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 _____	02/11/2019

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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	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 Long Term Care Survey was conducted at BridgePoint Subacute and Rehab National Harbor from February 5, 2019 through February 11, 2019. Survey activities consisted of a review of 32 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census during the survey was 60. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M Washington LNHA	Administrator	3/15/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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
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)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney

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F 000	Continued From page 2 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 SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		
F 584 SS=E	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 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	**F 584** **1. Corrective action for resident** Resident Rooms #301, 317, 318, 320, 330, 331, 332, 334, 335, 341, 342, 343 and entrance door to the dayroom on 3 West and the entrance door to the dayroom on 3 East have been re-painted. The bathroom sink in room 335 has been unclogged. The ice machine on 3 West has been cleaned. The faucet in room 314 has been tightened. **2. Identify other residents** An audit of resident room doors, dayroom doors, sinks, and faucets was conducted by the Director of Plant Operations to determine if other residents were affected by this alleged practice. There were no additional findings related to this citation. **3. Systemic changes** Plant operations staff have been educated on the importance of environmental rounds/inspections and subsequent follow up. The Director of Plant Operations will be responsible for validating environmental rounds/inspections and subsequent follow up on findings.	

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F 584	Continued From page 3 §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, the facility failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by marred doors and door jambs in twelve (12) of 40 resident's rooms, a clogged bathroom sink in one (1) of 40 resident's rooms, one (1) of one (1) soiled ice machine on one (1) of two (2) resident care units and a loose water faucet from the hand sink in one (1) of 40 resident's rooms. During an environmental tour of the facility on February 6, 2019 between 12:55 PM and 4:15 PM the following observations were made: 1. Entrance doors and door jambs to twelve (12) of 40 resident's rooms were marred, specifically rooms #301, 317, 318, 320, 330, 331, 332, 334, 335, 341,	F 584	**4. Monitor corrective actions** The Director of Plant Operations will complete audits of all environmental rounds/inspections to assess compliance with follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 584	Continued From page 4 342, 343, the entrance door to the dayroom on 3 West and one (1) of two (2) entrance doors to the dayroom on 3 East. 2. The bathroom sink was clogged in resident room #335, one (1) of 40 resident's rooms. 3. One (1) of one (1) ice machine on 3 West was soiled with mineral deposits at the tip of the water dispenser. 4. The water faucet from the hand sink was loose in resident room #314, in one (1) of 40 resident's rooms observed. Employee #8 acknowledged the findings during a face-to-face interview on February 6, 2019, at approximately 4:15 PM.	F 584		
F 620 SS=E	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for	F 620	**F 620** **1. Corrective action for resident** Residents #8, # 19, #61, and #112 no longer reside in the facility. All of the responsible parties for the residents were contacted in attempts to complete the Admissions Agreement. **2. Identify other residents** All resident records were audited for completed admissions agreements. Resident representatives were contacted for any resident that did not have a completed Admissions Agreement on file. All residents and/or their representatives in the facility at the time of the identification of this issue was given a copy of the resident's rights.	

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F 620	Continued From page 5 losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission,	F 620	**3. Systemic changes** Admissions and Business Office staff have been educated by the Administrator on the Admission Agreement policy and expectations for completion and documentation of attempts to review Admissions Agreement. The Administrator will be notified of any barriers to completing the Admissions Agreements timely for guidance and assistance. The Admissions/Business Office will reach out to perspective resident and/or their representative to schedule a meeting prior to admission whenever possible. If they are unable to meet prior to the admission, the appointment will be scheduled for the earliest available date during the first 24-48 hours of admission. In cases of extreme hardship, the Admissions agreement will be mailed, faxed, or emailed per the representative's direction. A staff member will be available for telephone consultation to address any questions that might come up regarding the Admissions Agreement. **4. Monitor corrective actions** The Business Office Manager will complete audits of all new admissions to assess compliance with completion of Admissions Agreements weekly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 620	Continued From page 6 expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 32 sampled residents, the facility staff failed to ensure residents and/or their representatives received and signed an admissions contract/packet upon the residents admission to the facility. Residents' #8, #19, #61 and #112. Findings included ... The facility's Admission Agreement Policy Statement dated 12/17/2018, stipulates, "All residents have a signed and dated Admission Agreement on file...Policy Interpretation and Implementation: 1) At the time of admission, the	F 620		

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F 620	Continued From page 7 resident (or his/her representative) must sign an Admission Agreement (contract). 2) The Admission Agreement (contract) will reflect all charges for covered and non-covered items, as well as identify the parties that are responsible for the payment of such services. 4) A copy of the Admission Agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident's permanent file." Review of resident files showed the following: 1)Resident #61 was admitted to the facility on December 31, 2018, with diagnoses that included Anemia, Gastroesophageal Reflux Disease, Benign Prostatic Hyperplasia, Diabetes Mellitus, Respiratory Failure, and Dependence on Respirator [Ventilator] Status. At the time of this review, February 7, 2019 (38 days post admission to the facility) the resident did not have a signed Admission's contract on his electronic health record or paper chart. 2) Resident #8 was admitted to the facility on September 14, 2018, with diagnoses that included Fracture of Right Lower Leg, Major Depressive Disorder, Dysphagia, Essential Hypertension, Sleep Apnea, Unspecified Atrial Fibrillation, and Chronic Respiratory Failure. At the time of this review, February 7, 2019 (146 days post admission to the facility) the resident did not have a signed Admission's contract on her electronic health record or paper chart. 3) Resident #19 was admitted to the facility on September 14, 2018, with diagnoses that	F 620		

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F 620	Continued From page 8 included Dysphagia, Gastroesophageal Reflux Disease, Acute and Chronic Respiratory Failure, Hypoxemia, Heart Failure, Essential Hypertension, and Muscle Weakness. At the time of this review, February 7, 2019 (146 days post admission to the facility) the resident did not have a signed Admission's contract on his electronic health record or paper chart. 4) Resident #112 was admitted to the facility on January 30, 2019, with diagnoses that included Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia and Dependence on Respirator [Ventilator] Status, Atrial Fibrillation, Hypothyroidism, Anemia, and Pulmonary Hypertension. At the time of this review, February 7, 2019, (8 days post admission to the facility) the resident did not have a signed Admission's contract on her electronic health record or paper chart. There was no evidence the facility staff had provided the resident and/or their responsible party with the Admission's contract/packet disclosing to them notice of special characteristics or service limitations of the facility upon admission. During a face-to-face interview with Employee #10 Admissions Supervisor on February 7, 2019, at 11:10 AM, she acknowledged the findings.	F 620		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		

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F 655	Continued From page 9 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655	**F 655** **1. Corrective action for resident** Residents #8, # 19, #59, and #63 no longer reside in the facility. Residents #7, and #58 still reside in the facility have had their care plans reviewed and shared with them and/or representatives. **2. Identify other residents** All current resident's medical records were audited to identify any other residents that may have been affected. Any affected residents and/or their representatives will be updated on the resident's current care plan goals. **3. Systemic changes** Licensed staff in the facility have been educated by the Director of Nursing and/or the Director of Reimbursement on the policy of completion of Baseline Care Plans within 48 hours and documentation of the receipt of the summary by the resident and/or their representative. New hires will be educated on the baseline care plan policy at time of orientation.	

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F 655	Continued From page 10 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for six (6) of 32 sampled residents, facility staff failed to develop a baseline care plan with goals and approaches within 48 hours of the residents admission to address their initial care needs. Residents' #7, #8, #19, #58, #59 and #63. Findings included... 1. Facility staff failed to develop and provide a baseline care plan within 48 hours of admission to Resident #7 or their representative. Resident #7 was admitted on November 8, 2018, with diagnoses to include Chronic Respiratory Failure, Pressure Ulcers, Epilepsy, Contracture, Feeding Difficulties, Tracheostomy Status, Anemia, and Bipolar Disorder. A review of Resident #7's medical record showed no evidence of the 48 hour baseline care plan. During a face-to-face interview with Employee #3 on February 11, 2019, at approximately 3:00 PM , she acknowledged the findings. 2.Facility staff failed to develop and provide a baseline care plan within 48 hours of admission	F 655	**4. Monitor corrective actions** The Unit Managers will complete audits of all new admission Baseline Care Plans during clinical meetings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 655	Continued From page 11 to Resident #8 or their representative. Resident #8 was admitted to the facility on September 14, 2018, with diagnoses that included Fracture of Right Lower Leg, Major Depressive Disorder, Dysphagia, Essential Hypertension, Sleep Apnea, Unspecified Atrial Fibrillation, and Chronic Respiratory Failure. A review of Resident #8's medical record showed no evidence of the 48 hour baseline care plan. The resident baseline care plan within 48 hours was not available for review. During a face-to-face interview with Employee #3 on February 11, 2019 at approximately 3:00 PM , she acknowledged the findings. 3. Facility staff failed to develop and provide a baseline care plan within 48 hours of admission to Resident #19 or their representative. Resident #19 was admitted to the facility on September 14, 2018, with diagnoses that included Dysphagia, Gastroesophageal Reflux Disease, Acute and Chronic Respiratory Failure, Hypoxemia, Heart Failure, Essential Hypertension, and Muscle Weakness. A review of Resident #19's medical record showed no evidence of the residents 48-hour baseline care plan. The Resident baseline care plan within 48 hours was not available for review. During a face-to-face interview with Employee #3 on February 11, 2019, at approximately 3:00 PM, she acknowledged the findings.	F 655		

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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 655	Continued From page 12	F 655		

4. Facility staff failed to develop and provide a baseline care plan within 48 hours of admission to Resident #58 or their representative.

Resident #58 was readmitted to the facility on January 16, 2019, with diagnoses, which included hypertension, hyperlipidemia, urinary tract infection, gastrostomy, respiratory failure, contracture left and right hand, dependence on respirator status and a gastrostomy tube in place.

A review of the clinical record for Resident #58 lacked evidence that a baseline care plan was developed within 48 hours of the resident's admission. The family representative not was provided with a summary of the baseline care plan that included initial goals of the resident; a summary of the residents current medications and dietary instructions; services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility.

During a face-to-face interview with Employee #2 on February 8, 2019, at approximately 11:15 AM, she stated we have the assessment part of the baseline care plan, but we do not review the written summary with the resident or the family within 48 hours of admission.

5. Facility staff failed to develop and provide a baseline care plan within 48 hours of admission to Resident #59 or their representative.

Resident #59 was admitted to the facility on January 9, 2019, with diagnoses that included Quadriplegia, Anxiety Disorder, Acute and

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F 655	Continued From page 13 Chronic Respiratory Failure, Dependence on Respirator [Ventilator] Status, Peripheral Vascular Disease, Hypothyroidism, Dysphagia and the resident has a gastrostomy tube. A review of Resident #59's medical record showed no evidence of the residents 48 hour baseline care plan. During a face-to-face interview with Employee #3 on February 11, 2019, at approximately 3:00 PM, she acknowledged the findings. 6. Facility staff failed to develop and provide a baseline care plan within 48 hours of admission to Resident #63 or their representative. Resident #63 was admitted to the facility on October 25, 2018, with diagnoses, which included Respiratory Failure, Tracheostomy Status, Chronic Obstructive Pulmonary Disease, Seizure Disorder, Depression, Muscle Weakness, and Dependence on Respirator Status. A review of Resident #63's closed medical record showed no evidence of the 48 hour baseline care plan. The Resident's baseline care plan within 48 hours was not available for review. During a face-to-face interview with Employee #2 on February 8, 2019, at approximately 11:30 AM, she acknowledged the findings.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 14 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 section.	F 656	**F 656** **1. Corrective action for resident** Residents #19 and #59 no longer reside at the facility. Residents #24, #44, and #60 still reside in the facility. The residents that still reside in the facility have had their care plans reviewed and revised as appropriate to reflect their current needs. **2. Identify other residents** An audit of other residents in the facility was conducted to determine if other residents were affected by this practice. No other residents were identified. **3. Systemic changes** The interdisciplinary team has been educated by the Director of Nursing and/or the Director of Reimbursement on the policy of comprehensive care plan completion and revisions. New hires will be educated on the care plan policy at time of orientation. Care plans will be reviewed (revised as needed) by the IDT team on admission, changes in medications or treatments, significant changes (improvements or declines), quarterly, and prior to discharge.	

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F 656	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for five (5) of 32 sampled residents, the charge nurse failed to develop and implement a comprehensive care plan for a Bi-level Positive Airway Pressure (BIPAP) machine for one (1) resident, dental care for one (1) resident, for nine (9)or more medications for one (1) resident, the use of a neck collar for one (1) resident and for respiratory therapy care for one (1) resident. Residents' #19, #24, #44, #59 and #60. Findings included . . . 1) Resident #19 was admitted to the facility on September 14, 2018, with diagnoses that included Dysphagia, Gastroesophageal Reflux Disease, Acute and Chronic Respiratory Failure, Hypoxemia, Heart Failure, Essential Hypertension, and Muscle Weakness. A review of the Quarterly Minimum Data Set (MDS) completed November 23, 2018, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions. Review of the Physician's orders directed, "Place BIPAP on at night until [Doctor's name] review ABG (arterial blood gases) at bedtime". A review of the care plans lacked person-centered goals and approaches to	F 656	**4. Monitor corrective actions** The Unit Managers will complete audits of 10 resident records weekly for care plan accuracy. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 656	Continued From page 16 address the use of the BIPAP machine for Resident #19. During a face-to-face interview with Employee #3 at approximately 9:30 AM on February 11, 2019 she stated the resident uses the BIPAP but sometime he refuses to wear it. Employee #3 further acknowledged that the care plans with goals and approaches to address the use of the BIPAP machine was not developed. 2.The charge nurse failed to develop and implement a comprehensive care plan for Resident #24's dental care needs. Resident #24 was admitted to the facility on December 3, 2016, with diagnoses which included Hypertension, Hyperlipidemia, Diabetes Mellitus, Dysphagia, Oropharyngeal Phase, Prostate Cancer, Gastroesophageal Reflux Disease and Major Depressive Disorder. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of December 15, 2018, showed Section C0500 a Brief Interview for Mental Status (BIMS) score of "14" which is an indication that the resident is cognitively intact and able to make decisions. Under Section L Oral/Dental Status L0200 Broken or loosely fitting or partial denture (chipped, cracked, uncleanable, or loose) and Mouth or facial, discomfort or difficulty with chewing was left blank, indicating there were no dental issues at the time of assessment for Resident #24.	F 656		

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F 656	Continued From page 17 A review of the Physicians' order sheet from December 2018 to February 8, 2019 showed the following orders: "Dental follow up for crowning with [Dentist's Name] on 12/05/2018 at 12 PM" "Dental consult one time only until 01/02/2019" "Follow up a dental appointment with [Dentist's Name] on 01/24/19 at 9:15 AM one time only for one day". A review of the Progress notes on February 8, 2019, at approximately 10:00 AM showed the following: "1/11/2019 at 15:15 Psychosocial note: Resident Broke his dental plate ..." "1/17/19 at 21:27 Psychosocial note: Resident has an appointment next week with the dentist to repair his dental plate." "1/25/19 at 12:34 Psychosocial note: Resident visited the dentist today and show off his bridge to the therapist." A review of the care plans on the clinical record showed evidence that the charge nurse failed to develop a care plan with person-centered goals and interventions to address the dental care for Resident #24." A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019, the employee acknowledged the findings.	F 656		

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F 656	Continued From page 18 3. The charge nurse failed to develop and implement a comprehensive care plan for Resident #44's use of nine (9) or more medications. Resident #44 was admitted to the facility on June 23, 2018, with diagnoses which include Chronic Respiratory Failure, Hypertension, Diabetes Mellitus, Dysphagia, Oropharyngeal Phase, Gastroesophageal Reflux Disease, Acute Kidney Failure, Tracheostomy, Gastrostomy, and Colostomy. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of January 10, 2019, showed a Brief Interview for Mental Status (BIMS) score of "12" which is an indication that the resident is moderately cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident is totally dependent on two or more persons for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. He receives all enteral feeding and medication via gastrostomy tube. A review of Resident #44's Medication Administration Record on February 8, 2019, showed the following medications: Routine Medications 1. Lantus inject 12 unit subcutaneously at bedtime for Diabetes Mellitus 2. Humalog 100U [unit]/ml [millimeters] inject as	F 656		

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F 656	Continued From page 19 per sliding scale subcutaneously with meals for Diabetes Mellitus 3. Multivitamin with minerals 5mg [milligrams] po [by mouth] one time a day for a supplement 4. Quetiapine Fumarate tablet 25mg give 2 tablets by mouth at bedtime for mood disorder 5. Divalproex 500mg give one tablet by mouth twice a day for mood disorder 6. Sertraline HCL [hydrochloride] tablet 25mg give 1 tablet by mouth one time a day for Depression 7. Zinc Sulfate give 1 capsule by mouth one time a day for wound healing 8. Ascorbic acid 500mg give 1 tablet by mouth two times a day for a wound healing 9. Ranitidine HCL 150mg give 1 tablet by mouth two times a day for GERD [Gastroesophageal Reflux Disease] 10. Tylenol 325mg give 2 tablets by mouth every day and every evening shift for pain 11. Aspirin 81 mg by mouth one time a day for DVT [Deep Vein Thrombosis] prophylaxis 12. Ergocalciferol Cap [capsule] 50000 unit give 1 capsule by mouth one time a day every Friday for a supplement 13. Ferrous Sulfate tablet give 325mg by mouth one time a day for a supplement 14. Thiamine tablet 100mg give 1 tablet by mouth one time a day for a supplement 15. Docusate sodium give 10 ml by mouth two times a day for bowel regiment 16. Lactobacillus tab 1 tablet by mouth three times a day for prophylaxis 17. Midodrine HCL 5 mg by mouth four times a day for Hypotension A review of the care plans on the clinical record showed evidence that the charge nurse failed to develop a care plan with person-centered goals and interventions to address the use of nine (9) or	F 656		

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F 656	Continued From page 20 more medications for Resident #44. A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019. The employee acknowledged the findings. 4) Resident #59 was admitted to the facility on January 9, 2019, with diagnoses that included Quadriplegia, Anxiety Disorder, Acute and Chronic Respiratory Failure, Dependence on Respirator [Ventilator] Status, Peripheral Vascular Disease, Hypothyroidism, Dysphagia and the resident has a gastrostomy tube. On February 6, 2019 at approximately 9:45 AM Resident #59 was observed wearing a neck collar while in bed. Review of the Physician's orders directed, "RN staff to remove c-collar q (every) shift and inspect skin for redness and pressure injuries. Support neck while turning and repositioning at all times ..." A review of the care plans lacked person-centered goals and approaches to address the use of the neck collar for Resident #59. During a face-to-face interview with Employee #3 at approximately 9:30 AM on February 11, 2019, she acknowledged that the care plans with goals and approaches to address the use of the neck collar was not developed.	F 656		

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F 656	Continued From page 21 5. The charge nurse failed to develop and implement a comprehensive care plan for Respiratory Therapy care for Resident #60. Resident #60 was admitted to the facility on September 7, 2018, with diagnoses, which include Acute and Chronic Respiratory Failure, Hypertension, Paraplegia, Epilepsy, Encephalopathy, Dysphagia, Oropharyngeal Phase, Gastrostomy, and Tracheostomy Status. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of December 15, 2018, under Section C Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of "3" indicating the resident's cognition was severely impaired (never /rarely made decisions). Under Section O, Special Treatments, Procedures and Programs Respiratory treatments were coded for "oxygen therapy, suctioning, and tracheostomy". A review of the Physicians' order sheet on February 8, 2019, showed the following: "FIO2 (Fraction of inspired oxygen): 28...Trach Size: 6 every shift for Respiratory Failure related to Acute and Chronic respiratory failure Unspecified whether with Hypoxia or Hypercapnia Wean FIO2 as tolerated and to keep sats [saturations] greater than 92%" "Trach care every shift and PRN every shift". A review of the care plans on the clinical record showed that the charge nurse failed to develop a	F 656		

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F 656	Continued From page 22 care plan with person-centered goals and interventions to address Resident #60's Respiratory therapy care. A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 8, 2019. The employee acknowledged the findings.	F 656	**F 677** **1. Corrective action for resident** Resident #58 still resides in the facility. The resident has been shaven. **2. Identify other residents** A review of other residents in the facility did not reveal any additional residents with unmet grooming needs. **3. Systemic changes** The CNAs Have been in-serviced on the importance of routine ADL care. Licensed staff have been in-serviced on monitoring residents for unmet ADL grooming needs. Residents will be assessed during rounds and any concerns brought to the attention of the CNA for correction. **4. Monitor corrective actions** The Unit Managers will complete audits of 10 resident records weekly for ADL care. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
F 677 SS=D	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 an observation, record review and staff interview for one (1) of 32 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain good grooming for Resident #58 who was observed unshaven for several days. Findings included ... A review of Resident #58's Admission Minimum Data Set (MDS) dated January 23, 2019, revealed that the resident was coded as severely cognitively impaired under Section C [Cognitive Patterns] and was totally dependent for ADLs (activities of daily living) under Section G0110 J [Personal Hygiene].	F 677		

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F 677	Continued From page 23 On February 5, 2019, at 3:06 PM Resident #58 was observed lying in bed unshaven. On February 6, 2019, at approximately 10:00 AM, Resident #58 was again observed lying in bed unshaven. After a face-to-face interview with Employee #2 on February 6, 2019 at 10:15 AM, she acknowledged the findings after observing the residents unshaven status. Facility staff failed to carry out activities of daily living necessary to maintain grooming for Resident #58.	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732	**F 732** **1. Corrective action for resident** The facility has begun posting the required staffing data daily. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** The Unit Manager or Supervisor (off hours/holidays/weekends) will be responsible for ensuring that the daily nurse staffing data is completed and posted with the total number of staff and actual hours worked per shift.	

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F 732	Continued From page 24 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations made during the initial tour of the facility on February 5, 2019, at approximately 9:30 AM, it was determined that the facility failed to post data of nursing staff directly responsible for resident care to include the total number of staff and actual hours worked per shift for Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. Findings included ... The daily nurse staffing data posted was observed and did not include the requirements of the total number of staff and actual hours worked per shift for Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. The observations were made during initial tour of the facility on February 5, 2019, at approximately	F 732	**4. Monitor corrective actions** The Unit Managers will complete daily audits of nursing staffing data. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 732	Continued From page 25 10:30 AM. Employee #2 acknowledged the findings during a face-to-face interview on February 5, 2019, at approximately 2:30 PM.	F 732	**F 761** **1. Corrective action for resident** The medication refrigerator has been checked by Plant Operations and is within required range. **2. Identify other residents** Every resident on 3 West has the potential to be affected by this alleged practice. **3. Systemic changes** Licensed nurses have been re-educated on the protocol for ensuring refrigerator temperatures are within range. The refrigerators will be checked every shift by a charge nurse. If a temperature is noted out of range, it must be addressed immediately. The charge nurse should contact the Unit Manager or Supervisor to follow up with Plant Operations. Actions taken are to be documented on the log sheet for reference. **4. Monitor corrective actions** The Unit Managers will complete daily audits of refrigerator logs for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, facility staff failed to ensure that medication refrigerator temperature logs that	F 761		

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F 761	Continued From page 26 were not within the facility's acceptable range were reported according to the facility's plan of correction to safely store refrigerated medicine in one (1) of two (2) medication refrigerators observed. Findings included... A review of the 3 West Medication Refrigerator log on February 11, 2019, at 11:00 AM showed the refrigerator temperature ranges for January 2019 and February 8, 2019 as follows: January 13, 14, 15, 16, 18, 23, 24, 25, 28, and 30, 2019, refrigerator was out of range (below 34 degrees Fahrenheit). No comment made as to the action taken. January 1, 3, 4, 6, 9, 16, 19, 20, 21, 22, 23, and 26, 2019, freezer temperature was out of range (above 10 degrees Fahrenheit). No comment made as to the action taken. February 8 and 11, 2019, refrigerator temperatures were out of range (below 34 degrees Fahrenheit). No comment made as to the action taken. According to the facility plan of action written at the bottom of the Medicine Refrigerator log form, the instructions directed: "Freezer temperature: 0-10 Degrees" "Refrigerator Temperature: 34 - 44 Degrees"	F 761		

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F 761	Continued From page 27 "Report to Maintenance and RCC (resident care coordinator) if temperature is out of range" Facility staff on 3 West unit failed to ensure the medication refrigerator temperature logs that were out of range were reported according to the facility's plan of correction as evidenced by the comment section left "blank" indicating, nothing was done to report the temperatures that were out of range. A face-to-face interview was conducted with Employee #4 at approximately 12:00 PM on February 11, 2019. The employee acknowledged the findings that there was no documented evidence on the reported action taken.	F 761	**F 812** **1. Corrective action for resident** The ham, scalloped potatoes, and puree pork were discarded and the residents were served foods at the appropriate temperatures. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** Dietary staff have been re-educated on the proper techniques to ensure that foods are served at the appropriate temperatures. The dietary manager/shift supervisor will monitor food temperatures during each meal service. **4. Monitor corrective actions** The Dietary Manager will complete weekly audits of 3 random tray temperatures for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
F 812 SS=E	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		

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F 812	Continued From page 28 §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, the facility staff failed to serve foods under sanitary conditions as evidenced by hot foods temperatures that were below 135 degrees Fahrenheit (F) on three (3) of 12 observations. Findings included ... During a food test tray assessment on February 8, 2019, at approximately 12:45 PM, hot foods such as Ham (117 F), scalloped potatoes (121 F), and puree pork (131 F) tested below 135 degrees Fahrenheit (F). During a face-to-face interview on February 8, 2019, at approximately 1:00 PM, Employee #7 acknowledged the findings.	F 812	**F 868** **1. Corrective action for resident** No residents were affected. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** The QAPI Committee has been in-serviced on the attendance requirements for meetings by the Administrator. A new sign in sheet has been created with all required committee members listed to prevent oversights. Notes will be kept to document why required members may not have been present at a particular meeting to future reference. I a regular member is unable to attend a meeting; every effort will be made to ensure that a suitable designee is present per the federal regulations.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and	F 868	**4. Monitor corrective actions** The Quality Coordinator will complete monthly audits of QAPI meeting sign-in sheets prior to the beginning of the meeting and again before the meeting adjourns. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 868	Continued From page 29 assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on review of the quality assessment and assurance committee meeting sign-in sheets and staff interview, the facility staff failed to ensure the Infection Preventionist was present at one (1) of one (1) Quality assessment and assurance (QAA) committee meetings. The facility census on the first day of survey 60. Findings included ... A review of the quality assessment and assurance committee meeting sign-in sheets revealed that the committee met on January 25, 2019. After a review of the committee sign-in sheets it was noted the facility did not have an infection preventionist present during the quality assessment and assurance meeting in January 2019. There was no evidence that an infection preventionist attended quarterly quality assessment and assurance meetings. During a face-to-face meeting on February 11, 2019 at approximately 2:00 PM, Employee #1 acknowledged the findings.	F 868		
F 880	Infection Prevention & Control	F 880		

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F 880 SS=E	Continued From page 30 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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	F 880	**F 880** **1. Corrective action for resident** No residents were affected. **2. Identify other residents** All residents had the potential to be affected by this alleged practice. **3. Systemic changes** The Infection Preventionist has been educated by the Director of Quality on the requirements of the role with regard to surveillance to identify, track, and monitor infections or communicable diseases within the facility. New tools have been created to facilitate facility surveillance activities. The findings will be reported monthly to the QAPI committee. **4. Monitor corrective actions** The Director of Quality will complete monthly audits of the Infection Control reports. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	

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F 880	Continued From page 31 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a system of surveillance to identify track and monitor infections or communicable diseases within the facility; failed to maintain one (1) of one (1) ice machine on the 3 West resident care unit in clean condition, and failed to conduct a facility risk assessment to identify where Legionella and other waterborne pathogens could grow and multiply. The facility census on the first day of survey 60.	F 880		

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F 880	Continued From page 32 Findings included... 1. The facility staff failed to develop a system of surveillance to identify track and monitor infections or communicable diseases within the facility. On February 7, 2019, at approximately 1:45 PM a review of the facilities infection prevention and control program was conducted. At this time, it was noted that the surveillance documentation presented was not a systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. Infectious surveillance data for April and May 2018, showed that the data was not used for staff education to help minimize the spread of the infection (e.g., staff education and competency assessment). Employees' # 1 and # 11 acknowledged the findings during a face-to-face interview on February 7, 2019, at approximately 1:45 PM. 2. One (1) of one (1) ice machine on West was soiled with mineral deposits at the tip of the water dispenser. Employee #8 acknowledged the finding during a face-to-face interview on February 6, 2019, at approximately 4:15 PM 3. A review of the facility's water management program on February 11, 2019, at approximately 1:55 PM showed	F 880		

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F 880	Continued From page 33 that a facility risk assessment that identifies areas where water borne pathogens such as legionella could grow and spread in the facility's water system was not available. Employee #9 acknowledged the finding during a face-to-face interview on February 11, 2019, at approximately 2:00 PM.	F 880	**F 908** **1. Corrective action for resident** The 18 residents that use wheelchairs were assessed for appropriate seating and positioning by the rehabilitation department. Their wheelchairs have been either repaired or replaced. **2. Identify other residents** No others residents were affected. **3. Systemic changes** The Rehabilitation, Plant Operations, Therapeutic Recreation, and Nursing staff have been educated on identifying wheelchairs in need of repairs, the process for reporting, repairing, and replacing wheelchairs. **4. Monitor corrective actions** The Director of Rehabilitation will complete monthly audits of the condition of resident wheelchairs. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. The facility's date of alleged compliance is **March 25, 2019.**	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain essential equipment in safe condition as evidenced by nine (9) of 18 resident's wheelchairs that were observed with various mechanical concerns. Findings included ... During an evaluation of resident's wheelchairs on February 7, 2019, at approximately 11:00 AM, nine (9) of 18 wheelchairs were observed with torn armrests, loose armrests, loose brakes and worn out wheels. During a face-to-face, interview on February 7, 2019, at approximately 11:00 AM, Employee #8 revealed that the facility does not stock wheelchair spare parts and does not maintain the	F 908		

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F 908	Continued From page 34 wheelchairs. These observations were acknowledged by Employee #8 during a face-to-face interview on February 7, 2019, at approximately 11:00 AM.	F 908		