DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 03/25/2022

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 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility on March 10 - 25, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 110 and survey sample included 53 residents. The following complaints were investigated during this survey: DC00010635, DC00010566, DC00010544, DC00010455, DC00010440, DC00010355 and DC00010167. The following facility reported incidents were investigated during this survey: DC00010614, DC00010497, DC00010473, DC00010461, DC00010360, DC00010221, DC00010172, DC00010108, and DC00010102. Federal and Local deficiencies were cited related to the investigation of: DC00010635, DC00010614, DC00010566, DC00010544, DC00010497, DC00010360, DC00010221, and DC00010102. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. This survey identified psychosocial harm at 42 CFR 483.12 (F600). The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status	F 000	F 000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	06/20/22

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

Olayinka Ayeni | ADMINISTRATOR | 06/22/2022

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		

ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of

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F 000	Continued From page 2 volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram The following deficieinces are a result of this survey:	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State	F 577	F 577 1. Corrective action for resident Residents and visitors will be notified that survey results will be located on top of the security desk for their review. Signage will be posted in a prominent location to notify them where the results are located.	

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F 577	Continued From page 3 surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to ensure that survey results were placed in a readily accessible location where residents and visitors wishing to examine them could do so without having to ask staff to see them. The census on the first day of survey was 110. The findings include: During a tour of the main lobby on 03/22/22 at approximately 3:20 PM, the past survey results were not visibly available to residents and visitors for review. When asked the security guard sitting behind the front desk reached under the desk	F 577	2. Identify other residents All residents/visitors have the potential to be affected by this practice. 3. Systemic changes The Administrator and front desk staff will be educated on ensuring that survey results are accessible to residents and visitors. The Administrator will be responsible for validating that survey results are accessible to residents and other stakeholders and subsequent follow up on findings. 4. Monitor corrective actions The Administrator/Designee will complete audits of the availability of survey results weekly and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 577	Continued From page 4 and produced a binder with the past survey results. Facility staff failed to ensure that survey results were visibly accessible to residents and visitors. During a face-to-face interview Employee #2 acknowledged the finding at the time of the observation.	F 577	578 1.Corrective action for resident The representatives of residents #30 signed the contract on 3/17/22. Resident #96 discharged to the hospital on 03/29/22 and returned on 05/10/22, discharged again on 05/20/22 and returned on 06/07/22. The representative for resident #96 was contacted on 06/09/22 to sign the contract (contract has still not been signed at this point.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s):483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578	Resident #26 was given information on formulating Advanced Directives on 06/10/22. The representatives for residents #30 and #96 were given information on formulating advanced directives on 06/09/22. 2. Identify other residents An audit of all other residents will be completed by 06/20/22. 3. Systemic changes Business Office staff will be educated on ensuring that residents/representatives are presented with the facility admissions contract within 72 hours of admissions. Social Services Staff will be re-educated on the importance of ensuring that residents/representatives are given information on formulating Advanced Directives. The Social Workers will be responsible for ensuring that residents and their representatives are informed of the right to formulate an advanced directive by presenting the information to them in person, via email, or via mail within 72 hours of admission. The Administrator will be responsible for follow up on findings.	

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F 578	Continued From page 5 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's staff failed to provide Advance Directive information to incapacitated resident or their representatives; and to offer a resident or their representative the opportunity to formulate an Advance Directive for three (3) of 53 sampled residents (Residents' #30, #96 and #26). The findings include: 1. Resident #30 was admitted to the facility on 07/10/16 with multiple diagnoses, including Respiratory Failure, Brain Stem Stroke Syndrome, and Atrial Fibrillation. Review of a Quarterly Minimum Data Set (MDS) dated 10/15/22 revealed that the Resident was coded for having memory problems with short-term and long-term memory and severely impaired cognitive skills for decision making. Review of the Resident #30's face sheet shows the resident had a representative (daughter).	F 578	4. Monitor corrective actions The Social Workers/Designee will complete audits of all resident records to ensure that all residents and their representatives have been offered the opportunity to formulate an Advanced Directive to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5.Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 578	Continued From page 6 Review of the resident's medical record showed the resident was a "Full Code. "However, the record lacked documented evidence the Resident #30's representative was provided information about Advance Directives. 2. Resident #96 was admitted to the facility on 01/06/22 with multiple diagnoses, including Anoxic Brain Damage, Dependence of Respiratory [Ventilator], and Tracheostomy. Review of an admission Minimum Data Set (MDS) dated 01/13/22 revealed that section C (Cognitive Pattern) was blank, indicating that the staff did not conduct a Brief Interview for Mental Status for the resident. Review of the Resident #96's face sheet shows the resident had a representative (daughter). Review of the resident's medical record showed the Resident was a "Full Code. "However, the record lacked documented evidence the Resident's representative was provided information about Advance Directives. During a face-to-face interview on 03/15/22 at approximately 9:30 AM, Employee #2 (Administration Representative) stated that residents representatives are provided written information about Advance Directive when they sign the admission contract. However, Residents #30 and #96 did not have signed admission contracts.	F 578		

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F 578	Continued From page 7 3.Facility staff failed to offer Resident #26 or their representative the opportunity to formulate an Advance Directive. Resident #26 was admitted on 02/11/21 to the facility with the following diagnosis, including Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Congestive Heart Failure, Type 2 Diabetes Mellitus, and Non-Alzheimer's Dementia Cerebrovascular Disease, Unspecified A Quarterly Minimum Data Set (MDS) dated 01/21/22 showed in Section C (Cognitive Patterns) that facility staff documented the resident as having a Brief Interview For Mental Status Summary Score (BIMS) of "15," indicating intact cognition A review of Resident #26 's clinical record revealed: 02/11/21 [Physician's Order]: "Full Code." There was no documented evidence that facility staff offered Resident #26 or their representative the opportunity to formulate an Advance Directive. During a face-to-face interview on 03/15/22 at 4:21 PM, Employee # 4 (Social Worker) acknowledged that there was no Advance Directive in Resident #26's medical record.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580	F 580 1. Corrective action for resident The representative of resident #102 was informed of the resident's change in condition on 2-3-22. 2. Identify other residents An audit of all other residents did not identify any other residents affected. There were no additional findings related to this citation.	

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F 580	Continued From page 8 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580	3. Systemic changes Licensed Nursing Staff will be re-educated on ensuring that representatives are informed of changes in resident's condition. The Director of Nursing will be responsible for ensuring that residents and their representatives are informed of changes in condition. The Director of Nursing will be responsible for the subsequent follow up on findings. 4. Monitor corrective actions The Director of Nursing/Designee will complete audits of 24-hour reports to ensure that all residents and their representatives have been notified of any changes in condition and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 580	Continued From page 9 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident's representative interview, the facility's staff failed to notify a resident's representative of a resident's change in status (self-decannulation), which resulted in the resident being transferred to the emergency room for re-insertion of a tracheostomy tube for one (1) of 53 sampled residents (Resident #102). The finding included: Review of a complaint received by the DC Department of Health on 02/28/21 documented, "He [the complainant] received a call at 3:35 AM from [hospital's name] because his sister ...trach [tracheostomy tube] came out or she pulled it out ...he never received a call from the facility indicating his sister was being transferred." Resident #102 was admitted to the facility on 01/02/22 with multiple diagnoses, including Chronic Respiratory Failure, Tracheostomy, and Spastic Diplegic Cerebral Palsy. On 03/17/22 at approximately 9:30 AM, Resident #102 was observed lying in bed with a tracheostomy tube and trach collar at 28% FiO2 [fraction of inspired oxygen]. Review of an admission Minimum Data Set dated 01/27/22 showed the resident had a Brief Interview for Mental Status summary score of "00" indicating Resident #102's cognition was severely impaired. Further review of the MDS showed that the resident was not coded for behaviors symptoms or rejection of care.	F 580		

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F 580	Continued From page 10 Additionally, the resident was coded for needing oxygen therapy, suctioning, tracheostomy care, and respiratory therapy services. Review of the medical record revealed the following: 01/21/22[physician order] - trach size #6.5. 01/21/22[physician order] - trach-collar at 28% [FiO2] every shift for respiratory failure. 02/02/22[nursing progress note] at 10:22 PM, documented, "Writer was told that the resident had decannulated [change in condition] herself. Respiratory therapist was with her when she removed [her] trach. [Dr. Benjamin Frizner] was notified and ordered to send her to the nearest ER Howard University Hospital for trach replacement. (11 [911] was called and resident was sent to Howard University Hospital." 02/02/22 [physician order] - Send resident to nearest ER (emergency room) for trach replacement one time only for trach decannulation. 02/02/22 [resident concern/complaint form], revealed, "On 02/02/22 [resident's name] decannulated self and she was transferred to the ER Howard University Hospital. The nurse assigned failed to call and notify the responsible party of the change in status and ER transfer." 02/03/22 [nursing progress note] at 1:07 PM, documented, "Resident came back to the floor ...with a replaced trach intact with no discomfort noted ...R (respirations) 18, SPO2 (oxygen saturation) 99% on trach collar."	F 580		

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F 580	Continued From page 11 Review of Resident #102's comprehensive care plan with a start date of 02/02/22 showed the following: Focus Area - [resident's name] is at risk for self-decannulation r/t (related to) ...self-decannulation. Interventions o Ensure that trach ties are secured at all times. o Monitor [resident's name] for any attempt to pull out her trach and follow up with MD (medical doctor). During a telephone interview on 03/17/22 starting at 9:00 AM, the complainant stated that the hospital called him and informed him that the resident was there because she had pulled out her trach (tracheostomy tube). He then said that he had a meeting with the facility, and the Administrator (Employee #1) apologized for the nurse not notifying him when his sister (Resident #102) was sent to the hospital. During a face-to-face meeting on 03/17/22 at approximately 3:00 PM, Employee #1 (Administrator) stated that the team had a virtual meeting with the complainant. And she apologized for the nurse not notifying him when his sister was transferred to the hospital.	F 580		
F 600 SS=G	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	F 600	F 600 1. Corrective action for resident Resident #266 no longer resides in the facility as of 5-4-22. The nurse and CNA involved in the incident were suspended pending investigation and subsequently terminated on 3-22-22. The CNA was an agency staff person. The agency was notified of the incident. The nurse and CNA were reported to the board of nursing on 3-22-22.	

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F 600	Continued From page 12 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- §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 review, staff, and resident interviews, for one (1) of 53 sampled residents, facility staff failed to ensure that Resident #266 was free from mental abuse and rough handling/physical abuse by a licensed practical nurse employed by the facility. These failures resulted in psychosocial harm to Resident #266. The findings include: Facility policy entitled Abuse Policy revised 07/2017 stipulates, "Definitions ...1.Abuse ... the willful infliction of injury, unreasoned confinement, intimidation or punishment with resulting physical harm, pain or mental anguish ...Includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Treatment/Management ...the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect ..." Resident #266 was initially admitted to the facility on 02/24/22, with multiple diagnoses that	F 600	2. Identify other residents Other like residents were interviewed during the survey with no like concerns noted. 3. Systemic changes All facility staff have been re-educated on identifying abuse and their responsibility to report suspected cases of abuse which could include elder abuse, rough handling, physical, mental emotional, verbal, and exploitation. Staff were also educated on the consequences for failure to report abuse which makes them a party to the abuse. The Administrator will be responsible for ensuring that residents are not abused. The Administrator will be responsible for the subsequent follow up on findings. 4. Monitor corrective actions The Administrator/Designee will complete rounds to monitor staff and resident interactions and follow up on any subsequent findings. Incident reports will be reviewed for any questionable activity weekly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5.Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 600	Continued From page 13 included: Traumatic Subarachnoid Hemorrhage without Loss of Consciousness, Traumatic Hemorrhage of Cerebrum, Unspecified with Loss of Consciousness, Multiple Fractures of Pelvis without Disruption of Pelvic Ring, Fracture Left Lower Leg, Fracture of Orbit Unspecified, encounter for Attention to Gastrostomy, Chronic Respiratory Failure with Hypoxia, Encounter for Attention to Tracheostomy, Encounter for Attention to Gastrostomy and Pedestrian injured in Traffic Accident Involving Unspecified Motor Vehicles. A review of Resident #266's medical record revealed physicians' orders documenting the following: -02/25/22 "Trach (tracheostomy) care q (every) shift for Trach care; -03/01/22 "Patient has Spanish/English communication binder in room. Review of the Admission Minimum Data Set (MDS) assessment dated 03/03/22, revealed that facility staff coded the following: -In section A (Identification Information): A1100 Language ...Preferred Language "Spanish"; -In section C (Cognitive Patterns): Should a brief Interview for Mental Status Conducted? "no". -The Brief Interview for Mental Status (BIMS) summary score section was "Blank". -In Section G (Functional Status): Bed mobility, Transfer and Toilet use were all coded as "Total Dependence" requiring "Two-person physical assist" -Bathing "total dependence" -Functional Limitation in Range of motion, Upper Extremity "No impairment" Lower extremity	F 600		

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F 600	Continued From page 14 "Impairment on both sides" -In section J (Health Conditions): Pain Management, Received scheduled pain medication regimen "No" -In section N (Medications): Medications received "Opioid" -In section O (Special Treatments, Procedures, and Programs): Respiratory Treatments "Oxygen Therapy, Suctioning and Tracheostomy Care". During a face-to-face interview on 03/17/2022 at approximately 3:30 PM Employee #1 informed the survey team that there was "an alleged allegation of emotional abuse that involved a staff member and [Resident #266] ...the residents daughter has the video tape of the staff emotionally abusing the resident ...this supposedly happened on yesterday (03/16/2022) ...we just reviewed the video ..." A face-to-face interview was conducted on 03/17/22 at approximately 5:00 PM with Resident #266's daughter-in-law who stated that yesterday her mom (Resident #266) told her please take me home there is a lot of mean people. At the time of this interview Resident #266's relatives provided the survey team with a video recording from a private device that they indicated was recorded the previous evening (03/16/22) in Resident #266's room on a private device. A review of the video revealed the following: -Two staff in Resident #266's room were identified as Employee #13 (Licensed Practical Nurse) and Employee #14 (Certified Nurse Aide). -While providing personal care for Resident #266, Employee #13 was observed handling the	F 600		

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F 600	Continued From page 15 and pushing her body to roll her]. The employee was also heard yelling, "what did you eat tacos and tequila?..."I'm telling you, you crazy f***k"....Why does she move like that? Does she have worms in her butt? Girl are you part of a human being..." The employee continued to taunt the resident by calling the resident's daughter's name multiple times and saying, "come and get your mama." -Further observation of the video showed Employee #13 changing the resident's incontinent brief, repositioning resident # 266 in the bed, and suctioning the resident while the resident was lying flat in the bed. -During this time, Resident #266 could be heard speaking Spanish loudly stating the following: "...Oh Father help me nobody wants to listen to me...This foot hurts...I have such pain...That's the hand that hurts." Further review of the video showed that Employees #13 and #14 failed to ask Resident #266 if she was in pain while they performed care. During a face-to-face interview on 03/17/22 at 4:34 PM, Employee #13 (LPN) was questioned by the writer regarding the care she provided for Resident #266 on 03/16/22 during the 3-11 PM shift. Employee #13 stated, "while we were changing the resident she said, "P***a" (Spanish expletive). Then I repeated back what she said. I think there is an English barrier, but I think she understands. I said turnover and she understood what I said. Then I said nothing else and the CNA [Certified Nurse Aide] said nothing else. Then the resident tried to take the trach out." A general progress note dated 03/17/22 at 10:22	F 600		

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F 600	Continued From page 16	F 600		

PM documented, "Resident is alert, oriented x3 and verbally responsive. Trach collar intact and suctioned prn with clear moderate sections noted. O2 at 5/L (liters) per min via tracheostomy tube 28% Fio2 (fraction of inspired oxygen) for respiratory support. Seen by NP [name] on unit and assess the patient. New order given to transfer resident to the [Hospital Name] for further evaluation due to chest pain and knee. No acute distress noted ...Resident was transferred to ER (emergency room) at 5:57 PM ..."

During a face-to-face interview on 03/18/22 at 4:44 PM, Employee #14 (CNA - Agency Staff) was questioned by the writer regarding the care she provided to Resident #266 on 03/16/2022 during the 3-11 PM shift. Employee #14 stated, "While I was in the room, she [Resident #266] gets a fear on her face. The charge nurse (Employee #13) likes to work with her CNAs, she does the work. I try to go in rooms by myself ...she picks the rooms she wants to do ...She does the work;" The surveyor asked Employee #14 to explain how she and Employee #13 work together and Employee #14 stated, "I just stand waiting for her to turn the resident ...This is the same thing that happens all the time. Nothing different. She washes the resident's face very roughly. Employee #13 pulls her (Resident #266) with her arm, we should use the sheet to pull them over. The resident likes to come to the middle of the bed and that upsets [Employee #13]. The lady (Resident #266) started saying "P***a" so [Employee #13] started calling her a "B***h". If the lady (Resident #266) tried to tell her something it made her angry. She yanks them around and she does it to everybody ..."

When asked if she has reported any of her

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F 600	Continued From page 17 observations or what she shared, she stated, "I have not reported this. I'm' not full-time here. I am not fearful of her [Employee #13] ... I don't want hostility. None of the other nurses do anything..." A physician's order dated 03/19/22 was also noted in the medical record that requested, "Pain assessment Q (Every) shift". During a face-to-face interview on 03/23/22 at approximately 3:03 PM with Employee #2, (Administration Representative) and Employee #15 (Social Worker) Employee #2 stated, "Through our investigation, we have bumped up the concern from verbal abuse to physical abuse because of the way [Employee #13] handled the resident."	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement its Abuse Investigation and Reporting policy by not	F 607	F 607 1. Corrective action for resident Resident #30 had an unwitnessed fall on 01/08/22 @ 11pm. The resident was unable to articulate what occurred. During a subsequent review of this incident during the survey, we were unable to ascertain the exact cause of the fall. The resident has their bed in the lowest position with floor mats. Resident #32's portable clip-on fan fell on them and caused a minor skin tear on 06/27/21. The incident was unwitnessed, and the resident was unable to articulate what caused the fan to fall. During a subsequent review of the incident during the survey we were unable to ascertain what caused the fan to fall. Based on the type of fan used, the vibration of the fan or resident movements could have caused the fan to fall. Moving forward, this type of fan will not be positioned close enough to residents for them to fall on the residents. Resident #79 had a witnessed fall with injury on 3/3/22. A subsequent review of the incident during survey revealed that a rehabilitation staff member was with the resident at the time of the fall. The staff member turned away to charge the resident's phone per the resident's request. The resident lost their balance when the looked back and fell. The staff member has been addressed regarding supervision of residents during treatment.	

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F 607	Continued From page 18 investigating the following incidents: (1) a resident who had an unwitnessed fall with injury resulting in the resident being transferred to the hospital for evaluation; (2) a resident who sustained a minor injury after a portable fan fell on the resident; (3) a resident who had a witnessed fall with a minor injury; (4) a resident who had an unwitnessed fall without injury; (5) a resident whose gastrostomy tube was dislodged; and (6) a residents whose midlines were dislodged. Residents' #30, #32, #79, #263, #105 and #207. The findings include: Review of the facility's policy titled, "Abuse and Neglect- Clinical Protocol," dated 11/01/21, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." Review of the facility's policy titled "Abuse Investigation and Reporting" dated 11/09/21 documented, "if an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual." 1.The facility's staff failed to investigate Resident #30's unwitnessed fall with injury resulting in the resident being transferred to the hospital for evaluation. Resident #30 was admitted to the facility on 07/10/16 with multiple diagnoses, including Respiratory Failure, Brain Stem Stroke	F 607	Resident #263 had an unwitnessed fall without injury on 3/12/22 @ 1:55pm. The resident was unable to articulate what occurred. A subsequent review of the incident during survey did not reveal the exact cause of the fall. Interventions are in place to include floor mats on left side of the bed. Resident #105's gastrostomy tube became dislodged on 3/17/22. A subsequent review of the incident during the survey did not reveal the exact cause of the dislodgement. Nursing staff are being in-serviced on how to provide personal care in a manner to decrease the chances of dislodgement during care (as a precaution). The resident was unable to articulate how the gastrostomy tube dislodged. The tube was replaced per the physician's order on 3/16/22. Resident #207's mid-line was dislodged on 3/14/22. A subsequent review of this incident during the survey did not provide an exact cause for the mid-line dislodgement. The resident was unable to articulate how the dislodgement occurred. We were unable to ascertain exactly who the dislodgement occurred. Moving forward, all falls and dislodgements will be fully investigated at the time of occurrence. 2. Identify other residents An audit of other incidents will be conducted by 06/20/22 to identify any additional residents that may have been affected.	

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F 607	Continued From page 19 Syndrome, and Atrial Fibrillation. Review of a facility-reported incident (FRI) received by the DC Department of Health on 01/11/22 documented that on 01/08/22 at 11:00 PM, the resident (Resident #30) "was observed on the floor laying on his back ...with a Medium-size laceration to left side eyebrow." Multiple observations from 03/10/22 to 03/17/22 from 9:00 AM to 6:00 PM showed that Resident #30 was in bed with the bed in the low position, quarter side rails up, and floor mats next to the bed. Review of Resident #30's medical record showed the following: 10/15/21[Quarterly Minimum Data Set] revealed that the resident was coded for having memory problems with short-term and long-term memory and severely impaired cognitive skills for decision making. Further review of the MDS showed Resident #30 was totally dependent on the physical assistance of two or more staff members for bed mobility and transfers. The MDS also revealed the resident was not coded for behaviors or falls. 01/08/22 at 11:15 PM [nursing progress note] - "Writer was doing last rounds for the shift at 2300 (11 PM) and observed resident on the floor by the bedside laying on his back ... resident was noted with blood on the floor and medium size laceration on the left side eyebrow, first aid provided to stop the bleeding ...RP (responsible party) and MD (medical doctor) notified and ordered to send resident out to the nearest ER for further evaluation."	F 607	3. Systemic changes Administrator and Nursing leadership staff will be re-educated on identifying incidents that must be investigated and reported to DOH. Incidents will be reported to the DON/Administrator, and they will submit the report to DOH. A nursing leader will be assigned to gather statements about the incident. The Administrator will be responsible for ensuring that incidents are investigated and reported per CMS/DOH guidelines. The Administrator will be responsible for the subsequent follow up on findings. 4. Monitor corrective actions The Administrator/Designee will complete a review of the 24-hour report to identify issues that may need to be investigated and reported and follow up on any subsequent findings daily. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5.Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 607	Continued From page 20 01/08/22 [physician order] instructed, "transfer resident to the nearest ER (emergency room) for evaluation following unwitnessed fall with left eyebrow(sp) laceration." 01/09/22 at 6:47 AM [nursing]- "Resident returned back from the ER at 0530 (5:30 AM) via ambulance ... CT scans did not show any new brain injury or broken bones. The cut was repaired with sutures that are absorbable ... continues on neuro check, floor mat in place, bed in low position. Resident was given 1x does Tylenol for generalized pain. Will continue to monitor." Review of Resident #30's comprehensive care plan dated 01/08/22 showed the following: Focus Area [Resident's name] has had an actual fall with injury on 01/08/22 r/t (related to) unaware of safety needs, jerking movement while coughing. Interventions o Place floor mats on sides of the bed at all times while in bed for injury precautions. o Assess left eyebrow swelling for any change every shift. o Left eyebrow laceration wound evaluation by wound nurse o Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, new-onset: confusion, sleepiness, agitation. o Neuro-checks x 72 hour. o Proper positioning when in the bed or chair. o PT/OT (physical therapy/occupation therapy) eval. s/p (status post) fall.	F 607		

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F 607	Continued From page 21 During a telephone interview on 03/10/22 starting at approximately 1:00 PM, the resident's responsible party stated that the facility called her and made her aware that her dad had a little accident of a fall and was being transferred to the hospital. The representative said the staff told her "the aide left the side rail down, and thats how he (Resident #30) fell out the bed." The representative then said when she visited with the resident the next day, his face was so swollen and bruised that she took pictures because she was so upset. During a telephone interview on 03/17/22 starting at 11:00 AM, Employee #18 (RN) stated that she observed the resident (Resident #30) on the floor when she made her rounds. When asked to describe what she saw, Employee #18 said, "The resident was lying on his back on the left side of his bed, the resident had a laceration to his brow, and the bed was in a low position with the side (quarter) side rails up." When asked how did the resident fall? The employee stated that the respiratory therapist told her that some residents could cough so hard that they could fall out of the bed. During a face-to-face interview on 03/17/22 at 11:33 AM, Employee #19(Medical Director) stated that he was aware of the incident. The employee then said that residents with Brain Stem injuries could have coughing episodes that cause their whole body to violently jerk. During a face-to-face interview on 03/17/22 at approximately 2:00 PM, Employee #2 (Director of Nursing) stated that she could not find documented evidence that an investigation was conducted for Resident #30's fall on 01/08/22.	F 607		

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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 607	Continued From page 22	F 607		

2. The facility's staff fail to investigate an incident of a minor injury after a portable fan fell on Resident #32.

Resident #32 was admitted to the facility on 07/28/16 with multiple diagnoses, including Respiratory Failure, Systemic Lupus, Ventilator Dependent, and Generalized Muscle Weakness.

Review of a facility reported incident (FRI) received by the DC Department of Health on 06/28/21 documented that on 06/27/21 at 8:30 AM, the resident (Resident #32) "sustained a small skin tear to the upper right braw [brow] measuring 0.5 inches after a small portable hand fan fell on the resident."

During an observation on 03/10/22 at approximately 1:30 PM, a white portable fan was noted clipped to the IV pole on the right side of the resident's bed.

Review of Resident #32's medical record showed the following:

06/05/21[Quarterly Minimum Date Set -MDS] documented that Resident #32 was in a persistent vegetative state with no discernible consciousness. Further review of the MDS showed that the resident was coded for being totally dependent and required the physical assistance of two or more people for bed mobility.

06/27/21 at 2:49 PM [nursing progress note] revealed, "Nurse was called at 8:30 am by the CNA (certified nursing assistant) and notified that while giving care to resident, the small portable

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F 607	Continued From page 23 handheld ...plastic fan that was clamped to the headboard, popped off and fell on resident and [Resident #32] sustained a small skin tear to the upper right eye braw [brow] measuring 0.5inches ...MD called and made aware, gave new order to apply bacitracin ointment to skin tear daily x 7 days." 06/27/21 [physician order] directed, "Bacitracin ointment 500 units/gm (gram) apply to right upper eye topically one time a day for open wound for 7 days." Further review of Resident #32's medical record lacked documented evidence that the facility staff investigated the incident of the resident sustaining a minor injury (skin tear) to the resident's right eyebrow on 06/27/21. During a face-to-face interview on 03/23/22 at approximately 4:00 PM, Employee #3 (Director of Nursing) stated, "I didn't do an investigation for that incident." 3.The facility's staff failed investigate Resident #79's witnessed fall with injury on 03/03/22. Resident #79 was admitted to the facility on 07/13/21, with multiple diagnoses that included: Encephalopathy, Traumatic Subdural Hemorrhage with Loss of Consciousness of 30 Minutes or Less, Heart Failure Unspecified, Muscle Weakness, and History of Falling. Review of the Quarterly Minimum Data Set (MDS) dated 02/02/22, revealed that facility staff coded the following: In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) Summary Score of "06"	F 607		

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F 607	Continued From page 24 Indicating severe cognitive impairment In section G (Functional Status) Bed mobility was coded "Extensive assistance" requiring "Two-persons physical assist" Transfer "Extensive assistance" requiring "Two-person physical assist" Walk in room was coded "activity did not occur" Functional Limitation in Range of Motion: Upper extremity was coded "Impairment on both sides" Lower extremity was coded "Impairment both sides" In Section O (Special Treatments, Procedures, and Programs) Physical Therapy is coded with a start date of 10/21/21 and there was no end date coded. Review of the physician's orders revealed the following: 01/12/22 "Fall Precaution Q (every) shift every shift ..." 03/01/22 "Patient is d/c'd (Discharged) from PT (Physical Therapy) and is now on restorative therapy program ..." 03/11/22 "Pt (Patient) will receive restorative nursing services 5x/wk. 12 wks (five times per week for 12 weeks) for ther (Therapy) exer (Exercise) and ambulation ..." Review of the care plan with a focus area [resident's name] has had an actual fall with Minor injury r/t (related to) mobility /gait and Hx. (history) of Encephalopathy" date initiated	F 607		

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F 607	Continued From page 25 03/03/22, revealed the following interventions: "Monitor /document /report PRN (as needed) X (times) 72h (hours) to MD (Medical Doctor) for s/sx (signs and symptoms): Pain bruises, Change in mental status, New onset: confusion, inability to maintain posture, agitation. Neurochecks Q (every) shift X 3 days, Patient education, PT (physical therapy)/OT (Occupational Therapy) /Restorative nursing, Treatment of minor injury as ordered by MD (medical doctor)" Review of the nursing progress notes revealed the following: 03/03/22 at 12:17 PM, "Patient had a fall today [at] 11am. Shift nurse assessed patient with minor skin abrasion and redness to right posterior arm. Treatment applied as ordered. Per patient report, Patient stated that he was walking with the walker and he turned back and acquired the fall. Patient was with Restorative assistant at time of fall. Per restorative assistant report, the Restorative assistant was walking with patient when patient worried about his cell phone not charging, the assistant turned away to get phone and that is when the patient had fallen. Patient was found sitting on floor in room by staff along with the Restorative assistant. ..." 03/03/22 at 3:30 PM, " ...writer heard the noise from the patient room, rushed in the room and found the patient sitting on the floor and the physical therapy staff standing beside the patient The patient stated that he lost he (his) balance while trying to look back. Physical Therapy staff stated that the patient asked him to plug his phone, he bow down to plug the phone, the patient fell ..."	F 607		

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F 607	Continued From page 26 The surveyor asked Employee #6 (Unit Manager) for the incident investigation for Resident #79's witnessed fall with injury that occurred on 03/03/22. Employee #6 failed to provide the surveyor with an investigation, however, she provided the following: a document titled "1914 witnessed fall" dated 03/03/22 11:00 AM and a documented titled "SBAR Communication Form Progress Note" which was reviewed by the surveyor. During a face-to-face interview on 03/16/22 at 4:23 PM, Employee #7 (Physical Therapist) stated "He fell while in therapy." During a face-to-face interview on 03/16/22 at 3:15 PM, Employee #6 acknowledged that there was no documented evidence of a completed falls incident (and potential neglect) investigation and made no further comments. 4. The facility's staff failed investigate Resident #263's unwitnessed fall without injury on 03/12/22. Resident #263's date of birth is 05/19/1920 and he was admitted to the facility 02/28/22, with multiple diagnoses that included: Unspecified Dementia without Behavioral Disturbance, Paroxysmal Atrial Fibrillation, Benign Prostatic Hyperplasia Without Urinary Tract Symptoms, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 03/07/22, revealed that the facility staff coded the following:	F 607		

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F 607	Continued From page 27 In section C (Cognitive Patterns): Brief interview for Mental Status (BIMS) Summery score of "08" indicating moderately impaired cognition. In section G (Functional Status): Bed mobility "Total dependence" requiring "Two-person physical assist" Transfer "Total dependence" requiring "One-person physical assist "Walk in room "Activity did not occur "Toilet use "Total dependence" requiring "Two-person physical assist" Review of a general progress note dated 03/12/22 at 4:12 PM documented "At 1:55PM, CNA (certified nurse aide) assigned reported to the writer that resident had a fall in his room and was assisted back to his bed. On assessment resident was found lying on his left side, denied pain. No distress noted. Floor mat in place ..." Review of the care plan with a focus area (resident's name) has had an actual fall with no injury on 03/12/22 r/t (related to) poor safety awareness, Dementia" date initiated 03/14/22 had the following interventions, "Continue interventions on the at-risk plan, Floor mat at left bed side for safety, Monitor/document /report ...change in mental status ... Neuro checks, vital signs ..." On 03/21/22, the surveyor asked Employee #6 (Unit Manager) for the incident investigation for Resident #263's unwitnessed fall without injury that occurred on 03/12/22. Employee #6 failed to provide the surveyor with an investigation,	F 607		

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F 607	Continued From page 28 however, she provided the following: a document titled "1925 un-witnessed fall", a Morse Fall Scale, and a document titled "SBAR Communication Form Progress Note" which was reviewed by the surveyor. During a face-to-face interview on 03/21/22 at 11:15 AM, Employee #6 (Unit Manager) stated "Its (falls incident investigation) supposed to be done at the time of the incident" Employee #6 acknowledged that the falls incident investigation was not completed. 5. The facility's staff failed to investigate the dislodgement of Residents #105's gastrostomy tube. On 03/17/22, a facility-reported incident (FRI) was provided to the state agency that documented: " ...at about 11:50 AM. It was noted the resident's G-tube (gastrostomy tube) site was leaking ...Staff noted the balloon was burging [bulging] out of the skin..." Resident #105 was admitted to the facility on 01/06/22 with multiple diagnoses including Encounter For Attention To Gastrostomy. Review of the Admission Minimum Data Set (MDS) dated 01/13/22 documented that facility staff coded the resident as having a Brief Interview for Mental Status Summary Score	F 607		

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F 607	Continued From page 29 (BIMS) of "00," indicating that: the resident was severely cognitively impaired. Facility staff also coded the resident as having a nasogatric or abdominal feeding tube (PEG - percutaneous endoscopic gastrostomy). During a face-to-face interview on 03/21/22 at 3:12 PM, Employee #8 (Registered Nurse) stated, "I notified my Nursing Supervisor about the incident." During a face-to-face on 03/21/22 at 10:54 AM, Employee #3 (Director of Nursing), stated she would check for the facility's investigation documents for the incident. It should be noted that the DON did not provide the surveyor with the request documents. 6. The facility's staff failed to investigate the dislodgement of Residents #207's midline (intravenous line). On 03/14/22, a facility-reported incident (FRI) was provided to the state agency documented: " ...CNA (Certified Nurse Aide) stated that she noticed the midline dislodge[d] while giving resident care...Midline insertion site intact, no bleeding noted .....No injuries observed at time of incident." Resident #207 was admitted to the facility on 03/07/22 with diagnoses multiple diagnoses including Chronic Respiratory Failure, Pneumonia, and Urinary Tract Infection. Review of the Admission Minimum Data Set dated 03/07/22, facility staff documented that Resident # 207 was rarely or never understood;	F 607		

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F 607	Continued From page 30 therefore, no Brief Interview Mental Status Summary Score (BIMS) was done. Facility staff also coded the resident as totally dependent and requiring physical assistance by two or more staff for bed mobility, transfers, dressing, and personal hygiene. During a telephone interview on 03/22/22 at 12:36 PM, Employee # 12 (Certified Nurse Aide/CNA), who was present when Resident #207's midline became dislodged, stated on Tuesday (the day after the incident), I had to write an incident report." During a face-to-face on 03/21/22 at 10:54 AM, Employee #3 (Director of Nursing), stated she would check for the facility's investigation documents for the incident. It should be noted that the DON did not provide the surveyor with the request documents.	F 607		
F 620 SS=E	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential	F 620	F 620 1. Corrective action for resident Resident #95s guardian signed their admissions contract on 3/28/22. 2. Identify other residents An audit of all current residents will be completed by 6/20/22. 3. Systemic changes Business office staff will be educated on ensuring that all residents and/or their representatives are presented with the opportunity to review and sign an admissions contract within 72 hours. The Business Office Manager will be responsible for ensuring that admissions contracts are presented to all new admissions. The Business Office Manager will be responsible for the subsequent follow up on findings.	

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F 620	Continued From page 31 residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. §483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and (ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the	F 620	4. Monitor corrective actions The Business Office Manager/Designee will complete a review of all new admissions weekly and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5.Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 620	Continued From page 32 contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident. §483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 53 sampled residents, facility staff failed to have an admissions policy in place; and failed to ensure residents and or their responsible party reviewed and signed an admission contract, informing them of the facility's approach to finances, residents' rights, care, treatment and services, and advance directives. Resident #95. The findings include: Facilty staff failed to ensure Resident #95 and or	F 620		

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F 620	Continued From page 33 their responsible party reviewed and signed an admission contract. Resident #95 was admitted on 01/07/2022 with diagnoses that included Chronic Respiratory Failure with Hypoxia or Hypercapnia, Cerebral Palsy, Pressure Ulcer Stage 4, Tracheostomy and Gastrostomy Review of the Resident's contract on 03/17/2022 dated showed that it was not dated and signed by the resident's responsible party. There is no evidence that Resident #95 or his responsible party was made aware of or provided notice regarding: Statement of Services and Charges, the Representatives' Rights and Responsibilities, Policies and Procedures concerning Personal Funds and Personal Property, Residents' Rights and Responsibilities, Information about how to apply for and use Medicaid Benefits, A list of physicians that practice at the facility, a list of services provided by outside health care providers, Consent of my personal funds, Photo Release, Resident Funds, Beauty and Barber Consent Form, Notice of Privacy Practices, Legal rights of District of Columbians to decide about future medical treatment and Advance Directives. During a telephone interview with Employee #10 (Business Office Manager) on 3/17/2022 at 3:10 PM she acknowledged the Resident's admission packet has not been signed. On 03/17/2022 at 10:45 AM, during a face-to-face interview with Employee #1, the writer requested a copy of the facility's Admission policy and when the Admission Contracts had to be signed.	F 620		

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F 620	Continued From page 34 Employee #1 stated, within 30 days from admission the contract must be signed; and did not provide the policy.	F 620	F 655 1. Corrective action for resident Resident #63's baseline care plan was not provided within 48 hours of being readmitted (we were unable to retrospectively correct this issue). The family was updated on the resident's plan of care on 3/30/22.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary	F 655	2. Identify other residents An audit of all new resident baseline care plans will be conducted by 06/20/22. All new admissions will their baseline care plans completed within 48 hours. 3. Systemic changes The IDT team (nursing, rehabilitation, social services, therapeutic recreation, and dietician) will be educated on ensuring that baseline care plans are created for each resident within 48 hours of admission. The Director of Reimbursement will be responsible for ensuring that all residents have interim care plans within 48 hours of admission. 4. Monitor corrective actions The Director of Reimbursement/Designee will complete daily audits of all new admissions to ensure that all residents have interim care plans within 48 hours (weekend/holiday admissions will be audited the next business day). The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 655	Continued From page 35 of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 53 sampled residents, facility staff failed to provide documented evidence that a baseline care plan was provided to a resident or his representative within 48 hours of readmission into the facility. Resident #63 The findings include: Resident #63 was readmitted to the facility on 12/2/21 with diagnoses including Chronic Respiratory Failure, Cerebrovascular Accident (CVA), Encounter For Attention To Gastrostomy, Encephalopathy and Urinary Tract Infection. Review of the Quarterly Minimum Data Set dated 12/28/21, facility staff documented that Resident #63 had a Brief Interview Mental Status Summary Score (BIMS) of "00" indicating the resident, had severe cognitive impairment. In addition, facility staff documented the resident: was "totally dependent, for bed mobility, transfers dressing, and eating; was always incontinent for bowel and bladder and had an indwelling urinary catheter, and the resident has a nasogastric or abdominal feeding tube percutaneous endoscopic gastrostomy (PEG).	F 655		

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F 655	Continued From page 36 Review of Resident #63's medical record showed: 12/22/21 (History and Physical/Type - Readmission) " ...Chief Compliant: intracerebral hemorrhage 2. History of Present Illness (HPI) ... multiple cerebellar strokes, resp.(respiratory) failure s/p (status pos) PEG 2/16 ...Assessment and Plan:..Cont. (continue) tube feeds ... cont. supportive care for ADLs (assisted daily living skills) UTI (urinary tract infection: cont. meropenem (antibiotic) for 7 (seven) more days." 12/22/2021 (48 Hour Baseline Care Plan) " ...A. Nursing Resident and Representative made aware of summary of initial care plan goals and updated comprehensive care plan based on current medical diagnosis, ADL care, medications, code status, advanced directives ...F. Signatures: [All areas were left blank] ...G. Notification [All areas were left blank] ..." There was no documented evidence that facility staff provided Resident #63's or his representative a 48-hour baseline care plan when the resident was readmitted back into the facility on 12/22/21. During a face-to-face interview on 03/15/22 at 2:45 PM , Employee #6 (Unit Manager) acknowledged that Section F: Signatures and Section G: Notifications of Resident #63's baseline care plan were left blank.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656	F 656 1. Corrective action for resident Resident #32's care plan was reviewed and updated on 3-24-22. Resident #96 DC'd 5-20-22 (we were unable to retrospectively correct these care plans). Resident #79's care plan was reviewed and updated on 5-2-22. Resident #2's care plan was reviewed and updated on 4-5-22. Resident #262 DC'd 4-6-22 (we were unable to retrospectively correct these care plans). Resident #263's care plan was reviewed and updated on 4-5-22	

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F 656	Continued From page 37 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656	2. Identify other residents An audit of all current resident care plans will be completed by 06/20/22. 3. Systemic changes The IDT team (Social services, Dietician, Rehabilitation, Recreation, and Nursing) will be educated on ensuring that comprehensive care plans are created for each resident and updated as needed. The Director of Nursing will be responsible for ensuring that all residents have comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 656	Continued From page 38	F 656		

section.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, for six (6) of 53 sampled residents, the facility's staff failed to develop a care plan with goals and approaches to address: the use of a portable fan; monitoring a resident for signs and symptoms of Depression; and restorative nursing for a residents; Dementia care for a resident; the use of antibiotics for a resident and to implement the interventions for a resident at risk for falls. (Residents' #32, #96, #79, #2, #262, and #263)

The findings include:

1. The facility's staff failed to develop a care plan to address Resident #32's use of a portable fan.

Resident #32 was admitted to the facility on 07/28/16 with multiple diagnoses, including Respiratory Failure, Systemic Lupus, Ventilator Dependent, and Generalized Muscle Weakness.

Review of a facility reported incident (FRI) received by the DC Department of Health on 06/28/21 documented that on 06/27/21 at 8;30 AM, the resident (Resident #32) "sustained a small skin tear to the upper right braw [brow] measuring 0.5 inches", after a small portable hand fan fell on the resident.

During an observation on 03/10/22 at approximately 1:30 PM, a white portable fan was noted clipped to the IV pole at the head of the bed

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F 656	Continued From page 39 Review of Resident #32's medical record showed the following: 06/05/21 (Quarterly Minimum Date Set) documented that she was in a persistent vegetative state with no discernible consciousness. Further review of the MDS showed that the resident was coded for total dependent and required the physical assistance of two or more people for bed mobility. 06/27/21 at 14:49 (nursing progress note) revealed, "Nurse was called at 8:30 am by the CNA and notified that while giving care to resident, the small portable handheld ...plastic fan that was clamped to the headboard, popped off and fell on resident and [she] sustained a small skin tear to the upper right eye braw [brow] measuring 0.5 inches ...MD called and made aware, gave new order to apply bacitracin ointment to skin tear daily x 7 days." 06/27/21 (physician order) directed, "Bacitracin ointment 500 units/gm (gram) apply to right upper eye topically one time a day for open wound for 7 days." Review of Resident #32's comprehensive care plans lacked documented evidence of interventions to address the resident's use of a portable fan. During a telephone conference on 03/23/22 at approximately 12:30 PM, Employee #3(RN) stated that the CNA called her into the resident's room and informed her that fan had fallen. When she entered the room, she observed that the resident had a small bump on her brow. She	F 656		

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F 656	Continued From page 40 rendered first aid and informed the physician and the resident's family of the incident. During a face-to-face interview on 03/23/22 at 5:46 PM, Employee #2 (DON) stated that the facility supplied and implemented the use of a portable fan for Resident #32 because she (the resident) gets hot. When asked if Resident #32 had a care plan to address the resident's use of the portable fan, Employee #2 said, "I'll look for it." It should be noted Employee #2 did not provide the surveyor with a care plan to address Resident #32's use of a portable fan. 2. The facility's staff failed to implement a care plan's intervention to monitor Resident #96 for signs and symptoms of Depression. Resident #96 was admitted to the facility on 01/06/22 with multiple diagnoses, including Depression. Multiple observations from 03/10/22 to 03/17/22, starting at approximately 9:00 AM to 6:00 PM, showed Resident #96 was observed sleeping, awake, watching television, or following simple staff commands. Review of an admission Minimum Data Set (MDS) dated 01/13/22 revealed that section C (Cognitive Pattern) was blank, indicating that the staff did not conduct a Brief Interview for Mental Status for the resident. Further review of the MDS revealed the resident was not coded for feeling depressed, appearing down, or rejecting care. Additionally, Resident #96 was coded for receiving anti-depressant and anti-psychotic medications.	F 656		

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F 656	Continued From page 41 Review of the resident's medical record revealed the following: 01/06/22 (physician order) instructed, "Aripiprazole (anti-psychotic drug) 5mg (milligrams) give 3 tablets via G-tube (gastrostomy tube) in the evening for Depression." 01/06/22 (physician order) instructed, "Mirtazapine (anti-depressant drug) 30 mg give 1 tablet g-tube at bedtime for Depression." 01/06/22 (care plan) Focus Area- [Resident's name] has an altered mood [related to] depression, anxiety on psych (psychiatric) medication. Goal - will be monitored for symptoms not managed on current regime ... Interventions: o Assess for s/sx (signs/symptoms) of depression and agitation. Notify MD (medical director), if current regime doesn't manage symptoms... o Medicate as ordered o Psych (psychiatric) eval (evaluate) and treat as indicated. Review of nursing progress notes, medication administration records (MAR), and treatment administration records (TAR) from 01/06/22 to 03/16/22 lacked documented evidence staff monitored Resident #30 for s/sx of Depression. During a face-to-face interview on 03/17/22 at 1:10 PM, Employee #2 (DON) stated that nurses document their monitoring of residents for signs and symptoms of Depression on MARs or TARs.	F 656		

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F 656	Continued From page 42 The employee reviewed Resident #96's MARs and TARs from 01/06/22 to 03/16/22 and said that she did not see documented evidence that staff monitored the resident for signs and symptoms of Depression. 3. Facility staff failed to include and develop a restorative nursing care plan in resident's plan of care. Resident #79 Resident #79 was admitted to the facility on 07/13/21, with multiple diagnoses that included: Traumatic Subdural Hemorrhage with Loss of Consciousness of 30 Minutes or Less, Heart Failure Unspecified, Muscle Weakness, and History of Falling. Review of the Quarterly Minimum Data Set (MDS) dated 02/02/22, revealed that facility staff coded the following: In section C (cognitive Patterns) Brief Interview for Mental Status (BIMS) Summary Score of "06" Indicating severe cognitive impairment In section G (Functional Status) Bed mobility was coded "Extensive assistance" requiring "Two-persons physical assist" Transfer "Extensive assistance" requiring "Two-person physical assist" Walk in room was coded "activity did not occur" G0400 Functional Limitation in Range of Motion: Upper extremity was coded "Impairment on both sides" Lower extremity was coded "Impairment both sides" In Section O (Special Treatments, Procedures, and Programs) Physical Therapy is coded with a start date of 10/21/21 and there is no end date coded.	F 656		

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F 656	Continued From page 43 Review of the physician's orders revealed the following: 03/11/22 "Pt (Patient) will receive restorative nursing services 5x/wk -12 wks for ther (Therapy) exer (Exercise) and ambulation ..." Review of the medical record showed that there was no documented evidence of a restorative nursing care plan. A face-to-face interview was conducted on 03/16/22 at 3:15 PM with Employee #6 (Unit manager Registered Nurse) stated "Restorative nursing is an extension of rehab once they reach baseline they want to maintain strengthening, so they won't have a decrease in functioning ..." Employee #6 acknowledged that there was no documented evidence in the care plan about the resident receiving restorative nursing. 4. Failed to develop a dementia care plan to address Resident #2's diagnosis of dementia. Resident #2 was admitted to the facility on 07/01/2000 with multiple diagnoses that included: Unspecified Dementia with Behavioral Disturbance, Major Depressive Disorder, and Psychotic Disorder with Hallucinations due to Known Physiological Condition. Review of the Quarterly Minimum Data Set (MDS) dated 02/12/22, revealed that the facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "10"	F 656		

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F 656	Continued From page 44 indicating moderately impaired cognition. In section I (Active Diagnoses): Neurological, Non-Alzheimer's Dementia Review of the medical record revealed that there was no documented evidence of a dementia care plan. A face-to-face interview was conducted on 03/21/22 at approximately 11:00 AM with Employee #6 (Unit Manager Registered Nurse) stated "We do the care plan as a team" Employee #6 acknowledged the findings. 5. Failed to develop and implement a care plan to include residents elevated white blood cell count and use of antibiotics. Resident #262 Resident #262 was admitted to the facility on 01/24/22, with multiple diagnoses that included: Traumatic Subarachnoid Hemorrhage with Loss of Consciousness, Elevated White Blood Cell Count Unspecified, and Pneumonia Unspecified Organism. Review of the Admission Minimum Data Set (MDS) dated 01/31/22, showed that facility staff coded the following: In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) Summary Score "00" indicating severe impairment. In section G (Functional status) for Bed mobility, transfer, dressing, toilet use, and personal hygiene resident was coded as "total dependence "requiring one or more staff assist"	F 656		

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F 656	Continued From page 45 Review of the white blood cell count lab values showed the following: 03/08/22, White blood cell count 15.8 H (High) 03/12/22, White blood cell count 15.0 H (High) 03/20/22, White blood cell count 15.3 H (High) Reference range (normal values) 3.8-10.8 Review of the physicians' orders revealed the following: 03/07/22 "Levaquin (antibiotic) Tablet 750 MG ... Give 1 tablet via PEC-tube one time a day for pneumonia ..." 03/19/22 "Meropenem Solution Reconstituted 1 GM Use 1 gram intravenously two times a day ..." Review of the document titled "Progress Note-MD (medical doctor)/DO (doctor of osteopathic medicine)/PA (physician assistant)/NP (nurse practitioner)" revealed, 03/08/22 at 9:00 AM in section E. "Assessment plan: ... WBC 15; cont. IV fluids ..." The medical record lacked documented evidence of a care plan that addressed residents prescribed antibiotics and elevated white blood cell count. A face-to-face interview was conducted on 03/23/22 at 5:40 PM, with Employee #3 (Director of nursing, unit manager) stated, "It's not there (plan of care for resident #262's elevated white blood cell count and use of antibiotics)" Employee #3, acknowledged the findings. 6. Facility staff failed to develop and implement the " at risk plan" following residents fall as instructed by residents care plan. Resident # 263 Resident #263's was admitted to the facility	F 656		

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F 656	Continued From page 46 02/28/22 with multiple diagnoses that included: Unspecified Dementia Without Behavioral Disturbance, Paroxysmal Atrial Fibrillation, Benign Prostatic Hyperplasia Without Urinary Tract Symptoms, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) dated 03/07/22, revealed that the facility staff coded the following: In section C (Cognitive Patterns): Brief interview for Mental Status (BIMS) Summery score of "08" indicating moderately impaired cognition. Review of the physician's orders revealed the following: 03/14/22 "Fall mat to left side of bed during periods of rest ..." Review of the General progress note showed the following, 03/12/22 at 4:12 PM "At 1:55 PM, CNA (certified nurse aide) assigned reported to the writer that resident had a fall in his room and was assisted back to his bed. On assessment resident was found lying on his left side, denied pain. No distress noted. Floor mat in place ..." Review of the care plan with a focus area of "(Resident # 263) has had an actual fall with no injury on 03/12/22, r/t (related to) poor safety awareness, Dementia" initiated on 03/14/22 had the following intervention "Continue interventions on the at-risk plan" There is no documented evidence in the medical record that facility staff developed or implemented an "at-risk plan" following Resident #263's fall. A face-to-face interview was conducted on 03/21/22 at 3:00 PM, Employee #6 (unit manager registered nurse) stated "The at-risk plan is determined by the IDT (interdisciplinary team) team" Employee #6 explained there was no	F 656		

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F 656	Continued From page 47 "at-risk plan" documented in the medical record and acknowledged the findings.	F 656	F 684	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for four (4) of 53 sampled residents, facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan as evidenced by failure to: (1) provide activities of daily living (ADL) in a manner that prevented a Resident #29's midline (intravenous line) from being dislodged; (2) administer Vancomycin (antibiotic) liquid to Resident #55 by the incorrect route; (3) administer Midodrine (increases blood pressure) to Resident #81 in accordance with the physician's order; and (4) obtain orders to treat Resident #92's noted rash on the perineum and legs. The findings include: 1. Facility staff failed to provide activities of daily living in a manner that prevented Resident #29's midline from being dislodged.	F 684	1. Corrective action for resident Resident #29 (resident no longer resides in the facility as of 4-7-22, had their midline replaced 3-10-22). Resident #55 we were unable to retrospectively correct this issue. The next dose was given via the correct form via correct route per physician orders. The nurse was re-educated on the 5 rights of medication administration. Resident #81 (resident no longer resides in the facility as of 4-29-22, we were unable to retrospectively correct this issue). Resident #92 had treatment orders obtained for their rash 3-8-22. The rash has been treated. Nurse involved was immediately in-serviced. 2. Identify other residents An audit of other residents with midlines, antibiotics, blood pressure medications, and skin rashes did not reveal any additional concerns. There were no additional findings related to this citation.	

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F 684	Continued From page 48 Resident #29 was admitted to facility on 12/27/21. The resident had a history of Multiple Sclerosis, Quadriplegia, and Sepsis. On 03/21/22 at approximately 2:15 PM, an observation showed Resident #29 lying in bed with a double lumen midline in the right upper extremity. The mid-line's transparent dressing was dry and intact. Further observation showed the midline insertion site had no drainage, redness, or swelling. The resident was wearing a hospital gown with snaps. And the resident's bilateral upper extremities were contracted. Review of Resident #29's medical record showed the following: 03/02/22 at 2:01 AM [physician's order] "replace left upper arm midline dsg (dressing) weekly and prn (as needed) every night shift every 7 day(s). prn" 03/08/22 at 11:38 PM [Situation, Background, Assessment, and Request (SBAR)] "Patient on Sodium Chloride 0.9% ...for sepsis, patient midline came out, MD (medical doctor) made aware, IV (intravenous) line to re replaced ...no acute distress noted" 03/09/22 at 6:30 AM [late entry nursing progress note] "Post midline dislocation, attempt X2 made unsuccessfully for peripheral line and resident scheduled to have midline reinserted for IVF (intravenous fluid) normal [saline] 0.9 % therapy. Vascular tech (technician) ...informed and is expected this am (morning)" 03/09/22 at 7:31 AM [physician's order] "Insert	F 684	3. Systemic changes A root cause analysis some potential events that could cause a dislodgement. Licensed nursing staff have been educated on the proper assessment of line/tubes/trach sites at regular intervals and pre/post dislodgement or discontinuance. In addition, all nursing staff will be educated on the potential causes of dislodgements such as: proper turning and repositioning of residents to preserve the integrity of their midlines/other IV accesses/g-tubes/foleys/trachs, correct way to remove the gowns via shoulder snaps to prevent potential dislodgements, resident behaviors that could lead to dislodgements like scratching/pulling/rubbing. They were also re-educated on giving blood pressure medications per physician orders (and the understanding of how and why Midodrine is given), giving antibiotics as prescribed per physician orders/routes, and rashes are identified/monitored/treatment orders obtained. The Director of Nursing will be responsible for ensuring that residents receive quality care. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete daily audits of ADL care, antibiotic administrations, blood pressure medication administration records, and skin sheets to ensure that quality care is being rendered and orders are being followed. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed	

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F 684	Continued From page 49 midline for IVF normal saline therapy" Review of Resident #29's comprehensive care plans revealed the following: Focus Area- "[Resident's name] has a midline for IV (intravenous) medications (start date 02/28/22). Interventions: Change dressing and record observations of the site every shift. Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician." Focus Area- "[Resident's name] has a midline to her LUE (left upper extremity) for antibiotic therapy (03/10/22). Interventions: Change midline every week and as needed. Change midline to LUE for patency and flush every shift and as needed. Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician." Further review of the resident's comprehensive care plans failed to include interventions to prevent dislodgement of Resident #29's midline during activities of daily living. There was no evidence that facility staff implemented measures or interventions to prevent the dislodgement of Resident #29's midline. During a face-to-face interview on 03/21/22 at approximately 4:00 PM, Employee #3 (Director of Nursing) stated that she believed that when the Certified Nurse Aide (CNA) was providing pm (evening) care (activities of daily living, e.g., bathing), Resident #29's midline became	F 684		

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F 684	Continued From page 50 dislodged. The employee then said the midline dislodgement was noted by staff during the shift change. 2. Facility staff failed to administer Vancomycin liquid to Resident #55 by the correct route. Institute for Healthcare Improvement, states, "One of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time." http://www.ihi.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx#:~:text=One%20of%20the%20recommendations%20to,route%2C%20and%20the%20right%20time Resident #55 was readmitted to the facility on 08/25/21 with diagnoses that included Diffuse Traumatic Brain Injury with Loss of Consciousness, Dysphagia, Anxiety Disorder, Anoxic Brain Damage, Hypertension, Clostridium Difficile (C-Diff), and Urinary Tract Infection (UTI). Review of the facility's incident report dated 03/06/22 documented: "On 6th of March 2022 at approximately I inadvertently administered Vancomycin IV instead of Vancomycin syrup via gt (gastrostomy tube), no adverse reaction noted, MD (medical doctor) made aware at 3/6/22 at 12.30 pm, NNO (no new order) given. Family member made aware of medication error on 3/6/22 at 1pm, to continue to monitor. v/s (vital signs) 118/67 (blood pressure),18 (respirations), 66 (pulse), 97.6	F 684		

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F 684	Continued From page 51 (temperature), pox (pulse ox) 99% 9 (percent of oxygen in the resident's blood)." Review of Resident #55's medical record revealed the following: 02/24/22 [Physician's order] "Vancomycin HCL (hydrochloride) solution 25 mg (milligram)/ml (milliliter) give 10 ml via peg-tube every 6 hours for c-diff for 14 days" March 2022 Medication Administration Record (MAR) for Resident #55 showed that Employee #23(Registered Nurse, Agency Staff) signed that she gave Vancomycin HCL solution 25 mg via peg-tube on 3/6/2022 at 1200 PM to Resident #55. 03/06/22 at 2:31 PM [General Progress Note] "ABT (antibiotic) Vancomycin in progress for C-Diff. IVF (intravenous fluid) NS (normal saline) via left arm midline at 100 ml/hr (hour) for hydration..." Physician's order for Resident #62: Resident #62's record showed a physician's order dated 03/03/2022 that directed, "Vancomycin HCl in NaCl Solution 1.25-0.9 gm/250 ml%... use 250 ml intravenously two times a day for sacral osteomyelitis ..." Employee #23 (Registered Nurse, Agency Staff) gave Resident #62's ordered Vancomycin HCL in NaCl Solution intravenously to Resident #55, even though Resident #55's order directed for Vancomycin HCL solution to be given a via peg-tube.	F 684		

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F 684	Continued From page 52 The evidence showed that Employee #23 filed to follow the professional standards when administering medications to Resident #55, resulting in her receiving another resident's medication via the wrong route. During a face-to-face interview on 03/16/22 at 10:56 AM with Employee #3 (Director of Nursing), she acknowledged the finding and stated, "I called the nurse, she admitted that she gave it and I sent her to education." 3. Facility staff failed to administer Midodrine to Resident #81 in accordance with the physician's order. Resident #81 was admitted to the facility on 11/05/21 with diagnoses that included Amyotrophic Lateral Sclerosis (ALS), Quadriplegia, Chronic Respiratory Failure with Hypercapnia, Retention of Urine, Tracheostomy and Gastrostomy. Review of the physician's order dated 03/14/22 directed, "Midodrine HCl Tablet 10 MG give 1 tablet via peg tube every 8 hours as needed for hypotension hold for blood pressure greater than 120 (systolic/top number on you reading)." Review of the Medication Administration Record for March 2022 showed Resident #81's blood pressure was documented as such: 80/50 on 03/14/22; 87/54 on 3/15/22 and 99/61 on 03/16/22. On the aforementioned dates, Midodrine was not administered to the resident although the blood pressures were lower than 120.	F 684		

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F 684	Continued From page 53 The evidence showed that facility staff failed to administer Midodrine in accordance with the physician's order. During a face-to-face interview with Employee #3 (Director of Nursing) on 03/22/22 at 10:22 AM, she acknowledged the findings. 4. Facility staff failed to obtain orders to treat Resident #92's noted rash on the perineum and legs. Resident #92 was admitted to the facility on 11/08/21, with multiple diagnoses that included: Morbid (Severe) Obesity Due to Excess Calories, Prediabetes, Rash and Other Nonspecific Skin Eruption, and Candidiasis Unspecified. Review of the Quarterly Minimum Data Set (MDS) dated 02/26/22, revealed that the facility staff coded the following: intact cognitive response, extensive assistance requiring one-person physical assist for bed mobility, transfers and toilet use, lower extremities had impairment on both sides, at risk for pressure/ulcer Injuries and applications of ointments/medications for skin and ulcer /injury treatments. Review of the physicians' orders revealed: 11/08/21 "Skill Nursing assessment every shift daily..." 01/17/22 "Skin assessment on shower days every day shift ..." 03/08/22 "Nystatin -Triamcinolone cream	F 684		

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F 684	Continued From page 54 (antifungal) 10000-0.1 Unit/GM(gram) % Apply to groin and perineal areas topically two times a day for fungal infection clean areas with soap and water ..." Review of the care plan with a focus area of, "(Resident #92) has a rash of the perineal and groin areas r/t (related to) contact dermatitis" initiated on 03/08/22, revealed the following intervention: "Monitor skin rashes for increased spread or signs of infection, seek medical attention if skin becomes bloody or infected, treatment per order." Review of the form titled "Skin Monitoring Comprehensive shower /Bed-bath Review" dated 02/25/22 through 03/15/22, all documented that Resident #92 had no skin impairment and skin was intact. Each form was signed by a Certified Nurse Aide and a licensed nurse. Review of the electronic health record section titled "Monitor Skin Observations" revealed that from 03/09/22 through 03/18/22 facility staff documented "none of the above observed" indicating that no skin impairment issues were observed. Review of a restorative program note revealed, 03/15/22 at 12:11 PM "Patient has good range of motion in upper extremities but does not feel comfortable with moving lower extremities due to an untreated sore on her legs..." During an observation and interview conducted on 03/21/22 at 10:30 AM, Resident #92 stated, "I told every nurse, tech, head nurse and caseworker [about rash on thighs and perineum] and I have not been checked." The surveyor	F 684		

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F 684	Continued From page 55 observed a large, red, raised rash covering both of Resident #92's thighs. The surveyor received 2 printed emails from Employee #15 (Social worker) on 03/21/22 at 1:30 PM, which documented communication between the social worker and the wound nurse about Resident #92. Review of the email dated 03/07/22 at 1:40 PM, documented, "...Resident asked me about the status of a rash she has..." Review of email dated 03/17/22 at 1:15 PM documented " ...Resident though (sp) you would f/u (follow up) with her to reassess her skin /rash ..." During a face-to-face interview conducted on 03/21/22 at 10:35 AM, Employee #21 (Wound Nurse) acknowledged that Resident #92's had an untreated rash, that the skin assessments were not accurate and stated, "Staff did not follow directions." Based on observations, record reviews, and staff interviews for four (4) of 53 sampled residents, facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan as evidenced by failure to: administer midodrine to a resident in accordance with the physician's order; provide activities of daily living in a manner that prevented a resident's midline (intravenous line) from being dislodged; and administer vancomycin liquid to a resident by the incorrect route; and to obtain orders to treat a resident with a noted rash	F 684		

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F 684	Continued From page 56 on the perineum and legs. (Residents' #81, #29, #55 and #92) The findings include: 1.Facility staff failed to administer midodrine to Resident #81 in accordance with the physician's order. Resident #81 was admitted to the facility on 11/05/2021 with diagnoses that included Amyotrophic Lateral Sclerosis (ALS), Quadriplegia, Chronic Respiratory Failure with Hypercapnia, Retention of Urine, Tracheostomy and Gastrostomy Review of the physician's order dated 03/14/2022 directed, "Midodrine HCl Tablet 10 MG give 1 tablet via peg tube every 8 hours as needed for hypotension hold for blood pressure grater the 120 (systolic/top number on you reading)." Review of the Medication Administration Record for March 2022 showed the resident s blood pressure on the following days: 80/50 on 03/14/2022; 87/54 on 3/15/2022 and 99/61 on 3/16/2022 On the aforementioned dates the Midodrine was not given when the residents blood pressure was lower than 120. There was no evidence that facility staff administered Midodrine in accordance with the physician's order. During a face-to-face interview with Employee #3	F 684		

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F 684	Continued From page 57	F 684		

(Director of Nursing) on 03/22/2022 at 10:22 AM, she acknowledged the findings.

2. The facility's staff failed to provide activities of daily living in a manner that prevented Resident #29's midline from being dislodged.

Resident #29 was admitted to facility on 12/27/21. The resident had a history of Multiple Sclerosis, Quadriplegia, and Sepsis.

On 03/21/22 at approximately 2:15 PM, an observation showed Resident #29 lying in bed with a double lumen midline in the right upper extremity. The mid-line transparent dressing was dry and intact. Further observation showed the midline insertion site had no drainage, redness, or swelling. The resident was wearing a hospital gown with snaps. And the resident's bilateral upper extremities were contracted.

Review of the resident's medical record showed the following:

03/02/22 at 2:01 AM [physician order] instructed, "replace left upper arm midline dsg (dressing) weekly and prn (as needed) every night shift every 7 day(s). prn."

03/08/22 at 11:38 PM [SBAR -Situation, Background, Assessment, and Request] documented, "Patient on Sodium Chloride 0.9% ...for sepsis, patient midline came out, MD (medical doctor) made aware, IV (intravenous) line to re replaced ...no acute distress noted."

03/09/22 at 6:30 AM [late entry nursing progress note] documented, "Post midline dislocation,

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F 684	Continued From page 58 attempt X2 made unsuccessfully for peripheral line and resident scheduled to have midline reinserted for IVF (intravenous fluid) normal [saline] 0.9 % therapy. Vascular tech ...informed and is expected this am." 03/09/22 at 7:31 AM [physician order] instructed, "Insert midline for IVF normal saline therapy." Review of Resident #29's comprehensive care plans revealed the following: Focus Area- [Resident's name] has a midline for IV (intravenous) medications (start date 02/28/22). Interventions: o Change dressing and record observations of the site every shift. o Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician. Focus Area- [Resident's name] has a midline to her LUE (left upper extremity) for antibiotic therapy (03/10/22). Interventions: o Change midline every week and as needed. o Change midline to LUE for patency and flush every shift and as needed. o Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician. Further review of the resident's comprehensive care plans failed to include interventions to prevent dislodgement of Resident #29's midline during activities of daily living. There was no evidence that facility staff	F 684		

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F 684	Continued From page 59 implemented measures or interventions to prevent the dislodgement of the Resident's midline. During a face-to-face interview on 03/21/22 at approximately 4:00 PM, Employee #3 (Director of Nursing) stated that she believed that when the certified nursing assistant was providing pm care (activities of daily living, e.g., bathing), the resident's midline became dislodged. The employee then said the midline dislodgement was noted by staff during the shift change. 3. Facility staff failed to administer vancomycin liquid to Resident #55 by the incorrect route. Institute for Healthcare Improvement, states, "One of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time." http://www.ihi.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx#:~:text=One%20of%20the%20recommendations%20to,route%2C%20and%20the%20right%20time Resident #55 was readmitted to the facility on 08/25/2021 with diagnoses that included Diffuse Traumatic Brain Injury with Loss of Consciousness, Dysphagia, Anxiety Disorder, Anoxic Brain Damage, Hypertension, Clostridium	F 684		

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F 684	Continued From page 60 Difficile (C-Diff), and Urinary Tract Infection (UTI). Review of the facility's incident report dated 03/06/2022 revealed the following: "On 6th of March 2022 at approximately I inadvertently administered vancomycin IV instead of Vancomycin syrup via gt [gastrostomy tube], no adverse reaction noted, MD[medical doctor] made aware at 3/6/22 at 12.30 pm, NNO [no new order] given. family member made aware of medication error on 3/6/22 at 1pm, to continue to monitor. v/s (vital signs) 118/67 (blood pressure),18 (respirations), 66 (pulse), 97.6 (temperature), pox (pulse ox) 99% 9 (percent of oxygen in the resident's blood)." Physician's order for Resident #55: Dated- 02/24/2022, Vancomycin HCL (used to treat infections caused by bacteria) solution 25 mg/ml give 10 ml via peg-tube every 6 hours for c-diff for 14 days. Physician's order for Resident #62: Resident #62's record showed he had a physician's order dated 03/03/2022 that directed, Vancomycin HCl in NaCl Solution 1.25-0.9 gm/250 ml%... use 250 ml intravenously two times a day for sacral osteomyelitis ... Review of the March 2022 Medication Administration Record for Resident #55 showed that Employee #23 signed that she gave Vancomycin HCL solution 25 mg via peg-tube on	F 684		

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F 684	Continued From page 61 3/6/2022 at 1200 to Resident #55. Review of the General Progress Note for Resident #55 showed 03/06/2022 at 14:31 [2:31 PM] showed, "ABT (antibiotic) Vancomycin in progress for C-Diff. IVF (intravenous fluid) NS (normal saline) via left arm midline at 100 ml/hr for hydration..." Employee #23 (RN, Agency Staff) gave Resident #62's Vancomycin HCL in NaCl Solution intravenously to Resident #55, although Resident #55's order directs for vancomycin HCL solution to be given a via peg-tube. There was no evidence that Employee #23 followed professional standards when administering medication to Resident #55 resulting in her receiving another resident's medication via the wrong route. During a face-to-face interview on 03/16/2022 at 10:56 AM with Employee #3 (Director of Nursing), she acknowledged the findings and stated I called the nurse she admitted that she gave it and I sent her to education. 4. Facility staff failed to obtain orders to treat a resident with a noted rash on the perineum and legs. Resident #92 Resident #92 was admitted to the facility on 11/08/21, with multiple diagnoses that included: Morbid (Severe) Obesity Due to Excess Calories, Prediabetes, Rash and Other Nonspecific Skin Eruption, and Candidiasis Unspecified.	F 684		

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F 684	Continued From page 62 Review of the Quarterly Minimum Data Set (MDS) dated 02/26/22, revealed that the facility staff coded the following: In section C (Cognitive Patterns) Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating intact cognition In Section G (Functional Status) Bed Mobility "Extensive assistance" requiring "One-person physical assist" Transfer "Extensive assistance" requiring "One-person physical assist" Toilet use "Extensive assistance" requiring "One-person physical assist" Functional Limitation in Range of Motion, Upper extremity "No Impairment" Lower extremity "Impairment both sides" Section M (Skin Conditions): Determination of pressure ulcer risk "Clinical assessment" Risk of pressure/ulcer Injuries, "Yes" Skin and Ulcer /Injury treatments "Pressure reducing device for bed" and "Applications of ointments/medications" Review of the physicians' orders revealed the following: 11/08/21 "Skill Nursing assessment every shift daily ..." 01/17/22 "Skin assessment on shower days every day shift ..." 03/08/22 "Nystatin -Triamcinolone cream 10000-0.1 Unit/GM % Apply to groin and perineal areas topically two times a day for fungal infection clean areas with soap and water ..." Review of the care plan with a focus area of "(Resident #92) has a rash of the perineal and	F 684		

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F 684	Continued From page 63 groin areas r/t (related to) contact dermatitis" with an initiated date of 03/08/22, revealed the following interventions "Monitor skin rashes for increased spread or signs of infection, seek medical attention if skin becomes bloody or infected, treatment per order" Review of the form titled "Skin Monitoring Comprehensive shower /Bed -bath Review" dated 02/25/22 through 03/15/22, all documented that Resident #92 had no skin impairment and skin was intact. Each form was signed by a certified nurse aide and a licensed nurse. Review of the electronic health record section titled "monitor skin observations" revealed from 03/09/22 through 03/18/22 facility staff documented "none of the above observed" meaning no skin impairment issues were observed. Review of a restorative program note revealed, 03/15/22 at 12:11 PM "Patient has good range of motion in upper extremities but does not feel comfortable with moving lower extremities due to an untreated sore on her legs. ..." The surveyor received 2 printed emails form Employee #15 (Social worker) on 03/21/22 at 1:30 PM, which documents communication between the social worker and the wound nurse about Resident #92. Review of the email dated 03/07/22 at 1:40 PM, documents " ...Resident asked me about the status of a rash she has ..." Review of email dated 03/17/22 at 1:15 PM documents " ...Resident though (sp) you would f/u (follow up) with her to reassess her skin /rash ..." An Observation and interview were conducted on 03/21/22 at 10:30 AM, with Resident #92, stated	F 684		

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F 684	Continued From page 64 "I told every nurse, tech, head nurse and caseworker (about rash on thighs and perineum) and I have not been checked. The surveyor observed a large red raised rash covering both residents' thighs. A face-to-face interview was conducted on 03/21/22 at 10:35 AM, with Employee #21 (Wound Nurse) stated "Staff did not follow directions" Employee #21 acknowledged that Resident #92 had an untreated rash and that the skin assessments were not accurate. A face-to-face interview was conducted on 03/21/22, at 1:08 PM with Employee #15 (Social Worker) stated, "The last complaint she (Resident #92) shared with me was about a rash and I passed this on to the wound nurse I will get you the email"	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686	1. Corrective action for resident Resident #261 was already discharged (12-15-21) at the time of the survey and we were unable to retrospectively go back and make changes. 2. Identify other residents All current residents with wounds will be reviewed by 06/20/22 to ensure that their wounds have been documented correctly. 3. Systemic changes The wound care nurse has been educated on ensuring that resident wounds are documented correctly in the resident record. The Director of Nursing will be responsible for ensuring that resident wound documentation is accurate.	

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F 686	Continued From page 65 Based on record review and staff interview for one (1) of 53 sampled residents, facility staff failed to accurately record the location and status of a wound Resident #261's. The findings include: Resident #261 was admitted to the facility on 11/25/20 with diagnosis that included Epilepsy, Hypertension, Retention of Urine, Malignant Neoplasm of Prostate and Chronic Vascular Disorders of Intestine. Review of the clinical record showed the following: 08/25/21 [Situation Background Assessment Request (SBAR) "Situation - Open Blister on the left buttocks (no measurements recorded)... Resident alert and responsive, during morning care the open blister was noted on his left buttock ...Order given to clean with wound cleanser pat dry and apply xeroform daily." 08/26/21 [Skin and Wound Evaluation] "Location: Sacrum; Describe: Pressure, Unstageable: Obscured full-thickness and tissue loss, slough and/or eschar; In house- acquired on 0825/2021; wound measurements: 4.1 cm (centimeter) x 4.0 cm x 0.2 cm; Granulation 6.50% would filled slough." There evidence showed that facility staff failed to accurately record the location of Resident #261's wound. During a face-to-face interview on 03/25/22 at approximately 7:00 PM, Employee #3 (Director of Nursing) and Employee #21 (Wound Nurse)	F 686	4. Monitor corrective actions The Director of Nursing will complete weekly audits of wound documentation to ensure that all residents have accurate documentation of wounds in resident records. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 686	Continued From page 66 acknowledged the findings and stated that it was found at a stage 3. Employee #21 further stated, "I documented the incorrect location of the wound. It should have been the left buttocks. It's the same area (left buttocks and sacrum); and there was no slough."	F 686	F 689 1. Corrective action for resident Resident #29's midline was reinserted 3-10-22 with no further incidents. The portable heater was removed from Resident #1's room on 3-16-22.	
F 689 SS=D	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 record review and staff interview, for two (2) of 53 sampled residents, the facility's staff failed to (1)provide supervison during activities of daily living (ADL) care which resulted in Resident #29's midline (intravenous line) being dislodged and (2) ensure that a space heater was not used to heat Resident #1's room. The findings included: 1. Facility staff failed to provide activities of daily living in a manner that prevented Resident #29's midline from being dislodged. Resident #29 was admitted to facility on 12/27/21. The resident had a history of Multiple Sclerosis, Quadriplegia, and Sepsis. On 03/21/22 at approximately 2:15 PM, an	F 689	2. Identify other residents An audit of other residents with mid-lines will be completed by 06/20/22 completed. An audit of all other resident rooms on 3/16/22 did not yield any additional portable heaters. There were no additional findings related to this citation. 3. Systemic changes Licensed nursing staff have been educated on the proper assessment of line/tubes/trach sites at regular intervals and pre/post dislodgement or discontinuance. In addition, all nursing staff will be educated on the potential causes of dislodgements such as: proper turning and repositioning of residents to preserve the integrity of their midlines/other IV accesses/g-tubes/foleys/trachs, correct way to remove the gowns via shoulder snaps to prevent potential dislodgements, resident behaviors that could lead to dislodgements like scratching/pulling/rubbing. All staff have been educated on ensuring that portable heaters are not allowed in patient care areas. The Director of Nursing will be responsible for ensuring that residents with midlines are assessed regularly and not dislodged during care. The Director of Maintenance/designee will be responsible for ensuring that there are no portable heaters in patient care areas.	

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F 689	Continued From page 67 observation showed Resident #29 lying in bed with a double lumen midline in the right upper extremity. The mid-line's transparent dressing was dry and intact. Further observation showed the midline insertion site had no drainage, redness, or swelling. The resident was wearing a hospital gown with snaps. And the resident's bilateral upper extremities were contracted. Review of Resident #29's medical record showed the following: 03/02/22 at 2:01 AM [physician's order] "replace left upper arm midline dsg (dressing) weekly and prn (as needed) every night shift every 7 day(s). prn" 03/08/22 at 11:38 PM [Situation, Background, Assessment, and Request (SBAR)] "Patient on Sodium Chloride 0.9% ...for sepsis, patient midline came out, MD (medical doctor) made aware, IV (intravenous) line to re replaced ...no acute distress noted" 03/09/22 at 6:30 AM [late entry nursing progress note] "Post midline dislocation, attempt X2 made unsuccessfully for peripheral line and resident scheduled to have midline reinserted for IVF (intravenous fluid) normal [saline] 0.9 % therapy. Vascular tech (technician) ...informed and is expected this am (morning)" 03/09/22 at 7:31 AM [physician's order] "Insert midline for IVF normal saline therapy" Review of Resident #29's comprehensive care plans revealed the following: Focus Area- "[Resident's name] has a midline for	F 689	4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of all residents with midlines to ensure that they are managed appropriately to prevent dislodgement. The Maintenance Director/Designee will audit 25% of resident's rooms weekly for portable heaters. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 689	Continued From page 68 IV (intravenous) medications (start date 02/28/22). Interventions: Change dressing and record observations of the site every shift. Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician." Focus Area- "[Resident's name] has a midline to her LUE (left upper extremity) for antibiotic therapy (03/10/22). Interventions: Change midline every week and as needed. Change midline to LUE for patency and flush every shift and as needed. Monitor midline site for redness, swelling, irritation, or drainage. Report any negative findings to the physician." Further review of the resident's comprehensive care plans failed to include interventions to prevent dislodgement of Resident #29's midline during activities of daily living. Further review of the resident's comprehensive care plans failed to outline how the staff were to provide supervision during ADL care to prevent the dislodgement of Resident #29's midline. During a face-to-face interview on 03/21/22 at approximately 4:00 PM, Employee #3 (Director of Nursing) stated that she believed that when the Certified Nurse Aide (CNA) was providing pm (evening) care (activities of daily living, e.g., bathing), Resident #29's midline became dislodged. The employee then said the midline dislodgement was noted by staff during the shift change. 2. Facility staff failed to ensure that a space heater was not used to heat Resident #1's room.	F 689		

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F 689	Continued From page 69 According to NFPA (National Fire Protection Association) 101 (Life Safety Code), 1985 edition, Section 13-5, paragraph 13-5.2.2, "Portable space heating devices shall be prohibited in all health care occupancies..." On 03/15/22 at approximately 10:50 AM, a space heater was observed on a dresser in Resident #1's room. The space heater was plugged into a surge protector power strip that was plugged into the wall outlet. At the time of the observation, Resident #1 stated, "[Employee #1 (Administrator)] gave it to me in December [2021]. It is hers, it was suppose to be a temporary solution. As far as I know, nothing else has been done." During a face-to-face interview on 03/15/22 at 11:22 AM Employee #1stated, "Yes, I gave it (space heater] to her (Resident #1). I didn't want her to get cold." Th evidence showed that facility staff failed to ensure that a space heater was not used as a heating source in Resident #'1 room.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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-	F 692	F 692 1. Corrective action for resident Resident #30 was re-weighed and verified, and their nutritional status was addressed on 3/22/22. Resident #63 was re-weighed and verified, and their nutritional status addressed on 3/30/22. 2. Identify other residents An audit of all residents will be completed, and all residents will be weighed and their weights documented and verified by 06/20/22.	

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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 692	Continued From page 70 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 53 sampled residents, facility's staff failed to address an unusual weight for a resident; and failed to ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight. Residents' #30 and #63. The findings included: Review of the "Nutritional Assessment" policy dated 11/02/21documented that the dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident ...as indicated by a change in conditions that places the resident at risk for impaired nutrition ...The assessment will be conducted by the multidisciplinary team and shall at least include the following components ...nursing[will assess]unusual weight ...dietitian [will determine] whether the resident's current intake is adequate to meet his or her nutritional needs." Review of the "Weight Assessment and	F 692	3. Systemic changes Licensed nursing staff and the Dieticians will be educated on the importance of ensuring that residents are weighed and weights verified and documented per physician orders. The Dietician will be responsible for ensuring that residents are weighed and weights documented and verified. Any irregularities will be discussed and addressed by the IDT team (nursing rehabilitation, social services, therapeutic recreation, and dieticians). 4. Monitor corrective actions The Dietician/Designee will complete weekly audits of all residents with orders to be weighed to ensure that weights are obtained, documented, verified, and addressed. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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Intervention" policy dated 11/09/21 documented that "the nursing staff will measure residents' weights ...monthly ...any weight change of 5% or more since last assessment will be retaken the next day for confirmation."

1. Facility's staff failed to address an unusual weight for Resident #30.

Resident #30 was admitted to the facility on 07/10/16 with multiple diagnoses, including Dysphagia, Gastrostomy, Brain Stem Stroke Syndrome, and Gastro-Esophageal Reflux. Review of a quarterly Minimum Data Set (MDS) dated 01/15/22 showed the resident was coded for having memory problems with short-term and long-term memory and severely impaired cognitive skills for decision making. Further review of the MDS showed Resident #30 was totally dependent on the physical assistance of one staff member for the intake of other nourishments [tube feeding]. The resident was not coded for swallowing disorders or weight loss of 5% in the last month or 10% in the last six months. Additionally, the resident was coded as having a weight of 141 pounds, using tube feeding, and receiving 51% or more proportion calories and 501cubic centimeters per day of average fluid intake through tube feeding.

Review of medical record showed the following:

10/06/21 [physician order]- Vital (tube feeding)1.55 at 55 milliliters per hour for 24 hours via GT (gastrostomy tube).

02/17/22 [physician progress note] - "No reports of recent vomiting, diarrhea ...No changes in

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F 692	Continued From page 72 bowel habits. Pt (patient) tolerating tube feeds at goal." 03/22/22 at 13:03 [dietary progress note] - "CBW (current body weight): 141.9 (pounds), 30-day 124.2 (pounds) ... Resident continues on TF (tube feeding) regimen w/ (with)no N/V/C/D (nausea, vomiting, constipation or diarrhea) reported per nursing. TF Provides: 1980 kcal (kilocalorie), 89 g (gram) Pro (protein), 1003 ml (milliliters)free water, 2203 ml total water ...Triggering for significant weight gain x 30 days- permissible as to resident baseline. Recommendations: Weight x1" Review of a comprehensive care plan dated 10/05/21 showed the following: Focus Area - [resident's name] requires tube feeding r/t (related to) Dysphagia. Goals - [resident's name] will have weight maintenance ... Interventions o RD (Registered Dietician) evaluates quarterly and prn (as needed), monitors caloric intake, estimates needs, and makes recommendations for change to tube feeding as needed. o The resident is dependent on tube feeding and water flushes. Review of Resident #30's weight log showed the following: -01/24/22 142.6 pounds -02/05/22 124.2 pounds -03/04/22 141.9 pounds -03/22/22 141.2 pounds During a face-to-face interview on 03/22/22 starting at 12:10 PM, Employee #21 (Dietician)	F 692		

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F 692	Continued From page 73 was asked how she addressed Resident #30's weight loss of 15.5 % from 01/24/22 to 02/05/22? The employee stated that she was not aware of the resident's February weight (124.2 pounds). The employee then said that the nursing staff is responsible for weighing residents, and she views residents' weights every month from the 1st to the 5th. Additionally, Employee #21 said that she believed the February weight was an error because the resident was at his baseline weight. It should be noted the resident had a 30-day weight loss of 15.05 % weight loss from 01/24/22 to 02/05/22. However, Employee #21 documented on her 03/22/22 progress note that the resident triggered for a significant weight gain from 02/05/22 to 03/04/22. During a face-to-face interview on 03/22/22 at approximately 4:00 PM, Employee #6 (RN) stated, "I put his (Resident #30) February weight (124.2 pounds) in the system (electronic medical record), and the system did not alert me that there was a significant change (5% or more) in the resident's weight. The employee said that when the system alerts of a significant change, staff will re-weigh the resident, and she would make the Dietician aware of the significant change. 2.Facility staff failed to ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight for one resident. Resident #63. Resident #63 was admitted to the facility on 09/15/21 with diagnoses including, Cerebrovascular Accident (CVA), Encephalopathy, Dysphagia, and Encounter For	F 692		

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F 692	Continued From page 74 Attention To Gastrostomy, Pressure Ulcer Of Other Site Stage 4, and Pressure Ulcer Of Sacral Region, Stage 4. Review of the Quarterly Minimum Data Set dated 12/28/21, facility staff documented that Resident #63 had a Brief Interview Mental Status Summary Score (BIMS) of "00" indicating the resident, had severe cognitive impairment. In addition, facility staff documented: the resident: was "totally dependent, for ADL care , had, two Stage 4 pressure ulcers that were present upon admission/entry or reentry, had a nasogastric or gastrostomy tube and weighed 129 pounds on admission. Review of Resident #63's medical record revealed: 09/15/21 at 8:49 PM [Weight Summary Report]: 130.5 lbs. (Bed) - Admission weight 09/21/21 at 3:41 PM [Weight Summary Report]: 130 lbs. (Mechanical Lift) 09/22/21 at 2:24 PM, [Nutrition/Dietary Note]: " ... Ht (height): 62 inches Weight: 130.0 # (lbs),..BMI (body mass index): 23.7 kg /m2 (kilograms/per meter squared)- normal. Goal of weight maintenance being met at this time." 09/27/21 at 11:40 AM [Weight Summary Report]: 130.4 lbs. (Mechanical Lift) 09/28/21 at 3:08 PM, [Nutrition/Dietary Note]: " ... Weight: 130.4 # (9/27/0, 130. # (9/21), 130.5 # (9/15)..BMI : 23.8 kg /m2- normal. Goal of weight maintenance of CBW (current body weight) 130 lbs. (+/- plus or minus 3%) through review date." 10/01/21 at 8:07 AM [Weight Summary Report]:	F 692		

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F 692	Continued From page 75 125.8 lbs. (Mechanical Lift) 10/16/21 at 4:01 AM [Weight Summary Report]: 125 lbs. (Mechanical Lift) 10/23/21 at 3:37 AM [Weight Summary Report]: 125 lbs.. (Mechanical Lift) 10/24/21 at 3:38 AM [Weight Summary Report]: 125 lbs. (Mechanical Lift) 11/05/21 at 10:15 AM [Weight Summary Report]: 129.2 lbs. 11/12/21 at 3:11 PM, [Nutrition/Dietary Note]: " ... Weight: 129.2 # (11/5) BMI : 23.6 kg /m2- normal ..." 12/22/21 at 9:55 PM [Weight Summary Report]: 129 lbs. (Bed) 12/24/21 at 10:27 AM, [Nutrition/Dietary Note]: " ... Weight: 129.0 # (12/22) BMI : 23.6 kg /m2 - normal. Goal of weight maintenance of CBW 130 lbs ..." 12/28/21 at 1:50 PM, [Nutrition/Dietary Note]: " ... Weight: 129.0 # (12/22) ...Weight trends : Stable ..." 12/30/21 [Physician's Order]: "Weekly weigh x 4, one time a day every Thu (Thursday) 4 weeks." 01/05/22 at 2:11 PM [Weight Summary Report]: 115.4 lbs. 01/31/22 at 1:04 [Nutrition/Dietary Note]: " ...Weight: 115.4# (11/5) BMI : 21.1 kg /m2-normal. Goal of weight maintenance of 1-2 #	F 692		

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F 692	Continued From page 76 per month towards CBW130# (+/-3%) through review date ...Recommendations: 1. Re-weigh ..." 02/02/22 at 2:00 PM [Nutrition/Dietary Note]: " ... CBW: 115# (1/5) Weight trends, weight loss x 30 days, 30d (days): 129# = (-10.8 %), 90 days = 125.8# (-8.58%) ... Noted significant weight loss of 10.5% x 30 days." 02/05/22 at 2:41 PM [Weight Summary Report]: 117.2 lbs. 02/11/22 at 12:11 PM: [Nutrition/Dietary Note]: " ...Weight: 115.4# (1/5) BMI : 21.1 kg /m2-normal. Goal of weight maintenance of 1-2 # per month towards UBW (usual body weight)..." 03/11/22 at 2:48 PM [Nutrition/Dietary Note]: " ...Weight: 117.2# (2/5) BMI : 21.4 kg /m^2-normal. Goal of weight maintenance of 1-2 # per month towards UBW ...Recommendations: monthly weight" 03/15/22 at 2:11 PM [Weight Summary Report]: 123.8 lbs. Resident #63's medical record revealed that when the resident was admitted on 09/15/21 he weighed 130.5 lbs. On 01/05/22 his recorded weight was 115.4 lbs. Five months from his admission Resident #63's weight was 13.3 lbs from his usual body weight. During a face-to-face interview on 03/24/22 at 3:27 PM, Employee #20 stated that Resident #63 had been in the hospital. She stated that she requested a re-weight for Resident #63, because she thought the resident's weight was incorrect. She added, the usual protocol is for her to notify	F 692		

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F 692	Continued From page 77 the physician and to call the nurse. The reweight should be by done by the next week and is recorded on the weekly weight reports on the unit. She reported she requested the re-weight for Resident #63 on 01/05/22 and then she did not see another weight for the resident until 02/02/22. Employee # was not able to provide documented evidence that she notified the physician or the nurse she spoke with when she requested that Resident #63 get re-weighed. In addition, and she could not provide a weekly weight report to show that the resident was re-weighed within a week of her request.	F 692	F 694 1. Corrective action for resident Resident #55 midline was discontinued on 3/14/22 the nurse failed to document an assessment pre/post the discontinuation. Resident #93, midline was dislodged. The midline was discontinued on 3/2/22. We were unable to positively determine what caused the midlines to dislodge. Since the dislodgements happened prior to the survey, we were unable to go back and retrospectively address the issues.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 53 sampled residents, facility staff failed to ensure the residents with Midlines (A catheter that is inserted in a peripheral vein and ends near the upper arm use for intravenous therapy) were assess for complications at the insertion site during the therapy and post removal or dislodgement of the catheter. (Residents' #55, #93, and #63.) The findings include: 1.Failed to assess Resident #55's Midline	F 694	Resident #63 midline was dislodged. The midline was dislodged on 11/30/21 and he was discharged to the hospital on 12/01/21. We were unable to positively determine what caused the midlines to dislodge. Since the dislodgements happened prior to the survey, we were unable to go back and retrospectively address the issues. We will have in-serviced all licensed nursing staff by 06/20/22 on assessing lines/tubes/trachs at regular intervals and pre/post dislodgement/discontinuation. 2. Identify other residents An audit of other residents with midlines will be completed by 06/20/22. They will be assessed for signs and symptoms of infection and integrity.	

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F 694	Continued From page 78 insertion site post removal or dislodgement; and failed to document the discontinue of the residents Midline. Resident #55 was readmitted to the facility on 08/25/2021 with diagnoses that included Diffuse Traumatic Brain Injury with Loss of Consciousness, Dysphagia, Anxiety Disorder, Anoxic Brain Damage, Hypertension, Clostridium Difficile (C-Diff), and Urinary Tract Infection (UTI). Review of the Quarterly MDS dated 12/09/2021 showed Resident #55 was coded as follows: Section C (Cognitive Pattern) his Brief Interview for Mental Status (BIMS) the resident is coded as rarely/never understood Section G (Functional Status), coded for needing total dependence with one/wo-person assistance for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The resident has functional limitation/impairment to both upper and lower extremities. Section H (Bladder and Bowel) the facility coded the resident as being always incontinent of urine. Section O Special Treatments and Programs was coded as the resident receiving Respiratory Treatments (tracheostomy care and ventilator). Care Plans: Review of the care plan revised on initiated on 08/25/2021 and revised on 12/29/2021- Focus area, " ...has a midline left upper extremity for antibiotic therapy" ...Interventions: Change	F 694	3. Systemic changes Licensed nursing staff have been educated on the proper assessment of line/tubes/trach sites at regular intervals and pre/post dislodgement or discontinuance. In addition, all nursing staff will be educated on the potential causes of dislodgements such as: proper turning and repositioning of residents to preserve the integrity of their midlines/other IV accesses/g-tubes/foleys/trachs, correct way to remove the gowns via shoulder snaps to prevent potential dislodgements, resident behaviors that could lead to dislodgements like scratching/pulling/rubbing. The Director of Nursing will be responsible for ensuring that residents with midlines are assessed appropriately. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of residents with midlines to ensure that they are assessed appropriately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 694	Continued From page 79 midline dressing to the LUE Q [every week] Check site for redness, swelling, irritation, or drainage and report any negative findings to the Physician. Review of the care plan revised on 03/14/2022-Focus area, " ...has a midline left upper arm" ...Interventions: Flush LUA (left upper arm) midline for patency as ordered. Monitor/document/report PRN s/sx (signs and symptoms) of infection at the site (LUA): drainage, inflammation, swelling, redness, warmth. Review of the medical record showed the following: 12/01/2021 (physician's order) directed, "Place midline for IV (intravenous) fluids" 12/02/2021 (Nursing Progress Note), "Resident's lab results reviewed by MD, gave new order to start Meropenem 1 gm IV BID x 7 days for UTI. 12/02/2021 (Vascular Company Name form), " ...Right upper arm extended dwelling PIV (midline) place w/o (without) complications. Pos (positive) blood return. Easy flush ..." Review of the Medication Administration Record December 2021 showed that on 12/02, 12/3 the resident received Meropenem 1 gm intravenously as ordered. 12/04/2021 (Nursing Progress Note).."PIV discontinued. Midline to be placed by IV nurse today ..." Review of the clinical record lacks evidence that	F 694		

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F 694	Continued From page 80 when facility staff noted the midline to be "discontinued" that the nurse performed an assessment of the resident left arm/IV site. 12/09/2021 (physician's order) directed, "Place midline" 12/09/2021 (Nursing Progress Note), " ...New IV line in right upper arm, old line not flushing this am ..." Review of the "PICC/Midline Insertion" Record dated 12/9/2021 showed the a midline was placed in the residents LUE. Review of the SBAR dated 12/09/2021 showed, "Midline D/C'd ...midline left upper arm was out. New line left upper arm." Review of the clinical record lacks evidence that when facility staff noted the midline to be "out" that the nurse performed an assessment, such as the catheter length, drainage, inflammation reddens or warmth at the left arm/IV site. 02/17/2022 (physician's order) directed, "Midline STAT" Review of the "PICC/Midline Insertion" Record dated 02/17/2022 showed a midline was placed in the residents RUE (right upper extremity). Review of the clinical record lacks evidence that when facility staff noted the midline to be removed and that the nurse performed an assessment, such as the catheter length, drainage, inflammation reddens or warmth at the right arm/IV site.	F 694		

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F 694	Continued From page 81 Review of the progress notes and sbars - lack evidence of what happened to the midline (dislodgement/removal) and there were no nurse assessments of the residents IV site post removal of the midline catheter. During a face-to-face interview with Employee #26 (Infusion Nurse) on 03/16/2022 at 3:00 PM. She was asked, How are you notified to place a midline? She stated, "They call me if somebody needs line. I get the reason. I know this patient. she is rubbing her upper arms (demonstrated the resident's movement). She [Resident #55] is very contracted. I secure the line with "stat lock" and I use skin prep. I ask that they (nursing staff) cover the arm with a sleeve to cover the dressing. I use an ultrasound machine that shows the artery and vein. I check the vessel when the line is in. I check for blood return. Ultrasound confirmation is not recorded on the form. The form is used as the note/progress note when I place a line and it [the form] is placed in the chart. During a face-to-face interview on 03/22/2022 at 3:11 PM with Employee #3 (Director of Nursing), she acknowledged the findings. 2. Facility staff failed to monitor Resident #93's left arm midline site for signs and symptoms of infection. Resident #93 was admitted to the facility	F 694		

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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 _____	C 03/25/2022

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 694	Continued From page 82 on1/14/2022 with diagnoses that included Pulmonary Fibrosis, Chronic Respiratory Failure with hypoxia or hypercapnia, Tracheostomy, Gastrostomy, and Pulmonary Hypertension. Review of the physician orders showed the following: 1/15/2022 at 1500 directed, "Flush left arm midline with 10cc NS (normal saline) every shift for keep patency)" 1/21/2022 at 2300 directed, "Change left arm midline dressing weekly every night shift" Care plan initiated 1/15/2022 with focus area: " ...midline to her LUE (left upper extremity) ...interventions: Change midline dressing Q week and as needed; Check and monitor midline site Q shift and as needed. Monitor for redness, swelling, irritation or drainage. Report any negative findings to the physician" Review of the February 2022 Treatment Administration Record showed the nursing staff were signing that they were flushing the left arm midline as ordered. However, through review of the clinical record there was no evidence that facility staff were monitoring and recording their assessment of Resident #93's left arm midline site for infection (redness, swelling, irritation or drainage). During a face-to-face interview on 03/22/2022 at 03:15 AM with Employee #3 (Director of Nursing), she acknowledged the findings.	F 694		

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F 694	Continued From page 83	F 694		

3. Resident #63 was admitted to the facility on 09/15/21 with diagnoses including Chronic Respiratory Failure, Urinary Tract Infection (UTI), Cerebrovascular Accident (CVA), Encounter For Attention To Gastrostomy, and Encephalopathy.

Review of the Quarterly Minimum Data Set dated 12/28/21, facility staff documented that Resident #63 had a Brief Interview Mental Status Summary Score (BIMS) of "00" indicating the resident, had severe cognitive impairment. In addition, facility staff documented the resident: was "totally dependent, for bed mobility, transfers dressing, and eating; and required physical assistance with two or more staff.

Review of Resident #63's medical record showed :

09/17/21 [Physician's Order]: "Change midline dressing every week every night shift every Fri (Friday), measure external catheter with every dressing change and document findings . End Date: 11/04/21."

10/08/21 [Physician's Order]: "Midline dressing change on left arm every 7 days. every night shift every 7 day(s) for midline care.

10/08/21 [Physician's Order]: Flush midline on left upper arm with 10 cc (cubic centimeters) NS (normal saline) syringe every shift. every shift for Midline care for patency. End Date10/26/2021."

10/17/2021 at 4:30 AM, [Nurse Progress Note]: "... Midline intact and patent no sign of infection or infiltration noted ..."

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F 694	Continued From page 84 10/26/2021 4:20 PM [Nurse Progress Note/Administration Note]: "Catheter not in use -Flush midline with 5 ml (milliliters) NS q (every) 12 hours every day and evening shift for patency." 10/27/21 at 6:27 PM, [Nurse Progress Note]: " ... (IDT) Interdisciplinary Team meeting via telephone with [Name of Resident Representative] today @ (at) 2pm. Education given r/t (related to) policy and procedures regarding midline/ IV access care..[Name of Resident Representative] instructed not to perform invasive treatments, ...midline care/removal on patient unless it is cleared by DON (Director of Nursing)/Admin (administrator)/ and MD (Medical Director) with education and return demonstration of procedure witnessed and approved by a member of the Clinical team ...." Review of resident #63's treatment administration record (TAR), from 10/08/21 through 10/28/21 October showed that facility staff marked they were administering the following treatments: "Change midline dressing every week ..., Measure external catheter with every dressing change, and document findings, ..." The TAR lacked evidence that facility staff's documented findings and measurements for the external catheter with weekly midline dressing changes. 10/28/21 at 3:27 PM, [Facility-Reported Incident (FRI)] documented: " ...Midline line was initially dangling on the patient left upper arm, ...family member at the bedside suggested. she could take it out, but the nurse told her no ...went to seek the unit manger ...before the charge [nurse] could return ...midline was completely out	F 694		

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F 694	Continued From page 85 indicating the desire by the family member intention of taking midline out ..." 10/28/21 at 9:06 PM [Nurse Progress Note]: "Midline catheter discontinued." 11/04/21 [Physicians Order]: "Place midline for IV (intravenous) fluids." 11/04/21 [Physicians Order]: " Change LUE (left upper extremity) midline transparent dressing, needless (needleless) head connector and securement device weekly and as needed every day shift every Thu (Thursday) for line [midline] care." 11/04/21 [Physicians Order]: "Patient has left upper extremity midline catheter. Midline catheter ...dual lumen ...expires 10/31/22. 4FR(French) basilic vein 20.5 cm (centimeter) internal length ..." 11/30/21 at 11: 27 PM, [Situation, Background, Assessment ,and Request (SBAR) Progress Note]: "Situation:...Midline came out during care ...Background: ..Medication alerts: Changes in the last week ...Assessment ... On abt (antibiotic) ...for UTI ... Request ...Nursing Notes: " ...at 9 pm went to give patient his antibiotic ...via midline ...noted the midline was out. Catheter measured ...no evidence of fragment at site, site remain intact with no bleeding ...MD made aware ...Patient responsible party [Name of Resident Representative] made aware ..." Review of resident #63's treatment administration record (TAR), from 11/04/21 through 11/30/21 showed that facility staff marked they were administering the following treatments: "Change midline dressing needleless head connector and securement device every day shift every Thu	F 694		

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F 694	Continued From page 86 (Thursday) for line [midline] care. ...Measure the external catheter with every dressing change, and document findings ..." The TAR lacked evidence of the facility staff's documented findings and measurements for the external catheter with weekly midline dressing changes. On 10/28/21 and again on 11/30/21 Resident #63's midline was dislodged. A review of Resident #63's medical records showed there was no documented evidence that facility staff noted their findings of the resident's midline and recorded measurements for the midline's external catheter with every dressing change. In addition. there were no measurements of the resident's midline catheters to ensure they were complete out of the resident's arm, when the midlines became dislodged on 10/28/21 and 11/30/21. During a face-to-face interview on 03/15/22 at 2:45 PM with Employee # 6 (Unit Manager), when asked about the resident midline dislodgement on 10/27/21 she stated, the daughter took it out... It [the midline] had migrated a little ...I told her I would get the vascular nurse. I left the room. I called the doctor and he wanted to keep it in. When I got back to the room the line was out. Employee #6 made no comment about the dislodgement of the resident's midline on 11/30/21 and she acknowledged that Resident #63's TAR lacked the facility's staff observations of the resident's midline and had no measurements for the external catheter.	F 694		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		

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F 695	Continued From page 87 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews for (1) one of 53 sampled residents, facility staff failed to provide respiratory care that is consistent with professional standards of practice for one resident who was receiving humidified oxygen. Resident #34. The findings include: Resident #34 was admitted to the facility on 05/07/21 with diagnoses including, Chronic Respiratory Failure , Unspecified, Dysphagia, Shortness of Breath, and Dependence on Supplemental Oxygen. Review of the Quarterly Minimum Data Set dated 01/11/22, facility staff documented that Resident #34 had a Brief Interview Mental Status Summary Score (BIMS) of "10" indicating the resident, had mild cognitive impairment. In addition, facility staff documented: the resident: was totally dependent and required assistance from one person for all ADL(assisted daily living) care, and was always incontinent for bladder. Review of Resident #34's medical record revealed: 10/02/21 (Physician's Order): "Change Nasal Cannula Tubing/Mask and Humidifier bottler	F 695	F 695 1. Corrective action for resident Resident #34 had their oxygen bottle changed and dated during survey. 2. Identify other residents An audit of other residents on oxygen did not reveal any other residents that were missing dates on their water bottles. There were no additional findings related to this citation. 3. Systemic changes Licensed nursing and Respiratory Therapy staff have been educated on ensuring that residents have oxygen water bottles dated when changed. The Respiratory Manager/designee will be responsible for ensuring that residents have their water bottles dated. 4. Monitor corrective actions The Respiratory Manager/Designee will complete weekly audits of residents on oxygen to ensure that they have their water bottles dated. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 695	Continued From page 88 weekly on Wednesdays ' every night shift every Wed." 10/06/22 (Physician's Order): " O2 (Oxygen) at 2 L/Min (2 liter/minute) via N/C (nasal cannula) for SOB (shortness of breath) every shift for ..." Review of Resident #34's treatment administration record for March 2022, revealed that facility staff marked that they were changing the resident's nasal cannula tubing, mask and humidifier bottle every Wednesday. During an observation on 03/15/22 at 12:23 PM, Resident # 34 was observed resting in her bed. She was receiving 2.0 liters of humidified oxygen via a nasal cannula The humidification bottle had no date, time or initials to indicate when it had been changed by facility staff. During a face-to-face interview on 03/15/22 at 12:30 PM, Employee #24 (Respiratory Therapist), stated that the humidifier bottles should be dated and initialed when they are changed. The Respiratory Therapist changes the humidifier bottles on the 6th floor. The nurses change the humidifier bottles for residents on the 4th and 5th floors. During a face-to-face interview on 03/15/22 at 12:35 PM, Employee #25 (Licensed Practical Nurse/Agency), stated there should be a date on the humidifier bottle. Night shift usually changes them. She then walked to Resident #34's room, observed there was no date on the humidifier bottle connected to the resident's oxygen, and acknowledged the finding.	F 695		
F 744 SS=D	Treatment/Service for Dementia	F 744	F 744 1. Corrective action for resident Resident #2 currently has a comprehensive care plan that addresses their dementia diagnosis and treatment as of 3-21-2022.	

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F 744	Continued From page 89 CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) out of 53 sampled residents, facility staff failed to provide treatment, services, and develop a plan of care for Resident #2's diagnosis of dementia. Resident #2 The findings include: Resident #2 was admitted to the facility on 07/01/2000, with multiple diagnoses that included: Unspecified Dementia with Behavioral Disturbance, Major Depressive Disorder, and Psychotic Disorder with Hallucinations due to Known Physiological Condition. Review of the Quarterly Minimum Data Set (MDS) dated 02/12/22, revealed that the facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "10" indicating moderately impaired cognition. In section I (Active Diagnoses): Neurological, Non-Alzheimer's Dementia Review of the medical record revealed that there was no documented evidence of a dementia care plan with goals that were achievable and interventions that were person-centered to address care needs of the resident.	F 744	2. Identify other residents An audit of other residents with dementia will be completed by 06/20/22. 3. Systemic changes Licensed Nursing and Social Service staff have been educated on ensuring that residents have care plans that address their dementia diagnoses. The Director of Nursing will be responsible for ensuring that residents have appropriate interventions for their conditions. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of residents with dementia to ensure that they have interventions for their active conditions. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 744	Continued From page 90 A face-to-face interview was conducted on 03/21/22, at approximately 11:00 AM with Employee #6 (Unit Manager Registered Nurse) stated "We do the care plan as a team" Employee #6 acknowledged the findings.	F 744		
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 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, facility staff failed to ensure one (1) expired vial of influenza vaccine and one (1) vial of tuberculin	F 761	F 761 1. Corrective action for resident All expired medications were discarded at the time of notification during survey. 2. Identify other residents An audit of all medication rooms was completed. There were no additional findings related to this citation. 3. Systemic changes Licensed nursing staff have been educated on ensuring that no expired medications are left in medication rooms. The Director of Nursing will be responsible for ensuring that no expired medications are left in medication rooms. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete weekly audits of each medication room to ensure that no expired medications are present. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 761	Continued From page 91	F 761		

Purified Protein Derivative, PPD injection, were discarded and not stored for use in two (2) of three (3) medication refrigerators observed.

The findings include:

According to the manufactures speciation's for the Influenza Vaccine stipulated, "16.2 Storage and Handling ...Once the stopper of the mulit-dose vial has been pierced the vial must be discarded within 28 days." https://www.fda.gov/media/117022/download

According to the manufactures speciation's for the Tuberculin Purified Protein Derivative, stipulated, "Storage ...A vial of Tubersol [Tuberculin Purified Protein Derivative] which has been entered and in use for 30 days should be discarded." https://www.fda.gov/media/74866/download

1.On 03/10/2022 at 3:18 PM an observation of the 4th floor medication storage room refrigerator was conducted. Observed stored was a vial of Afluria 2021-2022 Quadrivalent (Influenza Vaccine) with a fill date of 10/13/21. The open date on the vial was recorded as 11/21/21.

2.On 03/10/2022 at approximately 3:45 PM an observation of the 5th floor medication storage room refrigerator was conducted. Observed stored for use was a vial of tuberculin Purified Protein Derivative, PPD injection 5 unit/0.1ml. The open date on the vial was recorded as 12/14/21.

There is no evidence that facility staff discarded the vials of influenza vaccine and tuberculin Purified Protein Derivative, PPD injection when

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F 761	Continued From page 92 they were opened beyond the use dates. At the time of the observation, Employee #9 (Licensed Practical Nurse), stated-we don't even use it. We use the ones from the 6th floor and acknowledged the findings.	F 761	F 773 1. Corrective action for resident Resident #78 was medicated for a possible UTI at the time the lab was ordered and follow up lab showed no UTI. Licensed staff were educated on ensuring that lab tests are collected timely.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviw for two (2) of 53 sampled residents, facility staff failed to ensure Resident #78 received the appropriate treatment when he/she complained of pain during urination; and failed to obtain labs in accordance with the physician's order for Resident #81. The findings include: 1. Facility staff failed to ensure Resident #78 received the appropriate treatment when he/she complained of pain during urination.	F 773	Resident #81 no longer resides in the building as of 4-29-22 (we were unable to retrospectively address the issue). 2. Identify other residents An audit of all other labs ordered will be completed by 06/20/22. 3. Systemic changes Licensed nursing staff will be educated on ensuring that labs and/or repeat orders are carried out on the date ordered. The Director of Nursing and Infection Preventionist will be responsible for ensuring that all labs are completed per physician order when they are ordered. 4. Monitor corrective actions The DON/Infection Preventionist/Designee will monitor all labs to assure repeat labs are completed on the date specified by the physician. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 773	Continued From page 93	F 773		

Resident #78 was admitted to the facility on 06/15/2021 with diagnoses that included Neuralgia and Neuritis, Muscle weakness, anxiety disorder, and Lymphedema

Review of the Quarterly MDS dated 01/01/2022 showed the following:

Section C (Cognitive Patterns), facility staff coded Resident #78 with a Brief Interview for Mental Status (BIMS) summary score of "13", indicating intact cognitive response.

Section G (Functional Status), Resident #78 was coded for needing extensive supervision with two person assistance for bed mobility, transfers, toilet use, personal hygiene.

Section H (Bladder and Bowel) the facility coded the resident as frequently incontinent for urine and always incontinent of bowel.

Interview with Resident #78 on 03/14/2022 at 11:06 AM he stated, I experienced pain upon urination on the Saturday before the Super Bowl (02/12/2022). I told the nurse. They didn't treat me until Monday (02/14/2022).

02/14/2022 at 23:23 (Nursing Progress Note) " ...c/o (complaint of pain while urinated, MD notified, order for Bactrim DS 800 mg for 5 days and Lab: UA/C&S given, ...Started on ABT this evening ..."

Review of the physician orders directed:

On 02/14/2022 at 2100, Bactrim DS 800-160 mg 1 tablet orally every 12 hours for UTI prophylaxis

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

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F 773	Continued From page 94 for 5 days ... On 02/14/2022 at 2308, UA/C&S (Urinalysis/Culture and Sensitivity) tomorrow ...02/15/2022 Review of the care plan initiated 2/14/2022, Focus area, "on abx (antibiotic) therapy r/t (related to) Possible Urinary Tract Infection...Interventions ...monitor/record/report to MD for s/sx (signs and symptoms) UTI (Urinary Tract infection) ...obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Review of the Treatment Administration Record for February 2022 showed the UA/C&S was done on 02/15/2022. Lab Results Report Dated: 02/16/2022 showed, Culture, Urine- Result- Random three or more mixed flora. Possible contamination. Please recollect. Status -Final. Review of the Medication Administration Record for February 2022 showed that Bactrim DS was administered to Resident #78 on 02/14 at 2100, 02/15, 02/16, 02/17 and 02/18 at 0900 and 2100. Review of the physician orders on 02/20/2022 at 2300, directed, Repeat UA/C&S on Monday at 6 AM ... Review of the Treatment Administration Record for February 2022 - The repeat UA/C&S was done on 02/20/2022	F 773		

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F 773	Continued From page 95 Review of the progress notes showed the following: 02/15/2022 at 15:14 (Nursing Progress Note) " ...continue on ABT (antibiotic) Bactrim [DS] 800 mg BID day 2/5 ... 02/15/2022 at 17:56 (Nursing Progress Note) Lab result reviewed by MD, no new order given resident is currently on abt. 02/19/2022 at 15:21 (Nursing Progress Note) S/P (status post) abt for UTI ...UA, C&S results received and addressed by NP (Nurse Practitioner), order to repeat UA, C&S on Monday." Review of the facility's investigation/incident report showed the resident reported that he had a concern related to care on 02/16/2022 ... "1) [Resident #78] experienced pain upon urination the day of February 12, [2022] between 7:00 and 8:00 PM. He states that he reported the issue to [Name of CNA] ...2) ...reporting, the burning upon urination lasted over the course of the weekend until treatment was given on February 14, 2022. 5) when asked why he did not alert the nurses of his symptoms, he stated, "I assumed that the CNAs would report it." Interventions: 4) staff interviewed and in-serviced with education given related to reporting of patient issues/symptoms." There was no evidence that facility staff act timely to the resident's complaint of pain upon urination for two days and to the lab note to "Please recollect" the resident's urine for five days. During a face-to-face interview with Employee #6 on 03/25/2022 at 9:54 AM, she acknowledged the findings.	F 773		

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F 773	Continued From page 96	F 773		

2. Facility staff failed to obtain labs in accordance with the physician's order for Resident #81.

Resident #81 was admitted to the facility on 11/05/2021 with diagnoses that included Amyotrophic Lateral Sclerosis (ALS), Quadriplegia, Chronic Respiratory Failure with Hypercapnia, Retention of Urine, Tracheostomy and Gastrostomy

Review of the Quarterly Admission MDS dated 02/12/2022 showed Resident #81 was coded as follows:

Section C (Cognitive Pattern) his Brief Interview for Mental Status (BIMS) summary score was "15", indicating intact cognitive response.

Section G (Functional Status), coded for needing total dependence with two-person assistance for bed mobility, transfers, dressing, eating, toilet use and personal hygiene.

Section H (Bladder and Bowel) the facility coded the resident as having an indwelling catheter.

Section O Special Treatments and Programs was coded as the resident receiving Respiratory Treatments and IV (intravenous) Medications.

Review of the care plan-Focus area, Indwelling Catheter r/t (related to) Neurogenic Bladder and ALS...Interventions ...monitor/record/report to MD for s/sx (signs and symptoms) UTI (Urinary Tract infection) ...

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F 773	Continued From page 97	F 773		

Review of the physician orders on 02/11/2022 at 23:59, ...UA/C/S (Urinalysis/Culture and Sensitivity) one time only until 2/11/2022

Lab Results Report Dated: 02/12/2022 showed, Culture, Urine- Result- Random three or more mixed flora. Possible contamination. Please recollect. Status-Final.

02/12/2022 at 14:12 (Progress Note) " ...lab result came back stating that Micro Culture Result Three or more mixed flora. Possible contamination. Please recollect." MD made aware; order given to repeat urine culture on Monday ..."

02/13/2022 at 22:27 (Progress Note) " ...Patient denied any pain or discomfort, urine collected and put in the specimen refrigerator on the first floor for p/u (pick up) in AM."

Review of the physician orders on 02/14/2022 at 06:59, directed, Repeat urine culture on Monday ...

Review of the Resident's record lacked evidence that lab results were received/obtain from the 2/14/2022 order to repeat the culture. Also there was no evidence that facility staff follow up with the lab to determine the status of the specimen.

During a face-to-face interview on 3/22/2022 at 10:00 AM with Employee # 3 (Director of Nursing), she stated, "I cannot confirm that the

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F 773	Continued From page 98 lab was done."	F 773		
F 812 SS=B	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to store foods under sanitary conditions as evidenced by two (2 of six (6) slats in the main freezer that were torn throughout. The findings include: During a walkthrough of dietary services on March 17, 2022, at approximately 10:00 AM, two (2) of six (6) slats from the walk-in freezer were torn with missing pieces. Employee #16 acknowledged the findings during	F 812	F 812 1. Corrective action for resident The torn slats on the freezer were replaced on 3-20-22. 2. Identify other residents An audit of the kitchen did not reveal any additional torn slats. There were no additional findings related to this citation. 3. Systemic changes Dietary and Engineering staff have been educated on ensuring that food is stored under sanitary conditions. The Director of Dietary will be responsible for ensuring that food safety requirements are met. 4. Monitor corrective actions The Director of Dietary/Designee will complete weekly audits of freezer/refrigerators to ensure that the slates to the units are in good repair. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 812	Continued From page 99 a face-to-face interview on March 17, 2022, at approximately 10:30 AM.	F 812	F 880 1. Corrective action for resident Resident #81 no longer resides in the facility as of 4-29-22 (we were unable to retrospectively address this issue).	
F 880 SS=E	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;	F 880	Resident #103 was observed receiving trach care by a therapist who maintained a sterile field and did not touch the inner cannula with contaminated gloves on 3-17-22. Employee #11 was re-in-serviced on maintaining a sterile field when performing trach care. 2. Identify other residents An initial audit of infection control practices was completed. All residents have the potential to be affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, enhanced barrier precautions, and proper use of PPE). The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices. 4. Monitor corrective actions The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	

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F 880	Continued From page 100 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. 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 observation and interview, for two (2) of 53 sampled residents, the facility's staff failed to maintain Standards of Infection Control Practices when providing tracheostomy care for Resident #103 and when suctioning Resident #81.	F 880	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 880	Continued From page 101 The findings include: 1.The facility's staff failed to maintain Infection Control Standards when providing tracheostomy care for Resident #103. Resident #103 was admitted to the facility on 02/02/22 with multiple diagnoses including Tracheostomy, Respiratory Failure, and Dependence on Respiratory Ventilator. On 03/15/22 at 10:11 AM, Employee #11 (Respiratory Therapist) was observed setting up a sterile field with equipment to provide trach care for Resident #103. After setting up the sterile field, Employee #11 performed hand hygiene and put on sterile gloves. The employee was noted contaminating her sterile gloves when she touched a pack of 4X4s lying on an uncleaned bedside table. The employee then touched the resident's inner cannula tracheostomy tube with her uncleaned sterile gloves. The surveyor stopped Employee #11 and requested that she change her gloves and the sterile field before providing trach care services for the resident. Review of an Admission Minimum Data Set (MDS) dated 02/09/22 showed the resident was coded for memory problems with short-term and long-term memory problems and severely impaired cognitive decision-making skills. Further review of the MDS revealed the resident was coded for respiratory treatments, including oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator (ventilator or respirator). Review of Resident #103's medical record showed the following:	F 880		

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F 880	Continued From page 102 02/03/22 [physician's order] "trach size 7.0..." 02/03/22 [physician's order] "tracheostomy care every shift and prn (as needed) every shift" Review of the resident comprehensive care plan started on 02/05/22 showed the following: Focus Area- "[Resident's name] is ventilator dependent r/t (related to) respiratory failure. Interventions: Routine trach change by respiratory care. Maintain ventilator setting as ordered." During a face-to-face interview on 03/15/22 at approximately 10:20 AM, Employee #1 was asked if the Standard of Infection Control Practices was to touch the resident's tracheostomy inner cannula with uncleaned (contaminated) gloves? The employee stated, "No, I normally open all packages with other (non-sterile) gloves and then I use sterile gloves to provide trach care." 2. The facility's staff failed to maintain Infection Control Standards when suctioning Resident #81. According to the Center for Disease Control and Prevention, "Put on a face shield over the N95 ... to provide additional protection to the front and sides of the face, including skin and eyes ...hold on to the face shield with both hands, expand the elastic with your thumbs and place elastic behind your head, so that foam rest on the forehead. Once the shield is situated, check to make sure it covers the front and sides of the face, and no areas are left uncovered." https://www.cdc.gov/vhf/ebola/hcp/ppe-training/n9	F 880		

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F 880	Continued From page 103 5respirator_gown/donning_13.html According to the Center for Disease Control and Prevention, "Enhanced Barrier Precautions expand the use of PPE (personal protective equipment) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ...Face protection may also be needed if performing an activity with risk of splash or spray." https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html Resident #81 was admitted to the facility on 02/02/22 with multiple diagnoses including Pneumonia, Dependence on Respiratory Ventilator), Chronic Respiratory Failure with Hypoxia, Tracheostomy, Quadriplegic, and Amyotrophic Lateral Sclerosis (ALS). On 03/16/22 at approximately 11:30 AM, Employee #22 (Registered Nurse) was observed wearing a face shield inappropriately while suctioning Resident #81. The employee's face shield was pointed upward, which failed to cover the employee's eyes, face, and face mask. Further observation revealed a sign that indicated Resident #81 was on Enhanced Barrier Precautions. Review of a re-admission history physical dated 03/16/22 documented, "Pt. (patient) ... s/p (status post) recent hypercapnic resp. (respiratory) failure induced by ALS leadking (sp) to swallowing dysfunction and pneumonia ...cont.	F 880		

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F 880	Continued From page 104 (continue) Zosyn (antibiotic) until 03/26." Review of a comprehensive care plans with a revision date of 03/14/22 showed the following: Focus Area - "[Resident's name] is ventilator dependent r/t (related to) Respiratory Failure and ALS. Goals - [Resident's name] will be monitored for VAP (Ventilator-Associated Pneumonia) through the next review date. Interventions: Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of ...pneumonia..." Focus Area - "[Resident's name] has a tracheostomy r/t (related to) impaired breathing and ALS. Goals - [Resident's name] will be monitored for s/sx of infection through the next review period. Interventions: Suction as necessary." During a face-to-face interview on 03/16/22 at approximately 11:45 AM, Employee #22 aknowledged the finding and stated that she forgot to push her face shield down so it could cover her eyes, face and face mask before providing suction care to Resident #81.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883	F 883 1. Corrective action for resident Resident#262 (resident no longer resides in the facility as of 4-6-22 (we were unable to retrospectively address this issue). Resident #6 had their immunization records updated on 5-19-22 to reflect that they have been offered the covid-19 vaccine and educated on the risks versus benefits of taking the vaccine. Resident #263 had their immunization records updated on 3-23-22 to reflect that they have been offered the covid-19 vaccine and educated on the risks versus benefits of taking the vaccine. 2. Identify other residents An audit of all current residents will be completed by 06/20/22.	

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F 883	Continued From page 105 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883	3. Systemic changes Licensed Nursing staff will be educated on ensuring that residents are offered vaccines and ensuring that the residents and/or their responsible party are given information/education regarding the benefits and risks of immunization. The Infection Preventionist will be responsible for ensuring that vaccines are offered with information/education regarding the benefits and risks of immunization. 4. Monitor corrective actions The Infection Preventionist/Designee will complete weekly audits of vaccination reports to ensure that vaccines are being offered and the medical records of residents with new vaccinations to ensure that information/education regarding the benefits and risks of immunization. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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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 883	Continued From page 106 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 53 sampled residents, facility staff failed to ensure that there was documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization, the administration or the refusal of or medical contraindications to the vaccine(s). Residents' #6, #262 and #263. The findings include: 1. Resident #6 was readmitted to the facility on 12/15/21 with diagnoses that included Chronic Respiratory Failure, Anemia and Hypertension. Review of the Resident #6's Significant Change Minimum Data Set (MDS) dated 02/22/22 showed the resident was coded as not receiving the Influenza and Pneumococcal vaccinations and the stated reason was - "offered and declined". Review of Resident #6's medical record (electronic and paper) lacked documented evidence that facility staff provided information/education to the resident or their representative regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). 2. Resident #262 was admitted to the facility on	F 883		

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	095027	A. BUILDING _____ B. WING _____	C 03/25/2022

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F 883	Continued From page 107 01/24/22, with diagnoses that included: Traumatic Subarachnoid Hemorrhage with Loss of Consciousness, Elevated White Blood Cell Count Unspecified, and Pneumonia Unspecified Organism. Review of the Resident #262's Admission MDS dated 01/31/22 showed the resident was coded as not receiving the Influenza and pneumococcal vaccination and the stated reason was "not offered". There was no evidence that facility staff provided information/education to the resident or their representative(s) regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). 3. Resident #263 was admitted to the facility 02/28/22 with diagnoses that included: Unspecified Dementia Without Behavioral Disturbance, Paroxysmal Atrial Fibrillation, Benign Prostatic Hyperplasia Without Urinary Tract Symptoms, and Muscle Weakness. Review of the Resident #263's Admission MDS dated 03/07/22 showed the resident was coded as not receiving the Influenza and pneumococcal vaccinations and the stated reason was "not offered". There was no evidence that facility staff offered the resident or their representative the influenza and pneumococcal immunization. During a face-to-face interview on 03/23/22 at 10:38 AM Employee #29 (Infection Preventionist)	F 883		

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F 883	Continued From page 108 reviewed Resident #6's and #262's documentation and acknowledged the findings.	F 883	F 887 1. Corrective action for resident	
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff	F 887	Employee #27 is no longer on the schedule as of 3-27-22. 2. Identify other residents An audit of all current employees has been completed. There were no additional findings related to this citation. 3. Systemic changes Administration, Human Resources, and Infection Prevention staff have been educated on ensuring that staff are offered vaccines and ensuring that they complete their scheduled vaccine series. The Infection Preventionist will be responsible for ensuring that vaccines are offered, and series completed for all active employees. 4. Monitor corrective actions The Infection Preventionist/Designee will complete weekly audits of vaccination reports to ensure that vaccines are being offered and the medical records of residents with new vaccinations to ensure that information/education regarding the benefits and risks of immunization. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 887	Continued From page 109 under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure that one (1) staff member was in compliance with receiving the COVID-19 vaccination series. The resident census on the first day of survey was 110. The findings include: According to the Centers for Disease (CDC) "The number of doses needed depends on which vaccine you receive. To get the most protection:	F 887	5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 887	Continued From page 110 Two (2) Pfizer-BioNTech vaccine doses should be given 3 weeks (21 days) apart, two (2) Moderna vaccine doses should be given 1 month (28 days) apart and Johnson & Johnsons Jansen COVID-19 vaccine requires only one dose." https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html#:~:text=The%20number%20of%20doses%20needed,than%20the%20recommended%20interval. According to the District of Columbia Department of Health (DC DOH), "All licensees in the District of Columbia are required to be fully vaccinated against COVID-19. Licensees must have the single dose Jansen COVID-19 vaccine, or at least one dose of either the Pfizer or Moderna COVID-19 vaccine... with the second dose of said vaccines obtained within the recommended time frames. Failure to do so may result in disciplinary action against your license, including but not limited to suspension, revocation, or non-renewal of said license." https://dchealth.dc.gov/node/1556816 During a review of the facility's line listing of staff who were vaccinated showed that one (1) facility staff (Certified Nurse Aide) had not completed the two-dose requirement for COVID-19 immunizations for the Moderna vaccine. Employee #27 (Certified Nurse Aide) was administered the Moderna COVID-19 vaccine first dose on 09/30/21. Twenty-one days later, on 10/21/21, there was no documented evidence that a second dose was received/administered. The Employee continued to work at the facility from 10/21/21 through 03/23/22, without receiving	F 887		

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F 887	Continued From page 111 the second dose as mandated and required by DC DOH, the CDC and manufactures guidelines. During the face-to-face meeting with Employee #29 (Infection Control Preventionist) on 03/23/22 at approximately 5:00 PM, stated, "She (Employee #27) should have been removed from the schedule."	F 887	F 888 1. Corrective action for resident The employees in question are not providing patient care and are following the CMS guidance. 2. Identify other residents An audit of all current employees has been completed. There were no additional findings related to this citation.	
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888	3. Systemic changes Administration, Human Resources, and Infection Prevention staff have been educated on ensuring that staff are offered vaccines and ensuring that they complete their scheduled vaccines. The Infection Preventionist will be responsible for ensuring that vaccines are offered, and series completed for all active employees. Policies have been created to address employee vaccination status. 4. Monitor corrective actions The Infection Preventionist/Designee will complete weekly audits of vaccination reports to ensure that all active staff have been appropriately assigned based on their vaccination status and are following our policies for infection prevention. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is **June 20, 2022.**	

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F 888	Continued From page 112 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888		

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F 888	Continued From page 113 as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received	F 888		

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F 888	Continued From page 114 monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to updated their COVID-19 policies and procedures to include contingency plans for staff who are not fully vaccinated. The resident census on the first day of survey was 110. The findings include: Review of the facility's line listing of staff who were vaccinated showed that six (6) staff had not received the vaccine and applied for an exemption with the State Agency. It was further noted that two (2) of the staff members worked in non-resident areas; and four (4) of the staff members performed direct resident care. During the face-to-face meeting with Employee #29 (Infection Control Preventionist) on 03/23/22 at approximately 4:45 PM, an Infection Control interview and review of the facility's infection control policies and procedures was done. It was	F 888		

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F 888	Continued From page 115 noted that the policy did not address a contingency plan for staff who are not fully vaccinated due to a pending request for an exemption or that have been granted exemptions. Employee #29 stated that all of the employees had filed to be exempt with the State Agency and the requests were pending, and the staff are tested weekly. At the time of the review, Employee #29 acknowledged that the facility's infection control policies and procedures were not updated to include contingency plans for staff who are not fully vaccinated.	F 888		