Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	11/19/2020

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

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L 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) G-tube Gastrostomy tube HR- Hour	L 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.	

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L 000	Continued From page 1 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	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

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L 051	Continued From page 2 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents . This Statute is not met as evidenced by: A. Based on record reviews and staff interviews for five (5) out of eight (8) sampled residents, the charge nurse 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 ... 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.	L 051	**L 051** **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 1/7/2021 **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 December 2020, January 2021 and ongoing will be completed by the clinical team to ensure person –centered goals and interventions are in place and correct any deficient practice.	

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L 051	Continued From page 3 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 the charge nurse 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 onNovember 19, 2020, at approximately 11:15 AM, Employee #2 (Director of Nursing, DON) 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." 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	L 051	**What measures will be put into place or what system changes you will make to ensure that the deficient does not recur:** Interdisciplinary team will receive an in- service on person centered care plans with appropriate goals and interventions. **How the corrective action will be monitored to ensure the deficient practice will not recur:** Weekly audits will be completed by the unit managers and or supervisors to ensure person-centered care plans are in place for for COVID-19 positive residents. A daily huddle will be held to reconcile the COVID-19 positive resident status with the nurse's documentation in the chart. The QAPI nurse will monitor the process weekly x 4, then monthly x 3 and report findings to monthly QA meeting	

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L 051	Continued From page 4 November 11, 2020, showed that the charge nurse failed to update Resident #2'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. 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 LTAC by 2 nurses to SNF for continued care ..." A review of the care plan with a revision date of November 11, 2020, showed that the charge nurse 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,	L 051	**Include date(s) when corrective action(s) Will be completed.** The facility will be compliant with this corrective action by 1/21/21	

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L 051	Continued From page 5 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 with a revision date of November 11, 2020, at 21:43 (9:43 PM) showed," Resident from [Facility name] LTACH to room 6105 ..." A review of the care plan dated November 11, 2020, showed that the charge nurse 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 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 [positive] until 11/18/2020 23:59 (11:59 PM) ..." Review of the care plan last revised on date 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	L 051		

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L 051	Continued From page 6 compromised respiratory status ..." The charge nurse 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. B. Based on record review and staff interview for two (2) of eight (8) sampled residents, the charge nurse 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 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	L 051		

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L 051	Continued From page 7 resident's door. She 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? "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)	L 051		

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L 051	Continued From page 8 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 the charge nurse 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 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) ..."	L 051		

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L 051	Continued From page 9 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 the charge nurse monitored Resident #5's temperature and his oxygen saturation was documented only once at 9:03 AM. The charge nurse failed to document vital signs as 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	L 051		

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L 051	Continued From page 10 a shift." Employee #5 acknowledged the findings.	L 051		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute 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	L 091	**L 091** **Immediate corrective action:** The EVS employee no longer works in In the building. The CNA received education on the requirement for PPE in resident care areas **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** No other staff was observed in violation to this deficient practice	

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L 091	Continued From page 11 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 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,	L 091	**How the corrective action will be monitored to ensure the deficient practice will not recur:** All staff will receive an in service on the policy regarding requirement for wearing PPE while in resident care area. 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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L 091	Continued From page 12 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 hallways.	L 091	The Infection Control Preventionist will monitor the process weekly x4 then monthly x3 and report findings to the Infection Control Committee. **Include date(s) when corrective action(s) will be completed** The facility will be compliant with this corrective action by 1/21/21	