STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	**4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted at this facility from July 5 - 18, 2023. Survey activities consisted of observations, record review, and resident and staff interviews. The facility's census during the survey was 115 and the sample included 45 residents. The following complaints were investigated during this survey: DC~10476, DC~10676, and DC~11802. The following facility-reported incidents were investigated during this survey: DC~10444, DC~11675, DC~11734, and DC~11750 After analysis of the findings, it was determined that the facility was not in compliance with the requirements 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia	F 000	**F 000**- Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	09/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Samaria Washington, DHA, LNHA Interim Administrator 08/29/2023

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F 000	Continued From page 1	F 000		

DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic

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F 000	Continued From page 2 Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	F 584 1. **Corrective action for resident** The facility will correct or replace the privacy curtains in rooms 301, 302, 304, 311, 321, 324, 330, 331, 332, 333, 334, 336, 337, 338, 340, 341, 343, 344, 213, 217, 220, 221, 224, 252, 257, 258, 259, 152, 157, and 158 by September 18, 2023. **2. Identify other residents** All residents could be affected. All other resident rooms will be audited by The Director of Environmental Services and/or designee by September 18, 2023, to ensure that the privacy curtains are hung properly and not torn. Any deficiencies will be corrected. **3. Systemic changes** The Director of Environmental Services will provide education to	

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F 584	Continued From page 3 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by loose, torn, privacy curtains in 30 of 75 resident's rooms. The findings include: During an environmental walkthrough of the facility on July 10, 2023, between 10:00 AM and 4:00 PM, privacy curtains were torn or separated from curtain tracks in 30 of 75 resident's rooms. Unit 3 East: Six (6) of 24 resident rooms (#301, #302, #304, #311, #321, #324).	F 584	The EVS staff on ensuring that privacy curtains are hung properly and are not torn. **4. Monitor corrective actions** The Director of Environmental Services and/or designee will audit all resident rooms monthly x 3 months to ensure that the privacy curtains are hung properly and are not torn. Any privacy curtains that are not hung properly or torn, will be corrected and/or replaced. All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 584	Continued From page 4 Unit 3 West: (12) of 15 resident's rooms (#330, #331, #332, #333, #334, #336, #337, #338, #340, #341, #343, #344). Unit 2 East: Five (5) of 20 resident's rooms (#213, #217, #220, #221, #224). Unit 2 South: Four (4) of eight (8) resident's rooms (#252, #257, #258, #259). Unit 1 South: Three (3) of eight (8) resident's rooms (#152, #157, #158). These findings were acknowledged by Employee # 27 during a face-to-face interview on July 10, 2023, at approximately 3:00 PM.	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610	**F 610** 1. **Corrective action for resident** Resident #83's investigation findings were completed timely; however, the results were not sent to DOH until 03/31/23. The resident did not suffer any adverse effects from the delay in reporting the findings. 2. **Identify other residents** All residents involved in self-reports could be affected. Self-reports completed 30 days prior to the survey will be audited by the Administrator to ensure that they were completed, and the findings reported to DOH within 5 business days. Any deficiencies will be corrected.	

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F 610	Continued From page 5 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for 1 (one) of 45 sampled residents, the facility staff failed to report the results of its investigation regarding a Resident's injury of unknown origin to the State Survey Agency within 5 (five) working days of the incident. Resident #83. The findings included: Resident # 83 was admitted to the facility on 05/04/22 with diagnoses including Unspecified Dementia, Hypertension, Cognitive Communication Deficit, Age-related Physical Debility, Weakness, Fracture of the Right Femur, and Unspecified Fall. A review of Resident #83's medical record revealed an Admission Minimum Data Set (MDS) Assessment dated 05/11/22 documenting the following: the Resident had a Brief Interview for Mental Status (BIMS) score of "03," indicating the Resident had severely impaired cognition, required extensive assistance for bed mobility, transfers, dressings, toilet use, and personal hygiene, required limited assistance for eating, was totally dependent on staff for bathing and was always incontinent for urine and bowel. A care plan initiated on 08/25/22 documented: "[Resident #83] is on anticoagulant therapy related to post-surgical. Goal [Resident's #83] will be free from discomfort or adverse reactions related to anticoagulant use... Interventions" ...Monitor, document, report PRN (as needed) adverse reactions of anticoagulant therapy... bruising..."	F 610	**3. Systemic changes** The Administrator will in-service the DON on incident reporting Requirements and ensuring that findings are reported to DOH within 5 business days. The Administrator will review all self-reports to ensure compliance. Any deficiencies will be corrected. **4. Monitor corrective actions** The Administrator will audit all self-reports weekly x 3 months to ensure that all findings are reported to DOH within 5 business days. All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. Any deficiencies will be corrected. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 610	Continued From page 6	F 610		

A physician's order dated 09/28/22 documented: "Aspirin tablet chewable 81 milligrams give one tablet by mouth one time a day for DVT deep vein thrombosis prophylaxis."

A Facility Reported Incident (FRI), DC00011675, dated 02/16//23 at 9:23 PM documented the following: " ...Incident Date: 2/16/2023, Time: 1500, Injury of Unknown Origin-Resident observed with hematoma with [a] bruise on right inner hip measuring 2x2 cm,(centimeters) skin prep applied, no complain(t) of pain voice(d), no elevated temp(temperature). The Resident is on [an] anticoagulant (blood thinner) to prevent [a] DVT (deep vein thrombosis). Actions: Investigation initiated, Daughter in room with Resident and was made aware. Nurse Practitioner notified."

A facility report submitted to the State agency on 03/31/23 at 3:44 PM (31 working days after the incident) documented: "... Resubmitting final report: injury of known-origin-02/16/23-Time 1500. Outcome: Unsubstantiated ...Actions: Investigation initiated and completed. RP (representative) was made aware of the outcome. Nurse Practitioner was notified, and the provider advised that the Resident is on Aspirin 81 Mg (milligrams) and the side effect is bruising. The provider stated she would not discontinue the aspirin because of the Resident's age, and it is an expected side effect that is not dangerous to the Resident's life. An X-ray order was obtained and completed. X-ray result shows no fracture. Family (RP) (Representative) ...made aware of the discussion with the provider, and the nurse also discussed the x-ray results with RP. They voiced understanding, thankful of the X-Ray (was) done

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F 610	Continued From page 7 and the result." A review of a memo dated 04/03/23 at 6:20 PM from the facility's former Director of Nursing stated: "Good evening. This is to let you know that I am unable to find the whole incident folder, which is very strange. All documents are missing, including the staff statements, schedule, unit assignments, Department of Health report (initial and final), face sheet, X-ray results, provider notes, risk management report, etc. I have searched my office as well as the Administrator's office to no avail. This incident was completed and discussed with the former administrator. The writer discussed with the family (Resident's grandson, daughter, and granddaughter) parentheses the outcome of the investigation. I am trying to trace my steps back to the last time I had the folder, but it has [a]been long.[time].." Further review of Reisdent #83's medical record and review of the facility's investigation documents lacked documented evidence that the facility submitted the results of its investigation to the State agency within 5 (five) working days. During a face-to-face interview on 07/12/23 at approximately 12:30 PM, Employee #1 (Administrator) admitted that the facility could not provide documented evidence that facility staff reported the investigation results to the State agency within five (5) working days after the incident.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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F 623	Continued From page 8 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623	**F 623** 1. **Corrective action for resident** Resident #84's representative and Ombudsman's office were given more detailed information on why the resident was transferred to the hospital on 08/02/2023. 2. **Identify other residents** All residents transferred to the hospital could be affected. All 6-108's completed within 30 days prior to the survey will be audited by the Director of Social Services to ensure that they include detailed information on why the resident was transferred to the hospital. 3. **Systemic changes** The Director of Social Services will in-service the social service team on accurate completion of the 6-108 form. The Director of Social Services will review all completed 6108's for accuracy weekly. Any deficiencies will be corrected. 4. **Monitor corrective actions** The Director of Social Services and/or designee will audit 6-108's weekly x 3 months to ensure that they include detailed reasons for transfer.	09/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 9 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623	All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. Any deficiencies will be corrected. **4. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 10	F 623		

as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews for 1 (one) of 45 sampled residents, the facility staff failed to notify the Resident, the Resident's representative(s), and the Office of the State Long-Term Care Ombudsman of the reason for a resident's transfer to the hospital (in detail), before the Resident's transfer. Resident #84.

The findings included:

Resident #84 was admitted to the facility on 05/06/22 with the following diagnoses: Acute Infarction of the Spinal Cord, Acute and Chronic Respiratory Failure, Type 2 Diabetes, Chronic Kidney Disease, Dysphagia, Dependence on Respirator, Gastrostomy and Tracheostomy.

A review of Resident #84's medical record revealed:

A Quarterly Minimum Data Set (MDS) dated 05/13/23 documented that the Resident had a Brief Interview for Mental Status (BIMS) summary score of "7," indicating that the Resident required

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F 623	Continued From page 11	F 623		09/1/23

moderately impaired cognition. In addition, facility staff coded that the Resident required extensive assistance for most ADLs (grooming, personal hygiene), had received antibiotics for 6 out of 7 days prior to the assessment, was always incontinent of urine and bowel, and had one Stage 2 pressure ulcer.

A Situational, Background, Assessment, and Recommendation (SBAR) Note dated 07/08/23 at 4:27 PM, documented " ...change in condition nurse practitioner parentheses in NP (Nurse Practitioner) in house reviewed resident labs order given to send the resident to LTAC (long-term acute care hospital) for blood transfusion for anemia hemoglobin 6.5."

A physician's order dated 07/08/23 documented: "Transferred to LTAC for blood transfusion one time only for anemia hemoglobin 6.5."

A Department of Health "Notice of Discharge/Transfer or Relocation" form dated 07/10/23 at 10:55 AM documented the specific reason for transfer, "Resident was transferred out to the hospital.". In addition, the Resident transferred to the hospital on 07/08/23, and the notice of transfer was sent on 07/10/23 (2 days after the Resident's transfer).

During a face-to-face interview on 07/14/23 at 02:57 PM, Employee #4 (Social Worker) acknowledged that facility staff should have noted the specific reason for the transfer as a "change in condition, and should have provided the notification before the Resident's transfer to LTAC on 07/08/23. The Employee stated that she would provide an in-service with the staff assisting her in completing the "Notification of Discharge

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 12 /Transfer or Relocation, Form." She then said she would correct and resend the form to the Resident's representative and the Ombudsman.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews for two (2) of 45 sampled residents, the facility staff	F 625	**F 625** 1. **Corrective action for resident** Resident #84's representative and Ombudsman's office were given an updated 6-108 with bed hold days and bed hold policy on 08/02/2023. Resident #97's representative and Ombudsman's office were given an updated 6-108s with bed hold days and bed hold policy on 08/02/2023. 2. **Identify other residents** All residents transferred to the hospital could be affected. All 6-108's completed within 30 days prior to the survey will be audited by the Director of Social Services to ensure that they include detailed information on why the resident was transferred to the hospital. 3. **Systemic changes** The Director of Social Services will in-service the social service team on accurate completion of the 6-108 form. The Director of Social Services will review all completed 6-108s for accuracy weekly. Any deficiencies will be corrected.	

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F 625	Continued From page 13 failed to provide bed hold notices that included the number of bed hold days and/or the facility's bed hold policy to residents or their representatives at or before the residents' transfers to the hospital. Residents #84 and #97. The findings included: 1. Resident #84 was admitted to the facility on 05/06/22 with the following diagnosis Acute Infarction of Spinal Cord, Acute And Chronic Respiratory Failure, Type 2 Diabetes Cardiogenic Shock Chronic Kidney Disease, Dysphasia, Dependence on a Respirator, Gastrostomy and Tracheostomy. A review of Resident #84's medical record revealed a face sheet that documented that the Resident had a representative. A Quarterly Minimum Data Set (MDS) assessment dated 05/13/23 documented that the Resident had a brief interview for a mental status summary score of 7, indicating moderately impaired cognition, required extensive assistance for most ADLs had received antibiotics for 6 out of 7 days before the assessment was always incontinent of bow and bladder, had one stage 2 pressure ulcer. A Situational, Background, Assessment, and Recommendation (SBAR) note dated 07/08/23 at 4:27 PM documented " ...change in condition nurse practitioner (NP) in house reviewed resident labs order given to send the resident to LTAC (long-term acute care hospital) for blood transfusion for anemia hemoglobin 6.5 ..." A physician's order dated 07/08/23 documented:	F 625	**4. Monitor corrective actions** The Director of Social Services and/ or designee will audit 6-108's weekly x 3 months to ensure that they include detailed reasons for transfer. Any deficiencies will be corrected. All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 625	Continued From page 14 "Transferred to LTAC for blood transfusion one time only for anemia hemoglobin 6.5." A Department of Health, "Notice of Discharge/Transfer or Relocation, Form," dated 07/10/23 documented: " ...You are scheduled to be discharged, transferred or relocated on or by (date): July 08, 2023 ...Your number of bed hold days is: Resident transferred out to the Hospital ..." Further review of Resident #84's medical record lacked documented evidence that the facility notified the Resident or the representative of the correct number of bed hold days before the Resident's transfer to the hospital on 07/08/23. 2. Resident #97 was admitted to the facility on 01/11/23 with diagnoses including: Traumatic Subdural Hemorrhage with Loss of Consciousness Greater than 24 hours, Protein-calorie malnutrition, Pressure Ulcer of Sacral Region Stage 4, Unspecified Dementia, Dysphasia, Gastrostomy, Fluid Overload, and Dependence on supplemental oxygen. A review of Resident #97's medical record revealed a face sheet that documented that the Resident had a representative. A review of a Discharge Minimum Data Set assessment dated 06/21/23 that documented: the Resident had severely impaired cognition, was totally dependent on staff for transfers, dressing, eating, toilet use, personal hygiene, and bathing, required extensive assistance from staff for bed mobility, was always incontinent for bowel, had received anticoagulants, antibiotics, diuretics, and opioids within seven (7) days of the assessment.	F 625		

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F 625	Continued From page 15 In addition, the MDS documented that the Resident had multiple pressure ulcers that included: one (1) unhealed pressure ulcer, one (1) Stage 2 pressure ulcer, two (2) Stage 3 pressure ulcers, four (4) Stage 4 pressure ulcers and had three (3) unstageable pressure ulcers. A physician's order dated 06/21/23 documented: "Transfer resident to hospital r/t (related to) foot infection via non-emergency transportation." A Nurse's Progress Note dated 06/21/23 at 3:58 PM, documented: "...NP ([Name of Nurse Practitioner] assess(ed) resident and order given to transfer resident to [Name of Local Hospital] for evaluation via non-Emergency transportation for right wound infection ..." A Department of Health, "Notice of Discharge/Transfer or Relocation, Form," dated 07/10/23 at 11:33 AM, documented: " ...You are scheduled to be discharged, transferred or relocated on or by (date): July 09, 2023 ...If you are being transferred to a hospital or the transfer is for therapeutic leave, attached is the facility's bed hold policy. Your available number of bed hold days is n/a (not applicable)." Of note, the Resident transferred to the hospital on 06/21/23, and the number of bed hold days was sent to the Resident's representative on 07/10/23 (19 days after the Resident's transfer). In addition, there was no bed hold policy attached to the notice. During a face-to-face interview on 07/14/23 at 02:57 PM, Employee #4 acknowledged that facility staff failed to send the bed hold notices for Residents #84 and #97 to the residents' representatives before the Residents' transfers to the hospital and failed to document the number of	F 625		

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F 625	Continued From page 16 bed hold days accurately for both residents. In addition, the Employee acknowledged that facility staff did not attach a bed hold policy to the notification form for Resident #97. The Employee then stated that she would provide an in-service with the staff person assisting with completing the bed hold notices, and she would correct the forms for Residents #84 and #97. [Cross-reference 22B DCMR 3270.1]	F 625	**F 641** **1. Corrective action for resident** MDS Assessment for resident #107 was modified on 7/12/23 to correct the inaccurate coding for Resident having pressure ulcer on admission.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to ensure a resident's Significant Change MDS (Minimum Data Set) contained accurate information related to skin condition for one (1) of 45 sampled residents. (Resident #107) The findings included: Resident #107 was re-admitted to the facility on 03/06/23 with multiple diagnoses including Anoxic Brain, Acute Respiratory Failure, Weakness, and Type 1 Diabetes. A review of an admission nursing progress note dated 03/07/23 at 2:28 AM, "Resident is ...admitted from [Name of hospital] ...Resident is alert, non-verbal. Skin warm and dry to touch ...Skin color is normal, no cyanosis noted. Cap	F 641	**2. Identify other residents** All residents could be affected. All residents admitted/re-admitted from June 1st to date will be reviewed by the Director of Reimbursement and/or designee for proper MDS coding of presence of pressure ulcer on admissions/re-admission. MDS modification will be made as needed. **3. Systemic changes** MDS Department will be in-serviced by the Director of Reimbursement on how to code pressure ulcers that were present on admission/re-admission	

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F 641	Continued From page 17 [capillary] refills is less than 3 sec. [seconds]. Skin in non-tenting ..." A review of an admission wound team note dated 03/10/23 at 3:03 PM documented, "At risk for pressure ulcers/skin breakdown given immobility, dependence on oxygen, malnutrition/ dependence on TF (tube feeding), incontinence, and anoxic brain injury. No open wounds on today's skin assessment ..." A review of an Admission MDS dated 03/12/23 revealed Resident #107 had severe cognitive impairment and memory problems for both short and long-term memory. The resident was coded as being at risk for pressure ulcers. Furthermore, the resident was not coded as having pressure ulcers. A review of a Significant Change MDS dated 04/12/23, revealed Resident #107 had severe cognitive impairment and memory problems for both short and long-term memory. Additionally, the resident was coded as being at risk for pressure ulcers, having two Stage 2 pressure ulcers on admission, one Stage 4 pressure ulcer on admission, and one Unstageable pressure ulcer on admission. During a face-to face interview on 07/12/23 at 4:00 PM, Employee #18 (MDS Coordinator) stated that the Significant Change MDS dated 04/12/23 was inaccurately coded for Resident #107 having pressure ulcers on admission.	F 641	based on the RAI Manual by August 29, 2023. **4. Monitor corrective actions** Director of Reimbursement and/or designee will audit all admission/re-admission for appropriate coding of pressure ulcers that were present on admission/re-admission Monthly x 3 months. Any deficiencies will be corrected. All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 18 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	**F 656** **1. Corrective action for resident** Resident #111 care plan for mittens was completed on 7/25/23. Resident #105 care plan was reviewed/ revised for unplanned weight loss on 07/18/23. Resident #111 care plan for ventilator and trach use was reviewed and updated on 7/25/23. **2. Identify other residents** All residents have the potential to be affected. All current residents that have orders for mittens, use ventilators and/or trachs, unplanned weight loss greater than 5% within 30 days, use of 9 or more medications, and use of anticoagulants will be audited by the Unit Managers to ensure that they have comprehensive resident centered care plans with goals and interventions to address mittens, use ventilators and/or trachs, unplanned weight loss greater than 5% within 30 days, use of 9 or more medications, and use of anticoagulants issues. Any deficiencies will be corrected.	

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F 656	Continued From page 19 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility's staff failed to develop a resident's comprehensive person-centered care plan with goals and interventions to address a resident's unplanned weight loss of 11 percent in 30-Days, a resident use of a Ventilator/Trach, and a resident use of hand mittens, use of anticoagulant (Warfarin) and use of nine (9) or more medications for three (3) of 45 sampled residents. (Resident #105, #109 and #111). The findings included: 1. Facility staff failed to develop a comprehensive person-centered care plan with goals and interventions to address Resident #105 unplanned weight loss of 11 percent in 30-Days. Resident #105 was admitted to the facility on 01/23/23 with multiple diagnoses including Protein-Calorie Malnutrition, Dysphagia, Percutaneous Endoscopic Gastrostomy, Gastro-Esophageal Reflux Disease, Multiple Sclerosis, and Quadriplegic. A review of the facility's Weight Assessment and Intervention policy dated 12/01/22 documented, "Care Planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or the	F 656	**3. Systemic changes** Staff educator and/or Designee will educate all license nurses on completing comprehensive resident centered care plans with goals and interventions to address all residents with mittens, use ventilators and/or trachs, unplanned weight loss greater than 5% within 30 days (Dietician), use of 9 or more medications, and use of anticoagulants. **4. Monitor corrective actions** Unit Managers and/or designees will audit care plans for residents with mittens, use ventilators and/or trachs, unplanned weight loss greater than 5%, use 9 or more medications, and use of anticoagulants monthly x 3 months. Any deficiencies will be corrected. All findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 656	Continued From page 20	F 656		

resident's surrogate. Individualized care plans shall address to the extent possible: The identified causes of weight loss; Goals and benchmarks for improvement; and Time frames and parameters for monitoring and reassessment."

A review of a physician order dated 01/24/23 instructed, "Jevity [enteral feeding] 1.5 at 50 ml/hr (milliliters/hour) via G-tube (gastrostomy tube) X 24 hours."

A review of a physician order dated 01/30/23 instructed, "Juven [supplement] two times a day ..."

A review of a nutritional progress note dated 01/30/23 at 3:15 PM documented, "Current TF (tube feeding) order: Jevity 1.5 at 50 ml/hr X 24 hours, [water] flush 161 ml Q4H (every four hours) ...Provides: 1800 cal (calorie), 77 g (gram) port (protein) ... CBW (current body weight) 104.6 [pounds] ...Goal - maintain weight ..."

A review of a physician order dated 02/12/23 instructed, "Active Liquid Protein [supplement] three-times-a-day via GT."

A review of a nutritional progress note dated 02/18/23 at 9:13 AM documented, "Current TF order: Jevity 1.5 at 50 ml/hr X 24 hr via GT (gastrostomy tube) ...Current weight 107 [pounds] ...BMI (body Mass Index) 16.8 underweight ..."

A review of the weight log revealed Resident #105 weighted 105.6 [pounds] on 03/09/23.

A review of a physician order dated 04/03/23

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F 656	Continued From page 21 instructed Vital HP [enteral feeding] at 60 ml/hr X 24 hr via GT." A review of a nutritional progress note dated 04/23/23 at 4:19 PM documented, "Current weight 93.8 [pounds] ...Severe malnutrition related to chronic illness and multiple wounds requiring higher energy needs as evidenced by moderate to severe muscle/fat wasting noted, ~11 % unintentional body weight loss in 1-month Current BW 87.1 [pounds] ... Resident triggering for weight loss ...not desired ..." A review of a Quarterly Minimum Data Set dated 04/28/23 revealed the "Resident #105 did not have a Brief Interview for Mental Status summary score indicating the resident was not able to be tested. In addition, the resident was coded for weighting 938 [93.8] pounds and losing 5% or more weight in the last month ..." A review of the resident's comprehensive care plans lacked documented evidence the facility revised the care plan to include goals and interventions to address Resident #105's unplanned weight loss. During a face-to-face interview on 07/18/23 at 10:45 AM, Employee #19 (RN/Interim Unit Manager) reviewed the resident's care plans and stated that he did not see a care plan to address the resident's unplanned weight loss. Cross refrence 22-B DCMR sec. 3210.4 2. Facility staff failed to develop a person-centered comprehensive care plan failed to outline goals and interventions to address	F 656		

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F 656	Continued From page 22 Resident #109's use of a Ventilator/Trach Resident #109 was admitted to the facility on 03/14/2023 with multiple diagnoses that included Cerebral infarction, Congestive Heart Failure, Hypertensive Heart Disease, and Dependence on Respirator ventilator, A review of the physician order dated 3/27/2023 7:00PM instructed, "Monitor area under trach mask for signs of discoloration\edema\redness every shift every shift". A review of the physician order dated 3/27/2023 at 7:00PM instructed, "Initiate Ventilator Weaning per protocol?:_yes_every day and night shift: Vent Mode: _AC____Rate:_12___TV:_390___ Peep 5 FIO2:_30____% Type of Trach: __Tracoe_____Trach Size:___8.0_____ A review of the physician order dated 3/27/2023 at 22:00 instructed, ""Trach care BID (twice a day) and PRN (as needed) for Airway management". Review of a Quarterly Minimum Data Set (MDS) dated 06/20/2023 showed that facility staff coded Resident #109 under section C (Cognitive Patterns) C1000 "3" indicating cognitively severely impaired. Section I Active Diagnoses I8000G Dependence on Respirator [ventilator] status ICD Z99.11, Section O (special treatment, procedures, and programs), facility staff coded the resident while a resident under O0100 respiratory treatments Oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator box was checked indicating that all treatment mentioned was being performed for the resident.	F 656		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 During the duration of the survey (07/05/2023 - 07/18/2023) Resident #109 was observed to be Dependent on a Ventilator for respiratory support. A review of General progress note 7/08/2023 at 2:08PM documented, "Resident alert and responsive, but nonverbal, was on trach collar during the shift with no acute respiratory distress ... suction as needed ... aspiration precaution maintained with HOB elevated at 30 degrees ... " A review of General progress note 07/10/2023 at 6:26PM documented, "Resident alert and responsive with no acute respiratory distress. ... Breathing even with no labor. ... HOB elevated to 45 degrees for aspiration precautions. ... Dependent on Ventilator for respiratory support, suction as needed ..." A Review of Resident #109's Care Plan failed to outline goals and interventions to address Resident #109's trach/ vent airway management. During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #19 (3East Nurse Manager) acknowledged the findings and stated the care plan will updated to include the resident's use of a Ventilator/Trach. 3A. Facility staff failed to develop a person-centered comprehensive care plan failed to outline goals and interventions to address Resident #111's use of hand mittens. Resident #111 was admitted to the facility on 03/17/2023. The resident had a history of multiple including Chronic Respiratory Failure,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 656	Continued From page 24 Dependence on Respirator (Ventilator Status), Dementia, and Anxiety. A review of a physician order dated 3/18/2023 at 7AM instructed, "Apply Hand mittens. Remove every 2 hours to check for circulation every shift for prevent self-decannulation every shift". A review of the physician order dated 3/18/2023 at 10 AM instructed, "Mittens: Pt (patient) with both hands mittens due to pulling of medical equipment's. Take off mittens q2 hours and monitor for circulations and reapply two times a day for hand mittens". Review of an Admission Minimum Data Set (MDS) dated 05/11/2023 showed that facility staff coded Resident #111 under section C (Cognitive Patterns) C1000 "3" indicating cognitively severely impaired. Section P (Physical restraint), Limb Restraint "2" Used Daily box was checked indicating that all treatment mentioned was being performed for the resident. A review Resident #111's care plan failed to outline goals and interventions to address Resident #111's use of hand mittens. During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #19 (3East Nurse Manager) acknowledged the findings and stated the care plan will updated to include the resident's use of hand nittens. 3B. Facility staff failed to develop a person-centered comprehensive care plan outline goals and interventions to address Resident #111's use of Warfarin (anti-coagulant) .	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 656	Continued From page 25 Resident #111 was admitted to the facility on 03/17/2023 with multiple diagnoses that included Hyperlipidemia, Heart Failure and Congestive Heart Failure. Review of an Admission Minimum Data Set (MDS) dated 05/11/2023 showed that facility staff coded Resident #111 under section C (Cognitive Patterns) C1000 "3" indicating cognitively severely impaired. Section N (Medication), N0410 (Medication Received) E Anticoagulant (eg, Warfarin, heparin, or low-molecular-weight heparin) coded "3" box was checked indicating that resident mentioned received anticoagulant medication. A review of the physician's order dated 06/25/2023 instructed, "Warfarin [anticoagulant] Tablet 4 mg (milligrams) give via G-tube in the evening for treating/preventing blood clots." A review Resident #111's care plan failed to outline goals and interventions to address Resident #111's use of Warfarin. During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #19 (3East Nurse Manager) acknowledged the findings and stated the care plan will be updated to include Resident #111's use of Warfrin.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657	**F 657** **1. Corrective action for resident** Resident #111 care plan has been reviewed and updated on 7/25/23 to ensure goals are comprehensive and interventions are related to the use of a ventilator use and treatments are related to ventilator use and maintenance.	

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F 657	Continued From page 26 (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 observation, record review and interviews for one (1) of 45 sampled residents, facility staff failed to update the person center comprehensive care plan with goals and approaches to address Resident #111's use of vent/trach. Findings included: Resident #111 was admitted to the facility on 03/17/2023. The resident had a history of multiple including Chronic Respiratory Failure, Dependence on Respirator (Ventilator Status), Dementia, and Anxiety.	F 657	**2. Identify other residents** All residents with ventilators/trachs could be affected. An audit of care plans for all current residents with a ventilator/trachs will be conducted by the Director of Respiratory and/or designee to ensure goals and interventions are related to the use of a ventilator/ trach for respiratory support, and treatments are related to ventilator use and maintenance. Any deficiencies will be corrected. **3. Systemic changes** The Director of Respiratory and/or designee will educate all Respiratory Therapists on updating care plans to ensure goals and interventions are related to the use of a ventilator/trach. **4. Monitor corrective actions** Monthly audits of care plans for residents with ventilators/trachs will be conducted by the Director of Respiratory and/or designee for 3-months to ensure goals are appropriate for those residents on ventilators. Any deficiencies will be corrected.	

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F 657	Continued From page 27 A review of Resident #111's comprehensive care plan showed a focus area stating, "[Resident #111] has ADL self-care performance deficit related disease process of respiratory failure, bed bound, and vent dependent..." The care plan was initiated on 05/06/2023 with the following goals and interventions: "Goals: The resident will maintain the current level of function; Interventions: Bedfast- The resident is bedfast all or most of the time. Oral care routine q shift. Monitor/document/ report PRN any changes, any potential for improvement reason for self-care deficit, expected course declines in function." A Review of this comprehensive care plan did not reveal a goal or intervention related to the use of a ventilator for respiratory support, treatments related to ventilator use and maintenance. A review of Resident #111's "History/Physical" reports dated 05/09/2023 at 1:30 PM documented, "Chief complaint ... Chronic Respiratory failure s/p tracheostomy ... Review of system: Respiratory and no retractions. Patient has no sign of acute respiratory distress. Patient has no dyspnea with supine position, trach/vent..." Review of an Admission Minimum Data Set (MDS) dated 05/11/2023 showed that facility staff coded Resident #111 under section C (Cognitive Patterns) C1000 "3" indicating cognitively severely impaired. For section O (special treatment, procedures, and programs), facility staff coded under O0100 respiratory treatments Oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator box was checked indicating that all treatment mentioned was being performed for the resident.	F 657	All findings will be reported monthly, during QAPI for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 657	Continued From page 28 During an observation on 07/06/2023 at 1:30 PM, Resident #111 was lying on his bed, with hand mittens on and dependent on a ventilator for respiratory. A review of general progress note dated 07/10/2023 at 18:33 PM documented, "Resident alert and responsive with no acute respiratory distress. Breathing even with no labored ...HOB elevated to 45 degrees for aspiration precautions ... Dependent on ventilator for respiratory support. Suction as needed..." During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #19 (3 East Nurse Manager) acknowledged the findings and stated the care plan will updated to include the resident's use 111's use of vent/trach. .	F 657		
F 677 SS=D	22-B DCMR sec. 3210.4 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, residents' interviews, and staff interviews, the facility staff failed to ensure residents who were dependent on staff for activities of daily living received incontinent care, regularly scheduled showers, and foot care to maintain good personal hygiene for five (5) of 45 sampled residents.	F 677	**F-677** **1. Corrective action for resident** Resident # 29 was seen by podiatrist on 7/14/2023. Resident #8 podiatrist was notified of need for service on 7/11/2023, podiatrist saw resident on 8/15/2023. Resident # 33 was seen by podiatrist on 7/20/2023.	

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F 677	Continued From page 29 (Residents #29,#8, #33, #68, and #76) The findings included: A review of the Activities of Daily Living Policy dated 12/01/22 instructed that "Residents will [be] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living ... Appropriate care and services will be provided for residents who are unable to carry out ADLs (activity of daily living) independently, with the consent of the resident an in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, grooming) ...eliminating (toileting)..." 1.The facility's staff failed to ensure Resident #29's personal hygiene was maintained as evidenced by the resident's dry, scaly feet and very long toenails. Resident #29 was admitted to the facility on 01/16/20 with multiple diagnoses including Chronic Respiratory Failure, Muscle Weakness, Dementia... A review of a physician order dated 01/16/20 instructed, "Podiatry Consult and PRN (as needed) ..." A review of a two (2) physician orders dated 01/17/20 instructed the following: "Administer bed bath or sponge bath to residents daily during dayshift ..." and "Wash feet with soap and water, pat dry, apply moisturizer. Check between toes and feet. Report any unusual changes. Every evening shift on Monday and Friday. "	F 677	Incontinent care was completed on resident #68 on 7/12/2023 and resident was given a shower on 7/14/2023. Resident # 76 received incontinent care on 7/13/2013 and received a shower on 7/14/2023. **2. Identify other residents** All residents have the potential to be affected. Unit manager and/or designee will assess all current residents and new admissions feet to determine the need for podiatry services. Once determined that they need podiatry services, the resident's name will be added to the podiatry list. Unit Manager/charge nurse and/or supervisor will conduct 2 hourly walking rounds on each unit to ensure that CNAs complete incontinent care every 2 hours and as needed for residents. Unit Managers and/or designee will check shower books to ensure that residents are having their regularly scheduled showers. Any deficiencies will be corrected.	

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F 677	Continued From page 30 A review of the unit's Referral Log from 01/24/23 to 06/29/23 lacked documented evidence the facility's staff added Resident #29's name for a Podiatry Referral. A review of emails the facility's staff sent requesting services to the Podiatrist from 02/13/23 to 05/11/23, revealed Resident #29's name was not listed. A review of the Podiatry Service Policy dated 03/01/23 documented, "Residents requiring foot care who have complicating disease process will be referred to qualified professional such as a Podiatrist ...Foot disorders which may require treatment include, but not limited to ...nail disorders. Employees should refer any identified need for foot care to the unit secretary of designee. The unit secretary or designees will assist the resident in making and appointment ..." A review of the resident's Treatment Administration Records revealed from 04/01/23 to 07/04/23, the nursing staff signed their initials indicating that staff provided a bed bath or sponge bath to Resident #29 daily during the day shift. The resident's feet were cleaned with soap and water, patted dry, moisturized and toes and feet were checked every Monday and Friday during the evening shift. A review of a Quarterly Minimum Data Set dated 05/11/23 showed the resident had a Brief Interview for Mental Status summary score of "9" which indicated the resident had moderate impairment in [pronoun] cognitive function. In addition, the resident was coded for requiring extensive assistance from staff with personal hygiene. In addition, the resident was not coded for rejection (refusal) of care.	F 677	**3. Systemic changes** Staff Educator will educate all Licensed Nurses to add residents that need podiatry care to podiatry list weekly, charge nurses to validate podiatry visits and document in the resident progress notes all podiatry visits, and all CNAs on timely incontinent care every 2 hours and as needed and residents receive their regularly scheduled showers twice weekly. **4. Monitor corrective actions** Unit Managers and/or designee will audit 5 residents on each unit weekly x 3 months to ensure that proper feet care and incontinence care is being completed. Any deficiencies will be corrected. All audit findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 677	Continued From page 31	F 677		

A review of a care plan with a revision date of 05/29/23 showed the following: Focus area - [Resident #29] has an ADL (activity of daily living) self-care performance deficit r/t (related to) Disease Process. Intervention - Personal hygiene/oral care: The resident is totally dependent on staff for personal hygiene and oral care. Continued review of the resident's care plan lacked documented evidence of a refusal of care plan.

Multiple observations from 12:28 PM on 07/05/23 to 11:32 AM to 07/10/23 showed Resident #29 was lying in bed. The skin on the resident's feet appeared dry and flaky. In addition, the toenails on the resident's left and right first toe "big toe" were very thick and long. The left [big toe] toenail was so long it curved over the nail bed and appeared to be touching the skin of the resident's big toe.

During a face-to-face interview on 07/10/23 at 11:29 AM, Employee #29 (Unit Secretary) stated that nurses are responsible for adding resident names to the referral log for Podiatry services. After checking the referral log, she emails the Podiatrist to request services for the identified residents.

During a face-to-face interview conducted on 07/10/23 at 11:32 AM, Employee #6 (RN/Unit Manager) revealed that she would ensure staff provided care to the resident's feet immediately.

During a telephone interview on 07/10/23 starting at 12:15 PM, Employee #5 (Podiatrist) stated that she started working at the facility in November of 2022. She attempted to assess and treat Resident #29 in January 2023 and again in March

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 677	Continued From page 32	F 677		

2023, but the resident refused. Due to the resident's refusal, she did not observe the resident's feet. When asked if she had informed staff of the resident's refusal, she stated did not.

2. The facility's staff failed to ensure Resident #68 received incontinent care from 6 PM on 07/12/23 to 8:00 AM on 07/13/23 [14 hours]. And regularly scheduled showers, resulting in the resident receiving one shower this year (2023).

Resident #68 was admitted to the facility on 11/03/21 with multiple diagnoses including: Muscle Weakness, Rheumatoid Arthritis, Morbid Obesity, Fused Fingers
and Right Shoulder Pain.

A review of a Quarterly Minimum Data Set dated 04/19/23 showed the resident had a Brief Interview for Mental Status summary score of "15" indicating the resident was cognitively intact. In addition, the resident was coded for: using a wheelchair, requiring extensive assistance from staff for toileting, being frequently incontinent of urine and bowel, being totally dependent on staff for bathing, and receiving occupational therapy services.

A review of a Care Plan with a revision date of 05/17/23 showed the following: "Focus area [Resident's name] has limited physical mobility r/t (related to) Weakness. Interventions: Frequent rounding and toileting every 2 hours. The resident is totally dependent on staff for ADL care. Provide supportive care, assistance with mobility as needed ..."

A review of the certified nursing assistance task check list titled, "Documentation Survey Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 677	Continued From page 33	F 677		

v2" revealed the section Activities of Daily Living (toilet use) was blank for the 7PM to 7AM shift on 07/13/23 indicating that Employee #22 did not document what toileting services she provided for Resident #68.

A review of the unit's "Shower Book" revealed a document titled, "Skin Monitoring: Comprehensive Shower/Bed-Bath Review" dated 07/13/23 for Resident #68 that indicated staff conducted a skin assessment during Resident #68's bed bath and no new skin impairments were noted.

A review of the unit's "Weekly Shower Schedule" showed Resident #68's scheduled shower days were every Monday and Wednesday Morning Shift [7 AM to 7 PM].

During an observation on 07/13/23 at approximately 8:00 AM, Resident #68 was observed wearing a hospital gown awake lying in bed watching television. When asked how [he/she] was doing, the resident stated, "I have not been changed or seen the aide [Employee #22] since yesterday (07/12/23) around 6 PM. The aide usually comes in the morning, but she didn't come today." The resident was asked if [he/she] called for assistance, and stated no. The resident was asked if [he/she] was sleeping, how does [he/she] know that Employee #22 wasn't coming in every two hours as the facility's protocol required, and the resident said, "I am a light sleeper, and every time someone opens my door, I wake up. The aides don't come in my room every two hours. They only come when the first arrive in the evening (7 PM) and before they leave in the morning (7 AM) that they come. It should be noted the resident denied any pain or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 677	Continued From page 34	F 677		

discomfort at the time of the observation. And Resident #76 and Resident #68 are roommates.

During a second observation on 07/14/23 at approximately 11:30 AM Resident #68 was observed lying in bed with a blue gown and a matching hair bonnet watching tv. The resident was smiling and appeared very happy. When asked if [pronoun] she received a shower? Resident #68 said, "Yes, I did, and it felt so good to feel the water run all over my body. When I go home, the first thing I'm going do is take a shower for 30 minutes."

During a face-to-face on 07/14/23 at 10:18 AM, the regularly scheduled dayshift nurse [Employee #21 LPN], stated that she gave Resident #68 a shower last month, but she could not recall another time the resident had a shower.

During a telephone interview on 07/14/23 at 2:22 PM, Employee #22 [Certified Nursing Assistance] stated that she only provided incontinent care to Resident #68 at the beginning of her shift on 07/13/22. The employee then said she checked on the resident every two hours throughout the night, but the resident was asleep and did not request assistance, so she assumed the resident did not need any assistance.

3. The facility's staff failed to ensure Resident #76 received incontinent care from 5 PM on 07/12/23 to 8:00 AM on 07/13/23 [15 hours]. And regularly scheduled showers, resulting in the resident receiving one shower this year (2023).

Resident #68 was admitted to the facility on 11/03/21 with multiple diagnoses including: Hemiplegia and Hemiparesis following Cerebral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 35	F 677		

Infarction affecting Right Dominant Side, Cardiomyopathy, Muscle Weakness, Lack of Coordination, Difficulty Walking, and Visual Disturbance.

A review of the Activities of Daily Living Policy dated 12/01/22 instructed that "Residents will [be] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living ... Appropriate care and services will be provided for residents who are unable to carry out ADLs (activity of daily living) independently, with the consent of the resident an in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing) ...eliminating (toileting)..."

A review of a Quarterly Minimum Data Set dated 06/17/23 showed the resident had a Brief Interview for Mental Status summary score of "15" indicating the resident was cognitively intact. In addition, the resident was coded for: using a wheelchair, requiring extensive assistance from staff for toileting, being frequently incontinent of urine and bowel, and being totally dependent on staff for bathing.

A review of care plan with a revision date of 06/19/23 showed the following:
"Focus area [Resident's name] has an ADL (activity of daily living 0 self-care performance deficit r/t (related to) stroke. Intervention - The resident is unable to wash her upper body ..."

A review of the certified nursing assistance task check list titled, "Documentation Survey Report v2" revealed the section Activities of Daily Living (toilet use) was blank for the 7PM to 7AM shift on 07/13/23 indicating that Employee #22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 677	Continued From page 36	F 677		

documented an "8" for toilet use: self-performance and an "8" for toilet use-support provided. According to the key code on the previously mentioned document, the number "8" indicates that the "activity did not occur or family and/or non-facility staff provided 100% of the time for that activity."

A review of the unit's "Shower Book" revealed a document titled, "Skin Monitoring: Comprehensive Shower/Bed-Bath Review" dated 07/13/23 for Resident #76 that indicated staff conducted a skin assessment during the resident's shower and no skin issues were observed.

A review of the unit's "Weekly Shower Schedule" showed Resident #76's schedule shower days were every Tuesday and Thursday Morning Shift [7 AM to 7 PM].

During an observation on 07/13/23 at approximately 8:00 AM, Resident #76 was observed awake lying in bed watching television. When asked how [pronoun] was doing? The resident stated, "I have not been changed since the dayshift aide changed me yesterday (07/12/23) around 5 PM. The evening aide [Employee #22] took my vital signs around 7 PM and she didn't come back. The resident also said, "I had my first shower this year (2023) last week. It should be noted the resident denied any pain or discomfort at the time of the observation. And Resident #76 and Resident #68 are roommates.

During a face-to-face on 07/13/23 at 3:20 PM, the regularly scheduled dayshift nurse [Employee #21 LPN], stated, "I'm not aware of the last time the resident had a shower before 07/13/23. In

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 677	Continued From page 37	F 677	5tr	

addition, the employee said that residents receive showers twice a week as part of the facility's protocol.

During a telephone interview on 07/14/23 at 2:22 PM, Employee #22 [Certified Nursing Assistance] stated that she only provided incontinent care to Resident #68 at the beginning of her shift on 07/13/22. The employee then said she checked on the resident every two hours throughout the night, but the resident was asleep and did not request assistance, so she assumed the resident did not need any assistance.

4. The facility's staff failed to maintain Resident #8's personal hygiene, as evidenced by the Resident's dry, scaly feet and mycotic toenails.

Resident #8 was admitted to the facility on 12/03/15 with multiple diagnoses, including: Type 2 Diabetes Mellitus, Peripheral Vascular Disease, Congestive Heart Failure, Bilateral Cataracts, Bilateral Dry Eye Syndrome, Muscle Weakness, and Dementia.

A review of Resident #8's medical record revealed a physician's order dated 10/28/19 at 7:00 AM directed: "Wash feet with soap and water, pat dry apply moisturizer. Check in-between toes and feet, and report any unusual changes. Every day shift every Mon, (Monday), Thu (Thursday)."

A review of two Podiatry Consult Notes dated 03/02/23 and 06/05/23 at 12:00 AM documented: " ...Pt (patient) seen at bedside ...Referred by house staff. Pt is unable to maintain own foot care due to h/o (History of) DM2 (Diabetes Mellitus Type 2) ...Assessment and Plan:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 677	Continued From page 38	F 677		

Bilateral foot exam performed. Toenails debrided times 10 with sterile nippers. Rough edges smoothed with an electric file to the patient's tolerance. Lotion applied to feet sparing webspace ...Pt requires at-risk foot care due to DM (Diabetes Mellitus) and PVD (Peripheral Vascular Disease). Will follow up in 10-12 weeks or sooner if problem occurs."

A review of a physician's order dated 06/03/23 at 10:00 AM directed: "Weekly skin head to toe assessment: Write nurses note regarding resident skin condition on PCC (PointClickCare app) one time a day every Sat (Saturday)."

A review of a care plan with a revision date of 06/25/23 showed the following: "Focus area - [Resident's name] has an ADL (activity of daily living) self-care performance deficit r/t (related to) Disease Process. Intervention - Bathing/showering: Requires total care assistance from nursing staff. Continued review of the Resident's care plan lacked documented evidence of a refusal of care plan ..."

A review of a Quarterly Minimum Data Set dated 06/28/23 showed the Resident had a Brief Interview for Mental Status summary score of 11" which indicated the Resident had moderate impairment in cognitive function. In addition, the Resident was coded for requiring extensive assistance from staff with bed mobility and eating and was totally dependent on staff for personal hygiene and bathing. In addition, the Resident was not coded for refusal of care.

A review of Resident #8's Treatment Administration Records revealed from 07/01/23 to 07/05/23; the nursing staff signed their initials

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 39	F 677		

indicating that staff performed a weekly skin assessment on 07/01/23 and washed the Resident's feet with soap and water, patted them dry and
applied moisturizer.

On 07/05/23 at 11:04 AM, during an observation and interview, Resident #8 was observed resting in bed. The Resident reported that his left big toe was hurting. The surveyor reported the Resident's complaint to Employee #33, Agency Registered Nurse. Employee #33 uncovered the Resident's feet and removed the Resident's socks. The skin on the Resident's feet was dry, flaky, and scaly, and the Resident's toes were mycotic (jagged, yellowed, thickened). The skin on the left big toe was intact, and there was no redness.

A review of the July 2023 CNA Documentation Survey Report from 07/01/23 to 07/05/23 showed that the facility staff documented that they provided a bed bath or sponge bath to Resident #8 on 07/04/23 during the day shift and documented that they provided personal hygiene daily.

During a face-to-face interview on 07/05/23 at 11:04 AM with Employee #33, when asked who was responsible for providing ADL care for Resident #8, Employee #33 stated that the Certified Nurse Aides (CNA's) are usually responsible, but the facility was short-staffed today, so the Nurses were assigned to assist the residents with ADL care. The Employee stated that she was unsure if the CNA had provided ADL care to the Resident then said she would wash the Resident's feet. Before doing so, Employee #9, 3 West Unit Manager, was called to the Resident's bedside to assess the Resident's feet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 40	F 677		

Employee #33 looked at the Resident's feet and stated, "The Resident should have gotten foot care yesterday (Monday) since the Resident had an order for foot care every Monday." The Employee then acknowledged that the Resident's feet were dry and scaly and that facility staff needed to wash the Resident's feet.

During a face-to-face interview on 07/05/23 at 12:39 PM, Employee #32, CNA stated that she had provided ADL care, including a bed bath, to Resident #8 around 8:00 AM. When asked if she had washed and moisturized the Resident's feet, she admitted that she had changed and fed the Resident but had not washed or moisturized the Resident's feet. She also commented that she knew that CNAs are supposed to provide bed baths as part of ADL care, but that does not always happen due to insufficient staffing.

5.The facility's staff failed to maintain Resident #33's personal hygiene, as evidenced by the Resident's dry, scaly feet and thickened, discolored, and jagged toenails.

Resident #33 was admitted to the facility on 12/03/15 with multiple diagnoses, including Type 2 Diabetes Mellitus, Aphasia, Hemiplegia and Hemiparesis, Metabolic Encephalopathy, Anoxic Brain Damage, Schizoaffective Disorders, and Epilepsy.

A review of Resident #33's medical record revealed two (2) physician's orders dated 11/14/20 directing:

"Daily head-to-toe assessment q (every) shift. Notify MD/NP of any abnormalities and document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 677	Continued From page 41 your assessment every shift." "Bath/shower administer shower or sponge bath to Resident daily during the day shift as needed. Please document patients refusal and notify MD in the morning every Tue and Thur, every day shift every Tue, Thu." A review of a physician's order dated 11/19/20 directed: "For foot hygiene, wash feet with soap and water, pat dry, apply moisturizer. Check between toes and feet any usual changes, In the morning every Tue and Thur in the morning." A review of a physician's order dated 02/06/23 documented: "Podiatry consult." A review of a Podiatry Consult Note dated 02/16/23 at 12:00 AM documented: " ... [Resident's First Name] was referred by physician for diabetic foot exam ...toenails are overgrown ...is unable to maintain own foot care due to [pronoun] medical status ...Assessment and Plan: Bilateral foot exam performed. Toenails debrided times 10 with sterile nipper. R (right) great toe removed in toto(sp.)(total) ...Follow PCP (primary care physician)'s POC (plan of care) o maintain DM (Diabetes Mellitus) control. Pt (patient) requires at-risk foot care q 10-12 weeks due to h/o DM. Will follow up in 10-12 weeks or sooner if a problem occurs." A review of a Quarterly Minimum Data Set dated 05/15/23 showed the Resident had severely impaired cognition, required extensive assistance from staff with bed mobility, was totally dependent on staff for personal hygiene and bathing, and had bilateral impairment to lower extremities (hip, knee, ankle, foot).	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 42 On 07/05/23 at 3:45 PM, Resident #33 was observed resting in bed. The Resident's feet were dry and scaly, and the Resident's toenails on both feet were jagged and discolored. A review of Resident #33's Treatment Administration Records revealed from 07/01/23 to 07/13/23, the nursing staff signed their initials indicating that staff administered a shower or sponge bath to the Resident on 07/07, 07/06, 07/11, and 07/13; performed daily head to toe assessments every shift, and washed the Resident's feet with soap and water, patted them dry, and applied moisturizer daily. A review of the July 2023 CNA Documentation Survey Report showed that from 07/01/23 to 07/13/23, facility staff documented that they provided a bed bath or sponge bath to Resident #33 on 07/01, 07/04, 07/05, 07/07, 07/08, and 07/1, and provided personal hygiene daily. During a face-to-face interview on 07/17/23 at 1:45 PM, Employee #34, CNA, stated, "I had to prioritize the residents, I provided incontinent care, mouth care and fed the residents who needed assistance, and then I completed ADL care for those residents who have therapy, first. He then added I have not given the Resident a bed bath, but I will." During an observation on 07/18/23 at 12:03 PM, Resident #33 was observed resting in bed. The Resident's feet were dry and scaly, and the Resident's toenails on both feet were jagged and discolored. Employees #21 (Licensed Practical Nurse) and #6 (2 East Unit Manager) were present during the observation.	F 677		

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F 677	Continued From page 43 During an interview on 07/18/23 at 12:07 PM, Employee #6 stated that the CNAs were supposed to wash the Resident's feet as part of the ADL care, and she stated that the concern would be addressed with the nursing staff. The Employee then acknowledged the Resident's feet condition and the finding.	F 677	**F 684** **1. Corrective action for resident** Resident # 105 had a GI consultation on 7/14/2023. Residents #18, #22 and #53 have all been re-evaluated for therapy services and are on the current caseload. Resident #18 evaluation and pick up on 7/17/23; Resident #22 evaluation and pick up on 7/12/23; and Resident #53 evaluation and pick up on 7/13/23. 2. **Identify other residents** All residents have the potential to be affected. Unit manager and/or designee will audit current and new residents with GI consultations to ensure that the consults are completed per physician orders. The Rehabilitation Director and/or Designee will conduct an audit to ensure that all residents with orders for restorative nursing services are being seen appropriately.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and resident interviews for four (4) of 45 sampled residents, facility staff failed to ensure that residents received the treatment and care per standards of practice as evidenced by: 1) failure to provide a Gastro-Intestinal Consultation in a timely manner for one (1) resident #105 who had a 11 percent unplanned weight loss in 29 days 2) failure to follow physicians' orders for three residents. Residents #18, #53, and #97. The findings included: 1. Resident #105 was admitted to the facility on 01/23/23 with multiple diagnoses including Protein-Calorie Malnutrition, Dysphagia,	F 684		

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 44 Percutaneous Endoscopic Gastrostomy, Gastro-Esophageal Reflux Disease, Respiratory Failure, Multiple Sclerosis, Quadriplegic, and Depression. A review of a care plan dated 01/23/23 revealed the following: "Focus - [Resident 105] has a BMI indicative of underweight. Goal- [Resident 105] will have a gradual weight gain. Interventions- RD [registered dietician] to evaluate quarterly and PRN (as needed), monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed, check for tube placement and gastric content, the resident is dependent with tube feeding and water flushes ..." A review of a nutritional progress note dated 01/30/23 at 3:15 PM documented, "CBW (current body weight) 104.6 [pounds] ... TF (Tube feeding) providing estimated needs ...continue to monitor weights, labs ... goals- maintain weight ..." A review of weight log documented on 03/09/23 - Resident #105 weighted 105.6 pounds. A review of a nutritional progress note dated 04/03/23 at 8:02 PM documented, "CBW (current body weight) 101.6 [pounds] on 03/28/23 ...Resident continues with TF (tube feeding) regimen w/o (without) intolerance or residual ...No N/V/D/C (nausea, vomiting, diarrhea, constipation). Resident with severe muscle wasting in lower and upper extremity (sp) require high calorie/protein needs. Will continue to monitor TF tolerance, weights, labs as available ..." A review of weight log for 04/07/23 documented	F 684	3. **Systemic changes** Staff Educator and or designee will educate all License Nurses on following up on GI consultations to ensure that they are completed per physician orders. Evaluating therapists (PT, OT, and ST) were provided an in-service on 7/24/23 by the Rehabilitation Director on the proper process after discharge for placing residents on restorative nursing services. **4. Monitor corrective actions** The Unit Manager and/or designee will audit GI consults weekly x 3 months to ensure completion of the consults per physician orders. The Rehabilitation Director will conduct an audit monthly x 3 of the restorative nursing program to ensure that all processes are being followed for all newly discharged therapy residents that are appropriate for restorative care plans. Any deficiencies will be corrected. The results of these audits will be reported to QAPI for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 45 Resident #105 weighed 93.8 pounds. A review of a nutritional progress note dated 04/23/23 at 4:19 PM documented, "Current weight 93.8 [pounds] ...Severe malnutrition related to chronic illness and multiple wounds requiring higher energy needs as evidenced by moderate to severe muscle/fat wasting noted, ~11 % unintentional body weight loss in 1-month Current BW 87.1 [pounds] ... Resident triggering for weight loss ...not desired ..." A review of a Quarterly Minimum Data Set dated 04/28/23 revealed the Resident #105 did not have a Brief Interview for Mental Status summary score indicating the resident was not able to be tested. In addition, the resident was coded for weighting 938 [93.8] pounds and losing 5% or more weight in the last month. A review of a nurse practitioner's note dated 05/06/23 at 1:40 PM documented, "Palliative care on board following patient ...dysphagia/protein calorie malnutrition - continue enteral feeds-RD (registered Dietician) to follow [resident] ..." A review of a physician order dated 05/11/23 instructed, "GI consult ... for possible malabsorption ..." A review of the resident's Treatment Administration Record and nursing progress revealed no documented evidence that the resident had a GI consultation scheduled or completed from 05/11/23 to 07/13/23. A review of the unit's lacked documented evidence Resident #105's name was added for a GI (Gastro-Intestinal) consult from May 17, 2023	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 46 to July 11, 2023. During a face-to-face interview on 07/13/23 at approximately 10:30 AM, Employee #11 (Dietician) stated that she had changed the resident's feeding and supplements several times to address the resident's unplanned weight loss. The resident, however, continued to lose weight. She then recommended a GI consultation for possible malabsorption in May (2023), which had not been completed as of 07/13/23. In response to the question whether she informed the resident's physician/nurse practitioner that a GI consult had not been done? She explained that she discussed it in the weekly "Risk Meeting" where the "physician" is present. During a face-to-face interview on 07/13/23 at 11:57 AM, Employee #30 (Unit Secretary) stated that the facility's protocol is for nursing staff to notify her of new orders for consults. Then she will call the physician to schedule the consultation and document it on the "Consultation Tracking Sheet". Also, the resident's TAR is updated with the consult. When asked if she called to schedule the GI consult? Employee #30 said she did call to schedule the GI consult, but she doesn't know why it's not on the tracking sheet or the TAR. During a telephone interview on 07/13/23 at approximately 12:30 PM, Employee #31 (Nursing Practitioner) stated that she believed the resident was evaluated by the gastroenterologist. The employee said that the resident's weight loss may be related to declining secondary to the Multiple Sclerosis diagnosis. Additionally, they approached the resident's responsible party about hospice care for Resident #105, but the responsible party was not receptive.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 47 During a telephone interview on 07/13/23 at approximately 4:00 PM, the Gastroenterologist stated that she was not aware of Resident #105's order for a GI consult in May 2023. Additionally, the Gastroenterologist said that Multiple Sclerosis can contribute to weight loss. However, she would come in and evaluate the resident to determine a possible cause for the unplanned weight loss. 2. Facility staff failed to follow the physician's orders for three residents to receive restorative nursing for Residents #18 and #53 #97. A. Facility staff failed to offer Resident #18 restorative nursing for donning and doffing an orthotic after the Resident's physical therapy was discontinued per a physician's order. Resident #18 was admitted to the facility on 05/12/20 with diagnoses including: Other Sequelae of Cerebral Infarction, Hemiplegia, Unspecified Affecting Left Nondominant Side, Schizophreniform Disorder, Contracture, Right Hand. A review of Resident #18's medical record revealed: A review of an Annual Minimum Data Set (MDS) assessment dated 05/05/23 documented that: the Resident had a Brief Interview for Mental Status Summary (BIMS) score of "14," indicating the Resident had intact cognition; the assessment also revealed that the Resident required extensive assistance from staff for bed mobility, transfers, locomotion off unit, dressing, toilet use,	F 684		

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 684	Continued From page 48	F 684		

personal hygiene, was totally dependent on staff for bathing, used a wheelchair for mobility, ended physical therapy on 05/05/23.

A review of a care plan initiated on 05//05/23 documented: "[Resident #18's Name] will participate in the restorative program as needed and as tolerated. Goal: [Resident #18's Name] will maintain the current level of function through the next review date. Interventions: Bridging x 10 reps; Donning of LUE (left upper extremity) elbow extension orthosis 3-5x/week; PROM (passive range of motion) on LUE (left upper extremity). Free weight on RUE/RLE.(right upper extremity/right lower extremity) AROM (active range of motion) on LLE in all available planes for 10 reps.(repetitions) 3-5x/week."

A review of a physical therapy discharge summary dated 05/05/23 at 11:22 AM documented: " ...Discharge Recommendations, RNP placed ...Donning of L elbow extension orthosis and a hand carrot/roll, daily 7 hours. Inspection of skin after doffing the orthotics...D/C (discharge) Reason: Maximum Potential Achieved, referred for RNP ..."

A review of a physician's order dated 05/11/23 documented: "DC (Discharge) from PT (physical therapy) 5/6/23. RNP (Restorative Nursing Program) for donning of L (left) elbow extension orthosis for 3-5 days per week, as tolerated ROME (range of motion for extremities) on UE/LE (upper extremities/lower extremities) all planes, as tolerated."

On 07/06/23 at 10:27 AM, Resident #18 was observed laying in a supine (flat on one's back) position in [pronoun] bed. The Resident's left arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 684	Continued From page 49 was contracted at the elbow. A splint was observed on the Resident's windowsill. During a face-to-face interview during the observation, the Resident said that [pronoun] had not worn the splint since physical therapy stopped about one month ago. On 07/11/23 at 11:20 AM, Resident #18 was observed lying supine (on one's back) in bed. The Resident's left arm was contracted at the elbow. A splint was observed on the Resident's windowsill in the same position as the day before. Further review of Resident #18's medical record and observations of the Resident on 07/06/23, and 07/11/23 lacked evidence that facility staff provided the Resident with restorative nursing and assistance with applying or removing the left arm splint as directed by the physician's order. During a face-to-face interview on 07/11/23 at 12:24 PM, Employee #28 (Director of Rehabilitative Services) stated that restorative nursing was done by the restorative nursing aides (RNAs) unless the RNAs have trained the nursing staff. When asked where the RNAs document their care, she stated that each RNA hand-writes the care they provide in notebooks. When asked if she could provide the RNA's hand-written documentation for Resident #18, she acknowledged that when the Resident's physical therapy ended, facility staff failed to communicate that the Resident had a physician's order for restorative nursing to the RNA; therefore, the Resident did not receive restorative nursing. B. Facility staff failed to add Resident #53 to the restorative nursing caseload after the Resident's physical therapy ended on 05/11/23.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 50	F 684		

Subsequently, Resident #53 received no restorative nursing from 05/11/23 to /07/12/23.

Resident #53 was admitted to the facility on 11/04/20 with diagnoses that included: Cerebral infarction, Dysphagia, Aphasia, Gastrostomy, Weakness, Fall, Initial Encounter, and Dementia.

A review of Resident #53's medical record revealed:

A review of an Annual Minimum Data Set (MDS) assessment dated 05/10/23 documented that: the Resident had a Brief Interview for Mental Status Summary (BIMS) score of "11," indicating the Resident had moderately impaired cognition. The assessment also revealed that the Resident was totally dependent on staff for eating, and required extensive assistance with dressing, toilet use, personal hygiene, and bathing total dependence, started physical therapy on 03/13/23 and received physical therapy for four (4) out of seven (7) of the days during the assessment.

A physician's order dated 05/11/23 directed: "D/C (discharge) skilled PT effective 5/12/23. Referred to RNP (restorative nursing program) for ROME (sp) (range of motion) repositioning and donning/doffing of R (right) knee extension orthosis 3-5 days, as tolerated on UE/LE (upper extremity/lower extremity) and repositioning, to prevent any decline on (in) functional mobility."

A physical therapy discharge summary note dated 05/11/23 documented: " ...D/C Destination Maximum Potential Achieved, referred for RNP ...Discharge Recommendations: RNP was established - ROME on UE/LE ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 684	Continued From page 51	F 684		

A care plan revised on 05/12/23 documented : " Focus: [Resident #53 will participate in restorative program as needed as tolerated...Interventions: BUE (bilateral upper extremiity) exercises in all safe and available planes as toleratedd 3-5x (times) /week...donning of R (right) knee extension splint as tolerated 3-5x/week..."

During an observation on 07/05/23 at 11:46 AM, Resident #53 was observed laying in a supine (flat on one's back) position in [pronoun] bed. The Resident's daughter was at Resident'# 53's bedside.. The Resident's daughter stated that she had been visiting with the Resident and, " [Pronoun] is not getting out of bed." She added, "No one has been working with [pronoun]. [Pronoun] is supposed to receive PT (physical therapy) or someone is supposed to working with the [pronoun], but I have not seen anyone and I have not seen [pronoun] progression."

During an observation and a face-to-face interview on 07/07/23 at 10:13 AM, Resident #53 was lying in his bed on his back. The Resident stated that [pronoun] had not received therapy or restorative nursing that day and could not recall the last time [pronoun] had. The Resident then pointed to a gait belt draped over a walker leaning against the wall to the right side of the Resident's bed and stated, "That walker and the strap (gait belt) have been in my room for six (6) months and have never been used."

Further review of Resident #53's medical record, two observations made on 07/05/23 and 07/07/23, and an interview with the Resident on 07/07/23, lacked evidence that facility staff provided the Resident with restorative nursing after the Resident's physical therapy ended on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 684	Continued From page 52 05/12/23. During a face-to-face interview on 07/12/23 at 3:49 PM, Employee #28, Director of Rehabilitative Therapy, stated, "[Resident #53] is on my list for a physical therapy re-evaluation tomorrow. [pronoun] should have been on the caseload for restorative [nursing] when PT ended on 05/11/23 per the physician's order. "The Employee then acknowledged that Resident #53 had not received restorative therapy from 05/11/23 to 0712/23 C. Facility staff failed to obtain and confirm a new weight for Resident #97 for two (2) days as directed by the physician's order. A review of the facilities policy entitled, Weight Assessment and Intervention," revised on 12/01/22, documented: "... Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing." Resident #97 was admitted to the facility on 01/11/23 with diagnoses including: Traumatic Subdural Hemorrhage with Loss of Consciousness Greater than 24 hours, Protein-calorie malnutrition, Pressure Ulcer of Sacral Region Stage 4, Unspecified Dementia, Dysphasia, Gastrostomy, Fluid Overload, and Dependence on supplemental oxygen. A review of Resident #97's medical record revealed:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 53	F 684		

A physician's order dated 02/28/23 at 1:56 PM directed:" Weekly weight x 4 weeks then monthly thereafter every shift every Mon (Monday). If weight discrepancy noted +/- 5 lb (pound), re-weight must be completed within 24 hours and confirmed by RN manager/supervisor/DON."

A physician's order dated 06/16/23 at 9:40 AM directed: "Obtain new weight for June to confirm one time only for 2 days."

A review of Resident #97's weight report from May 2023 to June 2023 documented the following:
"5/22/2023 5:17 PM 187.7 lbs (pounds)
Mechanical Lift
6/7/2023 12:22 PM 173.5 lbs (pounds)
Mechanical Lift"

Of note, the weight report showed a 14.2 weight loss (7.5%) from 05/22/23 to 06/07/23.

During a face-to-face interview on 07/07/23 at approximately 1:15 PM with Employee #11 stated that per her progress note and e-mails sent to the unit managers and department heads, she requested a re-weight for Resident #97. The Employee then provided the following e-mails:

1) An e-mail with an attachment dated 06/12/23 at 12:14 PM, from Employee #11, Registered Dietitian, to the unit manager and department heads, documented: "Good morning, Here's a list of residents on weekly weights and ones that I've requested a re-weigh for. Attached to the e-mail was a document entitled "Weekly Weight List .docx.," which included Resident #97 in the list of residents to be re-weighed.

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 684	Continued From page 54 2) An e-mail with an attachment dated 06/12/23 at 12:14 PM, from Employee # 11, Registered Dietitian, to the unit manager and department heads, documented: "Good morning, Here's are the requested weekly weights for this week aside from the monthly weights pending. Attached to the e-mail was a document entitled "Weekly Weight List .docx.," which included Resident #97 in the list of residents to be re-weighed. During a face-to-face interview on 07/07/23 at 1:22 PM, Employee #9, 3 West Unit Manager, stated that she created the May and June 2023 documents that noted the 3 West residents and their weights. She added, "I noticed Resident #97's weight was inaccurate in June, and I told the dietician, so I and the CNA rechecked the Resident's weight together, and the Resident's weight was 163.2 lbs. The Employee then provided a copy of a weight report that she created, listing each Resident in the 3 West unit and their hand-written weights. Of note, the weight report created by the Employee documented that in May 2023, the Resident's weight was 187.9 lbs and, when re-weighed, was 177.9 lbs. For June, the Resident's weight was 163.2 lbs. The Employee provided no comment to address why the Resident's weights for May and June were documented differently on her reports compared to those in the Resident's medical record. The Employee acknowledged that the Resident was never re-weighed in June, per the dietician's request and the physician's order. [Cross-over 22B DCMR 3211.1(a)]	F 684		

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 686	Continued From page 55	F 686	**F 686**	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on an observations, record reviews, and staff interviews, the facility's staff failed to ensure a resident's wound care was provided in consistency with professional standards, as evidence by not providing wound treatment as ordered for one (1) of 45 sampled residents. (Resident #105) The findings included: Resident #105 was admitted to the facility on 01/23/23. The resident had a history of Multiple Pressure Ulcers to include a Stage 4 Left Trochanter and Left Buttocks Pressure Ulcer, Protein-Calorie Malnutrition, Dysphagia, Percutaneous Endoscopic Gastrostomy, Gastro-Esophageal Reflux Disease, Respiratory Failure, Multiple Sclerosis, and Quadriplegic. A review of Resident #105's care plan dated	F 686	1. **Corrective action for resident** Resident #105 discharged 8/8/2023. The Nurse who provided the wound care was educated on 07/11/2023. The resident did not suffer any negative outcomes related to this citation. 2. **Identify other residents** No current residents were affected as observed by Wound Care Director during wound treatments on 7/11/2023. **3. Systemic changes** Staff Educator will educate all licensed nurses to ensure wound treatments are completed as ordered on the correct site. 4. **Monitor corrective actions** Random observations of at least 5 residents with pressure ulcers weekly x 3 months by Wound Care Director to ensure that wound care is completed as ordered for current and newly admitted residents. Any deficiencies will be corrected. All audit findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring and education as needed.	

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 686	Continued From page 56 01/27/23 documented the following: Focus area- the resident has potential/actual multiple areas of skin integrity ...Interventions: keep skin clean and dry ...weekly treatment documentation to include ...any notable changes or observations ... A review of a Quarterly Minimum Data Set dated 04/28/23 revealed Resident #105 did not have a Brief Interview for Mental Status summary score indicating the resident was not able to be tested. In addition, the resident was coded for having six (6) Stage 3 Pressure Ulcers five (5) were present upon admission/reentry, six (6) Stage 4 Pressure Ulcers four were present upon admission, five (5) Unstageable Pressure Ulcers four were present upon admission/re-entry, and one (1) Unstageable Deep Tissue Injury. In addition, the resident was coded for using a pressure reducing bed, nutrition or hydration intervention, pressure ulcer care, surgical wound care and application of ointments/medications. A review of physician's order dated 06/29/23 instructed, "Cleanse right trochanter with wound cleanser apply collagen followed by silver alginate to promote autolytic debridement secured with boarder foam. Change dressing daily or if soiled/ dislodged." A review of physician order dated 07/06/23 instructed, "Cleanse left trochanter clustered with left buttock injury with Vashe wound wash, apply Medi-honey followed by Silver Alginate to promote autolytic debridement and secured with boarder foam. Change dressing daily or if soiled or dislodge." An observation on 07/11/23 starting at 11:00 AM showed Employee #16 (LPN- Wound Care	F 686	**5. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 57 Nurse) providing the following wound treatment for Resident 105's left trochanter and left buttocks pressure ulcer wounds: -cleaned wounds with wound cleanser. -applied collagen (sprinkles), -applied silver alginate, and -covered the wounds with a boarder foam dressing. During a face -to- face interview on 07/11/23 at approximately 11:15 AM, Employee #16 was asked if the current treatment for Resident 105's left trochanter and left buttock wound was used at the time of the observation, and she stated, "Yes". During a face -to- face interview on 07/11/23 at approximately 11:20 AM, Employee #17 (Director of Wound Care Services) said that the treatment provided by Employee #16 was for the right trochanter, not the left. A review of a "Wound Assessment Report" dated 07/12/23 documented, "Left Trochanter -Stage 4 Pressure Ulcer...Dressing Change Frequency - Daily and PRN (as needed), Clean wound with - Vashe, Primary Treatment - Silver alginate, medical grade honey, Other dressing- Boarder Foam.."	F 686		
F 726	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 726	**F 726** **1. Corrective action for resident** Resident #18's room was audited on 07/18/23 by the DON, and no medications were found at the bedside. Magnesium level was completed for Resident #18 on 08/22/23 with no new orders from the physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 726	Continued From page 58 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation record reviews, staff, and resident interviews for one (1) of 45 sampled residents, the facility staff failed to follow professional standards of practice when administering medication to a resident. Resident #18 Resident #18 was admitted to the facility on 05/12/20 with diagnoses including Other Sequelae of Cerebral Infarction, Hemiplegia, Unspecified Affecting Left Nondominant Side, Schizophreniform Disorder, Tremor, Unspecified, Vitamin Deficiency, Unspecified, and	F 726	**2. Identify other residents** All residents have the potential to be affected. Unit managers audited all resident rooms on 07/18/2023 to ensure that no medications were left at the bedside. No deficiencies were noted. **3. Systemic changes** Staff Educator will educate all Licensed Nurses on the five rights of medication administration. **4. Monitor corrective actions** Unit Manager and/or Designee will complete weekly rounds of resident's rooms x 3 months to ensure that no medications are left at bedside. Any deficiencies will be corrected. All findings will be reported monthly to the QAPI Committee for (3) consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 59 Hypomagnesemia. A review of Resident #18's medical record revealed an Annual Minimum Data Set (MDS) assessment dated 05/05/23 documenting the Resident had a Brief Interview for Mental Status Summary (BIMS) score of "14," indicating the Resident had intact cognition; the assessment also revealed that the Resident required extensive assistance from staff for bed mobility, transfers, locomotion off unit, dressing, toilet use, personal hygiene, was totally dependent on staff for bathing, used a wheelchair for mobility, ended physical therapy on 05/05/23. A review of a physician's order dated 05/12/20 directed: "Magnesium Oxide tablet 400 mg (milligrams). Give 2 tablet(s) by mouth three times a day for low magnesium." On 07/11/23 at 11:20 AM, Resident #18 was observed lying supine with the bedside table pulled across the bed in front of the Resident. On the bedside table was a Resident's phone, and beside the phone was a medication cup with two (2) large loose white pills. Of note, the pills were not moistened and were fully intact. During a face-to-face interview with Resident #18 during the observation, the Resident stated, "Those are my magnesium pills that the overnight nurse left for me to take. I was asleep when she came, so she left them for me to take later." During a face-to-face interview with Employee #35 (Licensed Practical Nurse) on 07/11/23 at approximately 11:25 AM, Licensed Practical Nurse), she stated, "I did not leave them there. The Resident must have hidden them when I	F 726		

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F 726	Continued From page 60 came in earlier because I did not see them." During a telephone interview on 07/11/23 at 12:55 PM, Employee #36 (Licensed Practical Nurse) stated, "The Resident took all his medications. I gave the magnesium to the [Resident #18]. I handed the Resident the cup with [pronoun] medications in it. I stood there and waited when the Resident pretended to put them in [pronoun] mouth. I cannot recall if I saw the Resident swallow or not. The Resident usually takes [pronoun] medications with no problem. I will make sure he swallows the pills the next time. It will not happen again." Employee #2, Director of Nursing, was made aware of the finding and stated that she would conduct an in-service on medication administration to the nurses.	F 726		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	**F 812** **1. Corrective action for resident** No residents reported issues with meal temperature on 07/10/2023. Dietary staff will do test trays prior to each meal service x 1 week. All four convection ovens were thoroughly cleaned on 08/23/2023. A splash guard will be placed between the fryer, grill, tilt skillet and the convection ovens. 2. **Identify other residents** All residents have the potential to be affected. Test trays will be audited by the Dietary staff prior to each meal service x 1 week. Any deficiencies will be corrected. 3. **Systemic changes** Staff Educator will educate Dietary and Maintenance staff on proper cleaning of the convection ovens and the need for a barrier between the convection ovens and other kitchen equipment to prevent cross contamination. Dietary will be educated on cooking foods to the appropriate temperatures prior to plating meals. Nursing staff will be educated on delivery methods to maintain food temperatures during meal service.	

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 812	Continued From page 61 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 135 degrees Fahrenheit (F) on seven (7) of seven (7) observations, four (4) of four (4) convection ovens that were soiled throughout, and cooking equipment such as two (2) of two (2) grease fryers, one (1) of one (1) tilt skillet, and one (1) of one (1) grill that were exposed to potential food contamination. The findings include: 1. Test tray food temperatures were inadequate as puree hot foods such as chicken (114.0 F), green beans (131.0 F), rice (131.3 F), and regular hot foods such as chicken (125 .0 F), green beans (119.6 F), rice (122.5 F) and soup (117.8 F) tested at less than 135 degrees F. 2. Four of four convection ovens were soiled throughout. 3. Cooking equipment such as two (2) of two (2) grease fryers, one (1) of one (1) tilt skillet, and one (1) of one (1) grill were positioned unprotected, at less than 12 inches from the back of four (4) of four (4) convection ovens with no barrier in between. The motors from the convection ovens were soiled with dust and/or particulate matter and presented a potentially hazardous source of food contamination.	F 812	4. **Monitor corrective actions** The Dietary Manager and/or designee will audit the convection ovens weekly to ensure that they are clean and that barriers are in place to prevent cross contamination between the convection ovens and other kitchen equipment weekly x 3 months. Test trays will be audited by the Dietary Manager prior to each meal service on each unit weekly after initial audits are completed. Any deficits will be corrected. All audit findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring and education as needed. 5. **Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 812	Continued From page 62 There was no separation between the back of the convection ovens and the fryers, the tilt skillet, and the grill. These observations were acknowledged by Employee #14 during a face-to-face interview on July 11, 2023, at approximately 10:00 AM.	F 812		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and resident interviews for three (3) of 45 sampled residents, the facility staff failed to provide restorative nursing services for three residents. Residents #18, #22, and #53.	F 825	**F 825** **1. Corrective action for resident** Residents #18, #22 and #53 have all been re-evaluated for therapy services and are on the current caseload. Resident #18 evaluation and pick up on 7/17/23; Resident #22 evaluation and pick up on 7/12/23; and Resident #53 evaluation and pick up on 7/13/23. **2. Identify other residents** The Rehabilitation Director and/or Designee will conduct an audit to ensure that all residents with orders for restorative nursing services are being seen appropriately.	

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 825	Continued From page 63 1. Facility staff failed to offer Resident #18 restorative nursing for donning and doffing an orthotic to the Resident's left elbow which was contracted. Resident #18 was admitted to the facility on 05/12/20 with diagnoses including Other Sequelae of Cerebral Infarction, Hemiplegia, Unspecified Affecting Left Nondominant Side, Schizophreniform Disorder, Contracture, Right Hand. A review of Resident #18's medical record revealed an Annual Minimum Data Set (MDS) assessment dated 05/05/23 documenting that the Resident had a Brief Interview for Mental Status Summary (BIMS) score of "14," indicating the Resident had intact cognition; the assessment also revealed that the Resident required extensive assistance from staff for bed mobility, transfers, locomotion off unit, dressing, toilet use, personal hygiene, was totally dependent on staff for bathing, used a wheelchair for mobility, ended physical therapy on 05/05/23. A review of a care plan initiated on 05/05/23 documented: [Resident #18's] will participate in the restorative program as needed and as tolerated. Goal: [Resident #18's] will maintain the current level of function through the next review date. Interventions: Bridging x 10 reps; Donning of LUE (left upper extremity) elbow extension orthosis 3-5x/week; PROM (passive range of motion) on LUE (left upper extremity). Free weight on RUE/RLE. (right upper extremity/right lower extremity) AROM (active range of motion) on LLE in all available planes for 10 (ten) reps.	F 825	**3. Systemic changes** Evaluating therapists (PT, OT, and ST) were provided an in-service on 7/24/23 by the Rehabilitation Director on the proper process after discharge for placing residents on restorative nursing services. **4. Monitor corrective actions** The Rehabilitation Director will conduct an audit monthly x 3 of the restorative nursing program to ensure that all processes are being followed for all newly discharged therapy residents that are appropriate for restorative care plans. Any deficiencies will be corrected. The results of these audits will be reported to QAPI for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 825	Continued From page 64 (repetitions) 3-5x/week. A review of a physical therapy discharge summary dated 05/05/23 at 11:22 AM documented: " ...Discharge Recommendations, RNP placed ...Donning of L elbow extension orthosis and a hand carrot/roll daily for 7 hours. Inspection of skin after doffing the orthotics...D/C (discharge) Reason: Maximum Potential Achieved, refereed for RNP ..." Review of a physician's order dated 05/11/23 documented: "DC (Discharge) from PT (physical therapy) 5/6/23. RNP (Restorative Nursing Program) for donning of L (left) elbow extension orthosis for 3-5 days per week, as tolerated ROME (range of motion for extremities) on UE/LE (upper extremities/lower extremities) all planes, as tolerated." On 07/06/23 at 10:27 AM, Resident #18 was observed laying in a supine (flat on one's back) position in bed. The Resident's left arm was contracted at the elbow. A splint was observed on the Resident's windowsill. During a face-to-face interview during the observation, the Resident said that [pronoun] had not worn the splint since physical therapy stopped about one month ago. On 07/11/23 at 11:20 AM, Resident #18 was observed lying supine in bed. The Resident's left arm was contracted at the elbow. A splint was observed on the Resident's windowsill in the same position as the day before. A review of Resident #18's medical record and observations of the Resident on 07/06/23, 07/07/23, and 07/11/23 lacked evidence that facility staff provided the Resident with restorative	F 825		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 825	Continued From page 65	F 825		

nursing and assistance with applying or removing the left arm splint.

Observations of Resident #18's sitting on the windowsill in the same position and a review of Resident #18's medical record, there was no evidence that facility staff offered the resident restorative nursing to the Resident.

During a face-to-face interview on 07/11/23 at 12:24 AM, Employee #28 (Director of Rehabilitative Services) stated that restorative nursing was done by the restorative nursing aides (RNAs) unless the RNAs have trained the nursing staff. When asked where the RNAs document their care, she stated that each RNA hand-writes the care they provide in notebooks. When asked if she could provide the RNA's hand-written documentation for Resident #18, she acknowledged that when physical therapy ended for Resident #18, facility staff did not communicate that the Resident had a physician's order for restorative nursing to the RNA; therefore the Resident did not receive restorative nursing.

2. Facility staff failed to provide restorative nursing to Resident #22 for range of motion on the Resident's UE/LE (upper and lower extremities) to prevent a decline in functional mobility.

Resident #22 was admitted to the facility on 10/31/17 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Nondominant Side, Epilepsy, Encephalopathy, Traumatic Brain Injury, Post Traumatic Stress Disorder, and Generalized Weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 825	Continued From page 66	F 825		

A physician's order dated 08/26/22 directed: "D/C (discharge) skilled PT secondary to achieving the highest functional mobility at this time. The patient was referred to RNP (restorative nursing program) for ROME (sp) (range of motion) on UE/LE (upper extremity/lower extremity) and repositioning to prevent any decline on (in) functional mobility."

A physician's order dated 03/30/23 directed:" Occupational therapy evaluation only. Occupational therapy is not indicated at this time."

A review of a Quarterly Minimum Data Set (MDS) assessment dated 04/18/23 documented that: the Resident had a Brief Interview for Mental Status Summary (BIMS) score of "15," indicating the Resident had intact cognition. The assessment also revealed that the Resident required extensive assistance for bed mobility and personal hygiene, was totally dependent on staff for dressing, and toilet use, had impairment on one side to the upper extremity and lower extremity, and received physical therapy, which ended on 01/18/23 and started occupational therapy on 04/07/23

A care plan states revised on 06/08/23 target 09/17/23 documented: [Name of Resident #22] will participate in the restorative program as needed and as tolerated ...Interventions: BUE (bilateral upper extremity) exercise in all safe and available planes as tolerated 3-5x/week ..."

An occupational therapy evaluation and plan of treatment dated 06/21/23 documented: "Certification period: 6/21/2023-6/21/2023 ...Clinical Impressions: Pt (patient) presents with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 67 decreased ROM (range of motion) and endurance with all functional ROM and endurance ...Risk factors: Due to the documented physical impairments and associated functional deficits without therapeutic intervention, the patient is at risk for decreased ability to return to a prior level of assistance, increased dependency upon caregivers, and limited out-of-bed activity ..." On 07/05/23 at approximately 11:15 AM, Resident #22 was observed asleep in bed, lying in a supine position. The bed was in its lowest position and had bed mats placed on each side of the bed. On 07/07/23 at approximately 1:00 PM, Resident #22 was observed asleep in bed, lying in a supine position. The bed was in its lowest position and had bed mats placed on each side of the bed. On 07/12/23 at approximately 3:00 PM, Resident #22 was observed in bed lying on his right side. During a face-to-face interview at the time of the observation, the Resident stated that he had not been getting restorative nursing or any therapy. A physical therapy discharge summary note dated 01/26/23 documented: " ...Prognosis to maintain CLOF (current level of functioning) = Excellent with participation in RNP ...Discharge Recommendations: Air mattress, assistance with ADLs, FMP(functional maintenance program)/RNP. Low bed and 24-hour care ..." A review of Resident #22's medical record lacked documented evidence that facility staff offered or provided the Resident with restorative nursing after the Resident's occupational therapy evaluation.	F 825		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 825	Continued From page 68 During a face-to-face interview on 07/12/23 at 3:17 PM, Employee #28, Director of Rehabilitative Therapy, stated that the occupational therapist (OT) reevaluated the Resident to see if [pronoun] could benefit from OT, but the Resident was unwilling to participate. The Employee acknowledged that the Resident had no refusal care plan and should have been offered restorative nursing after the Resident's OT (occupational therapy) re-evaluation. 3. Facility staff failed to add Resident #53 to the restorative nursing caseload after the Resident's physical therapy ended on 05/11/23. Subsequently, Resident #53 received no restorative nursing from 05/11/23 to 07/12/23. Resident #53 was admitted to the facility on 11/04/20. A review of an Annual Minimum Data Set (MDS) assessment dated 05/10/23 documented diagnoses that included: Cerebral infarction, Dysphagia, Aphasia, Gastrostomy, Weakness, Fall, Initial Encounter, and Dementia. The Resident had a Brief Interview for Mental Status Summary (BIMS) score of "11," indicating the Resident had moderately impaired cognition. The assessment also revealed that the Resident was totally dependent on staff for eating, and required extensive assistance with dressing, toilet use, personal hygiene, and bathing total dependence, started physical therapy on 03/13/23 and received physical therapy for four (4) out of seven (7) of the days during the assessment. A physician's order dated 05/11/23 directed: "D/C	F 825		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE & REHAB NATIONAL HARBORSIDE	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 825	Continued From page 69	F 825		

(discharge) skilled PT effective 5/12/23. Referred to RNP (restorative nursing program) for ROME (sp) (range of motion) repositioning and donning/doffing of R (right) knee extension orthosis 3-5 days, as tolerated on UE/LE (upper extremity/lower extremity) and repositioning, to prevent any decline on (in) functional mobility."

A physical therapy discharge summary note dated 05/11/23 documented: " ...D/C Destination Maximum Potential Achieved, referred for RNP ...Discharge Recommendations: RNP was established - ROME on UE/LE ..."

A review of Resident #53's medical record lacked documented evidence that facility staff provided the Resident with restorative nursing after the Resident's physical therapy ended on 05/11/23.

During a face-to-face interview on 07/07/23 at 10:13 AM, Resident #53 stated that [pronoun] did not receive therapy or restorative nursing and could not recall the last time [pronoun] had either. The Resident then pointed to a gait belt draped over a walker leaning against the wall to the right side of the Resident's bed and stated, "That walker and the strap (gait belt) have been in my room for six (6) months and have never been used."

During a face-to-face interview on 07/12/23 at 3:49 PM, Employee #28, Director of Rehabilitative Therapy, stated, "[Resident #53] is on my list for a physical therapy re-evaluation tomorrow. [Pronoun] should have been on the caseload for restorative [nursing] when PT ended on 05/11/23 per the physician's order." The Employee acknowledged that Resident #53 had not received restorative therapy from 05/11/23 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 825	Continued From page 70 07/12/23.	F 825		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842	**F 842** **1. Corrective action for resident** Resident # 5 TAR was corrected on 8/21/2023 to reflect turning and repositioning (TURP) every 2 hours. Resident # 104 was discharged on 8/17/2023. **2. Identify other residents** All residents with TURP orders have the potential to be affected. Unit Manager and/or designee will complete an audit of all current residents and new admissions with TURP orders to ensure that orders for TURP is reflected in the TAR every 2 hours for signature. **3. Systemic changes** Staff Educator will educate all License Nurses to ensure that all residents with TURP orders are reflected on the TAR for every 2 hour signature by licensed nurses.	

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F 842	Continued From page 71 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview staff failed to ensure medical record (Treatment Administration Record) for two (2) of 45 sampled resident were complete. (Resident #5, and #104) The findings included: 1. Resident #5 Treatment Administration Record	F 842	**4. Monitor corrective actions** Unit Managers and or designee will audit 10 resident records and observations to ensure that orders for TURP are reflected in the TAR for 2 hourly signatures by Licensed Nurse and performed by nursing staff weekly x 3 months. Any deficits will be corrected. All audit findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring, and education as needed. **5. Date correction action completed** Date of Compliance 09/18/23	

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F 842	Continued From page 72 (TAR) showed failed to complete documentation in the allotted area as evidence below: Resident #5 was admitted to the facility on 04/11/2023 with diagnoses that included: Acute Respiratory Failure, Pneumonia, Chronic Obstructive Pulmonary Disease, Heart Failure, Hypertension, and Hyperlipidemia. Review of a physician's orderd dated 4/12/23 instructed, "Record urine output every shift." Review of a physician's orderd dated 4/12/23 instructed, "Bilateral hand mittens to prevent trach decannulation, check and monitor blood circulation q2 hours and PRN." Review of a physician's orderd dated 4/12/23 instructed, "Mouth care q4hrs and PRN." However, a review of the June 2023 TAR lack documented evidence that staff initial the designated area for 6/09/23 evening shift (1800hour), 6/27/23 night shift (0200, 0400, 0600 hours) and 6/30/23 evening shift (1800hour) indicating that the treatment had been provided as ordered However, a review of the June 2023 TAR lack documented evidence that staff initial the designated area for 6/10/23 evening shift (1800hour), 6/27/23 night shift (0200, 0600 hours) and 6/30/23 evening shift (1800hour) indicating that the treatment had been provided as ordered. However, a review of the June 2023 TAR lack documented evidence that staff initial the designated area for 6/27/23 night shift (7PM-7AM) and 6/30/23 day shift (7AM - 7PM)	F 842		

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F 842	Continued From page 73 indicating that the treatment had been provided as ordered During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #19 (3East Nurse Manager) acknowledged the findings. 2.Resident #104 Treatment Administration Record (TAR) showed failed to complete documentation in the allotted area as evidence below: . Resident #104 was admitted to the facility on 06/05/2023 with diagnoses that included: Cerebral Infarct, Acute and Chronic Respiratory Failure, Parkinson's Disease, Rheumatoid Arthritis, Pneumonia, Atrial Fibrillation, Hypotension, and Depression. Review of a physician's orderd dated 3/27/23 instructed, "Initiate Ventilator weaning per protocol every day and night shift." Review of a physician's orderd dated 3/27/23 instructed, "Monitor area under trach BID (twice a day) and PRN (as needed)." Review of a physician's orderd dated 3/27/23 instructed, "Trach care BID (twice a day) and PRN." However, a review of the June 2023 TAR lack documented evidence that staff initial the designated area for 6/16/23 day shift (7am -3pm) and 6/28/23 day shift (7am - 3pm) indicating that the treatment had been provided as ordered. However, a review of the June 2023 TAR lack	F 842		

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	095024	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 842	Continued From page 74 documented evidence that staff initial the designated area for 6/16/23 day shift (7a-3p), and 6/28/23 day shift 7-3) indicating that the treatment had been provided as ordered. However, a review of the June 2023 TAR lack documented evidence that staff initial the designated area for 6/16/23 evening shift (1000hour), and 6/28/23 night shift (1000 hours) indicating that the treatment had been provided as ordered. During a face-to-face interview on 07/17/2023 at 1:30 PM, Employee #6 (2East Nurse Manager) acknowledged the findings and stated, "staff will be reeducate and improve on their tasks.'	F 842	**F 880** **1. Corrective action for resident** Resident #107 with follow up wound care completed on 7/11/23 by wound nurse and observed by Director of Wound Care to ensure infection control practices were followed. **2. Identify other residents** All residents with pressure ulcers have the potential to be affected. Education on infection control and prevention practices on wound care done immediately with wound treatment nurse on 7/11/2023 by Director of Wound Care. **3. Systemic changes** Staff Educator will provide education to all licensed nurses on infection control and prevention practices during wound care. **4. Monitor corrective actions** Random observations of at least 5 residents with pressure ulcers weekly x 30 days by wound care director to ensure that wound care is completed as ordered for current residents and new residents. Any deficiencies will be corrected.	
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	F 880		

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F 880	Continued From page 75 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880	All audit findings will be reported monthly to the QAPI committee for 3 consecutive months for review, recommendations, monitoring and education as needed. 5. **Date correction action completed** Date of Compliance 09/18/23	

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F 880	Continued From page 76	F 880		

Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility's staff failed to maintain Infection Control and Prevention Practices during wound care for one (1) of 45 sampled residents. (Resident #107).

The findings included:

Resident #107 was admitted to the facility on 03/06/23. The resident had a history of multiple diagnoses including Stage 4 Sacrum Pressure Ulcer, Anoxic Brain, Acute Respiratory Failure, Weakness, and Type 1 Diabetes.

A review of the policy titled, Wound Management, instructed staff to " ...Perform hand hygiene, put on gloves and remove old dressing and discard, take off gloves and perform hand hygiene ...put on [clean] gloves and perform wound [care] ..."

A review of Resident #107's care plan dated 03/07/23 documented the following: "Focus area-[Resident #107] has potential for pressure ulcer development related to disease process ...Interventions: Administer treatments as ordered and monitor effectiveness ..."

A review of a Significant Change Minimum Data Set dated 04/12/23 revealed Resident #107 did not have a Brief Interview for Mental Status summary score indicating the resident was not

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F 880	Continued From page 77	F 880		

able to be tested. In addition, the resident was coded for having two (2) Stage 2 Pressure Ulcers, one (1) Stage 4 Pressure Ulcers and one (1) Unstageable Pressure Ulcers. In addition, the resident was coded for using a pressure reducing bed, turning and repositioning program, nutrition or hydration intervention, pressure ulcer care, surgical wound care and application of ointments/medications.

A review of wound evaluation dated 07/05/23 documented, "Stage 4 sacrum pressure ulcer ... Dressing change frequency - daily and as needed, Clean wound with- Vashe, Primary Treatment - Silver Alginate, and Other dressing - Boarder foam ..."

A review of a physician order dated 07/06/23 instructed, "Cleanse sacral injury with Vashe wound cleanser, gently pack with silver alginate and secure with super absorbent dressing, change dressing daily and prn (as needed) ..."

During an observation on 07/11/23 starting at approximately 10:30 AM, Employee #15 (RN/Wound Care Nurse) performed hand hygiene, applied gloves, removed the old dressing from Resident #107's sacral wound and discarded it. The employee, however, failed to follow Infection Control and Prevention Practices by failing to wash her hands and putting on clean gloves before performing wound care for the resident's sacral wound.

During a face-to-face interview on 07/11/23 at approximately 10:40 AM, Employee #15 stated that she should have performed hand hygiene after removing and discarding the old sacral wound dressing. She also said she should have

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F 880	Continued From page 78 put on new gloves after performing hand hygiene and before providing treatment for the resident's sacral wound.	F 880		