STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	08/15/2019

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F 000	INITIAL COMMENTS An unannounced Long Term Care Survey was conducted at Bridgepoint Sub-acute and Rehab Capitol Hill from August 05, 2019 through August 15, 2019. Survey activities consisted of a review of 59 sampled residents. The following deficiencies are based on observation, record review, 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 115. An immediate jeopardy (IJ) was identified at 42 CFR§ 483.10(e) (3) Resident Rights; F-558 Reasonable Accommodation of Needs/Preferences on August 7, 2019 at 5:00 PM. The facility's Administrator provided a letter with supportive documentation (to include residents were given the Breath Call System, staff education) noting a corrective action plan and the IJ was removed on August 22, 2019, at 5:41 PM. An immediate jeopardy (IJ) was identified at 42 CFR§ 483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation ; F600 Free from Abuse and Neglect on August 14, 2019 at 6:25 PM. The facility's Administrator provided a letter with supportive documentation (to include resident assessment and treatment, staff education on the facility's abuse policy assessments and reporting bruises and or injury of unknown origin) noting a corrective action plan and the IJ was removed on August 22, 2019, at 5:40 PM.	F 000		

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

Administrator 10/24/19

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		

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)

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F 000	Continued From page 2 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 558 SS=J	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interviews with residents and staff for four (4) of 59 sampled residents, facility staff failed to provide resident with a specialized call system to	F 558	F 558 SS=J 1. The residents were immediately assessed for the type of nurse call system needed and a breath call system was provided for resident #115 and #366. Resident #49 was repositioned to have an ability to use the breath call. 2. A. A new assessment tool was created: Resident Communication Assessment Questionnaire. B. An assessment of each resident's call system was completed, based on each resident's needs. C. Based on that assessment, each resident was provided either a breath call, standard, Geri-call or touch system.	8/5/19 8/6/19 8/8/19 8/8/19 8/8/19

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F 558	Continued From page 3 allow resident to call for assistance if in distress, and/or to make their needs known without waiting for staff to make rounds into the resident's room. Residents' #49, #56, #115 and # 366. Findings include . . . On August 7, 2019, at 5:00 PM an Immediate Jeopardy (IJ)-"J" was identified at 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences. On August 17, 2019, at 9:00 AM, the facility's Administrator provided a letter to the State Agency Survey team documenting the corrective action plan which included the following: "On 8/5/19 Resident #115 was provided a Breath Call System; on 8/6/19, Resident #49 was positioned to use Breath Call System while in his recliner chair or bed; and on 8/6/19 Resident #366 was given Breath Call System. Nursing Supervisors of the facility were to review all residents to ensure their current call system was appropriate for their use by reviewed all 8/7/19. On 8/8/19 by 3:00 PM an in-service to show the types of call system devices available, location of call system devices and education on how each device works will be done ...An assessment tool on types of devices available and how to determine the residents needs/appropriateness will be shared with the staff at the time of the in-service ... 8/8/19 and ongoing- all admissions and transfer documents will be reviewed for special communication needs so expected admissions can have the needed call devices available at the time of admission ...	F 558	D. The new assessment is being used to determine the type of system each resident needs at admission. E. The new assessment will also be used when there is a change in the residents' ability to use the current system. F. Care plans were put into place for the use of the type of call bell each resident uses 3. A. Staff education provided on the use of the new assessment tool and its addition to the Admission packet and general assessments. B. Periodic rounding will confirm that the appropriate call bell is in use and positioned properly for resident use. 4. Adverse results from the rounding or found from the admission packet will be reported at the bi-weekly Patient Care and Safety meeting for resolution. Results will be reported to QAPI monthly and Governing board bi-annually. QAPI process will monitor the communication system as: N = # of residents with the correct call light system D = monthly census. Goal: 100% ongoing	8/8/19 and ongoing 8/8/19 and ongoing 8/15/19 and ongoing 8/8/19 and ongoing 8/15/19 and ongoing 10/24/19

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F 558	Continued From page 4 8/8/19 by 5:00 PM, each resident will have a communication care plan done at the time of admission and those with needs for special call light devices will have an intervention stating the type of device needed and this intervention will appear daily forcing the staff to sign off the intervention of what device is needed and available to the resident. All current residents will have a care plan reviewed and reported to QAPI (Quality Assurance and Performance Improvement). The residents identified with a newly needed special communication call light device will be reviewed by-weekly at the resident care and safety meeting ..." The IJ was abated after the team verified that the plan of correction was in place on August 22, 2019 at 5:41 PM, the Immediate Jeopardy was removed. Consequently, the State Agency amended the scope and severity of the deficient practice to a "D." 1. On August 5, 2019 at approximately 11:00 AM, Resident #49 was observed in a Geri chair in his room. The surveyor observed that a call bell was clipped to the sheet on the Geri chair. However, Resident #49 was noted to have contractures to both arms and fingers. When asked if he could push the button to call for assistance the resident responded, "No"; and when asked how he received assistance if he needs it, he said that he has to wait until someone comes to the room. Employee #11 (Charge nurse) was called to the room and asked whether the resident is able to use the call bell. She responded "No" and added that the call bell was not in use and she was not sure why it was still in the room. At this time, this	F 558		

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F 558	Continued From page 5 writer observed a disconnected "touch pad" on the floor near the head of the resident's bed and pointed to it. The employee stated, "That's not the one. It's the other one over there" and pointed to another call system device (Breath Call) which was also disconnected. The employee further stated, "I will get the engineer to fix the device right away." The surveyor asked Employee #4 (Unit Manager) to come to the room. Employee #4 and Employee #11 both acknowledged that they failed to provide the resident with a call device that he could use to call for assistance when needed. A follow up visit was made to the room on 8/5/19 at approximately 3:00 PM. The resident was observed resting comfortably in bed. The "Breath Call" was correctly positioned and the resident demonstrated being able to use the machine. During a face-to-face interview on 8/5/19 at 12:00 PM, Employee #5 acknowledged the findings. 2. Observation of Resident #56's room on 08/07/19 at 10:15 AM, showed the resident lying in bed in supine position noted to have physical limitations and a tracheostomy with oxygen being delivered at 5 liters per minute by way of a tracheal mask was in place. The resident was also noted to have a specialized call system near his face that he could not reach to access. When the resident was asked by the surveyor to demonstrate how he used the specialized call system, the resident raised his head to reach the mouth piece of the call system, but he was unsuccessful. Resident #56 then stated, "I breathe into it to call the nurse. I can't reach it	F 558		

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F 558	Continued From page 6 right now, but I'm ok because I don't need anything." During a face-to-face interview at the resident's bedside on 08/07/19 at 10:20 AM, the Unit Manager, stated that when staff provides care for the resident, they forget to put the call system within reach for the resident. The Unit Manager then placed the call light within reach for the resident, and the resident was then able to demonstrate how he uses the call light to alert staff when he needs assistance. Review of Resident #56's current medical record showed that the resident had multiple diagnoses including: Quadriplegia, Tracheostomy, and Chronic Respiratory Failure. Continued review of the resident's current medical record revealed an annual Minimum Data Set (MDS) dated 06/05/19 that documented under Section G0110 (Functional Status- Activities of Daily Living)- the resident was coded as a "4", which indicated that Resident #56 is totally dependent on staff for all activities of daily living. Further review of the previously mentioned MDS also revealed that under Section G0400 (Functional Status- Limitation of Range of Motion) the resident was coded as a "2", which indicated that the resident had impairment of both upper and lower extremities. A second observation on 08/08/19 at 10:40 AM showed Resident #56 lying in bed in the supine position with a specialized call system near his face. The resident, however, was unable to access the call system at the time of this observation. When the resident was asked if he could use the	F 558		

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F 558	Continued From page 7 call light, he stated, "I can't reach it." Resident #56 also said that when the facility changed his bed about a year ago, the call light no longer fit on the side rail of his bed. During a face-to-face interview at Resident #56's bedside on 08/08/19 at 10:50 AM, the Unit Manager/Employee #5 stated, "The call light falls out of place sometimes, so we need to put some paper towels under it to keep it in place." Another observation on the same day (8/8/19) at 11:00 AM showed Resident # 56's call light was attached to the bed rail (left side) with multiple paper towels wedged beneath it. At the time of this observation, the resident was able to access the specialized call system. During a face-to-face interview on 8/8/19 at 11:30 AM, Employee ##5 acknowledged the findings. 3. Resident #115 was admitted to the facility on 7/15/19 with diagnoses which include: Orthostatic Hypotension, Quadriplegia, Anxiety Disorder and Respiratory Failure. Review of the Comprehensive Minimum Data Set (MDS) dated 7/22/19 showed a Brief Interview for Mental Status (BIMS) score of "10" to indicate moderately impaired cognition. Section G [Functional Status] resident is coded as "4" total dependence on staff for dressing, personal hygiene (combing hair, brushing teeth, shaving). G0400 [Functional Limitation in Range of Motion] resident is coded as "1" to indicate upper extremity (impairment on one side) and coded as "2" to indicate impairment on both sides for lower extremities.	F 558		

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F 558	Continued From page 8 Observation on 8/5/19 at 11:00 AM showed resident lying in bed and unable to use the call light. The resident was asked can you use the call light. The resident's daughter (present in the room) responded the call bell is in the box on top of the cooling system, it is not able to fit on the wall, they tried but it doesn't fit. The resident then stated, "I can't use the call light and they know this, my daughter has to get someone, or I just have to wait until someone comes in the room." Writer observed a specialized call system in a box labeled "Breath Call" model [X-XXX] placed on top of the HVAC (heating, ventilation, and air conditioning) system in the resident's room. During an interview on 8/6/19 at approximately 11:00 AM Employee # 3 was asked to tell me about Resident's call light, Employee #3 responded, "We know that she is not able to use the call light so we have an hourly monitoring system in place, here are the monitoring sheets, staff check her hourly." Review of the resident's care plan initiated on 7/16/19, failed to include the resident's method of communication. Review of document titled "1 Hour Monitoring Tool" showed staff did not consistently record monitoring the resident, staff was unable to provide evidence of monitoring sheets for the following dates: 7/15-7/19/19 7/27-7/29/19	F 558		

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F 558	Continued From page 9 7/31-8/7/19 During an interview on 8/6/19 at approximately 11:30 AM, Employee # 9 stated, "We ran out of the monitoring sheets so we do not have any sheets to give you." Employee #3 (Unit Manager -present during the interview) was unable to verify and or confirm that staff were monitoring the resident hourly. Review of the medical record showed no harm to the resident. Facility staff failed to provide resident with a specialized call system to allow the resident to call if in distress, or to make their needs known without waiting for staff to make rounds in to the resident's room. During a face-to-face interview on 8/6/19 at approximately 11:30 AM, Employee #3 acknowledged the finding. 4. Resident #366 was readmitted to the facility on 1/4/19 with diagnoses which include: Orthostatic Hypotension, Quadriplegia, Dysphagia and Respiratory Failure. Review of the Comprehensive Minimum Data Set (MDS) dated 7/22/19 showed a Brief Interview for Mental Status (BIMS) score of "14" to indicate cognition intact. Section G [Functional Status] resident is coded as "4" total dependence on staff for dressing, personal hygiene (combing hair, brushing teeth, shaving,). G0400 [Functional Limitation in Range of Motion] resident is coded as "2" for upper and lower extremity which indicates impairment "on both sides." During an interview on 8/6/19 at approximately	F 558		

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F 558	Continued From page 10 3:00 PM, the surveyor asked Resident #366 where is your call bell? The Resident responded, "I don't have a call bell." Resident was asked: How do you call for assistance? Resident then began to make a clicking sound with his mouth and stated, "If they can hear me making the sound then they come into the room otherwise I have to wait until someone comes into the room". Observation of the room did not show a call bell system in place. The resident's mother was also present in the room and stated, "Since coming back to a new room from the hospital (on 7/29/19) he has not had a call light". Employee #3, Unit Manager, was called to the room and her immediate response was "Where is your call light" (speaking to the resident), the resident stated, "I don't' have one [Breath Call] since I came back [to the facility] in this new room, they never hooked it up [Breath Call] it must be in my old room." Observation on 8/6/19 at 3:00 PM failed to show a call system in place for the resident to use to call if in distress and or to make his needs known to staff. Review of the medical record showed no harm to the resident. Facility staff failed to provide Residents' #49, #56, #115 and # 366 with specialized call systems to allow residents to call for assistance if in distress, and/or to make their needs known without waiting for staff to make rounds into the resident's room. During a face-to-face interview on 8/6/19 at 3:00 PM, Employee #3 acknowledged the findings.	F 558		

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F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account,	F 567	F 567 SS=E 1. Resident Fund Management Agreement was obtained for the following residents: #30, #80, #54, #63, #15, #46, #32, #8, #108, #11, #26, #59, #T13, #7, #94, #55, #72, #66, #18, #111, #88, #83. 2. An audit was conducted by the Business Office Manager (BOM) of the Resident Fund Management Agreement and no other resident files were identified as being deficient for this Agreement. 3. A. A newly created Monthly Checklist was created and in-service completed to include Resident Fund Management Agreements. B. This checklist will be submitted to the Administrator and Corporate Office monthly to assure all tasks are completed. C. The Regional Business Office Specialist will review the checklist and audit all information submitted on the checklist and will report back to Administrator in cases of discrepancy.	8/30/19 and ongoing 8/30/19 and ongoing 8/30/19 and ongoing

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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 567	Continued From page 12 interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 22 of 69 sampled residents with a resident funds account, facility staff failed to show written authorization for the facility to manage the residents' personal funds. Findings include ... The facility's policy Opening a Resident Fund Account [no date of initiation/revision and no signature] was provided to the State Agency and stipulated: " ...Written statements are issued to the resident or designated representative on a quarterly basis ....Resident Fund is based upon FTag F159 Management of Personal Funds, F160 Conveyance upon Death, F161 Assurance of Financial Security and F162 Limitations on Charges to Personal Funds ...If a resident wants Bridgepoint Healthcare to handle his or her personal funds, he or she fills out a Resident Fund Management Service Agreement Authorization Form authorizing the Company to do so ..." Review of the facilities trial balance as of August 8, 2019, showed the following residents had asterisk (*) next to their names indicating that the resident's, that had transferring accounts (automatic transfer of care cost payments due the facility) were missing an application:	F 567	4. Monitoring is on-going indefinitely. Data will be collected monthly and reported monthly to QAPI and bi-annually to Governing Board with the following data: N= # of residents with complete financial files D= # of resident financial files audited Goal=95% x 3 months	10/24/19 and ongoing

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	095027	A. BUILDING _____ B. WING _____	08/15/2019

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F 567	Continued From page 13 Resident # 30 Resident #80 Resident # 54 Resident # 63 Resident # 15 Resident # 46 Resident # 32 Resident # 8 Resident # 108 Resident # 11 Resident # 26 Resident # 59 Resident # T13 Resident # 7 Resident # 94 Resident # 55 Resident # 72 Resident # 66 Resident # 18 Resident # 111 Resident # 88 Resident # 83 There was no evidence that facility staff ensured that 22 of the 69 resident accounts had applications authorizing the facility to manage their funds. Employees' representing the business office were asked to provide proof that the 22 residents had given the facility authorization to manage their funds. Employee #9, stated the applications (authorizing the facility to manage the aforementioned resident funds) cannot be located at this time and acknowledged the findings, during a face-to-face interview on 8/14/19 at 2:00 PM.	F 567		

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F 567	Continued From page 14 Facility staff failed to show written authorization for the facility to manage 22 residents' personal funds.	F 567		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 59 sampled residents, facility staff failed to ensure resident information (name of facility and address) was accurate with the Social Security Administration (SSA) to ensure Resident #48 would receive her monthly allowance. Findings included ... A review of the facility's Trial Balance record dated August 8, 2019, showed Resident # 48 had an account balance of $0.63 and a monthly allowance of $70.00. A review of her personal funds account history showed that Resident # 48's Supplemental Security Income (SSI) had stopped as of June	F 568	F 568 SS=D 1. A. The address for resident #48 was corrected with SSI and Rep Payee was designated. B. SSI funds now come to the facility beginning September 2019. 1. An audit was conducted by the Business Office Manager (BOM) of the SSI receivables and no other resident files were identified as being deficient for this practice. 2. A. A newly created Monthly Checklist was created and in-service completed to include appropriate SSI filings. B. This checklist is submitted to the Administrator and Corporate Office monthly to assure all tasks are completed. *Continued next page.*	10/1/19 10/1/19 10/1/19 10/1/19 and ongoing

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F 568	Continued From page 15 2018. Review of a letter sent from the Social Security Administration dated April 20, 2018 that stated, " ...we have decided that Supplemental Security Income payments for [Resident #48] will be paid directly to her ...you may have saved some money for her. If you have, you should return it to us unless you have already made other plans with us for handling it ..." There was no evidence that from June 2018 to present that facility staff returned the $0.63 to the SSA and no further action, follow up or account activity has taken place. During a face-to-face interview with Employee #15 on 8/8/19 at approximately 1:00 PM. The writer asked, when it was noted that the resident did not receive funds what was done? Employee # 15 stated, We filed for Rep Payee (representative payee), however Social Security [sent] a letter stating that the payments would be sent directly to her. No checks ever came to the facility. On 8/9/19 at approximately 1:30 PM Employee # 15 provided the writer with a written statement that read, " ...Call Social Security and spoke with [Name of Representative] she indicated that [Resident #48 has no Rep Payee on file and her money is in suspense due to incorrect address. Address on their file is 700 Constitution Avenue, advised her that address is currently 223 7th Street, NE Washington, DC 20002. She agreed to update the system. She will release $1050.00 for June 2018 to current and projected that it should be received by next week. Effective	F 568	C. The Regional Business Office Specialist reviews the checklist and audit all information submitted on the checklist and reports back to Administrator in cases of discrepancy. 4. Monitoring is on-going indefinitely. Data will be collected monthly and reported to QAPI and bi-annually to the Governing board with the following data: N = # of residents with complete financial files D = # of resident financial files audited Goal = >95% (3 months)	10/1/19 10/24/19

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F 568	Continued From page 16 September [2019] her funds will be reinstated." According to the facility, the address changed on March 1, 2017 from, 700 Constitution Avenue, NE to 223 7th Street, NE Washington, DC 20002. There was no evidence that facility staff notified the Social Security Administration of the change, therefore Resident #48 did not receive her Supplemental Security Income from June 2018 to present. During a face-to-face and a telephone interview on 8/12/19 at 12:10 PM with the facility's Administrative staff, Employee #1 acknowledged the findings.	F 568		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the	F 569	F 569 SS=D 1. For patient #T1: A check of $960 was created and sent to DC Treasurer. 2. An audit was conducted by the Business Office Manager (BOM) of deceased residents and no other funds were identified as not disbursed with appropriate time frames. 3. A. A newly created Monthly Checklist was created and in-service completed to include appropriate fund conveyance upon death of a resident. B. This checklist is submitted to the Administrator and Corporate Office monthly to assure all tasks are completed. *Continued next page*	8/13/19 10/1/19 10/1/19

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F 569	Continued From page 17 individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of three (3) sampled residents who expired, facility staff failed to convey within 30 days of the resident's death a final accounting of funds. Resident # T1. Findings included... Resident #T1 was admitted to the facility on 2/15/16 and expired in the facility on 7/2/19. A review of the facility Trial Balance record dated August 8, 2019, showed a pending balance of $960.83 for Resident #T1. Facility staff failed to convey Resident #T1's, funds and provide a final accounting within 30 days of the resident's death. During a face-to-face interview on August 8, 2019, at approximately 4:00 PM with Employee # 7, Business Office Representative, she acknowledged that the resident's funds were not conveyed.	F 569	C. The Regional Business Office Specialist reviews the checklist and audit all information submitted on the checklist and will report back to Administrator in cases of discrepancy. 4. Monitoring is on-going indefinitely. Data will be collected monthly and reported to QAPI and the Governing board bi-annually with the following data: # of residents with complete financial files / # of resident financial files audited Goal=95% x 3 months	10/1/19 10/24/19
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583	F 583 SS=D 1. A. Staff assigned to the identified patient were provided education regarding a resident's right to privacy and it is required to knock on a resident's door and wait for acknowledgement prior to entering the room.	8/6/19

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F 583	Continued From page 18 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interview for one (1) of 59 sampled residents, an employee failed to respect one (1) resident's privacy when she entered the resident's room without obtaining permission. Resident #96. Findings include . . .	F 583	B. Staff apologized immediately to the patient for the invasion of privacy. 2. Other patients were asked to in Resident Council meeting as to ongoing concerns regarding resident privacy. No other concerns were expressed by residents. 3. A. Patient privacy has been added as an agenda item in Resident Council meetings. B. Staff education has been provided by the Director of Education regarding resident rights. C. Annual, all staff, Care Learning addresses resident rights and staff responsibilities. D. Skills Fair, occurring October 21, 22 & 23, 2019, also contains a component for refreshing resident rights knowledge and skills. This information is also taught in our monthly new staff orientation. E. Resident council reports privacy issues to Patient care and safety Committee bi-weekly now. *Continued next page*	8/6/19 8/6/19 9/3/19 10/21/19 10/21/19 9/3/19

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F 583	Continued From page 19 On August 6, 2019 at approximately 12:04 PM, while this writer was conducting an interview with the resident, Employee #8 pushed the door and entered the resident's room. The employee failed to knock on the door and wait to obtain permission from the resident before entering the room. Employee #8, said "excuse me" and attempted to leave the room. This writer stopped the employee and asked her why she had not knocked on the door before entering the room. The employee responded, "I forgot. That is why I said I was sorry. I usually always knock before I open the door." A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM. The employee acknowledged the finding that Employee #8 failed to respect Resident # 96' privacy.	F 583	4. Data will be collected monthly and reported to QAPI monthly and the Governing board bi-annually using the following values: N=Total number of complaints of patient privacy issues Trending	10/24/19
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584	F 584 SS=D 1. Soiled vents A. Maintenance removed the vents, cleaned and reinstalled in Rooms B. The Maintenance team checked 20% (23 rooms) 23/23 rooms were in compliance. C. Monthly PM findings are reported during the Bi-monthly EOC committee.	8/7/19 9/16/19 10/20/19

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F 584	Continued From page 20 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; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by soiled exhaust vents in two (2) of 17 residents' rooms on the sixth floor, and resident wheelchairs in need of	F 584	2. Wheelchairs need repair A. Maintenance performed a problem assessment of the three chairs from rooms, 5104,5147,4104 B. The Maintenance team assessed 20% (11 chairs) of the wheelchairs in SNF and found 2 that needed to be repaired, three need to be replaced. C. The Maintenance team will perform monthly monitoring and random wheel chair assessments D. Monthly PM findings will be reported during the Bi-monthly EOC committee.	10/8/19 9/25/19 9/25/19 10/15/19

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F 584	Continued From page 21 repair in three (3) of 46 residents' rooms. During an environmental walkthrough of the facility on August 5, August 6, and on August 7, 2019, between 2:30 PM and 4:00 PM, the following were observed: 1. Exhaust vents were soiled on the inside with dust in two (2) of 17 resident's rooms on the sixth floor (#6128 and #6133). 2. Wheelchairs were observed in a state of disrepair in the following residents' rooms: #4104: The left armrest was missing. #5104: Both armrests were torn. #5147: The brakes did not lock the wheels and both armrests were torn. Employee #16 and/or Employee #17 acknowledged the above findings during a face-to-face interview on August 7, 2019 at approximately 4:00 PM.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600	F 600 SS=J 1. A. Incident report was written on 8-7-19, upon discovery of its absence. Resident #80 - An Orthopedic appointment was held on 8/09/19 with recommendations from the orthopedic doctor to continue physical therapy and all previous orders were continued for Rehab. B. Investigation into the fall began immediately. 2. A. Families and residents on the 4th floor was called or questioned by social work as to any reports of	8/7/19 8/7/19

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F 600	Continued From page 22 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews family and staff interviews for two (2) of 59 sampled residents facility's staff failed to follow-up on injuries of unknown origin with the potential for abuse or neglect by failing to: (1) investigate a bruise to the left eye of Resident #58 who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of Resident #80 (who is Hispanic and English is her second language). Findings included ... On August 14, 2019, at 6:25 PM an Immediate Jeopardy (IJ)-"K" was identified at 42 CFR §483.12 F600, Freedom from Abuse, Neglect, and Exploitation. On August 15, 2019, at 1:00 PM, the facility's Administrator provided a letter to the State Agency's Survey team documenting the corrective action plan which included the following: "Resident #58 - On 8/14/19 Resident #58 was given an x-ray of the left orbit where the bruise was located, and on her left hand where the second bruise was noted and on her left knee where scrape was noted. X-ray of left hand and left knee are both negative. However, the x-ray of the left orbit shows a possible fracture that must be confirmed by CT-scan [computerized tomography] due to poor visualization of the orbit by x-ray. The resident will be sent to ER on	F 600	falls or incidences that may not have been previously reported or reported and not followed through. B. A skin sweep was done on the 4th floor to assure no other residents had sustained unreported falls. C. The results were negative to #1 and #2. 3. A. Staff education provided to include the importance of following through with all adverse events reported regardless of who reports the issue: families, staff, ancillary personnel, etc. B. Education was provided on Bridgepoint Abuse and Neglect Policy. C. Education was provided on incident reporting: timeliness and flow of information. D. Spot rounds are conducted daily on the 4th floor with results reported to DON and Administration. E. Post-Fall investigation Report will be instituted to assess each fall. 4. Adverse incidences are reported at the bi-weekly Patient Care and Safety meeting for resolution. Results will be reported to QAPI monthly and the Governing board bi-annually. QAPI process will monitor the rounding data as: N = Number of injuries of unknown origin found on rounding that were not reported. Trending data	9/3/19 9/3/19 9/3/19 8/15/19 10/1/19 8/8/19 10/24/19

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F 600	Continued From page 23 8/15/19 to accomplish the CT expeditiously. 8/15/19 - Residents on the fourth floor where [Resident #58] is located will be interviewed to determine if there are any other falls previously unreported or any new pain via pain assessment. Resident #80- 8/14/19- X-ray result received on 6/24/19 showed unremarkable for the left hip. However, a subsequent MRI [magnetic resonance imaging] done on 8/2/19 showed two displaced and two non-displaced fractures. An Orthopedic appointment was held on 8/09/19 with recommendations from the orthopedic doctor to continue physical therapy and all previous orders were continued for Rehab. On 8/13/19 Rounds and interview conducted by Social Worker on all residents on the fourth floor with no indications or concerns of mistreatment. 8/13/19 Rounds conducted by RCC [Resident Care Coordinator] and assigned CNA [Certified Nurse Aid] to verify no other residents are affected by the deficient practice. 8/15/19 and ongoing In-service will be provided to licensed staff on assessments to include injuries of unknown origin. All clinical staff will be educated on proper pathways of communication methods to facilitate proper assessments and follow up to non-English speaking residents as they receive information from families, visitors and other disciplines. 8/15/19 and ongoing- All staff will be in-serviced on language line use whether or not the family is present for interpretation. All staff will be in-serviced on the BridgePoint Abuse and Neglect Prevention Policy to include injury and or abuses of unknown origin. All licensed staff will be	F 600		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24 in-serviced on situations requiring incident reports and DOH [Department of Health] notifications. Managers and supervisors will be in-serviced on appropriate rounding methods. 8/15/19 Daily rounding will occur by one of the above-named department heads based on the created schedules, every day on the fourth floor with results matched with the 24-hour reconciliation report. This data will be shared with the Administrator and the DON [Director of Nursing]. 8/19/19 and ongoing- Clinical and non-clinical staff who enter a resident's room will be in-serviced on the two forms of communication when they notice injury or other change in condition or comfort by: a) Verbalizing to a nurse on a same shift and providing a written note (similar to a stop and watch program). The IJ was abated after the team verified that the plan of correction was in place on August 22, 2019 at 5:40 PM, the Immediate Jeopardy was removed. Consequently, the State Agency amended the scope and severity of the deficient practice to an "H"." 1.Facility staff failed to follow-up on injuries of unknown origin with the potential for abuse or neglect by failing to investigate a bruise to the left eye of Resident #58 who was totally dependent on staff for all activities of daily living. Definition: Bruise (per Taber's Dictionary): A traumatic injury (usually to the skin but	F 600		

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F 600	Continued From page 25	F 600		

sometimes to internal organs) in which blood vessels are broken but tissue surfaces remain intact. Discoloration, swelling, inflammation, and pain are typical signs and symptoms. Fresh bruises on the skin are often red or purple. Older bruises may turn green and then yellow or brown, as the blood products within them age and are reabsorbed, but gauging the age of a bruise by its color is imprecise, at best. Bruising in infants may suggest occult child abuse. Bruising in older adults is more often an indication of the use of anticoagulant drugs than of physical mistreatment. https://www.tabers.com/tabersonline/view/Tabers-Dictionary/767873/all/bruise

Observation of Resident #58's room on 08/13/19 at 9:28 AM showed the resident lying in bed on her right side with a purple-yellowish bruise under her left eye. Continued observation revealed that the resident had limited physical ability, and was tracheostomy dependent with oxygen being delivered at 5 liters per minute by way of a tracheal mask.

During a face-to-face interview on 08/13/19 at 9:30 AM, Employee #19 (RN), who was assigned to the resident, stated that when she conducted rounds at the beginning of her shift, she observed the resident with a bruise under her left eye. Employee #19, said that she did not know when the resident acquired the bruise, nor did she ask the off-going nurse about it. Additionally, Employee #19, RN, stated, "I haven't worked on this floor in two months. I was floated to this floor today." Employee #19, RN, regularly works on another unit.

On 08/13/19 at 9:40 AM, during an interview,

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F 600	Continued From page 26 Employee #22 (CNA) assigned to the resident stated, "I saw the bruise under the resident's left eye last Thursday [08/08/19], and I told the nurse (Employee #22- RN)." On 08/13/19 at approximately 9:45 AM, the surveyors Called the Administrator, Unit Manager (Employee #5), and Director of Nursing, to Resident # 58's room to observe the bruise under the resident's left eye. During a face-to-face interview at the resident's bedside, they all stated that before this observation, they were not aware of the bruise under Resident # 58's left eye. Continued interview revealed they would start an investigation. During a face-to-face interview on 08/13/19 at 2:25 PM, the Administrator, stated, "While during our investigation, we pulled her (Resident # 58) up in bed, and noticed the way she's positioned [her body] hits the side rail where her bruises were." The Administrator then said that the resident had a history of seizures and "padded rails are now in place, as an intervention." Review of the nursing notes dated from 01/02/19 through 08/13/19 showed there was no documented evidence that Resident #58 had seizure activity during that period. Additionally, a review of the Plan of Care initiated on 12/08/18 lacked documented evidence of how the staff was to manage or monitor Resident #58 for seizure activity. On 08/13/19 at 3:05 PM, during an interview, Employee #23, CNA, stated that she provided care for Resident #58 during the evening shift on 08/08/19. When asked, while working with the resident on 08/08/19, did she notice anything different with the resident, she stated, "Yes, she	F 600		

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F 600	Continued From page 27	F 600		

had a bruise under her left eye, and I called the charge nurse (Employee #21- LPN) into the room to see the resident. After the LPN left the room, I continued providing care."

During a face-to-face interview on 08/13/19 at 4:40 PM, Employee #21 (LPN), stated that she had worked with Resident #58 on 08/08/19 during the evening shift. Employee #21, LPN, also said, "I did not notice a bruise under the resident's eye." When asked, if Employee #23, CNA, made her aware about anything different with the resident, Employee #21, LPN, stated, "No, she did not."

During a face-to-face interview on 08/14/19 at 11:26 AM, RN #2 stated, "I worked with the resident last week, and I did not see anything different with the resident." When asked, if anyone made her aware of a bruise under Resident #58's left eye, she stated, "No, they did not." Review of the staffing sheets revealed Employee #20, RN, worked with Resident #58 during the day shift on 08/05, 08/06, 08/08, 08/09 and 08/10/19.

On 08/14/19 at 1:15 PM, during an interview, Employee #24, CNA, stated, "When I worked last week (dayshift-08/10/19), I saw a bruise under the resident's left eye, and I told the nurse (Employee #20, RN)."

On 08/14/19 at 1:30 PM, during an interview, the Respiratory Therapist stated, "I worked with the resident (Resident #58) last week (08/06/19), and I didn't notice anything different with her."

Review of Resident #58's current medical record on 08/13/19, starting at 12:00 PM showed a

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F 600	Continued From page 28 physician' assessment dated 08/13/19 at 11:00 AM. The physician documented that the resident had a history of "anoxic brain injury, chronic respiratory failure, trach dependent, and seizures due to brain injury." The physician also documented, "[Resident's name] noted to have contusion below the left eye and dorsal aspect [of] left hand." Further review of the record revealed a "Skin & Wound" evaluation dated 08/13/14 at 11:04 AM that showed the following wound assessments: 1. Left eye- purplish-gray discoloration under-eye "discoloration appears to be dissipating" with the following measurements: area 5.3 centimeters, length 3.7 centimeters, and width 2.0 centimeters. The injury was acquired in-house on the "exact date of 08/13/19". 2.Left knee- dry abrasion with reddish color with the following measurements: area 1.2 centimeters, length 1.5 centimeters, and width 1.1 centimeters. The injury was acquired in-house on the "exact date" of 08/13/19. 3.Left hand- purple discoloration on the dorsum aspect with the following measurements: area 1.9 centimeters, length 2.0 centimeters, and width 1.3 centimeters. The injury was acquired in-house on the "exact date" of 08/13/19. Continued review of the resident's current medical record revealed nursing notes dated from 08/01/19 to 08/12/19 that lacked documented evidence that Resident #58 had a bruise below her left eye, a left knee abrasion, or a bruise on the dorsal aspect her left hand.	F 600		

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F 600	Continued From page 29 Further review of the medical record revealed medication administration records that failed to show evidence that the resident had been assessed or medicated for pain from 08/01/19 to 08/12/19. The medication administration record also showed that the resident was not on anticoagulant therapy. Review of certified nursing assistants "Task Sheets" dated from 08/01/19 to 08/12/19 revealed that the certified nursing assistants were to monitor Resident# 58's skin and documented any changes every shift. The task sheets, however, lacked documented evidence of changes to the resident's skin to include left eye bruise, left knee abrasion or left-hand bruise. Review of the Respiratory Therapist's note dated 08/06/19 lacked documented evidence Resident #58 had skin injuries to include left eye bruise, left knee abrasion, or left-hand bruise. Review of the Nursing Reconciliation Reports/24 Hour Report (used to monitor all issues or concerns with residents) for the dates of 08/01/19, 08/05/19, 08/06/19, 08/07/19, 08/08/19, 08/09/19, and 08/12/19 lacked document evidence of Resident #58's left eye bruise, left knee abrasion or left-hand bruise. Review of the Care Plan with a revision date of 03/02/17 documented, "[resident's name] requires skin inspection every 2 [hours] observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse." The resident's current clinical medical record and certified nursing assistant's task sheets (from 08/01/19 to 08/12/19) lacked documented evidence that the resident's skin was assessed every two hours.	F 600		

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F 600	Continued From page 30 The annual Minimum Data Set dated 06/04/19 showed in section G (Functional Status) the resident was coded as total dependence and required two (2) person assist with bed mobility. During interviews with Employees #22, #23, #24 (certified nursing assistants), however, they all stated that they provided bed mobility (turning and repositioning) for Resident #58 without the assistance of a second person. Review of an Orbital X-ray dated 08/14/19 documented the following conclusion, "Radiographic suggestion of acute minimally displaced fracture at the left orbital medial wall. This can be further evaluated with CT (computed tomography) examination of the facial bones." Review of Computed Tomography Scan (Axial scans through the brain and facial bones without contrast) dated 08/15/19 revealed the following impression: "No acute intracranial process. Extensive encephalomalacia in the bilateral cerebral and cerebellar hemispheres is new since prior exam. Depressed left nasal bone fracture. Old right orbital floor fracture." Facility's staff failed to follow-up on injuries of unknown origin as the potential for abuse or neglect for Resident #58 who was totally dependent on staff for all activities of daily living. During a face-to-face interview with Employees' #1, #2 and #5, on August 14, 2019 at 6:25 PM, they acknowledged the findings. 2. Facility's staff failed to follow-up on injuries of unknown origin with the potential for abuse or	F 600		

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F 600	Continued From page 31 neglect by failing to thoroughly investigate fractures sustained to the sacral and pubic areas of Resident #80 (who is Hispanic and English is her second language). According to the Minimum Data Set (MDS) the Resident lacks capacity to make decisions (Secondary to the removal of a brain tumor) and needs extensive assistance from staff for all activities of daily living. During a telephone call with Resident #80's family member on 8/12/19 at 1:45 PM she stated, "While visiting my mother on 6/22/19 at around 11:00 - 11:30 AM, she complained of pain to the left hip and told her, she had fallen. I informed the charge nurse of the fall on 6/22/19. (I don't recall her name). The charge nurse stated that no one had reported a fall. On 6/23/19 I told RN #10 [assigned to the resident] my mother fell and showed her the bruise. On 6/24 I spoke with RN #10 again and requested an X-ray because my mother continued to complain of pain and did not want to go to therapy. I also spoke with the physician and he said he would do the X-ray. The X-ray was done and it was negative but my mother still had pain." According to a Physical Therapist's progress note dated 6/24/19, Resident #80 had a bruise to the left elbow.	F 600		

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F 600	Continued From page 32 According to the incident report dated 6/27/19, the resident had an alleged fall on 6/22/19 . . . the facility was informed by the resident's daughter during a care plan meeting on 6/27/19. Review of the X-ray report of Resident #80's left hip joint dated 6/24/19 revealed an unremarkable examination of the left hip joint. Review of the Nursing notes dated 6/22 through 8/2/19 showed Resident #80 complained of pain and was medicated for left hip and leg pain on nine (9) occasions. Review of the facility's incident report dated 8/7/19 showed, "on 6/27/19, the facility reported the incident to DOH [Department of Health] on [6/22/19]. Due to complaints of pain an X-ray was done which was negative. Further report of pain prompted an MRI that shows two non-displaced fractures and two displaced fractures. Resident #80 received an MRI of left hip on 8/2/19 (six weeks after the initial complaint). The MRI showed the following injuries. 1. Acute fracture of the left sacral ala. 2. Acute non-displaced fracture of the anterior column of left acetabulum. Intact femur. 3. Acute non-displaced fracture of the left pubic bone. 4. Acute displaced fracture of the left inferior pubic ramus.	F 600		

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F 600	Continued From page 33 During a face-to-face interview with the Employee #5 (unit manager) she stated that she became aware of the fall during the care planning meeting on 6/27/19. Through interview with the charge nurse assigned to the resident on 6/23/19 she denied any knowledge of the fall or the bruise. However, through interview with the physical therapist on 8/12/19, she confirmed that she saw the bruise on the Resident's left elbow on 6/24/19. There is no evidence that the facility staff thoroughly investigated the family member's concern regarding her mother stating that she fell and failed to investigate how the resident sustained a bruise of unknown origin to the left elbow. The resident continued to complain of pain, subsequently an MRI was done and revealed that Resident #80 had multiple fractures (acute fracture of the left sacral ala, acute nondisplaced fracture of the anterior column of the left acetabulum, acute nondisplaced fracture of the left pubic bone and acute displaced fracture of the left inferior pubic ramus). Facility's staff failed to follow-up on injuries of unknown origin with the potential for abuse or neglect by failing to thoroughly investigate fractures sustained to the sacral and pubic areas of Resident #80 (who is Hispanic and English is her second language). During a face-to-face interview with Employees'	F 600		

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F 600	Continued From page 34 #1, #2 and #5, on August 14, 2019 at 6:25 PM, they acknowledged the findings.	F 600		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622	F 622 SS=D 1. Upon notification from the receiving facility, the needed transfer documents were provided for patient #17. 2. An audit of hospital transfers for the past 2 months reveals that all transfer documents were sent with patient upon transfer to hospital. 3. A. Staff was educated that any transfer to the hospital whether planned or unplanned, requires the same transfer paperwork to accompany resident. B. A new Resident Documents Transfer Checklist has been created, in-service provided and implemented to assure all transfer packets contain all needed documents. C. The new Resident Documents Transfer Checklist is completed on the shift when the transfer took place and will be reviewed by RCC's and DON within 24 hours. *Continued next page*	6/7/19 9/26/19 10/2/19 10/2/19 10/2/19

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F 622	Continued From page 35 exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.	F 622	4. A. QA reviews all Resident Documents Transfer Checklist upon submission by DON, with discrepancies reported to Patient Care and Safety meeting bi-weekly and then to QAPI monthly. B. The checklist will be monitored monthly through the QAPI process: N = number of completed transfer packages D = number of resident transfers Goal- 100%	10/24/19 10/24/19

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F 622	Continued From page 36 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview for one (1) of 59 sampled residents, the facility staff failed to ensure that transfer information documented on the 'Patient Transfer Form' to communicate the resident status was sent to the receiving health care provider. Resident #17 Findings included... Resident #17 was admitted to the facility on 4/29/19, with diagnoses to include Diabetes Mellitus, Heart Failure, Bipolar Disorder, Hypertension, Seizures, Cerebrovascular, Gastroesophageal reflux disease (GERD) A review of the Quarterly Minimum Data Set [MDS] dated 8/6/19, showed Section C [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision). A review of the medical record on 8/9/19 at 10:00	F 622		

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	095027	A. BUILDING _____ B. WING _____	08/15/2019

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

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F 622	Continued From page 37 AM showed Resident #17 was transferred to the hospital on 6/6/19. A review of the nurses' progress note dated 6/6/19 at 18:38 PM showed "Resident condition remains stable ... pick up by Lifestar transportation at 5:30 pm to [hospital] for g-tube replacement." A review of the resident's medical record showed there was no transfer form dated 6/6/19 on the medical record for Resident #17's transfer to an area hospital. During a-face-to-face Interview with Employee#3 [charge nurse] on 8/9/19 at approximately 10:10 AM the employee presented a complete Nursing Home to Hospital Transfer Form dated 6/2/19 that showed "Sent to [hospital name]." Employee #3 stated the resident transferred 6/6/19 to [hospital name]. Review of the [hospital name] final report form dated 6/7/2019 at 8:56 AM showed "Patient is nonverbal with minimal documentation provided by [facility] ... her son (son's name and phone number) knows little information about her medical conditions. So, it was challenging to obtain information about her PMH (past medical history)." The evidence showed that the facility failed to complete and send the transfer form to convey all pertinent information (the contact information of the practitioner responsible for care, resident representative contact information, physician in charge at the time of transfer, name and address of facility transferring from, diagnosis at time of	F 622		

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F 622	Continued From page 38 transfer, vital signs at the time of transfer, advance directives, code status, and all information necessary to address the resident's behavioral needs and mental status) to the receiving provider (area hospital). A face-to-face interview was conducted on 8/15/19 at approximately 10:00 AM with Employee#3 [charge Nurse]. She acknowledged the finding.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for two (2) of 59 sampled residents, facility staff failed to accurately assess and code the Minimum Data Sets (MDS) of one (1) resident who was not coded as edentulous under Section L (Dental Status), and of one (1) resident's diagnosis for Chronic Kidney Disease. Residents' #96 and #216. Findings include . . . 1 . Facility staff failed to accurately code the annual MDS for Resident #96 who is edentulous. During a face-to-face interview with Resident #96 on August 7, 2019 the resident stated that she	F 641	F 641 SS=D 1. MDS assessment was corrected by MDS staff at the time of discovery for: A. Resident # 96 to reflect the edentulous state of the resident. B. Resident # 216 to reflect Chronic Kidney Disease. 2. A. An audit of individual patient diagnoses will be conducted by MDS staff to assure proper assessment and subsequent proper coding. B. An audit tool has been created to record audit findings. *Continued next page*	9/10/19 9/10/19 9/10/19 9/10/19 and ongoing 9/10/19

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F 641	Continued From page 39 could not have dentures because she has no bone. The writer then observed the resident opened her mouth, point to her gums and stated, "See, no teeth but I can chew anything." A review of the annual MDS which was completed on January 7, 2019 showed that under Section L0200 (Dental Status) the resident was not identified under Item B (No natural teeth or tooth fragments) (edentulous). Instead, the resident was identified under Item Z (None of the above were present), which was an indication that the resident had no dental issues. A face-to-face interview was conducted on August 6, 2019 at 12:04 PM with Employee #6 regarding the coding of the Dental Section on the resident's MDS. The employee acknowledged that the resident has no teeth and that Section L (Dental Status) issues was coded incorrectly. 2.Facility staff failed to accurately code Resident 216's Minimum Data Set for Chronic Kidney Disease. Resident #216 was admitted to the facility on 7/29/19, with diagnoses to include Chronic Respiratory Failure, Dysphagia, Chronic Kidney Disease and Type 2 Diabetes Mellitus, A review of the Admission Minimum Data Set [MDS] dated 8/5/19 showed Section B [Hearing, Speech, and Vision] B0100 Comatose coded "yes" indicating Persistent vegetative state/no	F 641	3. A. New admission dental status will be assessed upon admission and as assessments become due. B. Status will be checked for accurate coding according to dental records and visual observation by MDS staff. C. Dentist assessment is located under the assessment tab in PCC for each resident. D. Reimbursement Director or designee reviews completed assignments for accurate dental status coding upon completion of each assessment and/or random reviews. E. Results will be forwarded to QA monthly for performance monitoring. 4. Monitoring is on-going indefinitely. Data will be collected monthly and reported to QAPI monthly and the Governing board bi-annually with the following data: QAPI monitoring will be a random sampling of all residents reflected as: N = # of patients with accurate diagnoses coding D = # of patient diagnoses coding reviewed. Goal: =100% x 3 months	9/10/19 and ongoing 9/10/19 and ongoing 9/10/19 and ongoing 9/10/19 and ongoing 10/24/19

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F 641	Continued From page 40 discernible consciousness. Section I Active Diagnosis, under I8000 Additional active diagnoses, Chronic Kidney disease with ICD code was not entered indicating, "Not done." A review of the admission summary dated 7/29/19 showed, "Diagnoses ... Hypertensive chronic kidney Disease with stage 1 through stage 4 ... Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease ..." There was no evidence that facility staff coded the MDS to include the Resident's diagnosis of Chronic Kidney Disease. During a face-to-face interview on August 15, 2019, at approximately 1:00 PM with Employees' #6 and #7. They acknowledged the finding.	F 641		
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 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	F 656	F 656 SS=E 1. A. The care plans were immediately adjusted to reflect communication devices for residents: #49. B. The patient #17 discharged C. The patient #216 discharged. D. The care plan was immediately adjusted to reflect G-Tube care for resident #217. 2. As residents become due for their initial or quarterly MDS, the Care Plan for each resident will be reviewed for accuracy and completeness. For all residents with G-tubes and communication issues care plans were reviewed and updated. 3. Care plans are reviewed upon admission, during monthly audit of selected charts and quarterly to assure accuracy.	8/10/19 8/10/19 10/15/19 10/24/19 9/10/19 10/1/19

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F 656	Continued From page 41 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 59 sampled residents, facility staff failed to initiate a person centered care plan for one (1) resident's use of Intravenous Fluid and G-tube (gastrostomy tube) placement post-hospitalization, for one (1) resident's use of a special device [Breath Call] that he uses to request assistance from staff, for one (1) resident's midline catheter care and, for one (1) resident's treatment for G-tube. Residents' #17, #49 #216 and #217.	F 656	4. Monitoring is on-going indefinitely. Data will be collected monthly and reported to QAPI monthly and the Governing board with the following data: N = # of patients with accurate care plans D = # of patient care plans reviewed. Goal = 90% X 3 months	10/24/19

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F 656	Continued From page 42 Findings include . . . 1A. Facility staff failed to develop a care plan for Resident #17's use of intravenous fluid. Resident #17 was admitted to the facility on 4/29/19, with diagnoses to include Diabetes Mellitus, Heart Failure, Bipolar Disorder, Hypothyroidism, Hypertension, Seizures, Cerebrovascular, GERD and UTI A review of the Quarterly Minimum Data Set [MDS] dated 8/6/19 showed Section C [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision). A review of the nurse's progress notes showed the dates the resident received intravenous fluids: 6/3/19 "Resident NPO till further notice, order Dextrose solution 5% (D5) at 75ml/hrs until transfer, ...the PM ... the supervisor was able to put a line in and IV fluid was initiated" 6/4/19 " ... the resident is receiving IVF (intravenous fluids) of D5 at 75ml/hr via left hand and tolerating well" 6/5/19 " ... continues on Dextrose 5% @75ml per hour via left-hand peripheral line ..." 6/6/19 " Resident condition remains stable ... pick up by life star transportation at 5:30 PM ... to [hospital name] for g-tube replacement ...continue on dextrose 5% ..." A review of the care plans on the clinical record failed to address care with person-centered goals and interventions to address the resident's use of	F 656		

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F 656	Continued From page 43 Intravenous Fluid. 1B. Facility staff failed to develop a care plan for Resident #17's G-tube (gastrostomy tube) placement post-hospitalization. Resident #17 was admitted to the facility on 4/29/19, with diagnoses to include Diabetes Mellitus, Heart Failure, Bipolar Disorder, Hypothyroidism, Hypertension, Seizures, Cerebrovascular, GERD, and UTI. Review of the Quarterly Minimum Data Set [MDS] dated 8/6/19 showed, Section [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision). A review of the nurse's progress notes showed the dates the resident was hospitalized and readmitted to the facility: 6/6/19 "Resident condition remains stable ... pick up by life star transportation, at 5:30 pm to [hospital name] for G-tube replacement ... no apparent distress at the time of transfer." 6/11/19 "Resident readmitted at [facility name] from [hospital name] on 6/11/19 post G-tube placement..." A review of the care plans on the clinical record failed to address care with person-centered goals and interventions to address the resident's g-tube placement post-hospitalization. A face-to-face interview was conducted with	F 656		

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F 656	Continued From page 44 Employee #3 [charge nurse] at approximately 2:00 PM on 8/15/19. The employee acknowledged the findings. 2. Facility staff failed to care plan Resident #49's use of a special device [Breath Call] that he uses to request assistance from the staff. Review of Resident #49's most recent quarterly Minimum Data Set dated June 07, 2019 shows that the resident is dependent on staff for all activities of daily living. The resident needs extensive assistance from one (1) person for eating, dressing and personal hygiene and is totally dependent on two (2) staff for bathing, bed mobility, toilet use and transfer. The resident is unable to use his hands and fingers due to contractures. Due to lack of ability to touch a call button to call staff when he needs assistance; he uses a special device (Breath Call) to request assistance. The tube for the "Breath call" is placed adjacent to the resident's mouth and he breathes into it to call for assistance. A review of the resident's care plans with updates dated August 12, 2019 showed no evidence that a care plan was ever initiated for the resident's use of the "Breath call" device.	F 656		

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F 656	Continued From page 45 A face-to-face interview was conducted with Employee #4 on August 12, 2019 at approximately 3:00 PM The employee reviewed the care plans and acknowledged that no care plan was initiated for use of the "Breath Call" device. 3. Failed to develop a care plan for Resident #216's midline catheter in the right upper arm. Resident #216 was admitted to the facility on 7/29/19, with diagnoses to include Chronic Respiratory Failure, Dysphagia, Chronic Kidney Disease, Type 2 Diabetes Mellitus, GERD, Hyperlipidemia, Encephalopathy, Vascular Dementia, and Anemia A review of the Admission Minimum Data Set [MDS] dated 8/5/19 showed Section B [Hearing, Speech, and Vision] B0100 Comatose coded "yes" indicating Persistent vegetative state/no discernible consciousness. A review of the Admission Summary dated 7/29/19 showed, " ... midline on RUA [right upper arm] inserted on 7/16/19 ..." A review of the Physician order sheet showed: 7/29/19 "Flush midline with 5ml NSS [normal saline solution] every shift for patency every shift" 8/1/19 "Assess RUE [right upper extremities] midline in place every shift" 8/5/19 "Midline dressing change weekly every night shift every 7days" A review of the care plans on the clinical record failed to address care with person-centered goals and interventions to address the resident's	F 656		

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F 656	Continued From page 46 midline catheter. A face-to-face interview was conducted with Employee #3 at approximately 2:00 PM on 8/15/19. The employee acknowledged the findings. 4. Failed to develop a care plan for Resident #217's G- tube treatment. Resident #217 was admitted to the facility on 7/20/19, with diagnoses to include Chronic Respiratory Failure, Anemia, Dysphagia, and Hypertension, Review of the admission Minimum Data Set [MDS] dated 7/27/19 showed, Section [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision). A review of the admission summary notes dated 7/20/19 showed " ... transferred ... from [hospital name] for comfort care ... status post peg tube ... " A review of the Physician order sheet showed: 7/29/19 "Enteral Feed order every shift Jevity1.5@42ml/hrx24hrs" 7/29/19 "Enteral Feed order every 4 hrs H2O [water] flush of 125ml H2OQ4hrs " 7/21/19 "Check for residual Q8H (every 8 hours) if 100 mls or over hold feeding for 1 hour and recheck if 100mls or over notify MD [medical doctor] document amount of MLS [milliliters] every shift" 7/21/19 " Flush tube with 30 ml of water before	F 656		

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F 656	Continued From page 47 and after each medication pass, flush the tube with 5mls of water between each medication every shift" A review of the care plans on the clinical record failed to address care with person-centered goals and interventions to address the resident's G-tube [gastrostomy] treatment. A face-to-face interview was conducted with Employee #3 at approximately 2:00 PM on 8/15/19. The employee acknowledged the findings.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657	F 657 SS=D 1. A. Resident #14 – Care plan revised to reflect PEG tube and PEG tube care. 8/10/19 B. Resident #56- Care plan revised to reflect Breath Call system. 8/8/19 2. Care plans are checked daily and copies of updated care plans are turned in with 24 hours reports. 8/1/19 3. A. Staff are educated to provide printed copies of change of condition of care plans every 24 hours. 9/3/19 B. Care plans are reviewed weekly at the care plan meeting to assess the need for revision. 9/3/19	

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F 657	Continued From page 48 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility's staff failed to review and revise Care Plans to address the one (1) resident with a gastrostomy tube and for one (1) resident's use of a specialized call system for two (2) of 59 sampled residents (Residents' #14 and #56). Findings include... 1. Facility staff failed to update/revise the care plan with resident-centered goals and approaches to address the care of Resident #14's percutaneous endoscopic gastrostomy (PEG) tube. Resident #14 was admitted to the facility on 4/17/19 with diagnoses which include: Heart Failure, Hypertension, Type II Diabetes Mellitus and Seizure Disorder. Review of the Quarterly Minimum Data Set (MDS) dated 5/3/19 showed resident Brief Interview for Mental Status (BIMS) is coded as "6" to indicate moderately impaired cognition. Further review of the MDS showed Section K [Swallowing/Nutritional Status] Nutrition Approach	F 657	4. A. Data is being generated weekly and reported to the Patient Care and Safety meeting bi-weekly as to care plans correct for feeding devices. B. Data will be reported monthly to QAPI and bi- annually to Governing Board with the following data values: N = # of correct care plans for feeding devices and breath call devices D= # of care plans reviewed of patients with patients with feeding and breath call devices Goal = 100% x 3 months	10/24/19 10/24/19

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 49 resident is coded as having a "feeding tube." Review of the physician orders dated 8/7/19 showed "enteral feed order every shift Glucerna 1.5 @ 60/ml/hr X 24 hours via G-tube; check G-tube for placement prior to each feeding.." On 8/7/19 at 3:00 PM review of the care plan failed to show goals and approaches for care of Resident #14 percutaneous endoscopic gastrostomy (PEG) tube. During an interview on 8/7/19 at 3:00 PM, Employee #3 acknowledged the findings. 2. Facility staff failed to update/revise the care plan with resident-centered goals and approaches to address Resident #56's use of a specialized call system. Review of Resident #56's current medical record on 08/08/19 at 11: 40 AM showed that the resident had multiple diagnoses, including quadriplegia, tracheostomy, and chronic respiratory failure. An observation on 08/07/19 at 10:15 AM showed Resident #56 had physical limitations and a tracheostomy with oxygen being delivered at 5 liters per minute by way of a tracheal mask. Continued observation also showed that the resident had a specialized call system attached to the bed's side rail (left side).	F 657		

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F 657	Continued From page 50 During an interview on 08/07/19 at 10:20 AM, the resident stated that he had been using the specialized call system for a few years, but he could not remember the exact date when he started using the specialized call system. A second observation on 08/08/19 at 10:40 AM showed Resident #56 had physical limitations and a tracheostomy with oxygen being delivered at 5 liters per minute by way of a tracheal mask. Continued observation also showed that the resident had a specialized call system attached to the bed's side rail (left side). Continued review of the current medical record revealed a care plan with an initiated date of 08/08/19, in which, the Communication Section outlined that, "The resident requires Breath Call System to communicate ... Resident will be positioned ...to facility the ability to utilize call system." During a face-to-face interview on 08/08/19 at 2:00 PM, the Employee #3/Unit Manager, stated that she had updated Resident #56's care plan today (08/08/19) to include the resident's use of the "Breath Call" system. When asked, why the resident's care plan was not updated when the resident started using the specialized call system, the unit manager, stated, "It was an oversight."	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658	F 658 SS=E 1. Resident # 17/Discharged A. # 61- gauze removed, g-tube site assessed by physician and order obtained for G-tube site dressing. Nurse educated on policy for time,	8/10/19 9/18/19

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F 658	Continued From page 51 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview for four (4) of 59 sampled residents, the facility staff failed to provide care in accordance with professional nursing standards as evidenced by the gauze dressings on the G-tube (gastrostomy tube) sites were not dated and initial to account for when the dressing was changed. Residents' #17, #61, #77 and #217. Findings included... Standard of Practice "After dressing changes, document the appearance of any drainage on the old dressing and indicate the degree of dressing saturation. If you find drainage on only one part of the dressing, note where. This may help determine if the drainage reflects a problem, such as pressure or bleeding, in one segment of the wound. Indicate how you cleaned the wound and what materials you used to dress the site. Document the patient's response to wound care and the dressing change. Write the date, time, and your initials on the dressing itself so the next nurse knows when you changed it." 2003, Lippincott Williams & Wilkins, Inc. 1. An observation made of Resident #17's G-tube on 8/5/19 at approximately 12:05 PM showed the insertion site was covered with a gauze dressing. The nurse pulled off the gauze dressing from around the insertion site, the areas around the insertion site began to bleed bright red blood, the	F 658	date and initials on all dressings. B. # 77-gauze removed and nurse educated on policy for time, date and initials on all dressings. C. # 17 – gauze removed, g-tube r dressing and nurse educated on policy for time, date and initials on all dressings. 2. A. An audit on all residents with G-tubes was conducted to determine condition of G-tube site and current treatment orders. 3. A. Staff education was provided to include the management of G-tube sites. B. Staff education provided on the policy for dating, timing and initialing all dressings. C. Once per month, the RCC conducts random G-tube rounds on 20% of patients with G-Tubes to assure condition of G-Tube site, any dressings present have orders and that dressings are dated, timed and initialed. *Continued next page*	9/18/19 8/10/19 9/18/19 9/3/19 9/3/19 and ongoing 10/24/19

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F 658	Continued From page 52 nurse applied pressure with the gauze as she wipes the blood away. The gauze dressing contained areas of dark brown crusty substance and areas of bright red blood. The gauze was not dated and had no nurse signature to account for when it was last changed. The evidence showed facility staff failed to provide care in accordance with professional standards of care when the G-tube site gauze dressing has not been, dated, time, and initial on the dressing itself so the next licensed healthcare professional (attending physician, nurse) knows when the dressing was changed. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings 2. An observation made of Resident #61's G-tube on 8/8/19 at approximately 10:40 AM showed the insertion site was covered with a gauze dressing. The nurse pulled the old gauze dressing off and the gauze dressing contained dark brown drainage substance that crusted. There was no date and no nurse signature to account for when it was last changed. The evidence showed facility staff failed to provide care in accordance with professional standards of care when the G-tube site gauze dressing has not been, dated, time, and initial on the dressing itself so the next licensed healthcare professional (attending physician, nurse) knows when the dressing was changed. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with	F 658	4. Reporting from DON G-Tube rounds will go to QAPI for monitoring monthly and to Governing Board bi-annually and will be reflected in the following reporting values: N = # of appropriate G-Tube sites with nursing time, date and initials D = # of G-Tube sites rounded upon. Goal = 100 % x 3 months	10/24/19

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F 658	Continued From page 53 Employee #3. She acknowledged the findings 3. An observation made of Resident #77's G-tube on 8/8/19 at approximately 10:50 AM showed the insertion site was covered with a gauze dressing with no drainage noted on it. There was no date, time and initials on the dressing itself. The evidence showed facility staff failed to provide care in accordance with professional standards of care when the G-tube site gauze dressing has not been, dated, time, and initial on the dressing itself so the next licensed healthcare professional (attending physician, nurse) knows when the dressing was changed A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings 4. An observation made of Resident #217's G-tube on 8/8/19 at approximately 10:55 AM showed the insertion site was covered with a gauze dressing with no drainage noted on it. There was no date, time and initials on the dressing itself. The evidence showed facility staff failed to provide care in accordance with professional standards of care when the G-tube site gauze dressing has not been, dated, time, and initial on the dressing itself so the next licensed healthcare professional (attending physician, nurse) knows when the dressing was changed. A face-to-face interview was conducted on August	F 658		

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F 658	Continued From page 54 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings	F 658		
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 observation, record review and interview facility staff failed to provide the necessary care and services to maintain grooming for one (1) of 59 sampled residents. Resident #115. Findings included ... Resident #115 was admitted to the facility with diagnoses which include: Orthostatic Hypotension, Quadriplegia, Anxiety Disorder and Respiratory Failure. Review of the Comprehensive Minimum Data Set (MDS) dated 7/22/19 showed a Brief Interview for Mental Status (BIMS) score of "10" to indicate moderately impaired cognition. Section G [Functional Status] resident is coded as "4" total dependence on staff for dressing, personal hygiene (combing hair, brushing teeth, shaving,). G0400 [Functional Limitation in Range of Motion] resident is coded as upper extremity (impairment on one side) and impairment on both sides for lower extremities'. On 8/5/19 at 10:30 AM resident was observed lying in bed with her daughter at the bedside. Resident was observed to have white flakes in	F 677	F 677 SS=D 1. CNA's were educated on hair hygiene as their primary function. In this instance, the beautician was accessed to complete the hair care per the patient's request. 2. Observation of residents during routine rounds did not identify any patient with unwashed or unkempt hair. 3. A. Nursing aides were re-educated on appropriate hair care per policy on hair care/personal hygiene. 4. The Director of Nursing/designee will observe nursing aides for routine hair hygiene on shower days and report findings, variance analysis and corrective action to Patient Care and Safety committee bi-weekly, QAPI monthly and Governing Board bi-annually. N = # of episodes of hair care completed D = # of shower days Goal=100% x 3 months	8/19/19 8/20/19 9/3/19 10/24/19

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F 677	Continued From page 55 her hair, and the hair was matted. Daughter stated "she has not had her hair washed since she was admitted." The resident was asked if she would like her hair washed, resident responded "yes". Review of the care plan initiated on 7/16/19 showed "Focus: resident has an Activities of Daily Living (ADL) self-care performance related to Quadriplegia; Interventions: the resident is totally dependent on (2) staff to provide bath/shower and as necessary." Subsequent observation on 8/6/19 at 11:00 AM showed resident lying in bed with hair matted and white flakes in her hair. At the time of the observation Employee #3 was also present in the room and the Employee stated "I see her hair, it needs to be washed I will get the CNA to wash her hair." During a face-to-face interview on 8/6/19 at 11:00 AM Employee #3 acknowledged the finding.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from	F 689	F 689 SS=E 1. Water Temperature above 110 F A. The Engineer lowered the outgoing water temperature from the Main Boiler room B. The Maintenance team audited 20% (23 rooms) and came back within the safe range of 110-95 degrees C. Monthly monitoring and random room water temperature checks. D. Monthly PM findings are reported during the Bi-monthly EOC committee.	8/6/19 10/14/19 10/16/19 Ongoing

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F 689	Continued From page 56 accident hazards as evidenced by water temperatures that were above 110 degrees Fahrenheit in 12 of 46 resident's rooms and electrical outlets with no cover plate on one (1) of three (3) resident care units. Findings included ... 1. During an environmental walkthrough of the facility on August 5, August 6, and on August 7, 2019, between 2:30 PM and 4:00 PM, water temperatures were above 110 degrees Fahrenheit (F) in 12 of 46 resident's rooms. Water temperatures were adjusted and were at less than 110 degrees F when retested. 2. The cover plate to an electrical outlet located above the resident's bed in room #6133 and the cover plate to an electrical outlet located in the hallway next to resident room #6127 were missing. As a result, electrical wires attached to the outlet were exposed and accessible and presented an electrical safety hazard to residents, staff and visitors. Employee #16 and/or Employee #17 acknowledged the above findings during a face-to-face interview on August 7, 2019 at approximately 4:00 PM.	F 689	2. Missing Electrical Outlets A. The Electrician replaced the wall plates in Room 6133,6127 B. The Maintenance team checked 20% (23 rooms) 19/23 rooms were compliant. The four that were found have been replaced. C. Measures put in place / system changes so deficiency will not happen again: Wall monitoring will be conducted Monthly by the Electrician during routine PM's D. Monthly PM findings will be reported during the Bi-monthly EOC committee. F693 SS=E 1. A. Resident # 17/Discharged B. # 61- gauze removed, g-tube site assessed by physician and order obtained for G-tube site dressing. Nurse educated on policy for time, date and initials on all dressings. C. # 77-gauze removed and nurse educated on policy for time, date and initials on all dressings.	8/5/19 10/16/19 10/16/19 10/20/19 8/10/19 9/18/19 9/18/19
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		

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F 693	Continued From page 57 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview for one (4) of 59 sampled residents, the facility staff failed to ensure staff assessed four resident g-tube by examining and cleaning the insertion site in order to identify, lessen or resolve possible skin irritation and local infection care in accordance with professional nursing standards as evidenced by the gauze dressings on the G-tube (gastrostomy tube) sites were not dated and initial to account for when the dressing was changed. Residents' #17, #61, #77 and #217. Findings included...	F 693	C. # 17 – discharged 2. A. An audit on all residents with G-tubes was conducted to determine condition of G-tube site and current treatment orders. 3. A. Staff education was provided to include the management of G-tube sites. B. Staff education provided on the policy for dating, timing and initialing all dressings. C. Once per month, the RCC conducts random G-tube rounds on 20% of patients with G-Tubes to assure condition of G-Tube site, any dressings present have orders and that dressings are dated, timed and initialed. 4. Reporting from DON G-Tube rounds will go to QAPI for monitoring monthly and to Governing Board bi-annually and will be reflected in the following reporting values: N = # of appropriate G-Tube sites with nursing time, date and initials D = # of G-Tube sites rounded upon. Goal = 100 % x 3 months	8/10/19 9/18/19 9/3/19 9/3/19 9/3/19 10/24/19

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F 693	Continued From page 58 According to the American Society for Gastrointestinal Endoscopy (ASGE): " A dressing will be placed on the PEG[Percutaneous endoscopic gastrostomy] site following the procedure. This dressing is usually removed after one or two days. After that, you should clean the site once a day with diluted soap and water and keep the site dry between cleansings. No special dressing or covering is needed. https://www.asge.org/home/for-patients/patient-information/understanding-peg A review of the facility policy Enteral Feedings - Safety Precautions Level 111 (revised November 2018), Title: Preventing skin breakdown. Keep the skin around the exit site clean, dry and lubricated (as necessary). Assess for leaking around the gastrostomy or jejunostomy frequently during the first 48 hours after tube insertion and then with each feeding or medication administration. Observe for signs of skin break down. 1. An observation made of Resident #17's G-tube on 8/5/19 at approximately 12:05 PM showed the insertion site was covered with a gauze dressing. The nurse pulled off the gauze dressing from around the insertion site, the areas around the insertion site began to bleed bright red blood, the nurse applied pressure with the gauze as she wipes the blood away. The gauze dressing contained areas of dark brown crusty substance and areas of bright red blood. The gauze was not dated and had no nurse signature to account for when it was last changed. A review of the physician order sheet for August 2019 showed there was no order provided for site	F 693		

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F 693	Continued From page 59 care at the time of the observation. The evidence showed facility staff failed obtained a physician order to ensure cleanliness at the G-Tube insertion site. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings and presented a physician order dated 8/6/19 that directed, "cleanse PEG [Percutaneous endoscopic gastrostomy] tube site with soap and water. Pat dry and apply 4x4 gauze daily and when needed." 2. An observation made of Resident #61's G-tube on 8/8/19 at approximately 10:40 AM showed the insertion site was covered with a gauze dressing. The nurse pulled the old gauze dressing off and the gauze dressing contained dark brown drainage substance that crusted.. There was no date and no nurse signature to account for when it was last changed. A review of the physician order sheet for August 2019 showed there was no order provided for site care at the time of the observation. The evidence showed facility staff failed obtained a physician order to ensure cleanliness at the G-Tube insertion site. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings 3. An observation made of Resident #77's G-tube	F 693		

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F 693	Continued From page 60 on 8/8/19 at approximately 10:50 AM showed the insertion site was covered with a gauze dressing. There was no date and no nurse signature to account for when it was last changed. A review of the physician order sheet for August 2019 showed there was no order provided for site care at the time of the observation. The evidence showed facility staff failed obtained a physician order to ensure cleanliness at the G-Tube insertion site. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings. 4. An observation made of Resident # 217's G-tube on 8/8/19 at approximately 10:55 AM showed the insertion site was covered with a gauze dressing. There was no date and no nurse signature to account for when it was last changed. A review of the physician order sheet for August 2019 showed there was no order provided for site care at the time of the observation. The evidence showed facility staff failed obtained a physician order to ensure cleanliness at the G-Tube insertion site. A face-to-face interview was conducted on August 6, 2019, at approximately 12:15 PM, with Employee #3. She acknowledged the findings.	F 693	F 732 SS=D Continued next page	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		

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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 732	Continued From page 61 §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 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:	F 732	1. The Nursing Daily Assignment Sheet was moved to the outside of the nursing station as to be visible to all residents, families and public. 2. A. RCC's are to check daily to be sure the Nursing Daily Assignment Sheet is posted on the outside of the nursing station and correct immediately upon discovery if not posted correctly. 3. Random rounds are conducted weekly on all floors by Director of QA, DON and/or Administrator. 4. Discrepancies noted in monitoring of the nursing daily assignment sheet will be reported to the Patient care and safety meeting bi-weekly, QAPI monthly and the Governing board bi-annually. N = # of times the assignment sheet was posted correctly D = # of times rounding occurred for the assignment sheet (8/flr) Goal = 100%	10/24/19 10/24/19 10/24/19 10/24/19 10/24/19

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	095027	A. BUILDING _____ B. WING _____	08/15/2019

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F 732	Continued From page 62 Based on observation and staff interview for three (3) of three (3) nursing units between the hours of 10:00 and 11:00 AM the facility failed to post staffing information to include the identification, classification and assignment of all staff on duty on a daily basis. Findings include . . . On August 5, 2019 between the hours of 11:00 AM and 12:30 PM there was no posting of the staff on duty on either the fourth, fifth or sixth floor. Due to the failed practice, lack of posting of the staffing information; resident's family members and visitors were unable to determine the names, classifications and assignments of the staff that were on duty. During a face-to-face interview with Employee #2 at approximately 2:00 PM on August 6, 2019 the employee acknowledged that the facility failed to post the daily nurse staffing information.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757	F 757 SS=D 1. A. An order to remove the old patch for resident #97 for 12 hours after application was entered.	10/20/19

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F 757	Continued From page 63 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for two (2) of 59 sampled residents, facility staff failed to monitor the resident's behavior while he was receiving an antidepressant. Physician specifically recommended monitoring of Resident #49's behavior; and failed to ensure the physician followed the pharmacist recommendations to review the dose limit for a prescribed medication for Resident #97. Findings include . . . 1. Facility staff failed to monitor the resident's behavior while he was receiving an antidepressant as the Physician specifically recommended monitoring of Resident #49's behavior	F 757	B. PCC Behavior monitoring tab is currently being evaluated for a system error. The "0" currently being recorded means no behavior being noted. C. Pregabalin- Patient has been discharged. 2. A. Pharmacy recommendations have been audited for completeness and accuracy. 3. A. written process for completing pharmacy recommendations has been put into practice. B. Staff, including the physician, have been educated on the use of the new process. C. QA has been monitoring pharmacy recommendations monthly to assure completion of the pharmacy recommendations. 4. Monitoring is on-going indefinitely. Data will be collected monthly and reported to QAPI monthly and the Governing board bi-annually with the following data: N = number of pharmacy recommendations completed D= of pharmacy recommendations made. Goal = 100% x 3 months	8/15/19 9/19/19 10/12/19 10/16/19 10/16/19 10/1/19 and ongoing 10/24/19

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F 757	Continued From page 64 Review of Section I (Active Diagnoses) of the quarterly Minimum Data Set dated June 07, 2019 showed the resident has a diagnosis of Depression. Review of Section N410 (Medications Received) shows the resident receives an Antidepressant. Resident currently receives Citalopram (Celexa) 10mg 1 PO daily for Depression. Last seen for Psychiatric evaluation and medication review on May 16, 2019. At that time the Psychiatrist documented the following, "GDR [Gradual Dose Reduction not indicated at this time give comorbidities and poor quality of living, he continues to remain at risk for depression. Recommendation; Please continue to monitor for worsening of low mood, anxiety and agitation. Review of the clinical record and the Medication Administration Record (MAR) failed to show any evidence that the resident's behavior was being monitored as recommended by the Psychiatrist. A face-to-face interview was conducted with Employee #4 at approximately 4:00 PM on August 14, 2019. The employee acknowledged that facility staff failed to monitor the resident's behavior as recommended by the Psychiatrist. 2. Facility staff failed to ensure the physician followed the pharmacist recommendations to	F 757		

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F 757	Continued From page 65 review the dose limit for a prescribed medication. Resident #97. Resident #97 was admitted to the facility on 7/3/19 with diagnoses which include: Chronic Respiratory Failure, Cardiomegaly, Hypertension, Quadriplegia and Chronic Pain Syndrome. Review of the Comprehensive Minimum Data Set dated 7/10/19 showed Section C [Cognitive Patterns] Brief Interview for Mental Status is score as "14" to indicate cognition is intact. Review of the medical record failed to show the Medication Regimen Review form. Employee # 6 was asked where are the Medication Regimen Review forms and she replied "they are kept in a folder at the nursing station." On 8/15/19 at 1:00 PM a review of the folder showed a Consultant's Pharmacist Medication Regimen Review form dated 8/4/19 which reads "recommendation: Lidocaine Patch 5% Apply to Neck one time a day for Pain, Please update directions: 12 hours on and 12 hours off; nursing must document patch removal on medication record after 12 hours." Further review of the pharmacist recommendation showed: Pregabalin Capsule 100 mg give 2 capsules via PEG (percutaneous endoscopic gastrostomy) tube in the morning for pain. Pregabalin capsule 75 mg give 2 capsules via PEG tube in the afternoon for pain. Pregabalin capsule 75 mg give 2 capsules via	F 757		

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F 757	Continued From page 66 PEG tube in the evening for pain. "Resident # 97 is on a total daily dose of Pregabalin 500mg/day. The recommended maximum daily dose is 300mg/day and doses greater than 450 mg is not recommended. With higher doses, it may increase the risk of dose dependent adverse reactions. Kindly review and use with care." Recommendation status reads "Pending." Review of the Physicians' Orders fail to show documentation to support the physician reviewed the Medication Drug Regimen Review. During a telephone conversation with Employee #10, Physician states "typically the nurses give me the forms and I review and sign it." Facility staff failed to provide evidence the dose limit of the prescribed medication was reviewed by the physician in accordance with the pharmacist recommendations. Review of the medical record showed there was no evidence of harm to the resident. During a face-to-face interview on 8/15/19 at 1:00 PM Employee #6 reviewed the record and acknowledged the finding.	F 757		
F 761 SS=D	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	F 761	F 761 SS=D 1. A new, working thermometer was immediately obtained by the RCC from Materials Management and placed into the refrigerator.	8/8/19

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F 761	Continued From page 67 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 record review, and staff interviews, facility staff failed to ensure that the Medication Refrigerator thermometer on one (1) unit was functional and the Medication temperature Log Protocol on two (2) units were followed as planned for safe medication storage. Findings included ... 1. During the medication storage review on 8/8/19, the refrigerator thermometer on unit #6 was observed to fall apart and the surveyor was not able to observe the medication refrigerator temperature. There was no information as to	F 761	Nursing staff was re-educated on the spot taking the medication refrigerator temperatures every 24 hours as required per policy. 2. No patients or medications were affected by this deficient practice as within approximately 30 minutes of the placement of the new thermometer, the temperature reflected the appropriate temperature range of 36-41 degrees F. for storage of medications in the existing refrigerator.	8/8/19
			3. RCCs review the refrigerator temperature logs for completion twice per week. Remediation or disciplinary action will occur for those staff failing to record the refrigerator temperature as required.	10/24/19 and Ongoing
			RCCs checks the medication refrigerator for the presence of a working thermometer in the medication refrigerator twice a week.	10/24/19
			4. Data will be collected monthly and reported to QAPI monthly and the Governing board bi-annually using the following values: N= # of refrigerator temperature checks with working thermometer present D= # of refrigerator checks done per month 2X/week Goal = 100 X 3 months	10/24/19

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F 761	Continued From page 68 when the last time the thermometer was serviced or replaced. The facility staff called the maintenance department. The evidence showed that the thermometer in the medication refrigerator on unit 6 was not functional at the time of the medication review on the aforementioned date. 2. During Medication storage review on 8/8/19 the Medication Refrigerator log for Unit 6 showed the following: On Unit 6, 7/28/19, 7/29/19, 7/30/19, and 7/31/19 the box allotted for recording refrigerator temperature was blank indicating not done. According to the facility Protocol for Medication Refrigerator Temperature Log, "Record Temp every day, desirable temp Range 36-41, if above or below call Maintenance Dept [department]. The evidence showed that facility staff did not ensure facility protocol for medication refrigerator temperature logs were being followed aforementioned dates were left blank indicating not done. A face-to-face interview was conducted with Employee #3 at approximately 12:00 PM on 8/7/19. The employee acknowledged the findings that there was no documented evidence on the reported action taken.	F 761	F 835 SS=F Continued next page	
F 835 SS=F	Administration CFR(s): 483.70	F 835		

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F 835	Continued From page 69 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, Administration failed to ensure that action plans were developed and implemented to ensure that: (1) Facility staff provided residents with a specialized call system to allow resident(s) to call for assistance if in distress and or to make their needs known without waiting for staff to make rounds into the resident's room. (2) Facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect by failing to (1) investigate a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of one (1) resident (who is Hispanic and English is her second language). The census on the first day of survey was 115. Findings included ... 1.In the area of 42 CFR §483.10(e)(3), F558-Reasonable Accommodations Needs/preferences. Administration failed to ensure facility staff provided residents with a specialized call system to allow resident(s) to call for assistance if in distress and or to make their needs known without waiting for staff to make	F 835	1. A. Facility staff provided residents with a specialized call system to allow residents (s) to call for assistance if in distress and or to make their needs known. B. Facility staff followed-up thoroughly on injuries of unknown origin that had the potential to be abused or neglected. i. Investigated a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living. ii. Thoroughly investigated fractures sustained to the sacral and pubic areas of one (1) resident. 2. A. Families and residents on the 4th floor was called or questioned by social work as to any reports of falls or incidences that may not have been previously reported or reported and not followed through. B. A skin sweep was done on the 4th floor to assure no other residents had sustained unreported falls. C. The results were negative to #1 and #2.	8/8/19 8/15/19 8/15/19 8/15/19 9/16/19 8/8/19 8/8/19

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F 835	Continued From page 70 rounds into the resident's room. On August 7, 2019, at 5:00 PM an Immediate Jeopardy (IJ)-"J" was identified at 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences. During a face-to-face interview on 8/5/19 at 12:00 PM, Employee #5 acknowledged the findings. Cross reference 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences 2. In the area of 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation, Administration failed to ensure that facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect by failing to: (1) investigate a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of one (1) resident (who is Hispanic and English is her second language). On August 14, 2019, at 6:25 PM an Immediate Jeopardy (IJ)-"K" was identified at 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation. During a face-to-face interview with Employees' #1, #2 and #5, on August 14, 2019 at 6:25 PM, they acknowledged the findings. Cross reference 42 CFR §483.12 F600, Freedom from Abuse, Neglect, and Exploitation	F 835	3. A. Staff education provided to include the importance of following through with all adverse events reported regardless of who reports the issue: families, staff, ancillary personnel, etc. B. Education was provided on Bridgepoint Abuse and Neglect Policy. C. Education was provided on incident reporting: timeliness and flow of information. D. Spot rounds are conducted on the SNF weekly by Director of QA floor with adverse results reported to DON and Administration. E. Post-Fall investigation Report was created to be instituted to assess each fall. 4. Adverse incidences are reported at the bi-weekly Patient Care and Safety meeting for resolution. Results will be reported to QAPI monthly and the Governing board bi-annually. QAPI process will monitor the rounding data as: N = Number of injuries of unknown origin found on rounding that were not reported. Trending data	9/3/19 9/3/19 9/3/19 8/15/19 10/10/19 8/15/19 10/24/19

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F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on staff interview, Governing Body failed to ensure that action plans were developed and implemented to ensure that: (1) Facility staff provided residents with a specialized call system to allow resident(s) to call for assistance if in distress and or to make their needs known without waiting for staff to make rounds into the resident's room. (2) Facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect by failing to (1) investigate a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of one (1) resident (who is Hispanic and English is her second language). The census on the first day of survey was 115.	F 837	F 837 SS=F 1. A. Facility staff provided residents with a specialized call system to allow residents (s) to call for assistance if in distress and or to make their needs known. B. Facility staff followed-up thoroughly on injuries of unknown origin that had the potential to be abuse or neglect. i. Investigated a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living. ii. Thoroughly investigated fractures sustained to the sacral and pubic areas of one (1) resident. 2. A. Families and residents on the 4th floor were called or questioned by social work as to any reports of falls or incidences that may not have been previously reported or reported and not followed through. B. A skin sweep was done on the 4th floor to assure no other residents had sustained unreported falls. C. The results were negative to #1 and #2.	8/8/19 8/15/19 8/8/19 8/15/19 9/16/19 Date

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F 837	Continued From page 72 Findings included ... 1.In the area of 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences. The Governing Body failed to ensure facility staff provided residents with a specialized call system to allow resident(s) to call for assistance if in distress and or to make their needs known without waiting for staff to make rounds into the resident's room. On August 7, 2019, at 5:00 PM an Immediate Jeopardy (IJ)-"J" was identified at 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences. During a face-to-face interview on 8/5/19 at 12:00 PM, Employee #5 acknowledged the findings. Cross reference 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences 2. In the area of 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation. The Governing Body failed to ensure that facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect by failing to (1) investigate a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of one (1) resident (who is Hispanic and English is her second language). On August 14, 2019, at 6:25 PM an Immediate Jeopardy (IJ)-"K" was identified at 42 CFR	F 837	3. A. Staff education provided to include the importance of following through with all adverse events reported regardless of who reports the issue: families, staff, ancillary personnel, etc. B. Education was provided on Bridgepoint Abuse and Neglect Policy. C. Education was provided on incident reporting: timeliness and flow of information. D. Spot rounds are conducted on the 4th floor with results reported to DON and Administration. E. Post-Fall investigation Report was created to be instituted to assess each fall. 4. Adverse incidences are reported at the bi-weekly Patient Care and Safety meeting for resolution. Results will be reported to QAPI monthly and the Governing board bi-annually. QAPI process will monitor the rounding data as: N = Number of injuries of unknown origin found on rounding that were not reported. Trending data	9/3/19 9/3/19 9/3/19 9/3/19 10/10/19 8/15/19 10/24/19

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

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F 837	Continued From page 73 §483.12, F600, Freedom from Abuse, Neglect, and Exploitation. During a face-to-face interview with Employees' #1, #2 and #5, on August 14, 2019 at 6:25 PM, they acknowledged the findings. Cross reference 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation	F 837		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842	F 842 SS=E 1. A. #115 – Initials of nurses are now corrected to reflect alpha instead of numeric codes. B. #216 – Novolin had been discontinued on 7-31-19. C. #217 – Staff disciplinary action for failing to sign the eMAR. D. #101 – Staff disciplinary action for failing to sign the EMAR 2. A random audit of 10% of eMAR records were inspected and found 1 unsigned medication that was also discontinued on the same shift and 2 unsigned TAR's for residents that transferred out of room. 3. A. Disciplinary action to take place for failing to sign the eMAR. B. MAR and TAR documentation added to 24 hour Reconciliation form and Supervisor Shift Reports for monitoring every shift. C. QA Director spot checks the MAR and TAR documentation twice a week to assure complete eMAR records.	10/9/19 7/31/19 10/24/19 10/24/19 10/16/19 10/24/19 10/1/19 10/15/19

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F 842	Continued From page 74 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	4. Monitoring is on-going. Discrepancies are reported bi-weekly to Patient Care and Safety meeting, monthly to QAPI and bi-annually to Governing Board: N = # of eMARS at 100% completion D = # of audits per month Goal – 100%	10/24/19

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F 842	Continued From page 75 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for five (5) of 59 sampled residents facility staff failed to accurately document the administration of medications and treatments for one (1) residents and to document in the spaces allotted for the administration of medications and treatments for four (4) residents. Residents' #61, #101, #115, #216 and #217. Findings included... 1. Resident #61 was admitted to the facility on 10/6/17 with diagnoses which include Chronic Respiratory Failure, Dysphagia, Encephalopathy, Hypertension, Atrial Fibrillation, Peripheral Vascular Disease, Cerebral Infarction, Cerebrovascular Disease, Epilepsy, Hyperlipidemia, Diabetes Mellitus 2, Anemia, Dementia, Gastroesophageal Reflux Disease, and Chronic Kidney Disease. A review of the Significant change in status Minimum Data Set [MDS] dated 6/10/19 showed Section [Cognition Patterns] C1000 Cognitive skills for daily decision making was recorded as "3" which indicates severely impaired (never/rarely made decision). A review of Resident #61 Medication and Treatment Administration Record for July 2019 showed that on the dates mentioned the evening shift left the spaces allotted to document medication and treatment were blank indicating not done:	F 842		

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F 842	Continued From page 76 7/14/19 day shift "Elevate both left and right heel on pillow every shift" 7/14/19 day shift "Monitor bowel and bladder pattern q shift every shift" 7/14/19 day shift "Skin assessment daily q shift every shift" 7/14/19 day shift " Turn and Reposition q2hrs and as needed every shift" 7/14/19 day shift "Air mattress for wound prevention every shift for skin protection" 7/14/19 day shift "Anticoagulant medication monitor for discolored urine, black tarry stools, sudden severe headache, nausea, and vomiting diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or v/s, sob. Nose bleed. 7/14/19 day shift "Calmoseptine Ointment 0.44-20.625%(Menthol-Zinc Oxide) apply to perineal topically every shift for diaper rash 7/14/19 day shift "Left-hand mitten every shift to prevent self decannulation. Remove every 2 hours x 15 minutes and PRN to assess skin integrity and circulation every shift 7/14/19 day shift "Mouth care Q-shift every shift" 7/14/19 day shift "Nasal/oral care every shift" 7/14/19 day shift "Suction as needed every shift" 7/14/19 day shift "Vital signs Q shift every shift" The evidence showed that facility staff failed to maintain a complete and accurate record by not documenting in spaces allotted for signing off the care and treatments were completed. During a face-to-face interview on 8/13/19 at 2:00 PM, Employee #3 acknowledged the finding at the time of the review.	F 842		

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F 842	Continued From page 77 2. Resident# 101 was admitted to the facility on 6/25/18 with diagnoses which include Encephalopathy, Chronic Atrial Fibrillation, Chronic Respiratory Failure, Dysphagia, Legal blindness, Hypertension, Thrombocytopenia, Atherosclerotic Heart Ds, Epilepsy, and Anemia A review of the Significant change in status Minimum Data Set [MDS] dated 4/19/19 showed Section [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision. A review of Resident#101 Medication and Treatment Administration Records July 2019, showed that on the dates mentioned the evening shift left the spaces allotted to document medication and treatment were blank indicating not done: 7/1/19 2100 "Heparin Sodium solution 5000unit/ml inject 5000unit subcutaneously every 12 hours for clotting prevention 7/1/19 2100 "Keppra tablet 1000mg give 10 ml via g-tube two times a day for a seizure disorder" 7/1/19 2100 "Lactobacillus capsule give 1 capsule via G-tube two times a day for probiotic" 7/1/19 2100 "Lactulose solution 10gm/15ml give 30ml via g-tube two times constipation" 7/1/19 2100 " Ranitadine HCl tablet 150mg give 1 tablet via g-tube two times a day for GERD" 7/1/19 evening "Enteral feed order every shift check peg tube for placement q 8hrs and prn" 7/1/19 evening "Enteral feed order every shift flush tube with 30ml of water before and after each medication administration. 7/1/19 evening "Enteral feed order every shift two	F 842		

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F 842	Continued From page 78 CAL HN@38ml/hr x24 hours via GT" 7/1/19 evening "off load bilateral heels with the off-loading device every shift for pressure redistribution every shift" 7/1/19 evening "Skin assessment Q shift q day every shift for assessment 7/1/19 1800 Enteral feed order every 6 hours water flushed 145 ml q6hr 7/4/19 and 7/12/19 evening shift "Mouth care every shift for hygiene" 7/4/19 and 7/12/19 evening shift " Oral/nasal care every shift" 7/4/19 and 7/12/19 evening shift "Resident at high risk for aspiration every shift" 7/4/19 and 7/12/19 evening shift "Turn and reposition q2hrs and as needed every shift to prevent aspiration" 7/4/19 and 7/12/19 evening shift "Turn and reposition every two hours while in bed for pressure redistribution on the sacral area every shift 7/4/19 and 7/12/19 evening shift " Vital signs Q shift every shift for monitoring 7/16/19 day shift" Vital signs Q shift every shift for monitoring The evidence showed that facility staff failed to maintain a complete and accurate record by not documenting in spaces allotted for signing off the care and treatments were completed. During a face-to-face interview on 8/13/19 at 2:00 PM, Employee #3 acknowledged the finding at the time of the review. 3. Resident #115 was admitted to the facility on	F 842		

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F 842	Continued From page 79 7/15/19 with diagnoses which include: Orthostatic Hypotension, Quadriplegia, Anxiety Disorder, and Respiratory Failure. Review of the Comprehensive Minimum Data Set (MDS) dated 7/22/19 showed a Brief Interview for Mental Status (BIMS) score of "10" to indicate moderately impaired cognition. Review of the Medication and Administration Record (MAR) for August 2019, showed the following medications: "Enoxaparin Sodium inject 40 mg subcutaneously one time a day to prevent blood clotting Ascorbic Acid tablet 500 mg 1 tablet via G-tube two times a day for a supplement Famotidine Tablet 20 mg give 1 tablet via G-tube two times a day for acid ingestion Baclofen Tablet 10 mg give 3 tablets via G-tube every 8 hours for Muscle Spasm ...." A further review of the MAR showed for dates 8/1-8/5/19, Employee #14 initials and the #2 was in the same box to indicate the medications (listed above) were administered. However, a review of the chart codes on the MAR showed #2= "drug refused." During an interview on 8/6/19 at 3:00 PM, Employee #3 stated this is a systems problem they are working to correct the coding, however, we verified the medication was administered to the resident here is the pharmacy requisition. Review of the medical record showed no harm to the resident. Facility staff failed to ensure the medication record accurately reflects the administration of	F 842		

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F 842	Continued From page 80 scheduled medications. During an interview on 8/6/19 at 3:00 PM, Employee #3 acknowledged the finding. 4. Resident #216 was admitted to the facility on 7/29/19, with diagnoses to include Chronic Respiratory Failure, Dysphagia, Chronic Kidney Disease, Type 2 Diabetes Mellitus, GERD, Hyperlipidemia, Encephalopathy, Vascular Dementia, and Anemia A review of the Admission Minimum Data Set [MDS] dated 8/5/19 showed Section B [Hearing, Speech, and Vision] B0100 Comatose coded "yes" indicating Persistent vegetative state/no discernible consciousness. A review of Resident #216 Medication and Treatment Administration Records for August, 2019 showed that on the date mentioned the evening shift left the spaces allotted to document medication and treatment were blank indicating not done. 8/6/19 1800 Novolin R Solution 9Insulin regular Human) Inject per sliding scale If 150-199 =1unit, 200-249=2units, 250-299 =3 units, 300-349 =4 units, Greater than 349mg/dl give % unit and notify MD, give subcutaneously before meals and at bedtime for diabetes The evidence showed that facility staff failed to maintain a complete and accurate record by not documenting in spaces allotted for signing off the care and treatment were completed.	F 842		

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F 842	Continued From page 81 During a face-to-face interview on 8/13/19 at 2:00 PM, Employee#3 acknowledged the finding at the time of the review. 5. Resident #217 was admitted to the facility on 7/20/19, with diagnoses to include Chronic Respiratory Failure, Anemia, Dysphagia, and Hypertension, Review of the admission Minimum Data Set [MDS] dated 7/27/19 showed, Section [Cognition Patterns] C1000 Cognitive skills for daily decision making were recorded as "3" which indicates severely impaired (never/rarely made decision). A review of Resident#217 Medication and Treatment Administration Record for July, 2019 showed that on the dates mentioned the evening shift left the spaces allotted to document medication and treatment were blank indicating not done: 7/30/19 2100 "Senna Tablet 8.6 mg give 8.6 mg enterally two times a day for bowel regimen" 7/30/19 evening "Enteral feed order every shift Jevity 1.5 @ 42ml/hr x24hrs" 7/30/19 1600 "Enteral feed order every 4 hours H2O flush of 125ml H2OQhhrs" 7/30/19 2000 "Enteral feed order every 4 hours H2O flush of 125ml H2OQhhrs" 7/3119 evening " mouth care q shift every shift" 7/31/19 'Check for residual Q8h if 100mls or over hold feeding for 1 hour and recheck if 100ml or over notify MD document amount of MLS every shift" 7/31/19 evening shift "Complete Foley cath care every shift for Foley catheter care" 7/31/ 19 evening shift "Flush G-tube with 30mls	F 842		

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F 842	Continued From page 82 of water before and after each medication pass every shift" 7/31/19 evening shift "Flush tube with 5mls of water between each medication every shift" 7/31/19 evening shift "Skin assessment q shift every shift" 7/31/19 evening shift "Suction and trach care q shift every shift" The evidence showed that facility staff failed to maintain a complete and accurate record by not documenting in spaces allotted for signing off the care and treatment were completed. During a face-to-face interview on 8/13/19 at 2:00 PM Employee #3 acknowledged the finding at the time of the review.	F 842		
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 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	F 868	F 868 SS=D 1. QA has added, Injuries of Unknown Origin and Communication to the QAPI monitoring monthly. 2. Data collection from rounding audits, random interviews with residents and families, review of newly created CNA and Licensed nurse reports, random rounds weekly with verification of all reporting of falls and bruises.	10/24/19 10/24/19

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F 868	Continued From page 83 by: Based on record review and staff interviews, the facility staff failed to develop and implement an effective comprehensive quality assurance and performance improvement (QAPI) program to identify and correct quality deficiencies that was inclusive of all areas of resident care by failing to implement systems to identify residents who need a specialized call system which allows them to call for assistance if in distress and or to make their needs known without waiting for staff to make rounds into the resident's room. Also, to ensue facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect and (2) thoroughly investigate resident who sustain fractures. The census on the first day of survey was 115. Findings include ... During the interview on August 15, 2019 at 10:50 AM, a review of the facility's quality assurance and performance improvement (QAPI) program was conducted with Employee #13. The surveyor asked, did the quality assurance assessment committee identify concerns with residents not being able to use their call lights and residents with bruises of unknown origin. Employee #13 stated, "We looked at falls and how the nursing document falls. Nursing documentation assessments are not part of QA. Bruises of unknown origin was not a problem for and not part of QA, the facility felt it [assessments] were being done." The review of the program showed the facility staff failed to identify concerns, and develop and	F 868		

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F 868	Continued From page 84 implement actions plans to correct identified areas of deficient practice in the area of 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences and the area of 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation. 1.On August 7, 2019, at 5:00 PM an Immediate Jeopardy (IJ)-"J" was identified at 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences for failure ensure facility staff provided residents with a specialized call system to allow resident(s) to call for assistance if in distress and or to make their needs known without waiting for staff to make rounds into the resident's room. 2. On August 14, 2019, at 6:25 PM an Immediate Jeopardy (IJ)-"K" was identified at 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation for failure to ensure that facility staff followed-up on injuries of unknown origin that had the potential to be abuse or neglect by failing to: (1) investigate a bruise to the left eye for one (1) resident who was totally dependent on staff for all activities of daily living; and (2) thoroughly investigate fractures sustained to the sacral and pubic areas of one (1) resident (who is Hispanic and English is her second language). During a face-to-face interview with Employee #13 on August 15, 2019, at 10:50 AM, she acknowledged the findings. Cross reference 42 CFR §483.10(e)(3), F558- Reasonable Accommodations Needs/preferences; and Cross reference 42 CFR §483.12 F600, Freedom from Abuse, Neglect, and Exploitation	F 868		

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	095027	A. BUILDING _____ B. WING _____	08/15/2019

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	F 880 SS=F A. Infection Prevention 1. A review of current Infection control log was reviewed and no negative patient outcomes were noted. 2. No patients were identified as having been affected by the lack of documentation 3. Infection Preventionist will ensure surveillance tool contains a column for education for infection events and outcomes for all events. 4. Infection Preventionist assures appropriate documentation on the monthly report to reflect the completion date of antibiotics or the abatement of symptoms, whichever is appropriate. The column for community or facility acquired has been filled out for each entry. A column has been added to infection control report to reflect education to nursing staff provided. B. Legionella 1. No residents have been affected by this practice. 2. No other residents have been identified as being affected by this practice	9/22/19 9/22/19 10/24/19 10/24/19 10/23/19 10/23/19

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F 880	Continued From page 86 (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 observations, interview and record review facility staff failed to implement a water management program with policies and procedures specific to its water system that identifies areas where Legionella and other waterborne pathogens could grow and multiply and failed to maintain a safe, sanitary environment as evidenced by two (2) of two (2) portable electric fans in use in the kitchen that were soiled with dust. In addition, Based facility failed to show evidence of how the surveillance	F 880	3. A. Policies and Procedures specific to BridgePoint Capitol Hill have been reviewed and updated. B. Legionella water management plan specific to BridgePoint Capitol Hill completed addressing management of water-borne pathogens. 4. This plan will be monitored bi-monthly by Infection Control Committee and Environment of Care Committee C. Soiled electric fans in the kitchen 1. The fans were removed from operation 2. Toured area to ensure all FANS were removed. No other additional fans were found 3. In the interests of circumventing potential cross contamination, the practice of using floor fans is discontinued in FANS. 4. No further action is required as portable fans will not be used in the kitchen again.	10/24/19 10/24/19 10/24/19 8/5/19 8/5/19 8/6/19 8/9/19

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F 880	Continued From page 87 data was used to ensure that staff minimized the spread of infection or communicable disease within the facility. The facility census on the first day of survey 115. Findings included ... 1. The facility's water management program did not include a risk assessment specific to the facility that identifies where water borne pathogens such as legionella could grow, spread and multiply. 2.During a walkthrough of the facility's dietary services on August 5, 2019, at approximately 9:30 AM, two (2) of two (2) portable electric fans, one (1) of which was in use across from the tray line, were soiled with dust particles. This deficient practice could potentially contaminate food items to be consumed by residents throughout the facility. Employee #17 and Employee #15 acknowledged the findings during a face-to-face interview on on August 12, 2019, at approximately 3:00 PM and on August 5, 2019, at approximately 10:00 AM. 3.The facility staff failed to show evidence of how the surveillance data was used to ensure that staff minimized the spread of infection or communicable diseases within the facility. On August 12, 2019, at approximately 2:20 PM a review of the facilities infection prevention and control program was conducted. At this time, it	F 880		

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F 880	Continued From page 88 was noted that the surveillance documentation presented for the months of May and June 2019. The documentation revealed that in May 2019, 21 residents were identified with infections and in June, 2019 26 residents were identified to have infections. There was no evidence that facility staff recorded if the infection was community or facility acquired for each resident identified. Also, there was no evidence that for May and June 2019, the infectious surveillance data collected was used for staff education to help minimize the spread of the infection (e.g., staff education and competency assessment). Employee #13 acknowledged the findings during a face-to-face interview on August 12, 2019 at approximately 2:20 PM.	F 880		
F 908 SS=D	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 a torn and worn door gasket from one (1) of one (1) produce cooler in Dietary Services. Findings included... During a walkthrough of the kitchen on August 5, 2019, at approximately 9:35 AM, a door gasket to	F 908	F 908 SS=D 1. Work order was submitted and Sertec called for service. 8/5/19 2. Director of Dietary observed gaskets on other equipment. None were identified as being loose. 8/5/19 3. As part of Director's weekly environment of care rounds, gaskets on equipment is reviewed and work orders placed accordingly for loose gaskets 10/5/19 4. Director of Dietary will collect, analyze and present the data to EOC and QAPI monthly and the Governing board bi-annually 11/0/19 N =number of observations where there are no loose gaskets D=Total number of gaskets reviewed Goal = 95%	

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F 908	Continued From page 89 one (1) of one (1) produce cooler was torn off the door and needed to be replaced. Employee #15 acknowledged the above findings during a face-to-face interview on July 26, 2019, at approximately 11:00 AM.	F 908		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by a call bell in two (2) of 46 resident's rooms that failed to alarm when tested. Findings included... During an environmental walkthrough of the facility on August 5, August 6, and on August 7, 2019, between 2:30 PM and 4:00 PM, the call bell in resident rooms #6129 and #4119 did not alarm when activated, two (2) of 46 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. Employee #16 and/or Employee #17	F 919	F 919 SS=E 1. Requested service from an outside contractor ARC Systems. Maintenance team attempted to replaced several parts to get nurse call operational. 2. The Contractor checked 20% (23 rooms) of the nurse calls and found 21/23 that had to be reprogrammed and they were reprogrammed. 3. The Maintenance team will perform monthly monitoring and random room checks. 4. Monthly PM findings will be reported during the Bi-monthly EOC committee. N = # of call lights functioning properly D= # of call lights checked monthly Goal = 95% x 3 months	8/5/19 9/4/19 10/2/19 10/16/19 10/20/19 10/24/19

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F 919	Continued From page 90 acknowledged the above findings during a face-to-face interview on August 7, 2019 at approximately 4:00 PM.	F 919		