STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	223 7TH STREET NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on November 12 through 19, 2020. The facility was found not to in compliance with 42 CFR §483.80 infection control regulations and has implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommend practices to prepare for COVID-19. The resident census was 115. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)	F 000	Our plan of correction should be considered to serve as our allegations of compliance to the cited deficiencies. This plan of correction is being filed as a matter of compliance but should not be construed as an admission to the validity of any of the cited deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Admiral Barr — TITLE: Administrator — (X6) DATE: 01/11/2020

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F 000	Continued From page 1 G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 2 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for five (5) out of eight (8) sampled residents, facility staff failed to update the care plans with person-centered goals and interventions for the residents diagnosed with COVID-19. Residents' #1, #2, #3, #4 and #5. Findings included ...	F 657	**§483.21(b) Comprehensive Care Plans** **Immediate corrective action:** Residents # 1, # 2, #3, #4 and #5 care plans for COVID -19 positive were revised and updated with person-centered goals and interventions on 1/7/2010 **How other residents potentially affected were identified and corrective actions taken:** A review of care plans for residents who tested positive for COVID-19 for the month of December 2020, January 2021 and ongoing will be completed by the clinical team to ensure person centered goals and interventions. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** The unit managers will receive an in- service on Person- centered care plans with appropriate goals and interventions.	

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F 657	Continued From page 3 1. Resident #1 was admitted to the facility on October 30, 2020, with diagnoses that included Ventricular Tachycardia, Chronic Kidney Disease, Thrombocytopenia, Dysphagia, CHF (Congestive Heart Failure) and Respiratory Failure. During a tour of the 6th floor unit on November 12, 2020, Employee #11 (6th floor unit manager) stated , "[Resident name] is off quarantine as of today." A review of the progress note dated November 12, 2020, at 15:02 (3:02 PM) showed, "General Progress note ... Resident removed to isolation as she completed her quarantine period. Remains asymptomatic. Will continue to monitor." A review of the care plan with a revision date of November 2, 2020, showed that facility staff failed to update Resident #1's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19 infection. During a telephone interview conducted on 11/19/2020, at approximately 11:15 AM, Employee #2 (Director of Nursing) acknowledged the findings. 2. Resident #2 was admitted to the facility on November 9, 2020, with diagnoses that included Chronic Respiratory Failure, Anemia, Hypertension, and Encephalopathy. During a tour of the 6th floor unit on November 12, 2020, Employee #11 stated, "[Resident's name] is a new admit on quarantine."	F 657	**How the corrective action will be monitored to ensure the deficient practice will not recur:** Daily huddle will be held to reconcile the residents with COVID-19 status with the nurse's documentation in the chart. Weekly audits will be completed by the unit managers and or supervisors to ensure person-centered care plans are in place for COVID-19 positive residents. QAPI nurse will monitor the process weekly x 4, then monthly x 3 and report findings to the monthly QA meeting. **Include date(s) when the corrective action(s) will be completed:** The facility will be compliant with this corrective action by 1/21/21	

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F 657	Continued From page 4 A review of the admission progress note dated November 9, 2020, at 6:34 PM showed, " ... admitted from [facility name] LTAC (Long-term acute care) to room 6119 at 11:10 PM in stable condition ... Staff educated on infection prevention and maintaining the quarantine for 14 days." A review of the care plan with a revision date of November 11, 2020, showed that facility staff failed to update Resident #2's care plan to show person-centered goals and approaches to address the resident's potential exposure to COVID-19 infection. During a telephone interview conducted on November 19, 2020, at approximately 11:15 AM, Employee #2 (DON) acknowledged the findings. 3. Resident #3 was admitted to the facility on November 10, 2020, with diagnoses that included Chronic Respiratory Failure, Dysphagia, Atrial Fibrillation, Hypertension, Hx (history) of Neoplasm of Bone and Hypothyroidism. During a tour of the 6th floor unit on November 12, 2020, Employee #11 stated, "[Resident's name] is a new admit on quarantine." A review of the Admission progress note dated November 10, 2020, at 22:04 (10:04 PM) showed, " ... transfer from Long-term Acute Care by 2 nurses to Skilled Nursing Facility for continued care ..." A review of the care plan with the revision date of November 11, 2020, showed that facility staff	F 657		

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F 657	Continued From page 5 failed to update Resident #1's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19 infection. During a telephone interview conducted on November 19, 2020, at approximately 11:15 AM, Employee #2 (DON) acknowledged the findings. 4. Resident #4 was admitted to the facility on November 11, 2016, with diagnoses that included Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Asthma, and Dementia. During a tour of 6th floor unit on November 12, 2020, Employee #11 stated, "[Resident's name] is a new admit on quarantine." A review of the progress note dated November 11, 2020, at 21:43 (9:43 PM) showed," Resident from [Facility name] Long-term Acute Care to room 6105 ..." A review of the care plan with a revision date of November 11, 2020, showed that facility staff failed to update Resident #4's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19 infection. During a telephone interview conducted on November 19, 2020, at approximately 11:15 AM, Employee #2 acknowledged the findings. 5. Resident #5 was admitted to the facility on 5/28/2020, with diagnoses that included Type 2	F 657		

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F 657	Continued From page 6 Diabetes Mellitus, Dysphagia, Anxiety and Chronic Respiratory Failure. Review of the document titled, "Infection Control Line Listing 2020", showed that Resident #5 was tested for COVID-19 on 11/9/2020, and a positive result came back on 11/11/2020. Review of the physician's order dated 11/11/2020, showed, "Place patient isolation for COVID 19 X 10 days ... every shift for is Covid pos [COVID positive] until 11/18/2020 at 23:59 (11:59 PM) ..." Review of the care plan dated last revised on 8/18/2020, showed in the, "Focus" section, "Due to the Coronavirus Pandemic [Resident's name] is at risk for developing the virus due to his compromised respiratory status ..." Facility staff failed to revise Resident #5's care plan to include new diagnosis of COVID-19 and specific goals and interventions for monitoring of signs and symptoms. During a telephone interview conducted on 11/13/2020, at approximately 4:00 PM, Employee #5 (4th floor nurse manager) stated, "I update the care plans whenever there is a new problem or event that occurs." Employee #5 acknowledged the findings.	F 657		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		

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F 842	Continued From page 7 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 8 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of eight (8) sampled residents, facility staff failed to document when one (1) resident test positive for COVID-19, the resident vital signs and the date quarantine started/ended; and failed to record the resident's vital signs for one (1) resident who was COVID-19 positive. Residents' #1 and #5. Findings included ... 1. Resident #1 was admitted to the facility on October 30, 2020, with diagnoses that included Ventricular Tachycardia, Chronic Kidney Disease, Thrombocytopenia, CHF (Congestive Heart	F 842	**§483.70(i)(5) Medical records must be contain.** **Immediate corrective action:** Resident #1 and #5 COVID-19 Positive status, vital signs, start and End dates of quarantine was documented on 1/11/21. **How other residents potentially affected were identified and corrective actions taken:** The unit managers and or supervisors will complete an audit from December 2020, January 2021 and ongoing to ensure that all COVID-19 positive residents have their COVID-19 status, vital signs, the start and end date of quarantine documented in their medical records and any deficient practice will be corrected.	

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F 842	Continued From page 9 Failure) and Respiratory Failure. During a tour of 6th floor unit on November 12, 2020, at 10:55AM, Employee #11 (sixth floor unit manager) was queried on Resident #1's COVID-19 status when staff was observed removing the infection precaution signs from the resident's doorShe stated, "[Resident's name] is off quarantine as of today. A review of the progress notes dated October 30, 2020, to November 12, 2020, showed only two notes mentioned below that addressed Resident #1's COVID-19 status and treatment: "November 7, 2020, at 23:52 (11:52 PM) "General Progress note ... Remains COVID positive and fall precaution maintained ..." "November 12, 2020, at 15:02 (3:02 PM) "General Progress note ... Resident removed to [from] isolation as she completed her quarantine period..." During a face-to-face interview conducted on November 12, 2020, at approximately 11:00 AM, Employee #10 (registered nurse) stated, "I have been working with [Resident's name] when she was positive COVID-19. We document on our residents every shift on the "COVID -19 screen- V2 sheet". A review of the "COVID-19 screen- V2" sheet dated from October 30, 2020, through November 12, 2020, showed the following responses to the question and reason for the answer given, "Have you been exposed to anyone positive or being tested for COVID-19?	F 842	**What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** Nursing staff will be educated on the policy and procedure in regards to the required documentation of COVID-19 positive resident, The DON/ADON will audit weekly to ensure that documentation on COVID-19 positive residents include scheduled vital signs, start and end dates of quarantine. **How the corrective action will be monitored to ensure deficient practice will not recur** The QAPI nurse will monitor the Process weekly x 4, then monthly x 3 and report the findings to Monthly QA meeting. **Include date(s) when the corrective action(s) will be completed:** The facility will be compliant with this corrective action by 1/21/21	

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F 842	Continued From page 10 "10/31/2020- 11/4/2020 Day shift nurse documented "No". Evening shift nurse documented "unknown" "11/5 /20 Day, evening and night shift nurses documented "yes" "11/6/ 20 Day shift nurse documented "no". Evening shift nurse documented "yes". Night shift nurse documented, "yes ... MD (medical doctor) called and no new orders; MD already aware. Resident place on isolation" "11/7/20 Day shift nurse documented "yes". Evening shift nurse documented "no" "11/8/20 Day shift nurse documented "no". Evening and night shift nurses documented, "yes ... Resident remains on droplet isolation for SARS-COVID19 at this time" "11/9/20 Day shift nurse documented "yes". Evening shift nurse documented "no" "11/10/20 Dayshift nurse documented "yes" "11/11/20 Day shift nurse documented "yes ... MD called and no new orders MD aware". Evening and night shift nurses documented "no" "11/12/20 Day shift nurse documented "no, Resident remove from Isolation", Evening and night shift nurses documented "no". There was no evidence that facility staff recorded the residents vital signs on the COVID-19 Screen V2 sheet, conveyed when the resident test positive for COVID-19, and failed to record the date to show when the quarantine started/ended. During a face-to-face interview conducted on November 13, 2020, at approximately 11:15 AM, Employee #4 (DON) acknowledged the findings. 2. Resident #5 was admitted to the facility on 5/28/2020, with diagnoses that included Type 2	F 842		

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F 842	Continued From page 11 Diabetes Mellitus, Dysphagia, Anxiety, Metabolic Encephalopathy and Chronic Respiratory Failure. Review of the facility's policy document titled, "Notice of Quarantine" showed, " ... Monitor the patient/residents' temperature at least twice per shift in the EMR (electronic medical record) ..." Review of the care plan dated 9/3/2020, showed the following "Interventions"; "Complete vital signs Q (every) shift and report any temperature above 100 [degrees Fahrenheit] to the Physician," "Staff will complete the COVID assessment Q shift until further notice." Review of the physician's order dated 11/11/2020, showed, "Place patient isolation for Covid-19 x 10 days ... every shift for is [COVID positive] until 11/18/2020 at 23:59 (11:59 PM)- Start date 11/11/2020 at 0700 [AM]." Review of the vital signs record showed the following documentation: On 11/11/2020, no documentation that staff monitored Resident #5's temperature or oxygen saturation. On 11/12/2020, there was documentation that facility staff monitored Resident #5's temperature and his oxygen saturation was documented only once at 9:03 AM. Facility staff failed to document vital signs as	F 842		

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F 842	Continued From page 12 directed by the facility's policy and in the care plan for Resident #5 who was diagnosed with COVID-19. During a telephone interview conducted on 11/13/2020, at approximately 4:00 PM, Employee #5 (4th floor unit manager) stated, "Vital signs are supposed to be done every shift. Sometimes it's every four (4) hours but at the minimum it is once a shift." Employee #5 acknowledged the findings.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		

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BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	223 7TH STREET NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	11/19/2020

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F 880	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, facility staff failed to wear required personal protective equipment (PPE) while in a resident care area; and to maintain infection control precautions while walking in the hallway. Findings included ... 1. Facility staff failed to wear required personal protective equipment (PPE) while in a resident care area. Review of the Facility document entitled, "Guidelines for PPE (personal protective equipment) Usage" dated 8/31/2020, showed, " ... Face shields or goggles are to be worn in all patient care areas." During a tour of the 4th floor on 11/12/2020, at approximately 10:30 AM, Employee #6 (housekeeper) was observed in the hallway not wearing a face shield or goggles. The evidence showed a Facility housekeeping staff on observation was not wearing the required PPE (face shield or goggles) while in a resident care area (the unit Hallway). During a face-to-face interview at approximately 10:30 AM, Employee #6 stated, "I was just looking for something." Employee #6 acknowledged the findings. 2. Facility staff failed to maintain Infection Control	F 880	**Infection Prevention & Control** **CFR(S): 483.80(a)(1)(2)(4)(e)(f)** **Immediate corrective action:** The EVS employee no longer works in the building. The CNA received education on the requirement for PPE in resident care areas **How other residents potentially affected were identified and corrective actions taken:** All staff will receive an in service on the policy regarding requirement of wearing PPE in resident care areas **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** Department heads will complete daily rounds 3x a week to re-enforce and identify any staff not following facility protocol with regards to required PPE while in resident care areas.	

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F 880	Continued From page 15 Precautions while walking in the hallway. According to Centers for Medicare & Medicaid Services, "Appropriate use of personal protective equipment includes... PPE appropriately discarded after resident care prior to leaving room followed by hand hygiene..." https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes During a tour of the 5th floor nursing unit on 11/12/20, at approximately 10:00 AM, Employee #9 (certified nursing assistant) was observed walking in the hallway wearing gloves, a yellow gown, a mask and a face shield. Continued observation revealed Employee #9 touching a hoyer lift and the nurse's station with her gloved hands. During a face-to-face interview on 11/12/20, at approximately 10:10 AM, Employee #9 stated that she was wearing the gloves and gown in the hallway because she needed to get the hoyer lift for a resident. The evidence showed observation of a certified nursing assistant that failed to maintain Infection Control Precautions when she was observed wearing gloves and yellow gown in the hallway, she then touched surfaces of a hoyer lift and the nursing station. During a telephone interview conducted on11/13/20, at 3:00 PM, Employee #4 (Director of Nursing, DON) acknowledged the findings and stated that it is the facility's practice and protocol that staff do not wear gloves and gowns in	F 880	**How the corrective action will be monitored to ensure the deficient practice will not recur:** The Infection Control Preventionist will monitor the process weekly x 4, then monthly x 3 and report findings to Infection Control Committee. **Include date(s) when the corrective action(s) will be completed:** The facility will be compliant with This corrective action by 1/21/21	

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F 880	Continued From page 16 hallways.	F 880		