STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	06/26/2018

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

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L 000	Initial Comments The Annual Licensure Survey was conducted at Bridgepoint Capitol Hill from June 18, 2018 through June 26, 2018. Survey activities consisted of a review of 46 residents' clinical records. The following deficiencies are based on observation, record review 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 following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status Apt- Apartment ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning	L 000		

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L 000	Continued From page 1 ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for	L 001		

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L 001	Continued From page 2 nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to ensure the contact information to include the names, mailing and email addresses for all pertinent State agencies and advocacy groups were posted and failed to ensure the posting included a statement that the resident may file a complaint with the State Survey Agency was posted in an accessible and understandable manner. The resident census was 113 on the first day of survey. Findings included ... During tour of the facility on June 22, 2018 at 2:30 PM, the "Important Facility Information" sign was observed posted on the wall beside the 6th floor elevator doors, at the height of elevator in small print. The "Important Facility Information" sign contained telephone numbers "to report grievances" to the following organization: the facility administrator, BridgePoint Healthcare Compliance Line, Department of Consumer and Regulatory Affairs, District Ombudsman, and District of Columbia Office of Aging. However, the signage failed to display the mailing or email address for aforementioned organization. In addition, the sign does not correctly reflect the current name of the State Survey agency. Listed on the sign is Department of Consumer and Regulatory Affairs; which should be the Department of Health, Health Regulations and Licensing Administration. Further inspection of the required posting showed that the font size of the print was very small and difficult to read for someone in a wheelchair.	L 001	L 001, 3002.1 Nursing Facilities F 575 SS=F, Required Postings 1. Old signs of important patient information were taken down and replaced with signs with larger fonts and placed at the height accessible to wheelchair patients. New signs with updated names, phone and emails addresses have been ordered and will be placed when received. 2. The important facility information signs when received will be posted at a level where wheelchair residents care able to see and read. 3. Recreation staff will be in-serviced to ensure that other posted signs are in bold print and posted where wheelchair patients can see. 4. Administrative staff will conduct monthly rounds to ensure that all signs are posted correctly at the correct level where patients can see and read. Findings from the rounds will be reported at the monthly QAPI Committee meeting. Monitoring will continue until 95% of compliance is sustained for 3 consecutive months	8/15/18 and ongoing 8/31/18 9/15/18 8/31/18 and ongoing

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L 001	Continued From page 3 The facility failed to ensure the posting accurately reflected all State agencies information to include mailing and email addresses, in a font size that is accessible and understandable by individuals in wheelchairs. During a face to face interview on June 22, 2018, at 3:00 PM, Employee #1, Administrator was shown the required posting of contact information. Employee #1 stated that she agreed that the font size utilized for the sign was too small. Employee #1 further stated that corrections would be made to the sign and move to a lower location so it can could be seen by individuals in wheelchairs. Employee #1 acknowledged all the findings.	L 001		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing	L 051		

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L 051	Continued From page 4 employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on observation, record review and interviews for one (1) of 46 sampled Residents, Charge nurse failed to initiate a care plan with goals and approaches for one (1) resident who had an Upper Respiratory Infection. Resident #79 Findings included... Resident# 79 admitted on April 12, 2007, with diagnoses to include Cerebrovascular Disease, Hyperlipidemia, Diabetes Mellitus, Hypertension, Hypothyroidism, and Peripheral Vascular Disease. June 20, 2018, 20:16 Nurse Practitioner Health Status Note showed, "Asked to assessed Resident with c/o [complaint of] worsening of a cough and chest congestion. Resident report the cough is worse and her chest feels more congested. Lungs coarse breathe sounds at bases... Increased a non-productive cough and chest congestion, on nebs and Guaifenesin as needed. Start Azithromycin 500mg PO [by mouth] x[times] 1, then 250mg PO daily times 5 days for an upper respiratory infection." Resident #79 was observed coughing continuously for three (3) days: June 22, 23, and 24, 2018. A review of care plan showed no evidence that charge nurse initiated a care plan with goals and approaches to address the resident's Upper	L 051	L 051, 3210.4 Nursing Facilities 1. Resident #79's care plan was initiated on 6/20/18 for Upper Respiratory Infection. Upper Respiratory infection of Resident #79 has since resolved. 2. Care plan of residents with change in condition are being reviewed daily by the unit managers/Charge Nurses at clinical meeting to ensure that there is a care plan in place for any patient who has a change in condition. 3. Licensed Nurses/Charge Nurses/House Supervisors will be in-serviced by the QA Director on initiating a care plan when there is a change in condition. 4. Unit Manager/Charge Nurse will review 5 resident's care plan a week of residents who has had a change in condition to ensure that the care plan has been initiated/updated to reflect the problem at hand. Result of the audit/review will be reported at the QA Committee meeting monthly. Monitoring for compliance will continue until 100% compliance is sustained for 3 consecutive months.	6/20/18 8/16/18 8/30/18 8/30/18

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L 051	Continued From page 5 Respiratory Infection. A face-to-face interview conducted with Employee# 6 on June 25, 2018, the employee reviewed the care plan and acknowledged the findings B. Based on observations, policy review, record reviews and staff interview for three (3) of 46 sampled Residents, the charge nurse failed to update the care plan to include goals and approaches to address two (2) residents who smoke a plan for safe smoking in a smoke-free facility and for a one (1) resident with multiple falls. Resident #34, #45 and #81. Findings included... 1. Facility staff failed to update the smoking care plan to include goals and approaches to address Resident #34 who smoke in a smoke-free facility. A. Resident #34 admitted to the facility March 1, 2005, with diagnoses to include Nicotine Dependence, Unspecified, and Uncomplicated During an observation on June 25, 2018, at 11:00 AM, Resident #34 observed seated in a smoke area not smoking. During a face to face interview with Resident #34 on June 25, 2018, at 11:00 AM, the resident stated that she smokes and her daughter buys her cigarettes, which are kept in her pocketbook. Medical record review conducted on June 25, 2018, showed an annual Minimum Data set dated October 14, 2017. The Resident was coded as	L 051	L 051, L 3210.4 Nursing Facilities 1. A. Smoking care plan for resident #34 was updated on 7/20/18. B. Smoking care plan for resident #81 was updated on 6/28/18 C. Fall Care plan for resident #45 was updated on 8/16/18 2. A. An audit of care plans for residents who smoke has been conducted by the unit managers/charge Nurse to ensure that there is a smoking care plan with goals that reflect a safe smoking plan for the resident living in a smoke free environment. B. The smoking care plan will be updated upon resident's admission/re-admissions to the facility and quarterly. C. Fall care plan of patients who fall are currently being revised timely to include interventions for the fall. 3. A. Licensed Nurses will be in-serviced on timely revision of smoking care plans of patients who smoke on admission/re-admission to the facility and quarterly. B. Licensed nurses will be re-in serviced on timely revision of fall care plans to include intervention for the fall that occurred. (Continued in next page)	7/20/18 6/28/18 8/16/18 8/17/18 8/30/18 8/30/18 8/30/18 8/30/18

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L 051	Continued From page 6 one (1) "Yes Tobacco Use" under Section J1300 (Current Tobacco Use). A review of the Resident's care plan for smoking lacked evidence that charge nurse updated the plan with new goals and approaches to reflect a safe smoking plan for the Resident living in a smoke-free facility. A face-to-face interview with Employee# 6 on June 25, 2018, she reviewed the care plan and acknowledged the findings. B. Resident #81 was admitted on June 6, 2017, with diagnoses to include Artheosclerotic Heart Disease, Atrial Fibrillation, and Diabetes Mellitus. During an observation on June 25, 2018, at 11:00 AM, Resident #81 observed seated in a smoke area not smoking. During a face to face interview with Resident #81 on June 25, 2018, the resident stated he smokes and he buys his own cigarettes, which are kept in the pocket. If the resident runs out of cigarettes, there are othr residents that are ble to provide one for him. Medical record review on June 25, 2018 showed an annual Minimum Data Set dated June 14, 2018. The resident was coded as one (1) "Yes Tobacco Use" under Section J1300 (Current Tobacco Use). A review of the Resident's care plan for smoking lacked evidence that charge nurse updated the plan with new goals and approaches to reflect a safe smoking plan for the resident living in a smoke-free facility. A face-to-face interview with Employee# 6 on	L 051	4. A. QA Director will audit charts of any resident who had a fall to ensure that the care plan has been updated with new intervention for the fall and that all required documentations are in place. B. QA Director will audit charts of patients who smoke weekly and quarterly to ensure that there is a smoking care plan with goals that reflect a safe smoking plan for residents living in a smoke free environment. Monitoring will continue until 100% compliance is sustained in 3 consecutive months.	8/30/18 8/30/18

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L 051	Continued From page 7 June 25, 2018, she reviewed the care plan and acknowledged the findings. 2. Facility staff failed to update the care plan to include goals and approaches for a resident with multiple falls. Resident# 45 was admitted on 4/25/18, with diagnoses which include Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominant side, Chronic Respiratory Failure, and Essential (Primary) Hypertension. Record review of the facility's undated policy titled "Falls and Fall Risk, Managing" showed "if falling recurs despite initial interventions, staff will implement additional or different interventions." Review of the medical record on 6/22/18, at 11:00 AM showed Resident #45 experienced falls as follows: "On 5/3/18 "resident observed lying on his back on the floor in his room, no injuries observed at this time." "On 5/12/18 "resident was observed sitting on the floor mat with head on the bed, no injuries observed." "On 5/17/18, resident observed on the floor mat next to his bed ...no injuries." "On 6/2/18 "resident was observed laying on the floor mat in his room, no injuries" A further review of the care plan on 6/22/18, at 11:30 AM failed to show evidence the charge nurse revised the care plan to include updated goals and approaches for each fall. During a face-to-face interview on 6/22/18, at	L 051		

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L 051	Continued From page 8 12:00 PM with Employee# 20, "I do the care plans, I see I was supposed to update the care plan after each fall assessment, Employee# 20 acknowledged the finding.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating;	L 052		

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L 052	Continued From page 9 (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, staff interview and medical record review for three (3) of 46 sampled residents charge nurse failed to maintain grooming/personal hygiene for residents who are unable to carry out activities of daily living (ADL). Residents' #4, #19 and #403 Findings included ... 1. Charge nurse failed to ensure that Resident #4's, who is unable to carry out her own activities of daily living, nails were trimmed. Resident #4 was admitted on July 28, 2016 with diagnosis that included Respiratory Failure, Chronic Obstructive Pulmonary Disease, Systemic Lupus Erythematosus, and Hemiplegia following a Cerebral Infraction, Dysphagia, Contractures, Seizures and Anemia. Review of the Quarterly Minimum Data Set dated June 9, 2018, revealed that Resident #4 was	L 052	L 052, 3211.1 Nursing Facilities 1. A. Resident #4 nails were trimmed on 6/18/18 B. Resident # 19 was provided ADL with the assistance of 3 Certified Nursing Assistants on 6/19/18 C. Resident #403 nails were immediately trimmed on 6/20/18 2. A. Audit of residents who are dependent on ADL was conducted on 8/12/18. No resident was identified who was affected by this deficient practice. B. 100% audit of residents' finger nails were completed on 8/17/18. Residents whose finger nails were identified as long were immediately trimmed. 3. A. Licensed nurses and Certified Nursing Assistants will be re-educated on providing ADL timely to residents who are dependent on ADL. B. Resident's nails are currently being trimmed on shower/bath days and as needed. 4. A. Unit Manager/Charge Nurse will check 5 resident's finger nails a week to ensure that the nails are trimmed. B. Unit Manager/Charge Nurse will monitor daily that dependent residents are provided with ADL timely and as needed. (Continued in next page)	6/18/18 6/19/18 6/20/18 8/12/18 8/17/18 9/15/18 8/17/18 9/15/18 9/15/18

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L 052	Continued From page 10 coded as total dependent on staff for personal hygiene, dressing and eating under Section G0110 (Activities of Daily Living Assistance). Also, under Section G0400 (Functional Limitation in Range of Motion) the resident was coded as having upper extremity impairment on both sides. On 6/18/18 at 2:17 PM Resident #4 was observed in bed with long nails. Employee # 25, who was present at the time of the observation acknowledged the resident's nails were long and stated, "Okay, I will cut them." Charge nurse failed to ensure Resident #4's nails were trimmed. 2. Charge nurse failed to ensure the provision of activities of daily living (bathing, dressing and toileting) care for one (1) Resident who was totally dependent on staff for all of his care. Resident #19. On June 20, 2018 at approximately 10:25AM Resident #19 was observed sitting in a recliner in his room with upper body exposed and hospital gown in his lap. There was a strong odor of urine in the room and the floor was "sticky". Employee #5 was asked to go to Resident #19's room. Resident #19 remained seated in the recliner. Resident #19 was admitted to the facility on March 15, 2017 with diagnoses which include Hypertension, Viral Hepatitis, Diabetes Mellitus, Hyperlipidemia and Alzheimer's Disease. On June 20, 2018 at 11:00 AM a medical record	L 052	Findings from the monitoring will be reported at the monthly QAPI meeting. Monitoring will continue until 95% compliance is sustained for 3 consecutive months.	

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L 052	Continued From page 11 review of Section G (Functional Status) Activities of Daily Living (ADL), in the annual MDS with an assessment reference date (ARD) of March 27, 2018 showed that Resident #19 is coded as a four (4), indicating that he is totally dependent on staff for all care and is coded as a three (3) for support, indicating that he needs physical assistance from two or more staff for dressing, toilet use and personal hygiene. The resident is coded as a (3) in Section H 300 Urinary Continence (Bladder and Bowel) indicating that he is always incontinent. At 12:00 PM on June 20, 2018 Resident #19 was again observed sitting in a recliner in his room with upper body exposed and hospital gown in his lap. The floor was still "sticky" and the odor of urine was much stronger. Employee #23, the assigned Certified Nursing Assistant (CNA) was identified immediately after the observation and was asked when would care be provided to Resident #19. Employee #23 responded that she could not provide care to the resident by herself. "It takes three of us to do him and everybody is busy so I have to wait." Employee #23 acknowledged that she had not provided any care to Resident #19 and further stated that the night staff had told her that they had washed him up before the left. A face-to-face interview was conducted with Employee #5, RN, Unit Manager, at approximately 12:40 PM. During the interview the employee confirmed that there were 38 residents and three (3) CNAs on the unit at that time. The census and staffing were verified by the posting on the assignment board.	L 052		

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L 052	Continued From page 12 The charge nurse failed to ensure the provision of ADL care to Resident #19 who was totally dependent on staff for his care. Employee #5 acknowledged the finding. 3. Charge nurse failed to maintain grooming/personal hygiene for a resident who is unable to carry out activities of daily living (ADL). Resident #403. Observation on 6/20/18, at 2:05 PM showed Resident #403 sleeping in Geri-chair with long fingernails to the right and left hand. Employee# 4, was present at the time of the observation stated yes the fingernails are too long, and the nurse should have trimmed them. Review of the medical record on 6/20/18, at 3:00 PM showed Resident# 403 admitted on 6/6/18, with diagnoses which include Encephalopathy (unspecified), Cerebrovascular Disease affecting unspecified side, Chronic Respiratory Failure, Cerebral Infarction (unspecified), Persistent Vegetative State. A review of the nursing care plan on 6/20/18, at 4:00 PM show Resident# 403 has an ADL, self-care performance deficit r/t (related to) Diagnoses of CVA (cerebral vascular accident), Encephalopathy, Respiratory Failure and Vegetative State requiring total care by staff. Goal: Resident is unable to express her preferred goal Diagnosis of Persistent Vegetative State;	L 052		

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L 052	Continued From page 13 therefore staff will anticipate and provide the care of all ADLs on a total care basis to meet/maintain her dignity thru the next review period. A further review of the medical record on 6/20/18, showed a Comprehensive Minimum Data Set (MDS) dated 6/15/18, show section G [Functional Status] ADL Self-Performance Resident was coded as 4, total dependence, full staff performance every time during the entire 7-day period, activities which include personal hygiene. Resident #403 was coded as 4 (total dependence on staff to perform). During a face-to-face interview on 6/20/18, Employee #4, acknowledged the finding.	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview during a review of staffing [direct care per Resident day hours], it was determined that facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per Resident per day for one of 16 (sixteen) days reviewed in accordance with Title 22 DCMR Section 3211,	L 056	L056, 3211.5 1. The days identified have been reviewed for accuracy and so acknowledged.	8/13/18

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L 056	Continued From page 14 Nursing Personnel and Required Staffing Levels. The findings include: According the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of Nurse Staffing was conducted on June 15, 2018, at approximately 1:00 PM. Of the sixteen (16) days reviewed, thirteen of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day as follows: Sunday, March 18, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours. Monday, March 19, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.03 hours. Sunday, April 1, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.74 hours. Monday, April 2, 2018, showed that the facility	L 056	2. 56 days were reviewed post survey; 5 days were found to be at risk to be under 4.1 3. A. Time and attendance for staff will be monitored for recognition or disciplinary action. B. Unit secretaries will be rotated on weekends to help obtain staffing coverage. Unit secretaries will be based on the 6th floor to help those supervisors with staffing needs. 4. A. Facility will establish a Staffing Committee to evaluate staffing patterns and make recommendations as needed. B. Staffing Committee will report findings/recommendations to QAPI Committee meeting monthly.	8/13/18 8/30/18 8/25/18 9/15/18

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L 056	Continued From page 15 provided direct nursing care per resident at a rate 3.89 hours. Tuesday, April 3, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.03 hours. Sunday, April 8, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.65 hours Sunday, April 15, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.71 hours Sunday, May 13, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.36 hours Saturday, May 26, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.60 hours Sunday, May 27, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.53 hours Monday, May 28, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.74 hours Friday, June 15, 2018, showed that the facility provided direct nursing care per resident at a rate of 4.03 hours	L 056		

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L 056	Continued From page 16 Saturday, June 16, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.46 hours Sunday, June 17, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.53 hours A face-to-face interview was conducted with Employee #26 at the time of the staffing review, he/she acknowledged the findings.		L 009, 3219.1 Nursing Facilities 1. A. 1. Work order submitted to track the repair of the curtains. A.2. Service call placed with contractor to replace the curtains B.1. W/O submitted to track the repair of the curtains. B.2. Service call placed with contractor to replace the curtains C. The soiled pans were re-washed in the 3-Compartment sink and allowed to air dry before use.	6/18/18 6/18/18 6/18/18
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to store and distribute foods under sanitary conditions as evidenced by two (2) of four (4) torn air curtains in the walk-in refrigerator, one (1) of five (5) torn air curtain in the produce cooler, five (5) of 23 four-inch pans that were stored wet and ready for use, and a soiled kitchen floor. Findings included... During a walk-through inspection of Dietary Services on June 18, 2018, at approximately 9:30 AM, the following were observed: 1. Two (2) of four (4) air curtain slats, installed to help maintain the temperature in the walk-in	L 099	D. The Director assessed the floor. Several areas have permanent stains due to the aging of the floor. Director confirmed general utility staff completes frequent daily cleaning. It has also been determined that while some improvement can be made on the floor, due to the age of floor, most tiles have permanent stains that cannot be removed. 2. A. Ambient temperature of both walk-in coolers were taken and logged below 40F. B. An inventory of all curtains conducted to confirm there were no other torn curtains. C. W/O submitted to track the repair of the curtains. D. Service call placed with contractor to replace the curtains	6/18/18 6/18/18 6/18/18 6/18/18

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L 099	Continued From page 17 refrigerator. 2. One (1) of five air curtain slats, installed to help maintain the temperature in the produce cooler, was torn. 3. Five (5) of 23 four-inch pans were stored wet in the clean, ready for use area, one on top of the other. When pans are not allowed to air-dry, the potential for bacterial growth increases. 4. The kitchen floor was stained throughout with some areas looking discolored, faded and dirty. During a face-to-face interview on June 18, 2018, at approximately 9:30 AM, Employee #9 confirmed the findings. Based on observations and staff interview, the facility failed to maintain foods at appropriate temperature as evidenced by cold food items such as peaches and milk that tested beyond required holding temperatures of 41 degrees Fahrenheit. Findings included ... During a test tray food temperature assessment on June 18, 2018, at approximately 1:30 PM, and on June 20, 2018, at approximately 1:15 PM the following were observed: Cold food items such as peaches (58 degrees Fahrenheit) and milk (53 degrees Fahrenheit and 43 degrees Fahrenheit) were held at temperatures above 41 degrees Fahrenheit. 1. On June 18, 2018, at approximately 1:30 PM, a	L 099	3. A. Food Service Director will review condition of curtain slates in the walk-in refrigerator monthly and will report to QAPI committee monthly until 6 consecutive months of compliance is sustained. B. Food Service Director will review condition of curtains slates in the produce cooler monthly and will report to QAPI committee monthly until 6 consecutive months of compliance is sustained. C. All general utility staff were in-serviced on the expectation of ensuring all pans are dry before storing on the dry rack. D. A request will be submitted to replace the floors 4. A. The director of food services will conduct monthly audits until 6 months of consecutive compliance is achieved. Goal: 100% Compliance Sample: 20 audits p/month N= number of days curtains are in good condition D= number of days of the audit B. The director of food services will conduct monthly audits until 6 months of consecutive compliance is achieved. Goal: 100% Compliance Sample: 20 audits p/month N= number of days curtains are in good condition	8/15/18 and ongoing 8/15/18 and ongoing 6/17/18 8/30/18 and ongoing 6/20/18 and ongoing 8/15/18 and ongoing

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L 099	Continued From page 18 bowl of peaches from a test tray tested at 58.6 degrees Fahrenheit and a half-pint carton of milk from the same test tray tested at 53.1 degrees Fahrenheit. 2. On June 20, 2018, at approximately 1:15 PM, a half-pint carton of milk from the test tray tested at 42.8 degrees Fahrenheit. During a face-to-face interview on June 18, 2018, at approximately 1:30 PM and on June 20, 2018, at approximately 1:15 PM, Employee #9 confirmed the findings.	L 099	C. The director of food services will conduct daily audits until 3 months of consecutive compliance is achieved. Goal: <10% Compliance Sample: 200 p/month N= number of pans that were wet in the dry rack D= number of pans audited	8/15/18 and ongoing
L 108	3220.2 Nursing Facilities The temperature for cold foods shall not exceed forty-five degrees (45°F) Fahrenheit, and for hot foods shall be above one hundred and forty degrees (140°F) Fahrenheit at the point of delivery to the resident. This Statute is not met as evidenced by: Based on observations made on June 18, 2018, at approximately 1:30 PM, and on June 20, 2018, at approximately 1:15 PM, it was determined that the facility failed to maintain foods at appropriate temperature as evidenced by cold food items that tested beyond required holding temperatures. Findings included ... Cold food items such as peaches ((58 degrees Fahrenheit) and milk (53 degrees Fahrenheit and 43 degrees Fahrenheit) were held at temperatures above 41 degrees Fahrenheit during a test tray assessment on June 18, 2018, and June 20, 2018.		D. The director of food services will conduct monthly audits to gauge condition of floor and will report findings to QAPI committee Goal: 90% Compliance Sample: 4 Observations monthly N= number of observations where floor is not soiled, cracked, stained, or otherwise dirty D= number of monthly observations	9/15/18 and ongoing
		L 108	L 108, 3220.2 Nursing facilities 1. A. The milk and peaches were immediately discarded and not served to residents. B. The Director immediately discarded the milk. It was not served to residents	6/18/18 6/20/18

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L 108	Continued From page 19 These observations were made in the presence of Employee #9 who acknowledged the findings.	L 108	L 108 Continued 2. A. The Director immediately reviewed temps to determine if other cold products were at room temperature. No food or milk products were identified above 41F.	6/18/18
L 182	3229.4 Nursing Facilities In conjunction with the resident's admission, stay, and discharge, the functions of the social services program shall include the following: (a) Direct service, including therapeutic interventions, casework and group work services to residents, families and other persons considered necessary by the social worker; (b) Advocacy on behalf of residents; (c)Discharge planning; (d)Community liaison and services; (e) Consultation with other members of the facility's Interdisciplinary Care Team; (f) Safeguarding the confidentiality of social service records; and (g) Annual in-service training to other staff of the facility on subjects including, but not limited to, resident's rights, psychosocial aspects of aging and confidentiality. This Statute is not met as evidenced by: Based on interview and record review for one (1)of 46 sampled residents facility staff failed to develop and implement an discharge plan that focused on the resident's desire to discharge from facility (Resident# 45).		B. The Director immediately reviewed temps to determine if other cold products were at room temperature. No food or milk products were identified above 41F. 3. A. i. Staff in-serviced that all cold items are to be stored in freezer 30 minutes before tray line begins. A. ii. Dietary Aide (Server) will temp cold food items before tray line starts. B. i. Staff in-serviced on process for serving milk before each tray line, which includes placing milk in freezer 30 mins before each tray line B. ii. Dietary Aide (Checker) will record temp of milk before tray line to verify temp is below 41F.	6/20/18 8/16/18 8/16/18 6/18/18 8/21/18

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L 182	Continued From page 20 Findings included... Resident# 45 admitted on 4/25/18, with diagnoses which include Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominant side, Chronic Respiratory Failure, and Essential (Primary) Hypertension. Review of the Initial Social Service Assessment on 6/22/18, at 11:00 AM dated 4/26/18, showed under section discharge potential there is a check in the box which reads "SW [Social Worker] has reviewed options for discharge planning with Resident/Responsible Party". Under section Anticipated Discharge Time Frame and Destination the note reads: "In speaking with the next of kin, the tentative plan is for Resident# 45 to return to his apartment or the Dominican Republic and Initial Discharge Plan: Home/Apt[Apartment]. Review of the medical record showed Resident# 45 is receiving therapy and a Physical Therapy daily note dated 6/14/18, "patient is consistent with participation in therapy." Review of the Physical Therapy Progress and Discharge Summary dated June 18, 2018, Resident #45 "End of Care" was schedule for June 19, 2019 secondary to lack of participation. Review of Speech Therapist Progress and Discharge Summary dated June 6, 2018, Resident #45 "End of Care" was scheduled for June 6, 2018. Family and staff education provide regarding resident's deficits and reasoning why oral intake and speaking valve not tolerated. Resident #45 continued to receive occupational		L 108 Continued 4. A. The director of food services will conduct daily audits of temperatures recorded for cold foods. Goal: 95% Compliance Sample: 20 Observations monthly N= number of observations where cold food items are <37F D= number of monthly observations B. The director of food services will conduct daily audits of temperatures recorded for cold foods. Goal: 95% Compliance Sample: 20 Observations monthly N= number of observations where cold food items are <37F D= number of monthly observations L 182, 3229.4 1. SW will review d/c plan and update as needed in a more specific manner. 2. Charts will be audited for d/c plan to ensure all resident/patients will not have the potential to be affected by the same deficient practice. (Continued in next page)	6/20/18 and ongoing 6/20/18 and ongoing 8/30/18 8/30/18

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L 182	Continued From page 21 therapy services. According to the Occupational therapist Progress and Updated Plan of Care dated June 20, 2018, the current "Goal date" is July 21, 2018 for bed mobility. A further review of the medical record showed a pre-discharge plan with the resident/family caregivers evaluate progress...evaluate/record the resident's abilities and strengths with family/caregivers/IDT [interdisciplinary team members], make arrangements with community resources to support independence post-discharge. The medical record lacked documented evidence the facility staff implement a discharge plan to address Resident #45 desire to return home or to move to Maryland to be closer to family. During an interview with Employee #8, on 6/22/18, at 1:00 PM stated I just inherited Resident # 45 from another Social Worker; let me look into this about the discharge plan. During an interview on 6/22/18, at 2:30 PM with Employee #8, stated the interventions written in the care plan were not completed. Also, Employee #8 stated she spoke to the responsible party, who indicated that it is his desire to move Resident #45 to Maryland to be closer to family. During a face-to-face interview on 6/22/18, at 3:30 PM Employee #8, acknowledged the finding.	L 182	3. A. D/C plan is discussed at the initial and quarterly care plan meetings. B. Resident #45's D/C plan will be discussed in a care plan meeting scheduled for 8/28/18 4. Social work will audit resident's D/C plan monthly and findings will be presented at QAPI meetings monthly. Monitoring will continue until 95% compliance is sustained for 3 consecutive months.	8/22/18 8/30/18 8/30/18
L 201	3231.12 Nursing Facilities Each medical record shall include the following information:	L 201	L 201, 3231.12 1. The medical records were reviewed to verify findings: Patient #22 – Chart Reviewed Patient #154 – Chart Reviewed	8/13/18

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L 201	Continued From page 22
	
	(a) The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion;
	
	(b) Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor;
	
	(c) Medicaid, Medicare and health insurance numbers;
	
	(d) Social security and other entitlement numbers;
	
	(e) Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses;
	
	(f) Date of discharge, and condition on discharge;
	
	(g) Hospital discharge summaries or a transfer form from the attending physician;
	
	(h) Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation;
	
	(i) Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease;
	
	(j) Current status of resident's condition;
	
	(k) Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo
		L 201	2. Review of 15 charts (5 from each floor – Floors 4, 5&6) was conducted and found similar findings. The findings were all corrected
			
			3. The Director of Health Information Management department/Designee will perform audits on the medical records on a weekly basis on the systematic organization of the medical records.
			Education will be provided to all disciplines to maintain the effectiveness of the process.
			
			4. The Director of Health Information Management/Designee will monitor compliance with audited charts.
			
			Sampling: 10 medical records/month
			Goal: 80%
			N = # medical records maintained in a systematically organized manner
			D = # medical records audited in data month
			
			The Director of HIM/Designee will report monthly findings; analysis and corrective actions will be reported to Risk Committee, Quality Assurance Performance Improvement (QAPI). Monitoring will continue indefinite.
				8/14/18
				
				8/20/18
				
				9/4/18

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L 201	Continued From page 23 condition; (l) The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m) Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o) The plan of care; (p) Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on medical record review and staff interview for one (1) of 46 sampled residents, facility staff failed to maintain a medical record that accurately documented a resident assessment (post fall) and failed to ensure that Resident medical records were maintained in a systematically organized manner. Residents' #22, 45, and #154.	L 201		

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

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L 201	Continued From page 24 Findings included ... 1. Facility staff failed to maintain a medical record that accurately documented a resident assessment (post fall). Resident #45. Review of the medical record on 6/25/18, at 9:00AM showed Resident# 45 admitted on 4/25/18, with diagnoses which include Hemiplegia and hemiparesis following Cerebral Infarction affecting left dominant side. Chronic Respiratory Failure, Essential (Primary) Hypertension. Review of the medical record on 6/21/18, showed a form dated 5/17/18, and under section Incident Description: Resident observed on the floor mat next to his bed, bed on low position [sic]. Immediate Action Taken: head to toe assessment done by nurse, no apparent injury noted and listed under section Injuries Report Post Incident select one: top of scalp was selected as the injury location. During an interview on 6/25/18, at 10:30 AM with Employee #4 stated "the resident did not have an injury, I believe that is a mistake." During an interview on 6/25/18 at 11:00 AM with Employee #19, affirmed that she completed the form stated "that is a mistake he did not have an injury how did that get there." A further review of the medical record failed to show evidence Resident #45 sustained a scalp injury post fall on 5/17/18. Facility staff failed to maintain a medical record with an accurately documented resident assessment.	L 201		

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L 201	Continued From page 25 During a face-to-face interview on 6/25/18, at 12:30 PM Employee # 4 and #19 acknowledged the finding. 2. The facility staff failed to ensure that Resident medical records were maintained in a systematically organized manner. Residents' #22 and #154. A. During a review of Resident #22's clinical record the resident's admission paperwork, history and physical, physician orders and consents were stored under the "order" section of the record. B. During a review of Resident # 154's clinical record the resident's discharge papers from the hospital were in the "Order" section of the record and admission paperwork was stored under the "Progress note" section of the record. There was no evidence that facility staff maintained the resident's paper chart in a manner that was systematically organized. Instead, the information located on the record was comingled and not categorized by section or relevance. During a face-to-face interview with Employees # 4 and #3 on June 25, 2018 at 12:50 PM they stated there has been no unit secretary for over a month and the facility is in the process of hiring someone for the position.	L 201		

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L 214	Continued From page 26	L 214		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain resident's area free of accident hazards as evidenced by two (2) uncovered electrical outlets with exposed electrical wires in two (2) of 55 resident's rooms. Findings included ... During observations on the fourth floor on June 19, 2018 at approximately 3:15 PM, two (2) electrical outlets located behind the resident's bed in two (2) of 55 resident's rooms (#4118 and #4157) lacked a cover plate to prevent exposure to electrical wires and connectors. During a face-to-face interview on June 19, 2018, at approximately 3:15 PM, Employee #10 confirmed the findings.	L 214		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a) Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b) In new facilities or when major renovations are made to existing facilities, be of type in which the	L 306		

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L 306	Continued From page 27 call bell can be terminated only in the resident's room; (c) Be of a quality which is, at the time of installation, consistent with current technology; and (d) Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the call bell system in good working condition as evidenced by a call bell in one (1) of 55 resident's rooms that failed to alarm when tested . Findings included ... During observations on the sixth floor on June 19, 2018, at approximately 1:45 PM, the call bell in resident room #6142 did not alarm when activated, which could hinder the resident's efforts to alert staff in the event of an emergency in one (1) of 55 observations. During a face-to-face interview on June 19, 2018, at approximately 3:15 PM, Employee #10 confirmed the findings.	L 306	L 410, 3256.1 1. The call bell in the resident room 6142 was checked by the nurse on 8/17/18 and it was noted to have alarmed at the nurse's station.	8/17/18
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and staff interview the facility failed to provide housekeeping and	L 410	2. 100% Call bell audit was conducted on 8/17/18 to ensure that all call bells alarm when tested. 1 room call bell did not alarm and work order was immediately put in place to have it fixed. No other room was affected by this deficient practice.	8/17/18

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L 410	Continued From page 28 maintenance services necessary to maintain a comfortable interior as evidenced by Fifty-five (55) of 109 broken Packaged Terminal Air Conditioning (P-tac) located in resident's rooms throughout the facility, soiled bathroom vents in six (6) of 55 resident's rooms, broken dresser drawers in three (3) of 55 resident's rooms, damaged floor tiles in 11 of 55 resident's rooms, dusty window blinds in eight (8) of 55 resident's rooms, a malfunctioning toilet in one (1) of 55 resident's rooms, and ambient temperatures that exceeded 81 degrees Fahrenheit (F) in two (2) of three resident activity lounges. Findings included ... Facility failed to ensure resident common areas were maintained in a safe, comfortable condition. During observations on the fourth, fifth and sixth floor on June 19, 2018, between 1:30 PM and 4:00 PM, and on June 21, 2018, between 1:00 PM and 4:00 PM, resident's rooms and common areas were observed with the following: 1. In fifty-five (55) of 109 resident's rooms, Packaged Terminal Air Conditioning (P-tac) units located in resident's rooms throughout the fourth, fifth and sixth floor did not provide cool air to enable residents to adjust room temperature to their preference. 2. Bathroom vents were soiled with dust in six (6) of 55 resident's rooms including rooms #4116, #4133, #4157, #5123, #5131, #5149. 3. Dresser drawers in resident's rooms #6119, #6131, and #6142 were hanging halfway open, unable to fully close due to chips, gashes and missing screws or nails in three (3) of 55	L 410	3. Nursing staff will be re-educated on completing work orders in Point click care for maintenance staff to address any call bell malfunctioning or any call light default that is observed. 4. Unit Managers/Charge Nurses will randomly audit 5 resident's rooms a week to ensure that the call light alarms when tested. Any negative findings from the audit will immediately be communicated to the maintenance team. These findings will be reported at the QA committee meeting monthly. Monitoring will continue until 100% compliance is sustained for 6 consecutive months. L 410, 3256.1 1. The bathroom vents in room 4116, 4133, 4157, 5123, 5131, and 5149 were cleaned immediately upon notification. 2. A random resident room audit, of at least 10 rooms/unit, was performed by the EVS supervisor. Bathroom vents found out of compliance were addressed immediately. 3. On 7/3/18, the EVS Supervisor held a mandatory in-service for all EVS staff to review the 13-step resident's room cleaning checklist. 4. The EVS Supervisor or designee will monitor compliance with resident room cleanliness.	9/15/18 9/15/18 6/19/18 6/19/18 7/3/18 7/3/18

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L 410	Continued From page 29 observations. 4. Floor tiles in 11 of 55 resident's rooms were warped and uneven (#4147, 5113, 5130, 6106, 6110, 6112, 6123, 6130, 6138, 6139, and 6143). 5. Window blinds in resident's rooms #4116, 5130, 5131,5138, 5144, 5145, 5146, 5149 were soiled with dust, eight (8) of 55 residents' rooms. 6. The toilet in room #4157 failed to flush when tested, one (1) of 55 resident's rooms. 7. The ambient temperature was 81.6 degrees F in the Activity lounge on the fifth floor and 81.5 degrees F in the Activity Lounge on the fourth floor on June 19, 2018, at approximately 4:00 PM. During a face-to-face interview on June 19, 2018, between 1:30 PM and 4:00 PM, and on June 21, 2018, between 1:00 PM and 4:00, Employee #10 and Employee #11 acknowledged the findings.	L 410	Sampling: 5 rooms/unit/week, total 15 rooms/week Goal: 90% N = # of observations that all elements of the checklist are performed D = # of observations in data month The EVS Supervisor will report monthly findings, analysis and corrective actions monthly to the Environment of Care Committee, and the Quality Assurance Committee at least quarterly. Monitoring will continue until 90% compliance is sustained for three consecutive months. L410, 3256.1 1. The window blinds in room 4116, 5130, 5131, 5138, 5144, 5145, 5146, and 5149 were dusted immediately upon notification. 2. A random resident room audit, of at least 10 rooms/unit, was performed by the EVS supervisor. Window blinds found out of compliance were addressed immediately. 3. On 7/3/18, the EVS Supervisor held a mandatory in-service for all EVS staff to review the 13 step resident's room cleaning checklist. 4. The EVS Supervisor or designee will monitor compliance with resident room cleanliness	6/27/18 6/27/18 7/3/18 7/3/18

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			Sampling: 5 rooms/unit/week, total 15 rooms/week Goal: 90% N = # of observations that all elements of the checklist are performed D = # of observations in data month The EVS Supervisor will report monthly findings, analysis and corrective actions monthly to the Environment of Care Committee, and the Quality Assurance Committee at least quarterly. L 410, 3256.1 1.A. Construction on new Air Handler Units (A/C and Heat) for the 5th and 6th floor B. Dressers in rooms # 6119, 6131,6142 have been replaced with new dressers. C. Room # 6106 renovation is complete D. Toilet was repaired E. Spot coolers were placed in the Activity Lounge on the 4th and 5th floors 2. Implemented daily EOC rounds by the Maintenance Department. Six (6) random rooms daily, one Maintenance per floor during checks. 3. A. Placed daily agendas and incorporated various trainings during daily Maintenance Dept. meetings.	8/1/18 and on going 7/20/18 7/17/18 & ongoing 6/22/18 6/21/18 6/20/18 6/27/18

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		L 306	B. Spot coolers where place in strategic areas to cool the resident rooms.	6/21/18
			4. A. Daily room temperature logs of resident's room are done in the morning and afternoon. Six (6) random rooms daily. All vent room on the 6th floor daily.	6/2018
			B. Daily room water temperatures and room temperatures are logged to ensure that they are within the Comfort range.	6/20/18
			Findings from EOC rounds and Corrective actions will be reported to the QAPI Committee monthly meeting.	
			Monitoring will continue until 90% compliance is sustained for 3 consecutive months.	