Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: ______ B. WING ______	08/15/2019

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

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L 000	Initial Comments	L 000		

An unannounced annual Licensure 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. The resident census during the survey was 115.

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

Abbreviations
AMS - Altered Mental Status
ARD - Assessment reference date
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CPR- Cardiopulmonary Resuscitation
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - Deciliter
DMH - Department of Mental Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability

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L 000	Continued From page 1 IDT - Interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention;	L 051	L 051 3210.4 Nursing Facilities 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.	8/10/19 8/10/19 10/15/19 10/24/19

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L 051	Continued From page 2 (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record 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. 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	L 051	2. As residents become due for their initial or quarterly MDS, the Care Plan for each resident will be reviewed for accuracy and completeness. 3. Care plans are reviewed upon admission, during monthly audit of selected charts and quarterly to assure accuracy. 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	9/10/19 10/1/19 11/1/19

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L 051	Continued From page 3 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 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	L 051		

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L 051	Continued From page 4 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 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.	L 051		

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L 051	Continued From page 5 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. 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	L 051		

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L 051	Continued From page 6 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 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.	L 051		

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L 051	Continued From page 7 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 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	L 051		

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L 051	Continued From page 8 findings. B. 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. 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"	L 051		

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L 051	Continued From page 9 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 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	L 051		

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L 051	Continued From page 10 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 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	L 051		

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L 051	Continued From page 11 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. 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:	L 051		

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L 051	Continued From page 12 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 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:	L 051		

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L 051	Continued From page 13 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 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.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that	L 052	L 052 3211.1 Nursing Facilities 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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L 052	Continued From page 14 the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, 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 allow resident to call for assistance if in distress,	L 052	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. 3. A. Staff education provided on the use of the new assessment tool and its addition to the Admission packet and general assessments. B. Care plans were put into place for the use of the type of call bell each resident uses. C. 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 8/8/19 and ongoing 8/15/19 and ongoing 8/15/19 and ongoing 11/1/19

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L 052	Continued From page 15 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 ... 8/8/19 by 5:00 PM, each resident will have a communication care plan done at the time of	L 052		

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L 052	Continued From page 16 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 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	L 052		

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L 052	Continued From page 17 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 right now, but I'm ok because I don't need anything." During a face-to-face interview at the resident's	L 052		

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L 052	Continued From page 18 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 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.	L 052		

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L 052	Continued From page 19 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. 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	L 052		

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L 052	Continued From page 20 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 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	L 052		

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L 052	Continued From page 21 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 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".	L 052		

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L 052	Continued From page 22 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.	L 052	L 056 3211.5 Nursing Facilities 1. A. Resident showers will be rescheduled to another shift. B. Unit secretaries that are cross-trained as certified nursing aides are put into staffing. C. Restorative aides have been converted to nursing aides. D. RCC's are put into staffing.	10/1/19
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice	L 056		

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L 056	Continued From page 23 registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day for 15 of 18 days reviewed in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.5. A review of Nurse Staffing was conducted on August 15, 2019, at approximately 1:00 PM. Of the 18 days reviewed, 15 of the 18 days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day as follows:	L 056	2. Each day the schedule is evaluated for sufficient staffing by the staffing coordinator, DON and RCC's. 3. A. A staffing committee has been developed to explore options for improving staffing. B. Overtime is allowed. C. Overtime incentives are being offered. D. We will be using agency aides when needed. E. Exploring with payroll and Human Resources using licensed staff from sister facilities. 4. Staffing report submitted to bi-weekly Patient Care and Safety meeting, to QAPI monthly and Governing Board bi-annually. Data will be collected for Trend represented as: N=number of days PPD was met D=number of days in the month	Ongoing 10/1/19 11/1/19

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L 056	Continued From page 24 Hours of Direct Care per resident per day Monday December 31, 2018, showed that the facility provided direct nursing care per resident at a rate of 3.7 hours. Tuesday January 1, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.7 hours. Saturday June 22, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Sunday, June 23, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Thursday July 4, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours. Thursday, August 1, 2019, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours. Friday, August 2, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours. Saturday, August 3, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours. Sunday, August 4, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Tuesday, August 6, 2019, showed that the facility	L 056		

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L 056	Continued From page 25 provided direct nursing care per resident at a rate of 3.9 hours. Wednesday, August 7, 2019, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours. Thursday, August 8, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.9 hours. Friday, August 9, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Saturday, August 10, 2019, showed that the facility provided direct nursing care per resident at a rate of 3.8 hours. Sunday, August 11, 2019, showed that the facility provided direct nursing care per resident at a rate of 4.0 hours. A face-to-face interview conducted with Employee #18 [the Staffing Coordinator] at the time of the staffing review and she acknowledged the findings. Of the 18 days reviewed, 15 of the days failed to meet a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day as follows: The review was made in the presence of Employee #18 who acknowledged the findings.	L 056		
L 088	3217.3 Nursing Facilities The Infection Control Committee shall establish	L 088	L 088 3217.3 Nursing Facilities *Continued next page*	

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L 088	Continued From page 26 written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute 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 data was used to ensure that staff minimized the spread of infection or communicable disease within the facility. The facility census on the first	L 088	A. Legionella 1. Legionella water management plan specific to BridgePoint Capitol Hill is completed addressing management of water-born pathogens. 2. Policies and Procedures have been reviewed and updated. B. 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. C. Infection Prevention 1. No patients were identified as having been affected by the lack of documentation 2. 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.	10/23/19 10/23/19 8/5/19 8/5/19 8/6/19 8/9/19 9/22/19 10/15/19

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L 088	Continued From page 27 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 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	L 088	A column has been added to infection control report to reflect education to nursing staff provided. 3. Report is checked monthly by Infection Preventionist. Administrator initials document monthly to assure compliance.	10/1/19

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L 088	Continued From page 28 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.	L 088		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observations, 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. Findings included ...	L 091	L 091 3217.6 Nursing Facilities B. Legionella 1. Legionella water management plan specific to BridgePoint Capitol Hill is completed addressing management of water-born pathogens. 2. Policies and Procedures have been reviewed and updated. B. 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.	10/23/19 10/23/19 8/5/19 8/5/19 8/6/19 8/9/19

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L 091	Continued From page 29 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.	L 091		
L 167	3227.18 Nursing Facilities Each facility shall comply with all applicable District and federal laws,regulations, standards, administrative guidelines, and rules that regulate the procurement, handling, storage, administering, and recording of medication. This Statute 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.	L 167	L 167 3227.18 Nursing Facilities 1. A new, working thermometer was immediately obtained by the RCC from Materials Management and placed into the refrigerator. 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	8/8/19 8/8/19

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L 167	Continued From page 30 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 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.	L 167	temperature range of 36-41 degrees F. for storage of medications in the existing refrigerator. 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. RCCs checks the medication refrigerator for the presence of a working thermometer in the medication refrigerator twice a week. 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	8/8/19 and Ongoing 8/8/19 11/1/19

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L 167	Continued From page 31 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.	L 167		
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute 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	L 190	L 190 3231.1 Nursing Facilities 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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L 190	Continued From page 32 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: 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	L 190	. 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%	11/1/19

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L 190	Continued From page 33 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. 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"	L 190		

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L 190	Continued From page 34 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 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	L 190		

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L 190	Continued From page 35 PM, Employee #3 acknowledged the finding at the time of the review. 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. 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.	L 190		

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L 190	Continued From page 36 Review of the medical record showed no harm to the resident. Facility staff failed to ensure the medication record accurately reflects the administration of 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	L 190		

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L 190	Continued From page 37 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. 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	L 190		

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	HFD02-0024	A. BUILDING: _____ B. WING _____	08/15/2019

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L 190	Continued From page 38 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 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.	L 190		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from 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 ...	L 214	L 214 3234.1 Nursing Facilities 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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L 214	Continued From page 39 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.	L 214	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.	8/5/19 10/16/19 10/16/19 10/20/19
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's	L 306	L 306 3245.10 Nursing Facilities 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.	8/5/19 9/4/19 10/2/19

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L 306	Continued From page 40 room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations and staff interview, 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 acknowledged the above findings during a face-to-face interview on August 7, 2019 at approximately 4:00 PM.	L 306	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 L 359 3250.1 Nursing 1. The existing drains were cut out and replaced with an air gap per code. 2. No harm to patients caused. 3. The drain lines have been permanently repaired; no further action needed 4. Maintenance completed routine monitoring of the drains and will continue monitoring to ensure proper drainage during our quarterly ice machine cleaning.	10/20/19 11/1/19 8/23/19 8/23/19 10/16/19 and ongoing
L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by:	L 359		

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L 359	Continued From page 41 Based on observations and staff interview, the facility failed to ensure that drain lines from food equipment were installed appropriately as evidenced by drain lines from three (3) of three (3) ice machines that extended into the drain on three (3) of three (3) resident care units. 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, drain lines from three (3) of three (3) ice machines located in the pantry of each resident care unit on the sixth, the fifth and the fourth floor were installed into the drain and provided no air gap. This deficient practice is in direct violation of the 2012 District of Columbia Food Code which states: 2403 DESIGN, CONSTRUCTION, AND INSTALLATION ? BACKFLOW PREVENTION, AIR GAP 2403.1 An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than twenty-five millimeters (25 mm) or one inch (1 in). Employee #17 acknowledged the above findings during a face-to-face interview on August 7, 2019 at approximately 4:00 PM.	L 359		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and	L 410	L 410 3256.1 Nursing Facilities 1. Soiled vents A. Maintenance removed the vents, cleaned and reinstalled in Rooms	8/7/19

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L 410	Continued From page 42 maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and 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 resident's rooms on the sixth floor, and resident wheelchairs in need of repair in three (3) of 46 resident's 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 resident's rooms: #4104: The left armrest was missing. #5104: Both armrest were torn. #5147: The brakes did not lock the wheels and both armrest 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.	L 410	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. 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	9/16/19 10/20/19 10/8/19 9/25/19 9/25/19 10/15/19
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care	L 442	L442 3258.13 Nursing Facilities *Continued next page*	

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L 442	Continued From page 43 equipment in safe operating condition. This Statute 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 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.	L 442	1. Work order was submitted and Sertec called for service. 2. Director of FANS observed gaskets on other equipment. None were identified as being loose. 3. As part of Director's weekly environment of care rounds, gaskets on equipment is reviewed and work orders placed accordingly for loose gaskets 4. Director of FANS will collect, analyze and present the data to EOC and QAPI monthly and the Governing board bi-annually N =number of observations where there are no loose gaskets D=Total number of gaskets reviewed Goal = 95%	8/5/19 8/5/19 10/5/19 11/0/19