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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
				-			С
		095027	B. WING			05	/23/2022
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		l	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	An unannounced Cor Incidents (FRI) survey BridgePoint Subacute facility from May 19, 2 Survey activities cons record reviews, reside Infection Control. The day of the survey was 111. The sample sampled residents. The following complaince with 42. The following complaince with 42. The following complaince were invested incidences were invested by the following is a direct and/or acronyms that report: AMS - Altered Merand/or acronyms that report: AMS - Assessment AV- Arteriovenous BID - Twice-a-da BIMS - Brief Interviting B/P - Blood Presson - Centimete CPR - Cardiopulm CMS - Centers for Services CNA- Certified Incomplication of CRF - Community	mplaints/Facility Reported y was conducted at a & Rehabilitation Capitol Hill 2022 to May 23, 2022. isted of observations, ent and staff interviews and a facility's census on the first size included six (6) ne facility was found to not CFR §483.10 to §483.95. ints and facility reported stigated during this survey: aint) ectory of abbreviations may be utilized in the atal Status at Reference Date ey ew for Mental Status sure ers onary resuscitation Medicare and Medicaid Nurse Aide Residential Facility Thrombosis	F	000 s	F 000-Preparation and/or execution of the of correction do not constitute admission agreement by provider of the truth of the alleged or conclusions set forth in the state of deficiencies. The plan of correction is prepared and/or executed solely because provisions of federal and state law require this plan is submitted as evidence of our compliance.	facts tement the the	06/20/22
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TILE		.(X6) DATE

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF Pr	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		1	223 7TH STREET NE		
			J	V	WASHINGTON, DC 20002		
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IAG	REOSETTORT S.C.	-30 IDENTIFE THIS HIS CHANGE COLORY	TAG		DEFICIENCY)	il E	2711
	-				-		-
F 000	Continued From page	- 1	F.	220			
1 000	,		FU	000			
	DCMR- District of C	olumbia Municipai					
	Regulations						
	D/C Discontinue						
	DI - deciliter						
	DMH - Department - EHR - Electronic H						
	EKG - 12 lead Elec	Health Record					
		cy Medical Services (911)					
	ESRD - End Stage F						
	G-tube Gastrostom						
	HR- Hour	ly tube					
	HSC - Health Serv	uice Center		1			
		itilation/Air conditioning		1			
	ID - Intellectual						
	IDT - interdiscipli			1			
	L- Liter	, many court		1			
	E .	nit of mass)		***	TO STATE OF THE ST		
	,	Administration Record		ř			
	MD- Medical Do			ŀ			
	MDS - Minimum D	oata Set					
	Mg - milligrams ((metric system unit of mass)		,			
	mL - milliliters (m	netric system measure of		ŀ		ļ	
	volume)			!			1
	mg/dl - milligrams բ			-			
	i	s of mercury		-			
	MN midnight			!			
	Neuro - Neurologic			1			
	NP - Nurse Prac	titioner		1		İ	
	O2- Oxygen	100.04		1			
	1	sion screen and Resident		ļ		ļ	
	Review			,			
	Peg tube - Percutane	ous Endoscopic	1		PROPERTY		
	Gastrostomy PPE - Personal P	Protective Equipment			TA DATA DE LA CALLANTA DE LA CALLANT		
	PO- by mouth	rotective Equipment		-			
	,	s order sheet					
	Prn - As needed			-			
	Pt - Patient			1			
	Q- Every			-		***************************************	
	Q- LVEIY			,			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	B. WING		C 05/23/2022
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND R	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002	0012312022
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TSH- Thyroid Sti TV- Television Ug - Microgram Right to be Free from CFR(s): 483.10(e)(1), §483.10(e) Respect ar The resident has a rigi and dignity, including: §483.10(e)(1) The righ physical or chemical repurposes of discipline required to treat the reconsistent with §483.1 §483.12 The resident has the resident has the reglect, misappropriat and exploitation as definctudes but is not limit corporal punishment, in any physical or chemical treat the resident's me §483.12(a) The facility §483.12(a) The facility	Notion le party le party le center Administration Record mulating Hormone Physical Restraints 483.12(a)(2) Ind Dignity. Int to be free from any estraints imposed for or convenience, and not esident's medical symptoms, 2(a)(2). Ight to be free from abuse, tion of resident property, fined in this subpart. This ted to freedom from involuntary seclusion and cal restraint not required to edical symptoms. In must- that the resident is free ical restraints imposed for or convenience and that at the resident's medical	F 604	F 604	estraint e e ger I to the al any tely or I the are not ed for or of ing that

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			`
		095027	B. WING_				23/2022
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		ZUIZUZZ
DDIDCED	OINT CUID ACUTE AND	DELLAD CADITOL 1811		2	23 7TH STREET NE		
שאוטעבר	OINT SUB-ACUTE AND I	REHAB CAPITOL HILL		٧	VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	indicated, the facility	ontinued From page 3 dicated, the facility must use the least restrictive		604	 Monitor corrective actions The Director of Nursing/Designee with 	11	
	alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of six (6) sampled residents, facility staff failed to ensure that Resident #2 was free from a physical restraint. The findings include: Review of the facility's policy, "Use of Restraints" with a revision date of February 2022 showed," Restraints shall only be used to the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including tucking sheets so tightly that a bed bound-resident cannot move"				complete weekly audits of all residents to ensure that no restraints are being used inappropriately. The results will be reported		
					to the QAPI Committee monthly x 3 for review and recommendations.		
					The QAPI Committee is responsible on-going monitoring for compliance.	for the	
					5. Date correction action comp	eted	
					The facility's date of alleged complia June 20, 2022.	nce is	
	Resident #2 was admitted to the facility on 12/27/21 with multiple diagnoses that included: Repeated Falls, Encephalopathy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side.						
	@ (at) around 0830 (Recreation Specialist observed [Resident # Nursing Station and t report, Investigation i	documented, "On 4/30/2022 8:30 AM) the Therapeutic t Director reported that she \$2] sitting in a recliner at the tied to the recliner. This initial is in progress"					
	Review of Resident#	2's medical record revealed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING	B. WING		C 05/23/2022	
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		223 7	ETADDRESS, CITY, STATE, ZIP CODE TH STREET NE HINGTON, DC 20002		5/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	the following: A Significant Change (MDS) dated 03/18/22 coded the following: sno presence of behave of care; extensive assignment of presence of behave of care; extensive assignment of motion (ROM) in between the following: sno presence of behave of care; extensive assignment of motion (ROM) in between the following: sno presence of (ADLs); functional important of (ROM) in between the following: sno present of (ADLs); functional important of (ROM) in between the following: sno present of (ADLs); functional intermediately every 2 following: sno present of the following	in Status Minimum Data Set 2 that showed facility staff severely impaired cognition, ioral symptoms or rejection sistance with two persons or activities of daily living pairment/limitations in range oth upper and lower se of physical restraints. Order] "Ativan (antianxiety) sam)/ML(milliliter) Inject 0.5 ery 6 hours as needed for Order] "Frequent rounding nours as tolerated and very shift" revised on 04/08/22 endent on staff for meeting physical, and social needs andent) Cognitive deficits, [General Progress Note] was less agitated today.	F	604			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002				
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F 604	Continued From page	∍ 5	F	304				
		emities without pain or assisted back to Geri	777 777	***************************************				
		order] "Neuro check q every shift for s/p (status I for 3 days"						
	04/28/22 [Physician's 5149"	Order] "Room transfer to						
200		Order] "Patient is a High and redirect as needed						
	plan related to recent remain (Alarm, roundi mat, bed in lowest pos apparent injuries note reviewed with IDT (int Nursing to continue w	vith P.O.C. (plan of care)."						
To the control of the	very agitated, trying to	[Behavior Note] "Resident is o stand and get out of gerì et by staff CNA (Certified l he is clean and dry."						
	Assessment Request 08:30 am, the Therap (director) reported tha sitting in a recliner at the recliner Assess responsive verbally, n condition intact with nediscoloration observed	at she observed resident the Nursing station tied to ment, Resident is alert and no acute distress noted, skin no redness, no bruises or						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			C 05/23/2022	
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CO 223 7TH STREET NE WASHINGTON, DC 20002	DE	00/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	·	ON SHOULD BE HEAPPROPRIA		
F 604	informed" 05/01/22 at 6:17 AM Entry] "Resident had bed) in Geri chair and station for on observabed" 05/02/22 at 11:20 AM Late Entry] "Writer w (Director of Nursing) incident that occurred facility and spoke with was interviewed by Fwriter. Patient was undenies pain and state During a unit tour cor PM, Resident #2 was chair in front of the 50 Resident appeared in complain of pain or disting up, with a bedie eating his lunch. The restraints or items the restraints or items the restraints on or arour was not interviewable During a face-to-face 05/19/22 at 3:10 PM, Recreational Special Saturday (04/30/22), change and update the station and saw [Restrying to reposition his around his chest to the There was also to be	[General Progress Note Late a quiet night. OOB (out of d brought to the nursing ation. Refused to sleep in his [General Progress Note as instructed by D.O.N. to call Police related to d 4/30/22. Police came to h writer and D.O.N. Patient Police officer in presences of hable to recall incident, and that he was fine" Inducted on 05/19/22 at 12:45 is observed sitting in a Geri th floor nurse's station. The leat, groomed and did not iscomfort. Resident #2 was side table over the chair, re were no observed at could be used as and the resident. Resident #2	F	604			

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	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		30/23/20/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	1	
F 604	Therapeutic Recreating (2022), [Employee #6] We walked onto the use went to my office and [Resident #2]. She [Examining to me saying the chair!' I immediate station. I saw a sheet chest. I looked at the was tied. I then asked come with me. We we told her you cannot the he was tied and proce from behind the Geri supervisor, reported in the Administrator." During a telephone in 05/20/22 at 11:56 AM Practical Nurse-LPN) nurse working that nig 7:00 AM on 04/30/22] the Geri chair when I at the desk charting we came and told me that tied to the back of the be restrained. I went a #2). I don't feel that he able to move around, He (Resident #2) was risks. It was hard to go in-service on abuse a explained in the trainic confinement is not who was a since the saying the restrained of the trainic confinement is not who was a sexplained in the trainic confinement is not who was a sexplaine	terview conducted on Employee #7 (Director of on) stated, "On April 30th of and I came in for a class. init (5th floor) together. I she went to talk to imployee #6] then came if He's [Resident #2] tied to only went to the nurse's around [Resident #2's] back and saw that the sheet if for the nurse assigned to one to [Resident #2] and I one a resident. She denied that beeded to untie the sheet chair. I called the nursing to to the Unit Manager and to	F	604			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			C 05/23/2022	
NAME OF PE	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	1 007	
BRIDGEP	OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	an order to give Ativa that's worse, being chathat's worse, being chathat's worse, being chathat's worse, being chathat's worse, being chathat 12:05 PM Nurse Aide) stated, "I that night [from 11:00 04/30/22]. He's a high Geri chair, in front of someone always has changed the resident soiled and put him basheet to cover his bod #7) passed by and as resident and said, 'That to the chair.' The nurse that he was not tied a the chair. I did not see on him was just to continuous physically restrain to for convenience. During a face-to-face 05/20/22 at 3:09 PM, (Administrator) and Eacknowledged the find "Disciplinary action wonurse and CNA were and reported to the beat states."	It they said I could've gotten if he was that agitated. But demically restrained." Iterview conducted on Employee #9 (Certified worked with [Resident #2) PM 04/29/22 to 7:00 AM In fall risk. He's usually in the eithe nurse's station so an eye on him. I last at 6:00 AM when he was ck in the chair with just a dry. Later, a lady (Employee ked who's in charge of the is man [Resident #2] is tied the came around and said no and started to untie him from the him tied. The sheet I put wer his body." We and staff interview, the temployee #8 tied a sheet Resident #2 for the purpose interview conducted on Employee #1 mployee #2 (DON) ding and stated, as taken immediately. The suspended at first then fired bards. Education was er nursing staff on abuse buse/Neglect Policies		504			
55 5	(-), 133,12(0)(1)	\-/					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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		095027	B. WING		05/23/2022	2
NAME OF PR	ROVIDER OR SUPPLIER		T I	STREET ADDRESS, CITY, STATE, ZIP CODE		
BBIDGED	NATOUR ACUTE AND F	DELIAD CADITOL IIII I	i	223 7TH STREET NE		
BRIDGER	DINT SUB-ACUTE AND F	KENAB CAPITUL HILL		WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION
				F 607		
F 607	Continued From page	9	F 60	77		
	§483.12(b) The facilit	y must develop and		1. Corrective action		
		cies and procedures that:			_	
	§483.12(b)(1) Prohibit and prevent abuse,			Investigations for residents #2 and #3 had completed.	ve been	
	neglect, and exploitat		-	2. Identify other residents		
	misappropriation of re	sident property,		2. Identify other residents		
	§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and			An audit of other incidents will be cond- 06/20/22 to identify any additional resid- may have been affected.		
	paragraph §483.95,	training as required at is not met as evidenced		3. Systemic changes		
	by: Based on record review and staff interview, for two (2) of six (6) sampled residents, facility staff failed to implement its policies and procedures for reporting and conducting investigations. Residents' #2 and #3.			Staff will be re-educated on completing investigations. The Administrator will be responsible for ensuring that incidents a investigated. The Administrator will be responsible for the subsequent follow up findings	e fully	
	The findings include:			4. Monitor corrective actions		
	and Reporting" revise report of resident abut misappropriation of reand or injuries of unknown be promptly reported investigated by facility investigator interview incident interview s who have had contact period of the alleged in	management Role of the wany witnesses to the taff members (on all shifts) twith the resident during the neident"		The Administrator/Designee will complereview of all investigations and follow us any subsequent findings. The results will reported to the QAPI Committee months months for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complete. The facility's date of alleged compliance 20, 2022.	p on Il be y x 3 i. the on-	Website the control of the control o
	Resident #2 was adm 12/27/21 with multiple	itted to the facility on diagnoses that included:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA	1
F 607	,		Fe	607		
	Repeated Falls, Ence Hemiparesis Followin Affecting Left Non-Do				,	
	Review of Resident# the following:	2's medical record revealed				
	(MDS) dated 03/18/2: coded the following: s no presence of behav of care; extensive ass physical assistance w (ADLs); functional impof motion (ROM) in be	in Status Minimum Data Set 2 that showed facility staff severely impaired cognition, rioral symptoms or rejection sistance with two persons rith activities of daily living pairment/limitations in range oth upper and lower se of physical restraints.				
	"Patient reported todal right side of head in the that someone walked bag over his head and head (points to right state the man held him and walked from the groom. Patient stated to	General Progress Note] ay that he was hit on the ne elevator. Patient stated I him to the elevator placed a d hit him in the back of his side of head). Patient stated I down but he got back up elevator and back to his that he could not see the as a man and could not poks like."				
	During a face-to-face 05/20/22 at 3:09 PM,	ed evidence that the eported to the state agency. interview conducted on Employee #1 wledged the finding and n was investigated				

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F 607	Continued From page	3 11	Fe	607			
		to interview and or obtain all employees who took care an alleged fall.					
	1	e diagnoses that included: leart Failure and Chronic					
	Review of Resident #: following:	3's medical record the					
	04/13/22 that showed following: severely im potential indicators of issues, for bed mobilit assistance with two powalk in room and corrone person physical a transfer (transfer betwheelchair), not stead staff assistance, funct in range of motion in textremities, does not in the severely important that showed that is the severely in t	psychosis, no behavior ty and transfers, extensive erson physical assist, for ridor, limited assistance with assist, for surface-to-surface ween bed and chair or dy, only able to stabilize with tional limitation/impairment					
	"C.N.A was asked to p mother present. Patie patient informed her the Monday morning (04/ reported it yesterday a stated that she did no check performed. Pati his left scapula/ back	/18/22). Per Mother, Patient afternoon. Patient mother of report it. Head to toe shin tient has two abrasions to					

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	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		223 7	EET ADDRESS, CITY, STATE, ZIP CODE 7TH STREET NE SHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 607	asked if he had hit his stated "yes". Writer a patient's head. No ab asked how the patient patient wanted to get push chair away. Patithe floor" 04/20/22 at 1:32 PM [Assessment Request Form] " Fall At 12 resident room, RP (rethat, Tuesday evening he fell Tuesday mornithe resident, he state [of] the bed. Manager went to the room. Head 2 abrasions noted on No c/o pain. MD notiff 04/20/22 [Physician's (every) shift x 3 days' 04/20/22 [Physician's report PRN (as need for s/sx (signs and sy change in mental stat sleepiness, inability to every shift for 3 Days' 04/21/22 [Physician's skin abrasions for chadoctor) for any signs of the patient of the state of the state of the system of the s	orted by his mother. Writer head during the fall, patient sessed the back of normalities noted. Writer t fell. Per verbal report out of bed and was trying to ient then slid out of bed onto sent the resident told her that ong (04/19/22): writer asked that was trying to get out made aware and both of us ad to toe assessment done, the left upper back noted. Sent sent sent sent sent sent sent sent s	F	507			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A, BOILDII	vo		ا ا	
		095027	B. WING				23/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PRINCER	DINT CUD ACUTE AND	DELIAR CARITOL III I		223	3 7TH STREET NE		
BKIDGEF	JIN I SUB-ACUTE AND	REHAB CAPITOL HILL		W	ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From pa		F 6		7 610		
	and 04/19/22 were is statements to get the of the alleged fall. During a face-to-face	d to Resident #3 on 04/18/22 interviewed or provided written seir recollection or knowledge se to interview conducted on I, Employee #2 (Director of		ii s p	The incident for resident #2 has been nevertigated by the DOH during the compurery. The facility failed to report the incident to the survey. There were no advertigated to the incident.	incident	
	comment.	ged the findings and made no		2	2. Identify other residents		
F 609 SS=D			F6	V	An audit of other incidents in the past 3 will be reviewed to ensure that they have eported as required.		
	must:	, or moneautient, the racinty		3	S. Systemic changes	:	
	involving abuse, ner mistreatment, include source and misapping are reported immed hours after the allege that cause the allege serious bodily injury the events that cause abuse and do not re-	ding injuries of unknown ropriation of resident property, liately, but not later than 2 gation is made, if the events ation involve abuse or result in or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to		o in s v a s	Leadership will be educated on the import of ensuring that all concerns and incident nestigated appropriately and reported a equired to ensure that residents are not subjected to potential abuse. The Admir will be responsible for ensuring that resident not subjected to potential abusive sittle econdary to the failure to properly investigated report allegations of abuse.	ts are as as astrator dents uations	
	officials (including to adult protective sent for jurisdiction in lon accordance with Sta procedures. §483.12(c)(4) Repo investigations to the designated represe accordance with Sta	the facility and to other of the State Survey Agency and vices where state law provides ageterm care facilities) in ate law through established at the results of all administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the		o e ti w n r	The Administrator will complete weekly of all Incidents Reported by the Facility ensure that all incidents are investigated horoughly and reported as required. The will be reported to the QAPI Committee nonthly x 3 months for review and ecommendations. The QAPI Committee is responsible for going monitoring for compliance.	to e results	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	r
		095027	B. WING		C 05/23/202	2
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002	00/20/202	<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 609	appropriate corrective This REQUIREMENT by: Based on record revione (1) of six (6) samfailed to report an alle Resident #2. The findings include: Review of the facility pand Reporting" revise report of resident abumisappropriation of reand or injuries of unknown be promptly reported. Resident #2 was adm 12/27/21 with multiple Repeated Falls, Ence Hemiparesis Followin Affecting Left Non-Do Review of Resident #2 the following: A Significant Change (MDS) dated 03/18/22 coded the following: so presence of behavof care; extensive ass physical assistance w (ADLs); functional impof motion (ROM) in be extremities, and no us 05/11/22 at 5:08 PM [6]	eged violation is verified action must be taken. is not met as evidenced ew and staff interview, for oled residents, facility staff gation of physical abuse of policy "Abuse Investigation of in July 2017 stated, "All se, neglect, exploitation, sident property, mistreat rown source ("abuse") shall in itted to the facility on diagnoses that included: phalopathy, Hemiplegia and go Cerebral Infarction minant Side. Let se medical record revealed in Status Minimum Data Set that showed facility staff everely impaired cognition, foral symptoms or rejection istance with two persons ith activities of daily living pairment/limitations in range	F 60	Date correction action complete The facility's date of alleged compliant 20, 2022.		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING_			ł	C 23/2022
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL		2	TREET ADDRESS, CITY, STATE, ZIP CODE 123 7TH STREET NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610 SS=D	that someone walked bag over his head and head (points to right sthat the man held him and walked from the croom. Patient stated the person but knew it was recall what the man look Review of the facility's showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to be showed no document allegation was ever reduced to show a show	him to the elevator placed a distribution in the back of his ide of head). Patient stated down but he got back up elevator and back to his hat he could not see the sign aman and could not looks like." Is investigation packet ed evidence that the ported to the state agency. Interview conducted on Employee #1 wledged the finding and in was investigated found to be orrect Alleged Violation (4) The to allegations of abuse, or mistreatment, the facility of the potential abuse, or mistreatment while the gress.		609	Investigations were completed/reviewed reinvestigated and appropriate actions taresolve the concerns for all residents. Re#3 will have their fall re-investigated. Identify other residents Identify other residents An audit of other resident's concerns and from the past 3 months will be complete Systemic changes Nursing staff and Leadership will be edu on the importance of ensuring that all falinvestigated appropriately. A new procemonitoring and investigating falls will be place. The Administrator will be responensuring that residents are not subjected potential abusive situations secondary to failure to properly investigate falls. Monitor corrective actions The Administrator will complete weekly of all Incidents Reported by the Facility ensure that all investigations are investigated thoroughly. The results will be reported QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for going monitoring for compliance.	ken to esident d falls d. cated lls are ess for e put in sible for to the audits to cated to the or	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			C / 23/2022
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	REHAB CAPITOL HILL	•	STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	incident, and if the alla appropriate corrective This REQUIREMENT by: Facility staff failed to interviews from all em Resident #3 after an a Resident #3 was adm 07/13/21 with multiple Muscle Weakness, He Respiratory Failure with Review of Resident #3 following: A Quarterly Minimum 04/13/22 that showed following: A Quarterly Minimum 04/13/22 that showed following: severely impotential indicators of issues, for bed mobilitiassistance with two pewalk in room and corrone person physical atransfer (transfer betweelchair), not stead staff assistance, funct in range of motion in textremities, does not and has had no falls seventry to the facility. 04/20/22 at 12:30 PM "C.N.A was asked to prother present. Patie patient informed her the Monday morning (04/10/14).	in 5 working days of the eged violation is verified a action must be taken. It is not met as evidenced interview and or obtain staff aployees who took care of alleged fall. Itted to the facility on a diagnoses that included: eart Failure and Chronic ith Hypoxia. B's medical record the Data Set (MDS) dated facility staff coded the paired cognition, no psychosis, no behavior by and transfers, extensive erson physical assist, for idor, limited assistance with ssist, for surface-to-surface ween bed and chair or dry, only able to stabilize with ional limitation/impairment poth upper and lower use any mobility devices ince admission/entry of [General Progress Note] option!	F 6	The facility's date of alleged compliance 20, 2022.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	SURVEY PLETED
		095027	B. WING			C /23/2022
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		223 7	EET ADDRESS, CITY, STATE, ZIP CODE 7TH STREET NE SHINGTON, DC 20002	 LUINGAA
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 610	stated that she did not check performed. Path his left scapula/ back patient what had happ what was already repasked if he had hit his stated "yes". Writer a patient's head. No absaked how the patient patient wanted to get push chair away. Patithe floor" 04/20/22 at 1:32 PM [Assessment Request Form] " Fall At 12 resident room, RP (rethat, Tuesday evening he fell Tuesday mornithe resident, he state [of] the bed. Manager went to the room. Head 2 abrasions noted on No c/o pain. MD notification of the complete of	ot report it. Head to toe shin tient has two abrasions to region Writer asked pened of which he confirmed borted by his mother. Writer is head during the fall, patient assessed the back of anormalities noted. Writer it fell. Per verbal report out of bed and was trying to ient then slid out of bed onto [Situation Background it (SBAR) Communication 2pm writer walked in appresentative informed writer in given that in the resident told her that in given to toe assessment done, the left upper back noted it is order] "Neurochecks Q" [Situation Background it is of the resident told her that in given to the resident told her that in given to the left upper back noted it is order] "Neurochecks Q" [Situation Background it is of the resident told her that in given to get out it is of the left upper back noted it i	F	610		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION	1, ,	SURVEY PLETED
		095027	B. WING			C /23/2022
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 641 SS=D	and 04/19/22 were intestatements to get their of the alleged fall. During a face-to-face 05/20/22 at 1:54 PM, Invising acknowledge comment. Accuracy of Assessmed CFR(s): 483.20(g) §483.20(g) Accuracy of The assessment must resident's status. This REQUIREMENT by: Based on record reviol (1) of six (6) sampled to ensure that Resident (MDS) accurately reflect to ensure that Resident #3 was admit 07/13/21 with multiple Muscle Weakness, Here Respiratory Failure with Review of Resident #3 the following: A Quarterly Minimum	investigation packet ed evidence that the o Resident #3 on 04/18/22 erviewed or provided written r recollection or knowledge to interview conducted on Employee #2 (Director of ed the findings and made no ents of Assessments. is accurately reflect the is not met as evidenced ew and staff interview, one residents, facility staff failed ent #3's Minimum Data Set ected the resident's status. etted to the facility on diagnoses that included: eart Failure and Chronic th Hypoxia. B's medical record showed Data Set (MDS) dated	F 64	1. Corrective action for resident Resident #3 has had their MDS update accurately reflect their condition on There were no ill effects to the residents. An audit of all current residents MI reveal any addition concerns. Their additional findings related to this citated in the MDS. To f Reimbursement will be responsible ensuring that resident's MDSs accurate their status.	ted to 5/20/22. nt. OSs did not e were no tion. he s status is he Director e for	
	04/13/22 that showed	facility staff coded the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095027	B, WING		1	C / 23/2022
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND I	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 641	G600, does not use in coded as no falls sind or prior assessment under section J1800. It should be noted that assessment was date 01/12/22 [Physician's every shift" 03/03/22 at 11:00 AM Assessment Request Form] "Patient acquir today @ (at) 11am. S with minor skin abras posterior arm. Treatm patient report, Patient with the walker and in the fall. Patient was for room by staff along w Patient stated that he his arm (patient show right posterior arm)' 03/03/22 [Physician's days s/p (status post) The evidence showed Resident #3's fall. During a face-to-face 05/20/22 at 1:33 PM, Rehabilitation) stated walker for ambulation	apaired cognition, in Section mobility devices and was be admission/entry or reentry whichever is more recent at the prior Quarterly MDS and 02/02/22. Order] "Fall precaution [Situation Background (SBAR) Communication ed a fall Patient had fall hift nurse assessed patient ion and redness to right itent applied as ordered. Per at stated that he was walking the turned back and acquired bund sitting on the floor in ith the Restorative assistant. Indid not hit his head but hit red order] "Neurochecks X 3 fall" If documented evidence of interview conducted on Employee #10 (Director of "IResident #3] has a rolling in the's had it for quite some only uses it during therapy	F 64	4. Monitor corrective actions The Director of Reimbursement/Descomplete random weekly audits of 1 resident's MDSs to ensure that their documented correctly. The results were ported to the QAPI Committee months for review and recommendate The QAPI Committee is responsible going monitoring for compliance. 5. Date correction action common The facility's date of alleged compliations are possible to the possible going monitoring for compliance.	0% of the status is rill be nthly x 3 ions. for the on-	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	1	LE CONSTRUCTION	(X3) DATE: COMPI	
		095027	B. WING		05/2	23/2022
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL	T T T T T T T T T T T T T T T T T T T	STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B' CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	had a documented or use of a rolling walker these in the resident's During a face-to-face 05/20/22 at approxima #11 (MDS Coordinato findings and stated the modifications. Care Plan Timing and CFR(s): 483.21(b)(2)(c) §483.21(b) (2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not limit (A) The attending physical (B) A registered nurse resident. (C) A nurse aide with the resident. (D) A member of food (E) To the extent practite the resident and the read and their resident reprinct practicable for the resident's care plan. (F) Other appropriate	d that although Resident #3 in 03/03/22 and documented in, facility staff failed to code is MDS. Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the Revision in)-(iii) Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the Revision in)-(iii) Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the Revision in)-(iii) Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the Revision in)-(iii) Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the Revision in)-(iii) Interview conducted on ately 3:00 PM, Employee in) acknowledged the at she would make the at sh	F 65		ins ts will ted by ive care	
	(iii)Reviewed and revi	sed by the interdisciplinary issment, including both the				

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PLE CONSTR G		(X3) DATE COMP	SURVEY PLETED
						(С
		095027	B. WING _			05/	23/2022
NAME OF PR	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
BRIDGEP	DINT SUB-ACUTE AND R	REHAB CAPITOL HILL			TREET NE		
				WASHING	GTON, DC 20002		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	(12002)	SO IDERTIFICAÇÃO ONIMATION	IAG		DEFICIENCY)	II E	2
F 657	Continued From page	21	E 6	₅₇ 4.	Monitor corrective actions		
, 007			F 0	97 1.	ividition dollated ive deficits		
	comprehensive and q assessments.	uarterly review		The M	DS nurses will complete monthly	andits	
		is not met as evidenced			prehensive care plans to ensure th		
	by:	is not met as evidenced			ts have updated/revised comprehe		
	-	iew and staff interview, for			ans. Audits will be completed du		
		pled residents, facility staff			t MDS completion. The results w		
	` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	ent #3's care plan to reflect			ed to the QAPI Committee monthly		
		staining a fall and Resident		months	s for review and recommendations	١.	
	#4's activities of daily	living (ADL) care plan.					•
					API Committee is responsible for	the on-	
	The findings include:			going n	nonitoring for compliance.	ļ	
				_	Data annualism autim a sta		
		policy titled, "Care Planning-	****	5.	Date correction action complete	XI DX	
		" revised 11/02/21, stated,		The fee	rility's data of allocad compliance	ia Tuma	
	"The care plan is ba			20, 202	cility's date of alleged compliance	is june	
	comprehensive asses	sment"		20, 202	,		
	Review of the facility r	policy titled, "Falls- Clinical					
	Protocol" revised 11/0						
		ng assessment, the staff					
		ntify pertinent interventions					
		s and to address the risks				į.	
	of clinically significant	consequences of falling"					
		o revise Resident #3's care					
	plan to reflect high fall	risks after sustaining a fall.					
	Decider 40	Had to the feether or					
	Resident #3 was admi	_					i
		diagnoses that included: eart Failure and Chronic					
a constant and a cons	Respiratory Failure wi						
		иттуроліа.					
	Review of Resident #3	3's medical record the					
	following:						
	-						
	A Quarterly Minimum	Data Set (MDS) dated					#
		facility staff coded the					
	Resident #3 with seve	rely impaired cognition.		THE STATE OF THE S			
				L			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
	095027	B. WING _			C 05/23/2022		
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB O	CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002				
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BI TAG REGULATORY OR LSC IDENT	PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 657 Continued From page 22 A Care Plan with a focus area 07/27/21, "[Resident #3] is a falls r/t (related to) confusion subdural hemorrhage" 03/03/22 at 11:00 AM [Situati Assessment Request (SBAR Form] "Patient acquired a fall today @ (at) 11am. Shift nurs with minor skin abrasion and posterior arm. Treatment app patient report, Patient stated with the walker and he turned the fall. Patient was found sit room by staff along with the F Patient stated that he did not his arm (patient showed right 03/03/22 at 11:38 AM [Morse Score 75 Category High Risk 04/20/22 at 12:58 AM [Morse Score 75 Category High Risk Review of the comprehensive 05/20/22 revealed that Resid focus area had not been revisits for falling", it documented "moderate falls risk". During a face-to-face interviee 05/50/22 at 1:50 PM, Employ Nursing) acknowledged the fill the care plan) should've be 2. Facility staff failed to revise daily living (ADL) care plan to of persons required to provide	Moderate risk for and traumatic on Background) Communication Patient had fall the assessed patient redness to right lied as ordered. Per that he was walking a back and acquired ting on the floor in Restorative assistant. This his head but hit posterior arm)" Fall Scale] " for Falling" Fall Scale] " for Falling" e care plan on ent #3's care plan sed to reflect "high it resident as a we conducted on eee #2 (Director of notings and stated, een updated." e the activities of reflect the number	F 6	57				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		E SURVEY IPLETED
		095027	B. WING_		Ož	C 5/23/2022
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRICE OF THE	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	
F 657	Dependence on Resp Muscle Weakness, He 03/28/22 at 9:18 PM [50 Category High Risl 03/29/22 (Revision da "[Resident #4] has an deficit r/t (related to) fa [Resident #4] requires with bathing/showerin necessary is totally for repositioning and thours) and as necessary An Admission Minimurevealed that facility s cognitively intact, no to care (including bed m	itted to the facility on diagnoses that included: irator (Ventilator) Status, emiplegia and Hemiparesis. Morse Fall Scale] " Score of for Falling" Intel [Care Plan focus area] ADL self-care performance atigue, impaired balance as assistance of one (1) staffing as scheduled and as dependent on one (1) staffing urning in bed Q2H (every 2 ary." Intel [Care Plan focus area] ADL obelity and transfer) - total (2) persons physical assist	Fé	,		
	the following: 04/15/22 at 8:08 AM ["respiratory called by AM), up on arriving to resident noted out of t 04/15/22 at 9:30 AM ["Called into patient's r taking care of patient. patient laying face do Patient was assessed					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_	B. WING		C 05/23/2022		
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CO 223 7TH STREET NE WASHINGTON, DC 20002	DDE	<u> US/</u>	23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 657	0.2 cm old scar recofficer and supervipatient to hospital 04/15/22 at 11:14 / Summary] "CT (Co Exam: noncontras spine CT no acute the cervical spine (holding skin and usuch as after an the edges of the wheen diagnosed who sustained an injury symptoms in the co 04/16/22 at 11:12 / s/p (status/post) fa	a cut above left eyebrow. 0.2 X opened to right hand House sor notified. Order to send for evaluation." AM [Hospital Discharge omputed Tomography) Scan thead CT, noncontrast cervical ate fracture is present or skull fracture or static subluxation of adhesive wound closure underlying tissue while it heals injury adhesive glue holds ound together) You have ith concussion or have	F6	857				
	05/20/22 at 9:54 A assigned to Reside stated, "I was char myself. I had him t and tucked the soi trying to put the cle off the bed then the side on the right. T rail on that side. I dweight pulled him oget to the other side performing ADL ca stated, "There hav nut most times I do	e interview conducted on M, Employee #12 (CNA ent #4 the day if the incident) nging him (Resident #4) by urned to the side on the left led linen under him and was ean linen on. First his feet fell e legs. I was on the opposite there was only one upper bed couldn't pull him back. His down off the bed before I could le." When asked why she was re by herself, Employee #12 e been times where I have help on't have help and the workload sk for help, I don't always get						

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			C 05/23/2022	
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND I	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODI 223 7TH STREET NE WASHINGTON, DC 20002		00/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689 SS=D	revise the ADL care por persons required to subsequently resulte. During a face-to-face 05/20/22 at 10:24 AM Nursing) acknowledg. "On this unit (6th flooresidents require 2 as repositioning. That's should say 2 people involved and all the oreducated about usiturning and reposition ventilators." Free of Accident Haza CFR(s): 483.25(d) (1) (1) (1) (2) (4) (2) (4) (2) (4) (3) (4) (4) (4) (4) (4) (4) (4) (5) (6) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	d that facility staff failed to plan to address the number of care for Resident #4 which d in a fall with injury. Interview conducted on I, Employee #2 (Director of ed the findings and stated, rr, ventilator unit), all the saist for turning and the standard. The care plan during ADL. The CNA ther nursing staff have been ing 2 people especially for hing residents on ards/Supervision/Devices (2)	F 64		revised to ired to safely s		
	by: Based on record rev one (1) of six (6) sam failed to revise the ac care plan to reflect th	iew and staff interview, for pled residents, facility staff tivities of daily living (ADL) e number of persons DL care to Resident #4,		Licensed nursing staff and MDS educated on the importance of residents have their care plans a staff know how to care for them of Nursing will be responsible fresidents care plans are revised reflect their currently functional	ensuring that revised so that n. The Director for ensuring that to accurately		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095027	B. WING		C	
NAME OF PROVIDER BRIDGEPOINT SE	UB-ACUTE AND R	EHAB CAPITOL HILL	\$	STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION	<u></u>	23/2022
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1	(X5) COMPLETION DATE
The file Revier Interdiffer Technical Technica	disciplinary Team ne care plan is based on the facility proof revised 11/0 don the precedir hysician will ident to prevent fall ident #4 was admitized with multiple ndence on Resple Weakness, Heategory High Risk with the facility stating/showering sary is totally positioning and the proof of the facility stating and as necessary and as necessary in the facility stating including bed mendence with two weighed 192 pour	policy titled, "Care Planning-" revised 11/02/21, stated, ased on the resident 's sment" policy titled, "Falls- Clinical 19/21 documented, " and assessment, the staff of titled pertinent interventions is and to address the risks consequences of falling" Itted to the facility on diagnoses that included: irator (Ventilator) Status, emiplegia and Hemiparesis. Morse Fall Scale] " Score is for Falling" Ittel [Care Plan focus area] ADL self-care performance atigue, impaired balance assistance of one (1) staff gras scheduled and as dependent on one (1) staff urning in bed Q2H (every 2 ary." Im Data Set dated 04/04/22 taff coded the following: ehavior issues, for all ADL obbility and transfer) - total (2) persons physical assist	F 689	The Director of Nursing/Designee will coweekly audits of 10% of residents care planter results will be reported to the QAPI Committee monthly x 3 months for revier recommendations. The QAPI Committee is responsible for togoing monitoring for compliance. Date correction action complete. The facility's date of alleged compliance 20, 2022.	ans. ew and the on-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		095027	B. WING _			C 05/23/2022
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, 223 7TH STREET NE WASHINGTON, DC 20002	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVI CROSS-REFERENCEI	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	
F 689	"respiratory called by AM), up on arriving to resident noted out of to a control of the control	[General Progress Note] CNA around 0620 (6:20 of the pt (patient) room, the bed on the floor." [General Progress Note] room by CNA who was . On arrival, nurse observed who on the floor next to bed, defrom head to toe and vital erred back to bed via hoyer at above left eyebrow. 0.2 X gened to right hand House or notified. Order to send evaluation." I [Hospital Discharge puted Tomography) Scan gead CT, noncontrast cervical fracture is present or skull cture or static subluxation of adhesive wound closure lerlying tissue while it heals ary adhesive glue holds and together) You have concussion or have hich may lead to concussion sing days" I [General Progress Note] " Left forehead laceration site and symptoms of infection	F6	589		
		#4 the day if the incident)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095027	B. WING		C 05/23/2022	
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002	03/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 726 SS=D	myself. I had him turn and tucked the soiled trying to put the clean off the bed then the leside on the right. Their rail on that side. I coul weight pulled him down get to the other side." performing ADL care it stated, "There have be nut most times I don't is heavy. When I ask it. But I understand it's The evidence showed revise the ADL care professons required to subsequently resulted. During a face-to-face 05/20/22 at 10:24 AM Nursing) acknowledge "On this unit (6th floor residents require 2 as repositioning. That 's should say 2 people of involved and all the ot reeducated about using turning and reposition ventilators." Competent Nursing Stoff (3):483.35 Nursing Serv The facility must have the appropriate competent competent solutions.	g him (Resident #4) by ed to the side on the left linen under him and was linen on. First his feet fell gs. I was on the opposite re was only one upper bed idn't pull him back. His rn off the bed before I could When asked why she was by herself, Employee #12 een times where I have help have help and the workload for help, I don't always get a a safety issue." I that facility staff failed to lan to address the number ocare for Resident #4 which if in a fall with injury. Interview conducted on the Employee #2 (Director of the the findings and stated, the ventilator unit), all the sist for turning and the standard. The care plan furing ADL. The CNA ther nursing staff have been the g 2 people especially for ing residents on taff (4)(c)	F 72	F 726 1. Corrective action for resident Resident #2 was released from the restrain soon as it was identified and #4's care plan will be revised by 06/20/22 to reflect the number of staff required to safely perfor ADLs. There were no ill effects related the incidents to resident #2. Resident #4 sustained a small cut above their left eye. The nurse involved with resident #2's incident no longer works for the facility was reported to the Board of Nursing on 05/06/22. The CNA involved in resident incident was suspended pending investigation. She was returned to work received additional education on safely providing ADL care to residents. 2. Identify other residents An audit of other like residents will be completed by 06/20/22.	n e e m to e and t #4's	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		E SURVEY PLETED		
			A. BUILDI	NG		_		
		095027	B. WING_		05	C 3 /23/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
DDIDCED	OINT OUR ACUTE AND	DELIAD CADITOL HILL		223 7TH STREET NE				
BRIDGER	OINT SUB-ACUTE AND	REHAB CAPITOL HILL		WASHINGTON, DC 20002				
(X4) ID		TATEMENT OF DEFICIENCIES	D D	PROVIDER'S PLAN OF COR		(X5)		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE		
F 726	Continued From page	o 20	F 7	3. Systemic changes				
1 720	Continued From pag		F /	'26 Nursing and IDT staff have been	educated on th	e		
		attain or maintain the highest		importance of ensuring that resid				
		mental, and psychosocial sident, as determined by		inappropriately restrained and have				
	-	s and individual plans of care		plans revised so that staff know				
	and considering the			them. The Director of Nursing	will be			
		lity's resident population in		responsible for ensuring that res		s		
	accordance with the facility assessment required			are revised to accurately reflect	their currently			
	at §483.70(e).	·		functional status.				
	§483.35(a)(3) The fa	cility must ensure that		4. Monitor corrective action	ons			
		the specific competencies	·					
	and skill sets necess	ary to care for residents'		The Director of Nursing/Designe				
	needs, as identified t	hrough resident	weekly audits of 10% of residents care plans and					
	assessments, and de	escribed in the plan of care.		observations to ensure that reside				
			ŀ	inappropriately restrained. The				
		ling care includes but is not		reported to the QAPI Committee months for review and recomme				
		evaluating, planning and		monuis for review and recomme	mations.			
		nt care plans and responding		The QAPI Committee is respons	tible for the on-			
	to resident's needs.			going monitoring for compliance				
	§483.35(c) Proficiend	cv of nurse aides.						
		ure that nurse aides are able		Date correction action of	completed			
	to demonstrate comp							
	techniques necessar	y to care for residents'		The facility's date of alleged con	npliance is June	;		
	needs, as identified t			20, 2022.				
		escribed in the plan of care.						
		T is not met as evidenced						
	by:			**				
		view and staff interview, for						
		pled residents, facility staff g staff with the appropriate						
	:	nursing and related services						
	· -	ifety as evidence by: (1) one						
		heet to restrain Resident #2						
		Resident #4's activities of						
		e plan, which resulted in a						
	fall with injury.	• •						
	The findings include:		1	1				

Facility ID: CAPITOLHILL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			C 5/23/2022	
	ROVIDER OR SUPPLIER	EHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		O, 110, 110 112	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
F 726	Continued From page	30	F 7	26			
	with a revision date of Restraints shall only to medical symptom(s) a staff convenience or f practices that inappro prevent resident mobile	permitted, including tly that a bed					
	Facility staff failed to was free from a physical	o ensure that Resident #2 cal restraint.					
	Repeated Falls, Ence Hemiparesis Followin Affecting Left Non-Do	diagnoses that included: phalopathy, Hemiplegia and g Cerebral Infarction minant Side.					
	@ (at) around 0830 (8 Recreation Specialist observed [Resident #	documented, "On 4/30/2022 3:30 AM) the Therapeutic Director reported that she 2] sitting in a recliner at the ed to the recliner. This initial					
	Review of Resident #: the following:	2's medical record revealed					
		in Status Minimum Data Set 2 that showed facility staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			C 05/23/2022	
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STAT 223 7TH STREET NE WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		МС
F 726	no presence of behave of care; extensive assistance for (ADLs); functional importance of motion (ROM) in be extremities, and no use 03/29/22 [Physician's Solution 2 MG (millign ml intramuscularly events of seizure activity" 04/06/22 [Physician's and toileting every 2 If accepted by patient extended by patient extended in the province of the pro	severely impaired cognition, rioral symptoms or rejection sistance with two persons or activities of daily living pairment/limitations in range of physical restraints. Order] "Ativan (antianxiety) ram)/ML(milliliter) Inject 0.5 ery 6 hours as needed for Order] "Frequent rounding nours as tolerated and very shift" revised on 04/08/22 andent on staff for meeting l, physical, and social needs endent) Cognitive deficits, " [General Progress Note] was less agitated today, ly reminded on the ng to get up and walk by m from falling. He verbalized ring 'I will try to be a good (General Progress Note] down on the floor in his ne floor mat No injuries to open skin. Resident is unities without pain or	F7	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			C 05/23/2022	
NAME OF PROVIDER OR S BRIDGEPOINT SUB-A		REHAB CAPITOL HILL	<u>,</u>	STREET ADDRESS, CITY, STATE, ZIP 223 7TH STREET NE WASHINGTON, DC 20002	CODE		
	CH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIA		
04/23/22 (every) sh post) unw 04/28/22 5149" 04/29/22 Fall risk, revery shift 04/29/22 plan relative remain (A mat, bed apparent reviewed Nursing to 04/30/22 very agitar chair. All Nurse Aid 04/30/22 Assessmon 08:30 am (director) sitting in a the reclinaresponsive condition discolorated discomford aware Finformed.	nift x 3 days vitnessed fall [Physician's [Physician's monitor, cueft" at 3:13 PM [ed to recent larm, round in lowest posinjuries note with IDT (into continue wat 4:37 AM [eted, trying to ADL care model) assigned at 11:30 AM ent Request , the Therap reported that a recliner at er Assessive verbally, rintact with noted Mi Resident's Ri"	Order] "Neuro check q every shift for s/p (status	F	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			C 05/23/2022	
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		0012012022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 726	Continued From page	e 33	F 7	26			
		d brought to the nursing ation. Refused to sleep in his					
	Late Entry] "Writer wa (Director of Nursing) incident that occurred facility and spoke with was interviewed by P writer. Patient was undenies pain and state During a unit tour cor PM, Resident #2 was chair in front of the 5th Resident appeared in complain of pain or distiting up, with a bedie eating his lunch. The restraints or items that	nducted on 05/19/22 at 12:45 to observed sitting in a Geri th floor nurse's station. The eat, groomed and did not iscomfort. Resident #2 was side table over the chair, re were no observed at could be used as and the resident. Resident #2					
	05/19/22 at 3:10 PM, Recreational Special Saturday (04/30/22), change and update the station and saw [Rest trying to reposition his around his chest to the There was also to be	interview conducted on Employee #6 (Therapeutic ist) stated, "I came in on a around 7:30 AM. I went to the board by the nurse's ident #2] in his chair. While the set feet, I saw a sheet tied the back of the geri chair. did tables confining him. I the mediately and reported it. sing staff."					
	05/19/22 at 3:18 PM,	nterview conducted on Employee #7 (Director of on) stated, "On April 30th	ACCES 127-00-0-127-0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			C 05/23/2022	
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP 223 7TH STREET NE WASHINGTON, DC 20002	CODE	33.23.23	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE OTHE APPROPRIA	1	
F 726	We walked onto the uwent to my office and [Resident #2]. She [E running to me saying the chair!' I immediate station. I saw a sheet chest. I looked at the was tied. I then asked come with me. We we told her you cannot the was tied and proce from behind the Geri supervisor, reported ithe Administrator." During a telephone in 05/20/22 at 11:56 AM Practical Nurse-LPN) nurse working that nig 7:00 AM on 04/30/22] the Geri chair when I at the desk charting we came and told me that tied to the back of the be restrained. I went a #2). I don't feel that he able to move around, He (Resident #2) was risks. It was hard to g in-service on abuse a explained in the trainic confinement is not who move his arms. After and Administrator and an order to give Ativat that's worse, being chemical process.	and I came in for a class. Init (5th floor) together. I she went to talk to imployee #6] then came I, 'He's [Resident #2] tied to ely went to the nurse's around [Resident #2's] back and saw that the sheet If for the nurse assigned to ent to [Resident #2] and I e a resident. She denied that eeded to untie the sheet chair. I called the nursing It to the Unit Manager and to Iterview conducted on I, Employee #8 (Licensed stated, "I was the only ght (11:00 PM on 04/29/22 to I, He [Resident #2] was in came. In the morning, I was when a lady (Employee #7) It [Resident #2] had a sheet I chair and that he shouldn't and untied him (Resident I e was restrained. He was there was no harm done. Is a nuisance and high fall et work done. I did receive nd restraints but what they ng as being abusive or nat I did. He was able to the fact, I met with the DON I dithey said I could've gotten In if he was that agitated. But	F	726			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER-		IPLE C	(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			05	C i/23/2022
	ROVIDER OR SUPPLIER	REHAB CAPITOL HILL		223	REET ADDRESS, CITY, STATE, ZIP CODE 7TH STREET NE ISHINGTON, DC 20002	1 33	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 726	Nurse Aide) stated, that night [from 11:0 04/30/22]. He's a hig Geri chair, in front o someone always ha changed the resider soiled and put him be sheet to cover his be #7) passed by and a resident and said, 'T to the chair.' The nut hat he was not tied the chair. I did not so on him was just to complete the content of convenience. During a face-to-face 05/20/22 at 3:09 PM (Administrator) and acknowledged the fill "Disciplinary actions nurse and CNA were and reported to the provided to all the of and use of restraints. 2. Facility staff failed daily living (ADL) can of persons required Resident #4 was ad 03/28/22 with multip	M, Employee #9 (Certified "I worked with [Resident #2) 0 PM 04/29/22 to 7:00 AM gh fall risk. He's usually in the f the nurse's station so s an eye on him. I last nt at 6:00 AM when he was lack in the chair with just a lody. Later, a lady (Employee lisked who's in charge of the lisman [Resident #2] is tied listed came around and said no land started to until him from liee him tied. The sheet I put lover his body." lew and staff interview, the lat Employee #8 tied a sheet la Resident #2 for the purpose le interview conducted on late, Employee #1 Employee #2 (DON) Inding and stated, was taken immediately. The le suspended at first then fired looards. Education was scher nursing staff on abuse	F	726			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_				C 23/2022
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL			•	STREET ADDRESS, CITY, STATE, ZIP COE 223 7TH STREET NE WASHINGTON, DC 20002)E		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
F 726	03/28/22 at 9:18 PM [50 Category High Ris 03/29/22 (Revision da "[Resident #4] has an deficit r/t (related to) fi [Resident #4] requires with bathing/showerin necessary is totally for repositioning and thours) and as necess An Admission Minimurevealed that facility s cognitively intact, no the care (including bed m dependence with two and weighed 192 pout Review of Resident #4 the following:	emiplegia and Hemiparesis. Morse Fall Scale] " Score k for Falling" ate) [Care Plan focus area] ADL self-care performance atigue, impaired balance is assistance of one (1) staffing as scheduled and as dependent on one (1) staffiturning in bed Q2H (every 2 ary." In Data Set dated 04/04/22 staff coded the following: behavior issues, for all ADL obility and transfer) - total (2) persons physical assist ands. 4's medical record revealed	F 7	726			
	"respiratory called by AM), up on arriving to resident noted out of the O4/15/22 at 9:30 AM ["Called into patient's retaking care of patient, patient laying face do Patient was assessed signs takenTransfelift. 2 cm X 0.1 skin cu 0.2 cm old scar reope	General Progress Note] room by CNA who was On arrival, nurse observed wn on the floor next to bed. If from head to toe and vital rred back to bed via hoyer at above left eyebrow. 0.2 X aned to right hand House a notified. Order to send					

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (XX) 10	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
RIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X04) ID (X0			095027	B. WING			1	_
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 726 Continued From page 37 O4/15/22 at 11:14 AM [Hospital Discharge Summary] "CT (Computed Tomography) Scan Exam: noncontrast head CT, noncontrast evical spine CT no acute fracture is present or skull fracture. No acute fracture or static subluxation of the cervical spine. adhesive wound closure (holding skin and underlying tissue while it heals such as after an injury adhesive yellow holds the edges of the wound together) You have been diagnosed with concussion or have sustained an injury which may lead to concussion symptoms in the coming days O4/16/22 at 11:12 AM [General Progress Note] " s/p (status/post) fall left forehead laceration site glued with no signs and symptoms of infection noted" During a telephone interview conducted on 05/20/22 at 9:54 AM. Employee #12 (CNA assigned to Resident #4 the day if the incident) stated, "I was changing him (Resident #4) by myself. I had him turned to the side on the left and tucked the solide linen under him and was trying to put the clean linen on. First his feet fell off the bed then the legs. I was on the opposite side on the right. There was only one upper bed rail on that side. I couldn't pull him back. His weight pulled him down off the bed before I could get to the other side. "When asked why she was performing ADL care by herself, Employee #12 stated, "There have been times where I have help nut most times I don't have help and the workload is heavy. When I ask for help, I don't always get it. But I understand it's a safely issue."					223 7TH STREET NE	ODE		
04/15/22 at 11:14 AM [Hospital Discharge Summary] "CT (Computed Tomography) Scan Exam: noncontrast head CT, noncontrast cervical spine CT no acute fracture is present or skull fracture. No acute fracture or static subluxation of the cervical spine adhesive wound closure. (holding skin and underlying tissue while it heals such as after an injury adhesive glue holds the edges of the wound together) You have been diagnosed with concussion or have sustained an injury which may lead to concussion symptoms in the coming days" 04/16/22 at 11:12 AM [General Progress Note] " s/p (status/post) fall left forehead laceration site glued with no signs and symptoms of infection noted" During a telephone interview conducted on 05/20/22 at 9:54 AM, Employee #12 (CNA assigned to Resident #4 the day if the incident) stated, "was changing him (Resident #4) by myself. Ihad him turned to the side on the left and tucked the soiled linen under him and was trying to put the clean linen on. First his feet fell off the bed then the legs. I was on the opposite side on the right. There was only one upper bed rail on that side. I couldn't pull him back. His weight pulled him down off the bed before I could get to the other side." When asked why she was performing ADL care by herself, Employee #12 stated, "There have been times where I have help nut most times I don't have help and the workload is heavy. When I ask for help, I don't always get it. But I understand it's a safety issue."	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BI THE APPROPRIA		COMPLETION
revise the ADL care plan to address the number	F 726	04/15/22 at 11:14 AM Summary] "CT (Comp Exam: noncontrast he spine CT no acute fracture. No acute fracture in a contrast he spine CT no acute fracture. No acute fracture in a contrast he spine CT no acute fracture. No acute fracture in acute in acute in the cervical spine a (holding skin and und such as after an injut the edges of the wour been diagnosed with a sustained an injury which symptoms in the comic od/16/22 at 11:12 AM s/p (status/post) fall glued with no signs ar noted" During a telephone in 05/20/22 at 9:54 AM, assigned to Resident stated, "I was changir myself. I had him turn and tucked the soiled trying to put the clean off the bed then the leside on the right. There is a could weight pulled him dow get to the other side. I could weight pulled him dow get to the other side." performing ADL care is stated, "There have be nut most times I don't is heavy. When I ask to it. But I understand it's The evidence showed	[Hospital Discharge outed Tomography) Scan and CT, noncontrast cervical fracture is present or skull oture or static subluxation of adhesive wound closure erlying tissue while it heals ary adhesive glue holds and together) You have concussion or have nich may lead to concussion ing days" [General Progress Note] " left forehead laceration site and symptoms of infection terview conducted on Employee #12 (CNA #4 the day if the incident) and him (Resident #4) by ed to the side on the left linen under him and was linen on. First his feet fellings. I was on the opposite re was only one upper bed lidn't pull him back. His are was only one upper bed lidn't pull him back. His are off the bed before I could when asked why she was by herself, Employee #12 een times where I have help have help and the workload for help, I don't always get as asfety issue."	F 7	26			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[(·) · · · · · · · · · · · · · · · · ·			ATE SURVEY DMPLETED	
		095027	B. WING				3
NAME OF DE	OVIDER OR SUPPLIER	03021	10:11:10		STREET ADDRESS, CITY, STATE, ZIP CODE	05/2	23/2022
AANIC OI I'I	COVIDENCINOSTIER				23 7TH STREET NE		
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL					VASHINGTON, DC 20002		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
					F 842		
F 726	Continued From page	38	F7	726			
		care for Resident #4 which			1. Corrective action for resident		
	subsequently resulted	d in a fall with injury.			Resident #1's no longer resides in the fa	oility on	
	Displace a face to face	toda - dans - a disada di a -			of 5/10/22. We could not go back	cinty as	
	-	interview conducted on			retrospectively to correct the issue.		
		, Employee #2 (Director of ed the findings and stated,					
		, ventilator unit), all the			2. Identify other residents		
	residents require 2 as	•					
		oning. That's the standard. The care plan An audit of other residents with trachs will be		ill be			
	should say 2 people of	•			completed by 06/20/22.		
		her nursing staff have been			3. Systemic changes		
		ng 2 people especially for			5. Systemic changes		
	turning and reposition ventilators."	ing residents on			Nursing and Respiratory staff will be ed	ucated	
F 842	Resident Records - Id	entifiable Information	F- 8	142	on the importance of ensuring that reside	ent	
SS=D	CFR(s): 483.20(f)(5),				records are accurate. The Director of N	ursing	
	· · · · · · · · · · · · · · · · · · ·				will be responsible for ensuring that resi	dent	
		t-identifiable information.			records are complete and accurate.		
	resident-identifiable to	•			4. Monitor corrective actions		
		lease information that is			The Director of Nursing/Designee will of	omplete	
	resident-identifiable to	o an agent only in ntract under which the agent			monthly audits of 25% of residents with		
		isclose the information			records to ensure that their records are c		
	•	ne facility itself is permitted			and accurate. The results will be reported		
	to do so.	, ,			QAPI Committee monthly x 3 months for	or	
					review and recommendations.		
	§483.70(i) Medical red				The QAPI Committee is responsible for	the on-	
	§483.70(i)(1) In accor				going monitoring for compliance.	aic oii-	
		s and practices, the facility Il records on each resident			Beautiful and a series of the		
	that are-				5. Date correction action complete	ed	
	(i) Complete;						
	(ii) Accurately docume	•			The facility's date of alleged compliance	e is June	
	(iii) Readily accessible				20, 2022.]	ł
	(iv) Systematically org	janized					
	§483.70(i)(2) The faci	lity must keep confidential					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			C 05/23/2022
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, 2 223 7TH STREET NE WASHINGTON, DC 20002	ZIP CODE	0012012022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE ITO THE APPROPRIATE HENCY)	(X5) COMPLETION DATE
F 842	regardless of the forr records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, particles operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpourposes, research purposes, research purpour of information agunauthorized use. §483.70(i)(3) The faction formation in the period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under States §483.70(i)(5) The met (i) Sufficient information in the comprehension of the research provided;	ned in the resident's records, in or storage method of the in release isport their resident is permitted by applicable law; syment, or health care ited by and in compliance is activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation surposes, or to coroners, uneral directors, and to avert ealth or safety as permitted is with 45 CFR 164.512. If it is must safeguard medical painst loss, destruction, or are date of discharge when ent in State law; or are after a resident reaches is law. Indical record must containation to identify the resident; sident's assessments; ive plan of care and services of preadmission screening evaluations and	F 8	342		

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		095027	B. WING _			05/3	C 23/2022
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL				STREET ADDRESS, CH 223 7TH STREET NE WASHINGTON, DC		00.2	
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC) REGULATORY OR L	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 842	services reports as re This REQUIREMENT by: Based on record revi one (1) of six (6) sam failed to ensure Resid accurately documents her tracheostomy. The findings include: Resident #1 was adm 05/09/22 with multiple Nondramatic Subarac Left vertebral Artery, (with Hypoxia and Enc Tracheostomy. Review of Resident # the following: The Entry Tracking Re dated 05/10/22 revea as the resident enterin Physician's Orders: 05/09/22 "Albuterol Se around the airways) N (milligram)/3ML(millilii	e's, and other licensed as notes; and logy and other diagnostic equired under §483.50. is not met as evidenced liew and staff interview, for pled residents, facility staff dent #1's medical record ed the right type and size of chronic Respiratory Failure counter for Attention to 1's medical record revealed lect that facility staff coded ng the facility on 05/09/22. ulfate (relaxes the muscles lebulization Solution 2.5 MG iter) 0.083% 3 ml via trach 6 hours as needed for meeded every shift"	F8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(×	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			C 05/23/2022	
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND	REHAB CAPITOL HILL	**************************************	STREET ADDRESS, CITY, STATE, ZIP 223 7TH STREET NE WASHINGTON, DC 20002	CODE	3372672022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From pag swelling, pain, drains	e 41 age and intactevery shift	F 8-	42			
	05/10/22 "Tracheost (as needed) every sh	omy care every shift and prn nift"					
	05/10/22 "Trach-colla of Inspired Oxygen)	ar (t/c) at 28% FIO2 (Fraction every shift"					
	Respiratory Treatme	nt Care Assessment:		:			
	suctionpre (before post (after) RR: 19; p post breath sounds: (endotracheal tube) (Extended-Length); 1 (oxygen saturation): breathing effort: norm						
	suctionpre RR: 19 sounds: rhonchi, pos Trach ET/Size 8 port SPO2: 99%; trach in	"28% t/c treatment type: , post RR: 19; pre breath st breath sounds: clear ex; pre SPO2: 99%; post tact: yes; breathing effort: ient remains stable on 28%					
	05/24/22 at 4:43 PM, Therapist) who docurespiratory assessmenter (Resident #1) tracannula's are never adon't remember wha	The XLT is the correct size."					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		((X3) DATE SURVEY COMPLETED	
	,					С
		095027	B. WING _			05/23/2022
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND R	REHAB CAPITOL HILL		223 7TH STREET NE		
				WASHINGTON, DC 20002		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLÉTION DATE			
				DEFICIENCY)		
F 842	Continued From page	42	F8	42		
	inaccurately documer	nted Resident #1's				
	tracheostomy type an					

and the same of th						
				777		
ООТЕМЬ						
AAAAAA						