the kitchen, 2 West		3. Systemic changes	<u> </u>
	and 3 West is not we been down prior to 5	orking. The air handler has /25/2021".		Staff have been educated on the import ensuring that they follow appropriate in control practices (including but not lim	nfection
		e could potentially cause ubstances to spread through		hand hygiene, enhanced barrier precaut proper use of PPE, wound care, and me	tions,
	the kitchen and conta			administration). Policies and procedure reviewed and updated. The Infection	
	These observations Employee #46 on Se approximately 3:00 F			Preventionist will be responsible for en that staff utilize proper infection contro prevention practices.	
				4. Monitor corrective actions	
		ed to maintain Infection ile providing wound care for		The Infection Preventionist/Designee w complete random daily audits on each w all shifts) of staff to ensure that proper	unit (on
	date of October 2010	d Care Policy with a revision) instructed staff to: place t to resident (under the		control and prevention practices are bet throughout the facility across all discip The results will be reported to the QAP	ing used lines. PI
	linen and other body	a barrier to protect the bed sitesloosen tape and iscard into appropriate		Committee monthly x 3 months for rev recommendations.	
	receptacle. wash and put on gloves	d dry your hands thoroughly.		The QAPI Committee is responsible fo going monitoring for compliance.	r the on-
		-admitted to the facility on dical record showed the		5. Date correction action comple	
	Sacral Pressure Ulce Ulcer, Stage 4 Right			The facility's date of alleged compliant November 2, 2021.	ce is
		leel Pressure Ulcer, and a essure Ulcer, Cerebral			

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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L 091	Continued From page	e 111	L 091			
		ependency on Respirator stomy, Gastrostomy, and				
	directed, "cleanse solution, then apply n dressing, cover with	noist to dry Dankin's solution abd (abdominal) pad and e [Stratasorb] dressing every				
	3:30 PM, Employee a failed to maintain Infe	n on 08/25/2021 starting at # 20 (Registered Nurse) action Control Practices while a for Resident #87, as				
	care supplies, the en 4X4's (used internally	the clean field with wound pployee removed sterile y in the sacral wound) from aced them on the clean field e table.				
	4X4's from the reside pressure wound), En	the wound packing including ent's sacral wound (Stage #4 nployee #20 placed the incontinent pad that she set dent's bed.				
		hen provided incontinent er, she failed to recover the ind before providing				
	to provide incontinen at the foot of Resider then removed her glo	laced all dirty supplies used t care on an incontinent brief nt #87's bed. Employee #20 oves but failed to perform putting on a new pair of				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		• • •	E SURVEY PLETED
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04.0.15	CLIMMADY C		NGTON, DC 20032	PROVIDER'S PLAN OF	CORRECTION	
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L 091	Continued From page	e 112	L 091			
	the dirty material (dre used to provide incor resident's bed before Resident #87's Stage 6th - Additionally, Err clean field under the providing wound care wound care on top of During a face-to-face approximately 4:00 F she should have perf removing her gloves incontinent care. The should have discarded	aployee #20 failed to place a resident's sacral area before e. The employee provided f a clean draw sheet. e interview on 08/25/21 at PM, Employee #20 stated that formed hand hygiene after				
		ed to maintain Infections Practice when administering dent #47.				
	with a revised date o staff to " follow esta	istering Medication policy f December 2012 instructed ablished facility infection e.g antiseptic technique) n of medications, as				
	9:28 AM, Employee a Infection Control Sta	n on 08/23/2021 starting at #36 (RN) failed to maintain ndards of Practice while ent #47 ' s medications, as				
	The employee remov					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		• •	E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		CON	
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L 091	Continued From page	e 113	L 091			
	placed them on top the that was in the reside placed the 30cc (cubic and a cup of water or hamper". Employee # packets one at a time While administering the Employee #36 was of touching the top of the multiple times. The employee # and removing all the #36 was also observed mixing the Miralax and employee attempted to administer the Miral	to walk towards the resident alax, the state surveyor to step out the room and				
	door had signage from Prevention and Contr resident was on Enha (are intended to provi gown/glove use that if factors and type of ca MDRO (multidrug-residen presence of indwellin wounds). https://www.cdc.gov/f g-Homes.html Additionally, the unit	is based on resident risk are, rather than based on sistant organism) status, ts at risk for acquisition (i.e., g medical devices or nai/containment/PPE-Nursin had six (6) residents with				
	Candia Aureus (classi					

	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		· · ·	E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
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(X4) ID			ID	PROVIDER'S PLAN OF ((X5) COMPLETE
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L 091	Continued From page	e 114	L 091			
	Resident #47 was ad	Imitted to the facility on				
		dical record revealed the				
		wing diagnoses Respiratory				
		Tracheostomy, Dysphonia,				
	Kidney Disease and	Anemia.				
	Review of the physic	ian's orders revealed the				
	following:					
	Review of the Augus	t 2021 Medication				
		d revealed Employee #36				
	administered the follo	owing medication during the				
	previously mentioned	d observation.				
	Polvethylene Glycol ((Miralax)3350 Kit give 17 mg				
	by mouth one time a					
	-	give 500 mg (milligrams) by				
	mouth one time a day					
	Docusate Sodium tak	olet give 100 mg by mouth				
	every 12 hours for la					
	-	e tablet give 10 mg by mouth				
	one time a day for an	give 1 tablet by mouth one				
	time a day for hyperte					
		Bmg give by mouth one time				
	a day for multivitamir					
	Sennoside Tablet giv	e 8.6 mg one time a for				
	laxative.					
	During a face-to-face	interview on 08/23/2021 at				
	-	M, Employee #36 was				
		ing the administer the				
		g the straw with her gloved				
		e "dirty clothes hamper?"				
		was going to administer				
		realize she had touched the employee then stated that				
		e Miralax and start over.				
		nen asked if it was the facility				
		er medications from the top				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		. ,	E SURVEY PLETED
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L 091	Continued From pag	e 115	L 091			
	stated, "I cleaned it v at 8:00 AM." When a the "dirty clothes har	namper", the employee when I came in this morning sked, how could she ensure nper" was still clean at 9:40 ailed to provide an answer.				
	of Patients & Healtho 10/09/2020, docume protective equipment	es for Quarantine and Testing care Providers" revised on nted, "PPE (personal t) requirements eye shield eld) at all times when working				
	stipulated the followi "Enhanced Barrier Pi Everyone Must:	recautions cluding before entering and				
	High-Contact Resider Bathing/Showering, Linens, Providing Hy assisting with toiletin Device care or use: Central line, urinary of tracheostomy	own for the following: It Care Activities. Dressing, Transferring, Changing giene, Changing briefs or				
	Do not wear the sam care of more than on 4A. During an observ	e gown and gloves for the e person" vation on Unit 3 West on .M, Employee #33 (Certified				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			SURVEY PLETED
			A. BUILDING:			С
		HFD02-0023	B. WING		09	/16/2021
	ROVIDER OR SUPPLIER OINT SUBACUTE AND F	4601 MA REHAB NATIONAL H	NDDRESS, CITY, STATE, ARTIN LUTHER KINC NGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOULD BE	(X5) COMPLE ⁻ DATE
L 091	Continued From pag	e 116	L 091			
	be noted that the res that directed, "Drople must wear eye pro eyes likely" During a face-to-face 08/23/2021 at 11: 00 (Administrator) state	thout an eye field. It should ident had a sign at his door et Precautionseveryone otection if splash/spray to e interview conducted on 0 AM, Employee #1 d, "All staff are required to hen they are doing any direct				
	08/24/2021 at 11:52 soap dispenser in ro Right below the non- was a bottle of "soot and body wash". It sh had a sign on the do Barrier Precautions.	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 or that directed, "Enhanced Everyone must clean their ore entering and when				
	time of the observation (Environmental Serv	ices) stated, "I was not made dispenser was out. I checked				
	08/24/2021 at 1:11 P	vation on Unit 2 East on M, a pile of soiled linen was of the sink in resident room				
	time of the observation Manager) acknowled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:			E SURVEY PLETED
						С
		HFD02-0023	B. WING		09	/16/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, Z			
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING	JR AVENUE SW		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
L 091	Continued From pag	e 117	L 091			
	08/31/2021 at 11:58 (Registered Nurse) w bed of the resident in assisting the residen not wearing a gown that room 333 had a directed, "Enhanced providers and staff m " During a face-to-face	vas observed leaning on the n room 333 Bed A while t to drink. The employee was or gloves. It should be noted sign on the door that Barrier Precautions nust wear gown and gloves e interview conducted at the on, Employee #35 stated that				
	entering a resident's On 8/23/2021 at app Employee # 47 was of #100 in room #159-A door to room 159 sta Precautions'' Everyo	o sanitize her hands prior to room to provide care. roximately 5:50 AM, observed caring for Resident A. The signage outside the ated, "Enhanced Barrier ne must: Clean their hands ering and when leaving the				
	medication cart and first sanitizing/cleanin an enteral feeding bo Employee #47 then of the room and procee #100's tracheostomy	observed leaving her entered room #159 without ng her hands. She then hung ottle for Resident #100. changed her gloves while in eded to suction Resident r. Employee #47 then and sanitized her hands room.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		HFD02-0023	B. WING	0	C 9/16/2021
AME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST		
				KING JR AVENUE SW	
RIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H	NGTON, DC 200		
(X4) ID	SUMMARY ST	TATEMENT 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE DATE
L 091	Continued From page	e 118	L 091		
	policy and offered no not perform hand hy residents room. There was no eveide	aware of the hand hygiene comment about why she did giene before entering the nce that facilty staff sanitized tering a resident's room to		L 099 Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, andserved in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR),	11/02/202
L 099	3219.1 Nursing Facil	ities	L 099	Chapter 24 through 40. 1. Corrective action for resident	
	from spoilage, safe for served in accordance forth in Title 23, Subt Regulations (DCMR) This Statute is not m Based on observation facility failed to serve conditions as evident that were below 140 (3) of nine (9) observ was in use, in the kite The findings include: 1. During a food test 30, 2021, at approxin September 1, 2021, at approximately 1: noodles (110 F), spin (114 F) tested below 135 degrees 2. A cooling fan was	hs and staff interview, the foods under sanitary ced hot foods temperatures degrees Fahrenheit on three ations and a cooling fan that chen. tray assessment on August nately 1:15 PM, and on 30 PM, hot foods such as lach (120 F), and puree fish Fahrenheit (F). being used in the kitchen of dietary services on		 Cooling fan has been removed and food temperature have been consistently within required range. Identify other residents All residents could have been affected. There were radditional findings related to this citation. Systemic changes Dietary and Engineering staff have been educated o the importance of ensuring that cooling fans are not used in the kitchen. The Dietary staff was also educated on food safety to include proper food temperatures. The Director of Dietary will be responsible for ensuring that food safety requirements are met. Monitor corrective actions The Director of Dietary/Designee will complete dai audits of food temperatures to ensure that food temperatures are within acceptable range. In addition, the Director of Dietary/Designee will complete random test tray audits weekly. The Director of Facility Management will do weekly audits of the kitchen to ensure that no cooling fans are in use. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-goin monitoring for compliance. Date correction action completed The facility's date of alleged compliance is 	no n ly ire

STATE FORM

HFD02-0023 B. WING Ogy16/2021 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW BRIDGEPOINT SUBACUTE AND REHAB NATIONAL H 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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (xe completicency)		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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det MARTIN LUTHER KING JR AVENUE SY WASHINGTON, DC 20032 (a) SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MATTING INFORMATION) Differ Information (EACH DEFICIENCY CR LSC IDENTIFYING INFORMATION) Differ Information (EACH DEFICIENCY CR LSC IDENTIFYING INFORMATION) Differ Information (EACH DEFICIENCY) Differ Information (Information (Information (Information) Differ Information (Information)			HFD02-0023	B. WING		09/16/2021
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WASHINGTON, DC 20032 PROVIDER'S FLAN OF CORRECTION, IEACH OFFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PRETX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) OWNER (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) L099 Continued From page 119 L099 L128 1140220 L 128 The supervising pharmacist approximately 3:00 PM. L 128 The supervising pharmacist approximately 3:00 PM. L 128 The supervising staff have been educated on the medication and all counts were reconciled and correct. Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of functional and ministration. 2. Identify other residents (a) Review the drug regimen of each resident at least monthy and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; L 128 The nurse signed out the medications and documentation of medications and dictional findings related to this citation. (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; 3. Systemic changes (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contrained and periodications and disposition of all controlled substances in maintatined and periodication scille ethat an account of all		NINT SUBACUTE AND R		ARTIN LUTHER	KING JR AVENUE SW	
PREFIX TAG CEAN CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF INF APPROPRIATE COMP CONTRESTIGUESTION OF A APPROPRIATE COMP CONTRESTIGUESTION OF A APPROPRIATE COMP CONTRESTIGUESTION OF A APPROPRIATE COMP CONTRESTIGUESTION OF A APPROPRIATE COMP CONSTREPENENCE OF INF APPROPRIATE Information CONSTREPENENCE OF INF APPROPRIATE Information CONSTREPENENCE OF INF APPROPRIATE <thinformation approp<="" constrepenencestice="" inf="" of="" td="" two=""><td></td><td></td><td></td><td>NGTON, DC 200</td><td>032</td><td></td></thinformation>				NGTON, DC 200	032	
 Logs Continued rrom page 119 Conservices and staff interview, facility staff failed to accurate gree conciled and periodically reconciled. This Statute is not met as evidenced by: Based on observicion, record review and staff interview, facility staff failed to accurately reconcile narcotics. Logs Continued rrom page 119 Logs Continue rrom page 119 Logs Continue rrom page 119 Logs Conting Continue rrom page 119 Logs Contr	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI	BE COMPLE
 Employee #46 on September 1, 2021, at approximately 3:00 PM. L 128 L 128 3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes (4) for the organisation of medications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances is maintained and periodically reconciled. This Statule is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics. The Director of Nursing/Designee will complete random weekly audits of 10 % of narcotic count she the medication counts match the medication on hand correctly and are documentation. 	L 099	Continued From page	e 119	L 099	L 128	11/02/202
approximately 3:00 PM.1. Corrective action for residentL 1283224.3 Nursing FacilitiesL 128The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthy and report any inregularities to the Medical Director, Administrator, and the Director of Nursing Services;L 128The nurse signed out the medication that had been previously given and all counts were reconciled and correct. Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration.(a) Review the drug regimen of each resident at least monthy and report any inregularities to the Medical Director, Administrator, and the Director of Nursing Services;L 128The nurse signed out the medication administration.(b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;J Identify other residents(c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, and possible side effects of commonly used medications;Nursing staff have been educated on the importance of accurate accounting of marcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document and counts match that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics.I. Corrective actions The Director of Nursing/Designee will complete<			÷ .		The supervising pharmacist	
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of Nursing Services;(b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly;(c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;(d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and(e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics.All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation.3. Systemic changes(u) Establish a system of records of receipt and disposition of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics.All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation.All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation.All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation.All other narcotic books were reviewed.All other narcotic books were r		least monthly and rep	port any irregularities to the			ration.
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 3. Systemic changes 3. Syst		the status of the phar	maceutical services and			
sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications;Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications.(d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and4. Monitor corrective actions(e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics.The QAPI Committee is responsible for the on-		statt performances, a	it least quarterly;		3. Systemic changes	
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reconciliation; and (e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics. The Director of Nursing/Designee will complete random weekly audits of 10 % of narcotic count sheets to ensure that medication counts match the medication on hand correctly and are documented when given. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-			•			
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Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics.reported to the QAPI Committee monthly x 3 months for review and recommendations.The QAPI Committee is responsible for the on-		maintained and perio	dically reconciled.		the medication on hand correctly and a	re
reconcile narcotics. The QAPI Committee is responsible for the on-		Based on observation	n, record review and staff		reported to the QAPI Committee month	hly x 3
		reconcile narcotics.				
		The findings include:				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		SURVEY LETED
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		HFD02-0023	B. WING		16/2021
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L 128	Continued From page	e 120	L 128	5. Date correction action completed	
	08/23/2021 at 6:51 A observed that a resic packet labeled, "Diaz (milligram) tab (table bedtime", had 20 rem	e narcotic storage box on M on Unit 3 West, it was lent's medication blister repam (antianxiety) 2 mg t) 1 tab by mouth at naining tablets. However, the ented, "21" tablets should be		The facility's date of alleged compliance is November 2, 2021.	
	time of the observation (Registered Nurse) s	tated, "I gave the resident at 10:00 PM but I forgot to			
L 161	3227.12 Nursing Fac	ilities	L 161	L 161	11/02/2021
	Each expired medica usage.	tion shall be removed from		Each expired medication shall be removed fromusage.	
	This Statute is not m Based on observation staff failed to safely s	n and staff interview, facility		1. Corrective action for resident	
	The findings include:			Medication carts and rooms are free of expired medications.	
	(3) resident's Glucag	n of 3 west, Team 2 3/25/2021 at 10:50 AM, three on (treatment for low blood nted an expiration date of		 Identify other residents An audit of all medication carts and medication rooms was completed. There were no additiona findings related to this citation. 	
	time of the observation (Registered Nurse) s	e interview conducted at the on, Employee #21 tated that she would remove n pens from the medication		 Systemic changes Nursing staff have been educated on the importance of ensuring that no expired 	
L 199	3231.10 Nursing Fac	ilities	L 199	medications are left on medication carts or in medication rooms. The Director of Nursing wil be responsible for ensuring that no expired medications are left in medication carts or	1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		HFD02-0023	B. WING		C 09/16/2021	
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X4) ID	SUMMARY ST		ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
RÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL	
L 199	Continued From page	e 121	L 199	medication rooms.		
		shall document the course		4. Monitor corrective actions		
	of the resident's condition and treatment and serve as a basis for review, and evaluation of the					
				The Unit Managers and Supervisors/Desig		
	care given to the resi			will complete random weekly audits of 1 u		
	This Statute is not m	et as evidenced by:		ensure that no expired medications are pre The results will be reported to the QAPI	esent.	
		ew and staff interview, for		Committee monthly x 3 months for review	and	
		led residents, facility's staff		recommendations.		
	failed to: accurately document the resident's					
		sident; accurately document		The QAPI Committee is responsible for th	e on-	
		dered by the physician and		going monitoring for compliance.		
	as directed in the car	-				
		ic medications for one (1)		5. Date correction action completed		
	•	the administration of the				
	resident receiving Symbicort Aerosol and Peri trach care on the Treatment Administration Record and Respiratory Medication			The facility's date of alleged compliance i	s	
				November 2, 2021.		
	-	e (1) resident. Residents' #3,				
	#5 and #119.			L 199	11/02/202	
				L 133	11, 02, 201	
	The findings include:					
				Each medical record shall document		
		dmitted to the facility on		the course of the resident's condition		
		iple diagnoses including		and treatment and serve as a basis for		
	Morbid Obesity, Cellu	Ilitis, and Lymphedema		review, and evaluation of thecare given to the resident.		
	Poviow of the media	l record showed a beasital		Siven to the resident.		
		al record showed a hospital rom a local hospital that		1. Corrective action for resident		
		it #3 's weight as 179.7				
	kilogram (396 pounds			Resident #3 has been re-weighed and their		
	0 (, -		current weight has been documented and		
	Review of Resident #	t3 ' s Weight Summary List		verified by the Dietician. Resident #5 has		
		dent weighed 285 pounds		evaluated by a psychiatrist and assessed for	or the	
		97.5 pounds on 08/04/2021,		effectiveness of their psychotherapeutic	the	
		of 212.5 pounds (72.15%		medications. Resident #119 has received		
	weight gain) in 25 day	ys.		ordered respiratory medications and treatm and they are being signed off as appropriation		
	During a face to face	piptonyiow with 00/20/2001		the Treatment Administration Record and		
		e interview with 08/30/2021 00 AM, Employee #28		Respiratory Medication Administration Re	ecord.	
	a approximately 10.0	JU AIVI, EITIPIUYEE #20	1	r r		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 09/16/2021	
		HFD02-0023	B. WING	·		
AME OF P	ROVIDER OR SUPPLIER	1	DDRESS, CITY, ST	ATE. ZIP CODE	00/10/20	
		4601 MA		KING JR AVENUE SW		
BRIDGEP	DINT SUBACUTE AND I		IGTON, DC 200	32		
(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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE CO	(X5) OMPLE DATE
L 199	Continued From pag	e 122	L 199	2. Identify other residents		
	the weight discrepancy and instructed staff to re-weight the resident. Employee # 28 was asked which weight was the accurate weight? She stated, "The 497.5 pounds was the resident ' s accurate rate."			An audit of other residents was compleThere were no additional findings relatecitation.3. Systemic changes		
	02/22/2017 with mult Anxiety Disorder, De Status.	admitted to the facility on tiple diagnoses that included: epression and Tracheostomy		Nursing staff and Dietician have been e on the importance of ensuring that resid weighed accurately and weights docum Nursing and Social Services staff have educated on the importance of ensuring residents are evaluated by a psychiatris	lents are ented. been g that	
	01/02/2020 "Is resid psychotherapeutic n	ian ' s orders revealed: ent free from side effects of nedications if no, document rogress note] very shift"		their psychotherapeutic medications are assessed for effectiveness per physiciar Respiratory Therapists were educated of importance of documenting respiratory medications and treatments are docume	n orders. on the	
	tablet 25 MG (milligr	ine Fumarate (antipsychotic) am) give 0.5 tablet via PEG copic gastrostomy)- Tube at hold for sedation"		the Treatment Administration Record a Respiratory Medication Administration The Director of Nursing, Dietician, Dir Cardiopulmonary Services, and Directo Social Services will be responsible for	record. ector of or of ensuring	
		al Minimum Data Set (MDS) vealed that facility staff coded		that medical records are complete for the respective disciplines.4. Monitor corrective actions	1611	
	"severely [cognitively			The Unit Managers and Nursing Supervisors/Designee will complete we audits of 10% of residents to ensure that	t medical	
		staff assessment of resident y score 00" (indicating the gn of depression)		records are complete and accurate. The will be reported to the QAPI Committe monthly x 3 months for review and recommendations.		
		ior), psychosis, behavioral behavior not exhibited"		The QAPI Committee is responsible fo going monitoring for compliance.	r the on-	
	In Section I (Active Dementia, Restlessr	Diagnosis), "Non Alzheimer's ness and Agitation"		 5. Date correction action comple 	ted	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
					С	
		HFD02-0023			09	/16/2021
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE KING JR AVENUE SW		
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, DC 200			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
L 199	Continued From page	e 123	L 199	The facility's date of alleged	compliance is	
	In Section N (Medications), medications received, "antipsychotic" Review of the care plan revealed: Focus area: "12/26/2019 [Resident #5] is receiving psychoactive medication Seroquel (Quetiapine Fumarate) daily for depression, interventions: " assess/monitor/document behavior daily on behavior monitoring sheet"			November 2, 2021.		
	medicines, interve possible signs and s reaction: falls, weight agitation, lethargy, co	018 [Resident #5] is on 9+ ntions: "Monitor for ymptoms of adverse drug t loss, fatigue, incontinence, onfusion, agitation, petite, constipation, gastric				
	(TAR) revealed a sec from side effects of p medications (if no, do every shift". In this se dates 08/01/2021 to documented nine (9)	ent Administration Record ction labeled, "Is resident free osychotherapeutic ocument side effects in PN) ection, it was noted that from 08/25/2021, facility staff times, "N (no)", indicating free of psychotherapeutic				
	-	interview conducted on AM, Employee #2 (Director				

STATEMENT	egulation & Licensing A OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		· · ·	E SURVEY PLETED
					С	
		HFD02-0023	B. WING		09	/16/2021
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
BRIDGEP	OINT SUBACUTE AND R	REHAB NATIONAL H	ARTIN LUTHER KINC NGTON, DC 20032	JR AVENUE SW		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 199	Continued From page 124		L 199			
	of Nursing) had no co	omments about the findings.				
	08/03/2021 with diag Obstructive Pulmona	ic Respiratory Failure with				
	08/10/2021, the resid Brief Interview for Me indicating she had no under Section O (Spe Programs) she was o	ission MDS completed on ent was coded as having a ental Status (BIMS) of "15" o cognitive impairment and ecial Treatments and coded as "While a Resident" therapy, suctioning and tach				
	and Respiratory Med	ent Administration Record ication Administration 21 showed the following:				
	control asthma and u treatment of chronic disease) puff inhale o not signed as being a 8/14/2021, 8/16/2021	60-4.5 Mcg/ACT 2 (helps to ised for maintenance obstructive pulmonary orally two times a day was administered on 8/12/2021, I, 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 8/12/2021, and 08/18/2021."				

	egulation & Licensing A	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X3) DATE	SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	: COMP	LETED	
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
	OINT SUBACUTE AND R		ARTIN LUTHER	KING JR AVENUE SW		
RIDGEF	UNIT SUBACUTE AND R		NGTON, DC 200	32		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
L 199	Continued From page	9 125	L 199			
	the Symbicort Aerosol care as ordered by the Although the medicat administered by the F staff failed to record t resident receiving Sym trach care on the Trea Record and the Resp Administration record During a face-to-face 8:36 AM, Employee #	forementioned dates tory therapist administered and performed Peri trach e physician. ion and treatment were Respiratory Therapist, the he administration of the abicort Aerosol and Peri atment Administration iratory Medication				
L 204	completed immediate forty-eight (48) hours	rsis of each incident shall be ly and reviewed within of the incident by the e Director of Nursing and	L 204	L 204 A summary and analysis of each incident shall becompleted immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing	11/02/2021	
		d description of the incident;		1. Corrective action for resident		
	(b)The name of the w	itnesses;		Investigations were reviewed and reinvestigated and appropriate actions taken to resolve the	1	
	(c) The statement of th			concerns for all residents. Employees #5 and #49 were terminated. Resident #95 is restrained	ł	
	(d) A statement indica pattern of occurrence	ting whether there is a ; and		for their safety appropriately. Resident #37 has her IPAD at her bedside. Resident #102's concerns were reviewed and addressed during		
	(e) A description of the	e corrective action taken.		the IJ abatement process. Residents #23and Resident # 105 no longer reside in the facility.		

STATE FORM

	OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			URVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:		COMPLE	ETED
		HFD02-0023	B. WING			C 09/16/2021	
	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
	CONDER OR SOFFLIER		ARTIN LUTHER				
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	NGTON, DC 200				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLE ⁻ DATE
L 204	Continued From page	e 126	L 204	2.	Identify other residents		
				An au	dit of all other resident's com	pleted.	
	This Statute is not m				were no additional findings re		
		ew and staff interview, for			n. All FRIs from January 202		
		ints and facility reported			eviewed and reinvestigated and		
	incidences, facility sta			priate actions taken to resolve			
	summary and analys			residents. Education files of			
	completed immediate forty-eight (48) hours			ed in the FRIs were reviewed			
	Medical Director or th		that ap	ppropriate actions were taken	regarding		
		n investigation: for three (3)		their ii	nvolvement.		
	0.1	d physical abuse from an					
	÷	gation of misappropriation of		3.	Systemic changes		
		pperty; and for improper use					
		(1) resident. (Residents' #23,		Staff a	and Leadership have been edu	cated on the	
	#37, #95, #102 and #			abuse	tance of ensuring that all alleg are reported and investigated		
	The findings include:			subjec	priately to ensure that resident ted to potential abuse. The A	dministrator	
		's policy entitled, "Abuse			e responsible for ensuring that		
		porting" with a review date of			t subjected to potential abusiv		
		The individual conducting			lary to the failure to properly tions of abuse.	investigate	
		as minimum interview the		anega	tions of abuse.		
	staff members (on all	y appropriate) interview l shifts) who have had		4.	Monitor corrective actions		
		lent during the period of the		The A	dministrator will complete	alth and to	
		terview other residents to			dministrator will complete we Incidents Reported by the Fac		
		mployee provides care or			that all investigations are inv		
	services"				ighly. The results will be repo		
	1 Facility staff failed	to thoroughly investigate an			Committee monthly x 2 mont		
		to thoroughly investigate an #23 who alleged physical			v and recommendations.		
				The O	API Committee is responsible	e for the on-	
	Resident #23 was ad 11/14/2020, with diag	Imitted to the facility on			monitoring for compliance.		
		e, Hypertension, Renal		5.	Date correction action com	pleted	
		es Mellitus, Anxiety Disorder					
	and Asthma.				cility's date of alleged compl nber 15, 2021.	iance is	
	According to the Qua	urterly MDS dated					

	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		. ,	E SURVEY IPLETED
					С	
		HFD02-0023	B. WING	09	9/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KING NGTON, DC 20032	G JR AVENUE SW		
(X4) ID	SUMMARY S			PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET
L 204	Continued From pag	e 127	L 204			
	02/21/2021, Resident #23 was coded as "rarely/never understood" and was not able to conduct the Brief Interview for Mental Status.					
	revealed: "the dau mother accused staff (Certified Nurse's Aid not able to give a dar incident occurred." " reliable witness and give the place of the employee was suspe- was initiatedthe re	ht report dated 04/22/2021 ghter called to say that her f member [Employee #49] e) of hitting her. She was te or time or when the the resident is not a the daughter could also not alleged strike. The ended, and an investigation sident was assessed for found to not be in distress."				
	9:40 AM, he stated the	0/08/2021 at approximately				
	facility's investigation	residents were interviewed,				
	-	ons posed to the residents at the CNA provided.				
		"Her care is poor. She don't o do. A couple of time she as going to die."				
		"She is okay, but sometimes time with my colostomy."				
	One resident stated, average. She somet get mad a her."	"Her care with me is imes forgets to feed me. I				

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING:		с		
		HFD02-0023	B. WING		09	09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,				
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	ARTIN LUTHER KINC NGTON, DC 20032	JR AVENUE SW			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
L 204	Continued From page	e 128	L 204				
	room to care for me. about her, nobody do	"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:					
	"She is good but grue	dgingly do stuff."					
	-	l. She does not care for the o wash the residents."					
	"I think her care is pro residents complain a	etty good. I have heard the bout her."					
	conducted the intervi other four (4) resider	ice that the facility staff who ews further investigated the its and three (3) other staff concerns related to the					
	09/08/2021, at appro	e interview conducted on ximately 9:40 AM with I no comments about the					
	-	to thoroughly investigate the at Resident #37's IPAD as missing.					
	09/01/2020 with the f	-admitted to the facility on ollowing diagnoses: Anemia, tes Mellitus, Hyperlipidemia r Accident (CVA).					
		7's Admission Minimum d 08/12/2021 revealed:					

Health Regulation & Licensing Administration STATE FORM

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CWPH11

If continuation sheet 129 of 149

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	NSTRUCTION	· · ·	SURVEY
		HFD02-0023	B. WING	C 09/16/2021		
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2		03	/10/2021
		4601 MA				
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H WASHIN	IGTON, DC 20032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
L 204	Continued From page	e 129	L 204			
		ve Patterns), Resident #37 for Mental Status (BIMS) 15" indicating intact				
	was coded as, "total	onal Status), Resident #37 dependence, one-person tressing, toilet use, and				
	•	Reported Incident (FRI) :52 PM documented the				
	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, a found under her mother the rsing) failed to give a report ell off the device it was she complained the aide ad at her mother [Resident e door isolating her mother. the identified aide, the facility ciate [Employee #25] and tion."				
	Employee #1 (Admin interviewed the staff, residents on the unit medical chart. The re quarantine, so the do The abuse and negle concluded, and it was investigation there was prove abuse and neg	s determined from the as no evidence presented to glect was committed towards on, Therefore, the case has				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
			A. BUILDING.		С	
		HFD02-0023	B. WING	09	9/16/2021	
	ROVIDER OR SUPPLIER OINT SUBACUTE AND F	ZIP CODE S JR AVENUE SW				
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
L 204	Continued From pag	e 130	L 204			
	documents on 08/30 evidence of interview #37, Resident #37's of During a face-to-face 08/31/2021 at 3:57 P	ty's investigative notes and /2021 lacked documented v statements from Resident daughter and Employee #25. e interview conducted on PM, Employee #1, stated that hs and statements should				
	have been included in documents for the ini- the initial complaint representative (dauge interview statement of stated that he would (Director of Nursing) questions from Empl	in the folder with the other vestigation. He reported that nade by Resident #37's hter) was considered the of what happened. He also check with Employee #2 in regards to the interview oyee #25 (CNA involved). I not provide the missing and statements from				
	3. Facility staff failed	to thoroughly investigate the #95's hand mitten being tied				
	01/19/2021, with mul Cerebral Infarc due t					
	Review of the physic following:	ian's orders revealed the				
		left wrist restraint q (every) 2 any findings every 2 hours"				
	prevent patient from	ft wrist restraint in place to pulling on her trach (gastrostomy) - Tube q shift"				

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION		E SURVEY PLETED
		HFD02-0023	B. WING		09	C 0/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R		RTIN LUTHER KING	G JR AVENUE SW		
BRIDGE			IGTON, 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 204	Continued From page	e 131	L 204			
		[#] 95's Admission (MDS) dated I that facility staff coded the				
	In Section C (Cognitive Patterns), "Severely impaired"					
	behavioral symptoms (e.g., hitting, kicking,	hers sexually) Behavior of				
	-	nal Status), "Bed mobility e-person physical assist"				
	In Section P (Restrain mitten]Used daily"	nt), "Limb restraint [hand				
	01/27/2021 documen 1/27/2021 her (Resid tied to the rail. It was	Reported Incident (FRI) on hted, " During rounds on lent #95) mitten was found immediately released, and ssedInvestigation is				
	Review of the progre	ss notes revealed:				
	her mitten was found immediately released and not found to be i	During rounds on 1-27-2021 I tied to the rail. It was I and patient was assessed In distress, pain or fearful.				
	appropriate agencies sweep conducted no to have an inappropri	, RP (representative) and s were notified. House wide other residents were found iate restraint. Investigation is tisfied and we told him we				

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STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			с
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND R	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, DC 20032			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 204	Continued From page	e 132	L 204			
	will be in communica	tion with the conclusion."				
		's investigation notes and				
		2021 revealed that only six				
	(6) staff members we investigation. There	ere interviewed as part of the				
		is from the respiratory				
	therapist who provide					
	tracheostomy care of staff who cleaned Re	r from the environmental esident #95's room.				
	It was also noted tha					
		asked, "Do you know the y and procedure" as part of				
	the investigation 's in					
		nented evidence that the				
	÷	ed up with those staff e documented evidence that				
		g/education was provided on				
		ity 's abuse reporting policy				
	• •	istrator) acknowledged that				
		hysically tied to the bedrail				
	nowever, he did not soccurred.	substantiate that abuse				
	•	e interview conducted on M, Employee #2 (Director of				
		tens are used for residents				
	who are a danger to	themselves. After the				
		ved the staff, assessed the				
		its of the other residents in mittens. We did not find any				
		nittens tied to the bedrail."				
	During a face-to-face	e interview conducted on				
	08/31/2021 at 9:45 A					
	(Administrator) stated ion & Licensing Administrati	d, "We couldn't substantiate				

Health Regulation & Licensing Administration STATE FORM

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
			A. BUILDING.			
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H		3 JR AVENUE SW		
	SUMMARY S		IGTON, DC 20032	PROVIDER'S PLAN OF ((XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
L 204	 204 Continued From page 133 the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did not find any other resident with hand mittens tied to the bed." During a face-to-face interview conducted on 		L 204			
	08/31/2021 at 10:54 and Language Patho is nonverbal with righ to paralyses. Left sid for left [hand] mitten. 01/27/2021) and noti were wrapped aroun rail, fully restricting h hand. I immediately the nurse aware and mitten was not to be	e interview conducted on AM, Employee #4 (Speech ologist) stated, "The resident at hemiparesis- pretty close e is intact. She had an order I walked into the room (on ideed the straps to the mitten d and tied to the upper bed er movement of the left removed the restraint, made educated the nurse that the used as a restraint. I then to my supervisor and the				
	visitation log on 08/3	at a review of facility's 1/2021 at 10:00 AM revealed d not have any visitors on /2021.				
	-	to thoroughly investigate plaint that a staff member slung it during care.				
	06/25/2021, with mul Multiple Fractures of	vith Hypoxia, and Pressure				
	statement dated 07/2	(Certified Nurse's Aide) 10/2021, documented, t to [Resident #102] said to				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON		(X3) DATE	SURVEY
		DENTI IOATION NOMBER.	A. BUILDING:			
		HFD02-0023	B. WING		C 09/16/2021	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	IP CODE		
	OINT SUBACUTE AND R	4601 MA	RTIN LUTHER KING	JR AVENUE SW		
_		WASHIN	IGTON, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
L 204	Continued From page	e 134	L 204			
	him we are here to cl	ean My nurse was				
		turned over the patient"				
	Review of a complair	nt and facility reported				
	incident dated 07/14/	2021 revealed the following:				
		stated when staff was				
		re snatched his leg and e [turn] over resident stated				
		sident alleges that staff				
		oy you can take a little pain.				
		identify staff persons who				
		are. An investigation is f has been suspended				
	pending ongoing inve					
	Review of a memo fr					
		1 07/14/2021, revealed, "				
	The abuse and negle	s determined from the				
		as no evidence presented to				
		lect was committed towards				
		on. Therefore, the case has				
	been unsubstantiated	d due to these findings."				
	Review of the facility	's investigation notes and				
		2021, revealed that the				
	0	obtain a statement from the				
	-	N) who was mentioned as dent #102's room during the				
	alleged incident. The	-				
	pre-printed interview	questionnaire forms and one				
		nt written by the involved				
	Employee #50. The p	pre-printed interview rered by staff and other				
	residents. Three (3)					
		nnaire forms had questions				
	that were left blank.	All the pre-printed				
		nnaire forms had names that				
	were illegible.					

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM		
		HFD02-0023	B. WING		09	C 09/16/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
	OINT SUBACUTE AND R		ARTIN LUTHER KING	G JR AVENUE SW			
BRIDGEF	OINT SUBACUTE AND P		NGTON, DC 20032				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
L 204	Continued From page	e 135	L 204				
	•						
	Resident #105's com stuffed her brief with	to thoroughly investigate plaint that Employee #5 pieces from a incontinence ative verbal comment.					
	05/26/2021, with mul						
	Minimum Data Set (M	105's Significant Change MDS) dated 07/13/2021, staff coded the following:					
		ive Patterns), Brief Interview MS) score "15", indicating onse.					
	external sensory stim	ces in the absence of real nuli) "No"; Delusions eliefs that are firmly held,					
	`	Functional Abilities and iene " total dependence assist".					
	09/08/2021 revealed Name] Employee Wa 07/29/2020. The form received a verbal wa	#5's personnel file on a form entitled; "[Facility's arning Notice" dated n revealed that Employee #5 rning on (07/16/2020) and a 7/20/2020) for "violation of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY IPLETED
			· · · · · · · · · · · · · · · · · · ·		С	
		HFD02-0023	B. WING		0	9/16/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RIDGEP	OINT SUBACUTE AND F	4601 MA	ARTIN LUTHER KING	G JR AVENUE SW		
			NGTON, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
L 204	Continued From page	e 136	L 204			
	policy/procedure".					
	notice was a docume	ously mentioned warning ent written by the (previous) nat revealed the following:				
	to the attention of the Wound Care Team m resided on unit 3 eas filled incontinence br Ultrasorb (under pad CNA (Employee #5) of the under pads ins	uly 16, 2020, it was brought e Director of Nursing by nember a resident [that st] was observed with a urine ief on and a urine saturated ls) in the incontinence Brief. was asked about the use side of the resident 's diaper. Resident's Name] is a heavy				
	330 A [unit 3 west] ha under pad taped toge brief and was taped to skinResident 330 E resident's roommate same makeshift inco urine soaked towel w resident's legs This within one week whe care to residents in a should not provide [Employee's Name] t Offense Acting in a abuse or neglect, or	B [the previously mentioned] was observed with the ntinence brief and in addition was found between the s is the second occurrence ere [Employee #5] provided a manner [Employee #5] The type of care provided by to the residents is a Type B a way that can be considered				
	State Agency that do reported to the Om	mplaint was received by the ocumented, "[Resident #105] budsman on the night of sing Aide stuffed [Resident				

STATEMENT	egulation & Licensing / OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		. ,	E SURVEY PLETED
			A. BUILDING:		С	
		HFD02-0023	B. WING		09	9/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
BRIDGEP	OINT SUBACUTE AND F	4601 MA REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
			IGTON, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
L 204	Continued From page 137		L 204			
	(incontinence pad) a you again tonight''	nd said 'I am not changing '				
	We interviewed the the unit (3 west) alor medical chart. The a investigation has cor determined from the evidence presented was committed towa #105] in question. Th unsubstantiated due	d 08/24/2021, documented, " e staff and other residents on ng with examining the buse and neglect ncluded, and it was investigation there was no to prove abuse and neglect rds the resident [Resident nerefore, the case has been				
	name] The residen Ombudsman C.N.	ocumented, "[Resident ts daughter reported to the A. (Certified Nurse's Aide) e caused him three days of ks too much."				
	08/30/2021 at 9:06 A (Administrator) state [Employee #5] and the not to assign him to a (Resident #105). The breakdown in the syst floated to 3 west (whe He was not originally	d, "The staff member ne Nurse Supervisor knew work with the resident ere was obviously a stem. The involved CNA was ere Resident #105 resided). A assigned to that unit. He ted that he did not say t #105] while he was supervisor is getting e involved CNA was 7/2021) and is being				
	-	e interview conducted on M with Employee #2				

	egulation & Licensing A					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			_
		HFD02-0023	B. WING		09	C 0/16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	•	
		4601 MA	ARTIN LUTHER KIN	G JR AVENUE SW		
BRIDGEP	OINT SUBACUTE AND F	WASHIN	NGTON, DC 20032			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE
L 204	Continued From page	e 138	L 204			
	(Director of Nursing),	, she stated, "We don't				
		nand-off (transfer of patient				
		ty from one healthcare				
		communication with the				
		e week. The supervisors				
	to work on the third fl	at the CNA involved was not				
	During a telephone ir	nterview conducted on				
		AM, Employee #6 (Nurse				
		The CNA [Employee #5] was				
		cause we didn't have a CNA				
		d that the CNA shouldn't be				
	issues on 3 West."	as not made aware about the				
		nterview conducted on				
		AM, Employee #5 stated, "I				
		st and was pulled to 3 West				
	because they were s					
		olved and no issues were he unit (3 west). I was taking				
		e (room 333 bed B) when				
		ed that she was wet and				
		s 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) ing this for 17 years. I have				
		to her nor intimidate her in				
	any way."					
	Review of the investi	gation 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				
	"abuse or neglect, or	-				
olth Regulat	ion & Licensing Administrati					

STATEMENT	egulation & Licensing A OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE COMP	SURVEY LETED
			A. BUILDING		С
		HFD02-0023	B. WING		16/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW 32	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET
L 204	Continued From page	9 139	L 204		
	verbally." Additionally	r physically, mentally or , Employee #5's personnel e why the employee was not nit 3 East.			
	approximately 10:30 . of Human Resources disciplinary actions (ti were not mentioned to until a meeting that or	interview on 09/08/2021 at AM, Employee #7 (Director) stated, "The previous hat occurred in 07/2020) o the Director of Nursing ccurred on 08/31/2021 when hypee #5) was discussed."			
	approximately 10:30 approx	made for Employee #5			
	approximately 10:30 (Administrator) stated previous allegations of	l, "I was not aware of any or disciplinary actions for the #5). I did not review his		L 214 Each facility shall be designed, constructed, located, equipped, and maintained to provide afunctional, healthful, safe, comfortable, and supportive environment for each	11/02/2021
L 214	3234.1 Nursing Facili	ties	L 214	resident, employee and the visiting public.	
	located, equipped, an functional, healthful, s supportive environme employee and the vis This Statute is not m Based on observation failed to provide an e accident hazards as o	iting public. et as evidenced by: is and interview, the facility		1. Corrective action for resident Resident #93 was educated on signing out when leaving the facility. The heater was removed from room 335. The resident was educated that such devices are a safety hazard and not permitted.	

Health Regulation & Licensing Administration STATE FORM

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CWPH11

If continuation sheet 140 of 149

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
			A. BUILDING:		COMPLETED
		HFD02-0023	B. WING		09/16/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H		KING JR AVENUE SW	
(X4) ID	SUMMARY ST		IGTON, DC 200	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL
L 214	Continued From page	e 140	L 214	2. Identify other residents	
	The findings include:			An audit of other resident LOAs was c An audit of resident rooms did not yiel	
	u	of the facility on August 30, Iy 12:00 PM, a portable		additional heaters. There were no add findings related to this citation.	
	room #335 on the 3 V	vest unit. The space heater		3. Systemic changes	
		ectrical outlet, ready for use.		Nursing and security staff have been each on the importance of ensuring that resi	
		on September 1, 2021, at		signed out appropriately and accounted no heaters are present. Nursing staff h	l for and
247	3238.3 Nursing Facili		L 247	educated on the importance of accurate documentation and validation of reside	2
	-	ed by a resident shall be		whereabouts throughout the shift. The of Security will be responsible for ensu	
	maintained at a minir	-		residents are engaged upon exit of the ensure that they have notified nursing	facility to
	maximum of eighty-o	ne degrees Fahrenheit en the room is occupied.		their whereabouts.	
	This Statute is not m			4. Monitor corrective actions	
	Based on observation staff failed to provide environment as evide	n and staff interview, facility a comfortable and homelike enced by the facility failing to		The Director of Nursing/Designee will weekly audits of all residents who go of LOAs to ensure that their absence and documentation is accurate. The Engin	out on related
	were maintained betw	resident room temperatures veen seventy-one degrees d a maximum of eighty-one 81°F).		department will audit 25% of resident? monthly for unauthorized appliances. results will be reported to the QAPI Co monthly x 3 months for review and	s rooms The
	The findings include:			recommendations. The QAPI Committee is responsible fo	or the on-
	During a walkthrough 08/23/2021 at approx	of unit 3 west on kimately 8:30 AM resident		going monitoring for compliance.	
	room temperatures w	using the facility's infrared		5. Date correction action comple	
	thermometer, temper	ature levels registered hrenheit in five (5) out of		The facility's date of alleged complian November 2, 2021.	ce is

	OF DEFICIENCIES	Administration (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY
		HFD02-0023	B. WING		C 09/16/2021
JAME OF P	ROVIDER OR SUPPLIER	I STREET A	DDRESS, CITY, ST		
		4601 MA		KING JR AVENUE SW	
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H WASHIN	IGTON, DC 200	32	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
L 247	Continued From page	e 141	L 247	L 247	11/02/2021
	Fahrenheit; room 336 room 339, 86.7 degre 89.4 degrees Fahren degrees Fahrenheit.	room 337, 81.9 degrees 6, 85.5 degrees Fahrenheit; ees Fahrenheit; room 335, heit and room 334, 81.7 ervation, Employee #37 dings.		Each room that is used by a resident shall bemaintained at a minimum temperature of seventy- one degrees Fahrenheit (71°F) and amaximum of eighty-one degrees Fahrenheit (81°F) at all times when the room is occupied.	
L 410	3256.1 Nursing Facili	ties wide housekeeping and	L 410	 Corrective action for resident No areas are greater than 81°F. Resident #68 low-air pressure mattress has been replaced. 	3's
	maintenance services exterior and the interi	s necessary to maintain the for of the facility in a safe, nfortable and attractive		The air handler is being addressed. Residents were checked with no concerns raised about individual room temperatures.	5
	This Statute is not me Based on observation failed to provide hous necessary to maintain environment as evide in the supply room the	ns and interview, facility staff		2. Identify other residents An audit of resident rooms and common area did not reveal any areas at or greater than 81° An audit of resident beds was completed. Th were no additional findings related to this citation.	Ϋ́F.
	The findings include:			3. Systemic changes	
	facility storage room i September 1, 2021, a five (5) ceiling tiles in two (2) ceiling tiles in marred with dark stain	ntal walkthrough of the in material management on at approximately 1:00 PM, the main supply room and the staff break room were ns throughout. wledged the findings during		Staff have been educated on the importance of ensuring that mechanical, electrical, and patie care equipment are in safe working condition include initiating service requests for equipm in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patie	ent (to ent or ent
		ew on September 1, 2021, at		care equipment are in safe working condition4. Monitor corrective actions	
				Engineering/Designee will complete weekly audits of mechanical, electrical, and patient c	are

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		HFD02-0023	B. WING		C /16/2021
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	10/2021
RIDGEP	DINT SUBACUTE AND F	REHAB NATIONAL H	NGTON, DC 200	KING JR AVENUE SW 132	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
L 521	Continued From page	e 142	L 521	equipment service requests to ensure that they are in safe working condition. The results will	
L 521	3269.1d Nursing Fac	ilities	L 521	be reported to the QAPI Committee monthly x months for review and recommendations.	
	(d) To be treated with	n respect and dignity and		months for review and recommendations.	
		ng treatment and when		The QAPI Committee is responsible for the on-	-
	receiving personal ca	are;		going monitoring for compliance.	
	This Statute is not m	net as evidenced by: ns, record review and staff		5. Date correction action completed	
) of 44, sampled residents		The facility's date of alleged compliance is	
	the facility 's staff fai	led to ensure a resident was		November 2, 2021.	
		privacy due to not covering			
	the urine collection b	ag. (Resident #102).		L 410	11/02/2021
	The findings include:				
	06/25/2021 with mult Stage 4 Pressure Uld bilateral buttocks pre	e-admitted to the facility on tiple diagnoses including cer of sacral area, Stage 4 essure ulcers, Multiple ad Unspecified Fracture of mur.		Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.	
	On 0.02/24/2021 at an	provimately 4:00 DM		1. Corrective action for resident	
	Resident #102 was o	proximately 4:00 PM, observed in his room with his uncovered and filled to		The ceiling tiles in the main supply room and the staff break room have been replaced.	
		an order dated 06/26/2021,		2. Identify other residents	
		heter) size # 18Measure		An audit of other areas throughout the facility were inspected. There were no additional findings related to this citation.	
	(MDS) dated 08/17/2	erly Minimum Data Set 2021 revealed in Section H		3. Systemic changes	
		the resident was coded as esence of an indwelling		Engineering staff have been educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Plan	nt
	approximately 4:00 F	e interview on 08/24/2021 at PM, Employee # 36 tated "A family member was		Operations will be responsible for maintaining safe, clean, and comfortable	

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE : COMP	SURVEY	
		HFD02-0023	B. WING		C 09/16/2021	
	ROVIDER OR SUPPLIER	STREET A 4601 MA		ATE, ZIP CODE KING JR AVENUE SW	10,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	WASHIN 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 APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
L 521	Continued From page	e 143	L 521	environment.		
	accident". The emplo comments to address collection bag was no			 Monitor corrective actions The Director of Plant Operations/Designee will complete random audits of ceiling tiles on one unit weekly and will follow up on any 		
L 526	possessions, as space would infringe on oth medically contraindic This Statute is not m	personal clothing and ce permits, unless to do so her residents' rights or is cated; het as evidenced by:	L 526	 subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the ongoing monitoring for compliance. 5. Date correction action completed 		
	documentation, facili staff interviews, for o residents, the facility protect Resident #10 physical abuse by Er	f clinical records, facility ty policies, and resident and one (1) of 44 sampled 's staff failed to prevent and 05 from psychological and mployee #5 and because of loyment history, there is a oloyee abusing other		 The facility's date of alleged compliance is November 2, 2021. L 521 To be treated with respect and dignity and assured privacy during treatment and when receiving personal care. 	11/02/202	
	Investigation and Re 08/2020 revealed, " ensure that further p	's policy entitled, "Abuse porting" with a review date of The administrator will otential abuse, neglect eatment is prevented"		 Corrective action for resident Resident #102 has been given a privacy bag. The urine collection bag was measured and emptied. Identify other residents 		
	Neglect- Clinical Pro 08/2020 revealed, " and staff will institute	's policy entitled, "Abuse and tocol" with a review date of The facility management e measures to address the nd minimize the possibility of ."		 An audit of other residents with urine collection bags did not identify any other residents affected. There were no additional findings related to this citation. 3. Systemic changes 	1	
	ion & Licensing Administrati			Staff have been educated on the importance of		

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0023					(X3) DATE SURVEY COMPLETED	
		B. WING		С		
		D. WIING	09/	16/2021		
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
RIDGEP	OINT SUBACUTE AND F	REHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW 32		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLE ⁻ DATE	
L 526	Continued From page 144 Facility staff failed to provide a safe environment to prevent and protect Resident #105 from the likelihood of abuse from Employee #5. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome. On 08/19/2021 a complaint was received by the		L 526	resident's rights to include privacy. The Director of Nursing and Unit Managers will be responsible for validating privacy rounds/inspections and subsequent follow up on findings.		
				4. Monitor corrective actions		
				The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee		
	State Agency that do reported to the Ombo August 18th [2021] th [Resident #105's] bri	ocumented, "[Resident #105 udsman on the night of le nursing Aide stuffed ef with pieces from a chuck nd said 'I am not changing		 monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed 		
	We interviewed the	1 08/24/2021, documented, " e staff and other residents on		The facility's date of alleged compliance is November 2, 2021.		
	medical chart. The a investigation has cor determined from the	ncluded, and it was investigation there was no		L 526 To keep and use personal clothing and possessions, as space permits, unless to do	11/02/2023	
	was committed towa	to prove abuse and neglect rds the resident [Resident herefore, the case has been to these findings."		sowould infringe on other residents' rights ofis medically contraindicated1.Corrective action for resident	r	
	State Agency that do name]The resident Ombudsman C.N./	mplaint was received by the ocumented, "[Resident is daughter reported to the A. (Certified Nurse's Aide) e caused him three days of		Identified resident #105 (no longer resides in the facility) was interviewed 9-8-2021 and signed their statement. The identified Aide was terminated on 9-01-2021.		
	pay, and that she tal	ks too much."		2. Identify other residents		
	Review of Resident #	#105's Significant Change		An audit of all other resident's completed.		

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD02-0023		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		B. WING		C 09/16/2021		
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST			
	KONDER OR SOLT EIER			KING JR AVENUE SW		
BRIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	NGTON, DC 200			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL	
L 526	Continued From page 145		L 526	There were no additional findings related	to this	
			2020	citation.		
	Minimum Data Set (MDS) dated 07/13/2021,					
	revealed that facility	staff coded the following:		3. Systemic changes		
		ve Patterns), Brief Interview		All FRIs from January 2021 to present we		
		MS) score "15", indicating		reviewed to ensure that they were properly		
	intact cognitive response.			investigated. Education files of any staff		
	In Castion E (Dahavi			involved in the FRIs were reviewed to en		
	In Section E (Behavio			that appropriate actions were taken regard	U	
	(perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No"; and in Section GG (Functional Abilities and Goals), Toileting hygiene " total dependence one-person physical assist".			their involvement. Education/Designee w	v1ll 1n-	
				service all staff on the Abuse Policy and	ina	
				procedures. New Administrator and Govern Board will in-service leadership on the Abu		
				Policy and procedures. In the future, any	180	
				employees involved in allegations of abus	se	
				neglect, exploitation, or mistreatment will		
				receive immediate in-servicing on the fac		
				Abuse Policies and Procedures. All future		
	-	ng a face-to-face interview conducted on		allegations conclusions will be forwarded	l by	
	08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was			email/writing the		
				LNHA/HR/DON/Departmental Supervise		
				[Licensed Nursing Home Administrator/H		
				Resource/Director of Nursing] with the re-		
				and preventative measures that have been	put in	
	-	ere Resident #105 resided).		place to protect the resident.		
		assigned to that unit. He		4. Monitor corrective actions		
		ed that he did not say		4. Monitor corrective actions		
	anything to [Resident	-		Administrator/ Designee will conduct an		
	providing care. The s			audit all FRIs weekly for 2 months to		
	-	anded, and the involved CNA was		ensure the facility has completed a	a	
	suspended (on 08/27/2021) and is being			thorough investigation of the alleged		
	terminated as of toda	у."		violation; prevented further abuse,		
	During a face to face interview conducted on			neglect, exploitation and mistreatment		
	During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2 (Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient care and responsibility from one healthcare			from occurring while the investigation		
				was in progress; and took appropriate		
				corrective action, as a result of		
		communication with the		investigation findings. Results of finding		
		e week. The supervisors		will be forward to QAPI for review and		

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD02-0023 HFD02-0023					(X3) DATE SURVEY COMPLETED		
			A. BUILDING	:		С	
		B. WING		09/16/2021			
ME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
RIDGEP	OINT SUBACUTE AND R	EHAB NATIONAL H	RTIN LUTHER	KING JR AVENUE SW			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLE DATE	
L 526	Continued From page	e 146	L 526	recommendations.			
	were made aware that to work on the third fl	at the CNA involved was not oor at all."		The QAPI Committee is responsible going monitoring for compliant			
		nterview conducted on		5. Date correction actio	n completed		
	08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 west because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 east. I was not made aware about the			The facility's date of alleged co September 15, 2021.	-		
	08/30/2021 at 10:50 J was working on 2 Ea because they were sl investigation was res found, so I went to th care of the roommate [Resident #105] state needed assistance as she made a report or any problems. The re wanted me to help he no issues during the J care. I have been doi never done anything any way."	olved and no issues were e unit (3 west). I was taking e (room 333 bed B) when ed that she was wet and s 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) ng this for 17 years. I have to her nor intimidate her in					
	09/08/2021 revealed Name] Employee Wa 07/29/2020. The form received a verbal war written warning on (0 policy/procedure".	n revealed that Employee #5 rning on (07/16/2020) and a 7/20/2020) for "violation of					
	notice was a docume	ously mentioned warning nt written by the (previous) at revealed the following:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD02-0023					(X3) DATE SURVEY COMPLETED	
					С	
		B. WING		09/16/2021		
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	OINT SUBACUTE AND F	4601 MA REHAB NATIONAL H	RTIN LUTHER KING	G JR AVENUE SW		
		WASHIN	IGTON, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	
L 526	Continued From page 147		L 526			
	to the attention of the Wound Care Team in resided on unit 3 east filled incontinence br Ultrasorb (under pad CNA (Employee #5) of the under pads ins [Employee #5] said [wetter" "On the morning of J #105] had a urine sta taped together to for was taped to the resi roommate] was obse makeshift incontinen soaked towel was for legs This is the sec week where [Employ residents in a manne provided by [Employ Type B Offense Ac considered abuse or	ce brief and in addition urine und between the resident's cond occurrence within one /ee #5] provided care to				
	Review of the investi- revealed there was n the facility's staff revi personnel record or i protect all residents i from the potential of mistreatment of a pa physically, mentally o Employee #5's perso	gation notes and documents o documented evidence that iewed Employee #5's implemented measures to including Resident #105, "abuse or neglect, or tient/resident either or verbally." Additionally, onnel record failed to outline as not allowed to work on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD02-0023		(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					с	
		B. WING		09/16/2021		
ME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
RIDGEPO	OINT SUBACUTE AND R	REHAB NATIONAL H	ARTIN LUTHER KING	G JR AVENUE SW		
		WASHIN	NGTON, DC 20032		1	
(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)		
L 526	Continued From page 148		L 526			
	of Human Resources disciplinary actions (t were not mentioned t until a meeting that o termination (of Emplo During a face-to-face approximately 10:30 of Nursing) stated, "I previous allegations (CNA) until the meeti During a face-to-face approximately 10:30 (Administrator) stated previous allegations of	a interview on 09/08/2021 at AM, Employee #1 d, "I was not aware of any or disciplinary actions for the a #5). I did not review his				