BRIDGEPOINT

SUB-ACUTE AND REHABILITATION

June 06, 2022

Ms. Ranada Cooper, MSW
Program Manager
Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration
899 North Capitol Street, NE 2nd Floor
Washington, DC 20002
ranada.cooper@dc.gov

Re: Form 2567 Plan of Correction for our march 25th, 2022 Survey (Provider #095027)

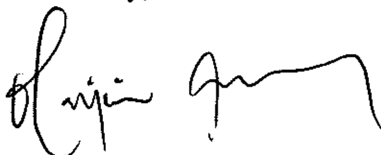
Dear Ms. Cooper,

We are submitting our Plan of Correction, Form CMS-2567 for our March 25th, 2022 survey. In addition, the following documents are also included:

- Form CMS-2567 for our March 25th, 2022 survey
- Form CMS-2567 for our May 25th, 2022 survey
- Infection Control Directed Plan of Correction (DPoC) in accordance with 42 CFR § 488.424

If you have any questions, please feel free to contact me via email at ooyekoya@bridgepointhealthcare.com or call me at 202-574-5700 (ofc) or 813-476-5443 (cell). Thank you.

Sincerely,



Olayinka Oyekoya, LNHA

Administrator

PRINTED: 05/27/2022
FORM APPROVED
OMB NO. 0938-0391

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 **01** B. WING	03/18/2022

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted March 17, and March 18, 2022, by the Department of Health, Health Regulation and Licensing Administration, in accordance with 42 CFR 483.73. The survey found that the facility was not in substantial compliance with Emergency Preparedness requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility's bed capacity is 117, the census was 110.	E 000	E 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.	
E 030 SS=E	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at	E 030		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 06/06/202

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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E 030	Continued From page 1 §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	E 030	E 030 1. Corrective action for resident The Emergency Preparedness Book has been updated with a current list of contractors. 2. Identify other residents A review of the Emergency Preparedness Book did not reveal any additional concerns. There were no additional findings related to this citation. 3. Systemic changes The Director of Maintenance has been educated on the importance of maintaining an updated contractors contact list in the Emergency Preparedness Book. The Director of Maintenance will be responsible for ensuring that the Emergency Preparedness Book is kept updated. 4. Monitor corrective actions The Director of Maintenance/Designee will complete monthly audits of the Emergency Preparedness Book to ensure that it is up to date. Any concerns will be addressed immediately. 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 13, 2022.	

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E 030	Continued From page 2 (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review, and interview, facility staff failed to maintain current, updated contact information for contractors who provide services in the facility. The findings include: Review of the facility's Emergency Preparedness plan on March 17, and March 18, 2022, showed the facility did not include in its emergency plan, current, updated contact information of contractors who provide services the facility. During a face-to-face interview on March 22, 2022, at approximately 11:00 AM, Employee #2 confirmed the findings.	E 030		

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K 000	INITIAL COMMENTS A Life safety Code survey was conducted at your facility March 17, and March 18, 2022. The following deficiencies are based on observation, interview, and record review.	K 000	K 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.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or	K 363	K363 1. Corrective action Rooms 4150, 4156, 5149, 6112, 6123, 6139, 6154 doors were not latching and have since been repaired. Fire door between rooms 5143 and 5144 failed to close automatically during a fire drill and have since been repaired. 2. Identify other residents The facility's doors have been audited and no additional issues noted. 3. Systemic changes Maintenance staff have been educated on the requirement to ensure that facility doors are in good repair. The Director of Maintenance will be responsible for ensuring the facility doors are in good repair.	

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K 363	Continued From page 4 frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain entrance doors to resident's rooms and fire doors in safe condition, as evidenced by seven (7) of 117 entrance doors to resident's rooms that failed to latch into frame when tested, and one (1) of four (4) fire doors on the 5th. Floor that did not automatically close during a fire drill. The findings include: 1. During a Life Safety Code walkthrough of the facility on March 18, at approximately 10:30 AM, entrance doors to resident's rooms: #4150, #4156, #5149, #6112, #6123, #6139, #6154, failed to latch into frame when tested, seven (7) of 117 resident's rooms. 2. The fire door located between resident room #5143 and #5144, failed to close automatically during a fire drill on March 18, 2022, at approximately 2:30 PM. This deficient practice could expose residents, staff, and visitors to smoke in a fire emergency. During a face-to-face interview on March 18, 2022, at approximately 2:30 PM, Employee #17 acknowledged the findings.	K 363	4. Monitor corrective actions The Director of Maintenance will complete audits of facility doors monthly to assess compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. 5. Date of compliance The facility's date of alleged compliance is June 13, 2022.	

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K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to ensure the safety of residents, staff and visitors as evidenced by a portable space heater that was plugged in, ready for use in one (1) of 117 resident's rooms. The findings include: During a walkthrough of the facility on March 15, 2022, at 11:08 AM, a portable space heater was observed on a nightstand, in resident room #5133 on the 5th. floor. The space heater was plugged into a surge protector, ready for use. The 2012 edition of NFPA 101 states: 19.7.8 Portable Space-Heating Devices. Portable space heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212 degrees Fahrenheit (100 degrees Celsius).	K 781	K781 1. Corrective action Room 5133 had a space heater which was removed immediately. 2. Identify other residents All rooms have been audited and no additional space heaters were found. 3. Systemic changes Maintenance and Administration staff have been educated on the importance of ensuring that space heaters are not in resident rooms. The Director of Maintenance will be responsible for ensuring the resident rooms are free of space heaters. 4. Monitor corrective actions The Director of Maintenance will complete audits of resident rooms monthly to assess compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. 5. Date of compliance The facility's date of alleged compliance is June 13, 2022.	

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K 781	Continued From page 6 This deficient practice endangers the safety of all residents, staff, and visitors in the facility. During a face-to-face interview on March 18, 2022, at approximately 2:30 PM, Employee #17 acknowledged the findings.	K 781		