STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING ______	C 05/23/2022

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F 000	INITIAL COMMENTS	F 000	F 000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.	06/20/22

An unannounced Complaints/Facility Reported Incidents (FRI) survey was conducted at BridgePoint Subacute & Rehabilitation Capitol Hill facility from May 19, 2022 to May 23, 2022. Survey activities consisted of observations, record reviews, resident and staff interviews and Infection Control. The facility's census on the first day of the survey was 111. The sample size included six (6) sampled residents. The facility was found to not in compliance with 42 CFR §483.10 to §483.95.

The following complaints and facility reported incidences were investigated during this survey:

DC00010751 (Complaint)
DC00010709 (FRI)
DC00010682 (FRI)

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

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
BIMS - Brief Interview for Mental Status
B/P - Blood Pressure
cm - Centimeters
CPR - Cardiopulmonary resuscitation
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
DVT - Deep Vein Thrombosis
D.C. - District of Columbia

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Olayinka [signature] TITLE: ADMINISTRATOR (X6) DATE: 6/14/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EHR - Electronic Health Record EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ESRD - End Stage Renal Disease G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASARR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PPE - Personal Protective Equipment PO- by mouth POS - physician's order sheet Prn - As needed Pt - Patient Q- Every	F 000		

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F 000	Continued From page 2 RN - Registered Nurse ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604	F 604 1. Corrective action for resident Resident #2 was released from the restraint immediately upon identification. The resident was assessed with no adverse effects noted. The resident has been assessed by psychiatry to address his agitation. The nurse involved no longer works at the facility and was reported to the board of nursing on 05/06/22. 2. Identify other residents An audit of all residents did not reveal any residents that were being inappropriately restrained or untreated for agitation or restlessness. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are not inappropriately restrained or untreated for agitation or restlessness. The Director of Nursing will be responsible for ensuring that residents are not inappropriately restrained.	

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F 604	Continued From page 3 indicated, the facility must use the least restrictive 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..." 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. Review of a facility reported incident (FRI) received on 05/03/22 documented, "On 4/30/2022 @ (at) around 0830 (8:30 AM) the Therapeutic Recreation Specialist Director reported that she observed [Resident #2] sitting in a recliner at the Nursing Station and tied to the recliner. This initial report, Investigation is in progress..." Review of Resident #2's medical record revealed	F 604	4. Monitor corrective actions The Director of Nursing/Designee will 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 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is June 20, 2022.	

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F 604	Continued From page 4 the following: A Significant Change in Status Minimum Data Set (MDS) dated 03/18/22 that showed facility staff coded the following: severely impaired cognition, no presence of behavioral symptoms or rejection of care; extensive assistance with two persons physical assistance for activities of daily living (ADLs); functional impairment/limitations in range of motion (ROM) in both upper and lower extremities, and no use of physical restraints. 03/29/22 [Physician's Order] "Ativan (antianxiety) Solution 2 MG (milligram)/ML(milliliter) Inject 0.5 ml intramuscularly every 6 hours as needed for Seizure activity..." 04/06/22 [Physician's Order] "Frequent rounding and toileting every 2 hours as tolerated and accepted by patient every shift" Care Plan focus area revised on 04/08/22 "[Resident #2] is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) (if dependent) Cognitive deficits, Physical Limitations..." 04/20/22 at 11:08 PM [General Progress Note] "Patient is stable. He was less agitated today. Patient was constantly reminded on the importance of not trying to get up and walk by himself, to prevent him from falling. He verbalized understanding by saying 'I will try to be a good boy'..." 04/23/22 at 5:28 PM [General Progress Note] "Resident found lying down on the floor in his room by the bed on the floor mat .... No injuries noted, no bleeding, no open skin. Resident is	F 604		

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F 604	Continued From page 5 able to move all extremities without pain or resistance. Resident assisted back to Geri chair..." 04/23/22 [Physician's Order] "Neuro check q (every) shift x 3 days every shift for s/p (status post) unwitnessed fall for 3 days" 04/28/22 [Physician's Order] "Room transfer to 5149" 04/29/22 [Physician's Order] "Patient is a High Fall risk, monitor, cue and redirect as needed every shift" 04/29/22 at 3:13 PM [Plan of Care Note] "Care plan related to recent fall events. Interventions remain (Alarm, rounding redirection/cues, fall mat, bed in lowest position and activities). No apparent injuries noted from fall. Interventions reviewed with IDT (interdisciplinary team). Nursing to continue with P.O.C. (plan of care)." 04/30/22 at 4:37 AM [Behavior Note] "Resident is very agitated, trying to stand and get out of geri chair. All ADL care met by staff CNA (Certified Nurse Aide) assigned he is clean and dry." 04/30/22 at 11:30 AM [Situation Background Assessment Request (SBAR)] "Situation... At 08:30 am, the Therapeutic Recreation Dir (director) reported that she observed resident sitting in a recliner at the Nursing station tied to the recliner... Assessment, Resident is alert and responsive verbally, no acute distress noted, skin condition intact with no redness, no bruises or discoloration observed, no swelling... no discomfort noted... MD (medical doctor)... made	F 604		

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F 604	Continued From page 6 aware... Resident's RP (representative) was also informed..." 05/01/22 at 6:17 AM [General Progress Note Late Entry] "Resident had a quiet night. OOB (out of bed) in Geri chair and brought to the nursing station for on observation. Refused to sleep in his bed..." 05/02/22 at 11:20 AM [General Progress Note Late Entry] "Writer was instructed by D.O.N. (Director of Nursing) to call Police related to incident that occurred 4/30/22. Police came to facility and spoke with writer and D.O.N. Patient was interviewed by Police officer in presences of writer. Patient was unable to recall incident, denies pain and stated that he was fine ..." During a unit tour conducted on 05/19/22 at 12:45 PM, Resident #2 was observed sitting in a Geri chair in front of the 5th floor nurse's station. The Resident appeared neat, groomed and did not complain of pain or discomfort. Resident #2 was sitting up, with a bedside table over the chair, eating his lunch. There were no observed restraints or items that could be used as restraints on or around the resident. Resident #2 was not interviewable. During a face-to-face interview conducted on 05/19/22 at 3:10 PM, Employee #6 (Therapeutic Recreational Specialist) stated, "I came in on a Saturday (04/30/22), around 7:30 AM. I went to change and update the board by the nurse's station and saw [Resident #2] in his chair. While trying to reposition his feet, I saw a sheet tied around his chest to the back of the geri chair. There was also to bedside tables confining him. I called my superior immediately and reported it.	F 604		

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F 604	Continued From page 7 She talked to the nursing staff." During a telephone interview conducted on 05/19/22 at 3:18 PM, Employee #7 (Director of Therapeutic Recreation) stated, "On April 30th (2022), [Employee #6] and I came in for a class. We walked onto the unit (5th floor) together. I went to my office and she went to talk to [Resident #2]. She [Employee #6] then came running to me saying, 'He's [Resident #2] tied to the chair!' I immediately went to the nurse's station. I saw a sheet around [Resident #2's] chest. I looked at the back and saw that the sheet was tied. I then asked for the nurse assigned to come with me. We went to [Resident #2] and I told her you cannot tie a resident. She denied that he was tied and proceeded to untie the sheet from behind the Geri chair. I called the nursing supervisor, reported it to the Unit Manager and to the Administrator." During a telephone interview conducted on 05/20/22 at 11:56 AM, Employee #8 (Licensed Practical Nurse-LPN) stated, "I was the only nurse working that night (11:00 PM on 04/29/22 to 7:00 AM on 04/30/22]. He [Resident #2] was in the Geri chair when I came. In the morning, I was at the desk charting when a lady (Employee #7) came and told me that [Resident #2] had a sheet tied to the back of the chair and that he shouldn't be restrained. I went and untied him (Resident #2). I don't feel that he was restrained. He was able to move around, there was no harm done. He (Resident #2) was a nuisance and high fall risks. It was hard to get work done. I did receive in-service on abuse and restraints but what they explained in the training as being abusive or confinement is not what I did. He was able to move his arms. After the fact, I met with the DON	F 604		

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F 604	Continued From page 8 and Administrator and they said I could've gotten an order to give Ativan if he was that agitated. But that's worse, being chemically restrained." During a telephone interview conducted on 05/20/22 at 12:05 PM, Employee #9 (Certified Nurse Aide) stated, "I worked with [Resident #2] that night [from 11:00 PM 04/29/22 to 7:00 AM 04/30/22]. He's a high fall risk. He's usually in the Geri chair, in front of the nurse's station so someone always has an eye on him. I last changed the resident at 6:00 AM when he was soiled and put him back in the chair with just a sheet to cover his body. Later, a lady (Employee #7) passed by and asked who's in charge of the resident and said, 'This man [Resident #2] is tied to the chair.' The nurse came around and said no that he was not tied and started to untie him from the chair. I did not see him tied. The sheet I put on him was just to cover his body." Through record review and staff interview, the evidence showed that Employee #8 tied a sheet to physically restrain Resident #2 for the purpose of convenience. During a face-to-face interview conducted on 05/20/22 at 3:09 PM, Employee #1 (Administrator) and Employee #2 (DON) acknowledged the finding and stated, "Disciplinary action was taken immediately. The nurse and CNA were suspended at first then fired and reported to the boards. Education was provided to all the other nursing staff on abuse and use of restraints."	F 604		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		

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F 607

Continued From page 9

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on 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.

The findings include:

Review of the facility policy "Abuse Investigation and Reporting" revised in July 2017 stated, "All report of resident abuse, neglect, exploitation, misappropriation of resident property, mistreat and or injuries of unknown source ("abuse") shall be promptly reported ... and thoroughly investigated by facility management ... Role of the investigator ... interview any witnesses to the incident ... interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident..."

1. Facility staff failed to report an allegation of abuse made by Resident #2.

Resident #2 was admitted to the facility on 12/27/21 with multiple diagnoses that included:

F 607

F 607

1. Corrective action

Investigations for residents #2 and #3 have been completed.

2. Identify other residents

An audit of other incidents will be conducted by 06/20/22 to identify any additional residents that may have been affected.

3. Systemic changes

Staff will be re-educated on completing investigations. The Administrator will be responsible for ensuring that incidents are fully investigated. The Administrator will be responsible for the subsequent follow up on findings

4. Monitor corrective actions

The Administrator/Designee will complete a review of all investigations and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed
The facility's date of alleged compliance is June 20, 2022.

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F 607	Continued From page 10 Repeated Falls, Encephalopathy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of Resident #2's medical record revealed the following: A Significant Change in Status Minimum Data Set (MDS) dated 03/18/22 that showed facility staff coded the following: severely impaired cognition, no presence of behavioral symptoms or rejection of care; extensive assistance with two persons physical assistance with activities of daily living (ADLs); functional impairment/limitations in range of motion (ROM) in both upper and lower extremities, and no use of physical restraints. 05/11/22 at 5:08 PM [General Progress Note] "Patient reported today that he was hit on the right side of head in the elevator. Patient stated that someone walked him to the elevator placed a bag over his head and hit him in the back of his head (points to right side of head). Patient stated that the man held him down but he got back up and walked from the elevator and back to his room. Patient stated that he could not see the person but knew it was a man and could not recall what the man looks like." Review of the facility's investigation packet showed no documented evidence that the allegation was ever reported to the state agency. During a face-to-face interview conducted on 05/20/22 at 3:09 PM, Employee #1 (Administrator) acknowledged the finding and stated, "The allegation was investigated thoroughly and it was found to be unsubstantiated."	F 607		

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F 607	Continued From page 11	F 607		

2. Facility staff failed to interview and or obtain staff interviews from all employees who took care of Resident #3 after an alleged fall.

Resident #3 was admitted to the facility on 07/13/21 with multiple diagnoses that included: Muscle Weakness, Heart Failure and Chronic Respiratory Failure with Hypoxia.

Review of Resident #3's medical record the following:

A Quarterly Minimum Data Set (MDS) dated 04/13/22 that showed facility staff coded the following: severely impaired cognition, no potential indicators of psychosis, no behavior issues, for bed mobility and transfers, extensive assistance with two person physical assist, for walk in room and corridor, limited assistance with one person physical assist, for surface-to-surface transfer (transfer between bed and chair or wheelchair), not steady, only able to stabilize with staff assistance, functional limitation/impairment in range of motion in both upper and lower extremities, does not use any mobility devices and has had no falls since admission/entry of reentry to the facility.

04/20/22 at 12:30 PM [General Progress Note] "C.N.A was asked to patient's room. Patient's mother present. Patient mother reported that patient informed her that patient had a fall Monday morning (04/18/22). Per Mother, Patient reported it yesterday afternoon. Patient mother stated that she did not report it. Head to toe shin check performed. Patient has two abrasions to his left scapula/ back region ...Writer asked patient what had happened of which he confirmed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12	F 607		

what was already reported by his mother. Writer asked if he had hit his head during the fall, patient stated "yes". Writer assessed the back of patient's head. No abnormalities noted. Writer asked how the patient fell. Per verbal report patient wanted to get out of bed and was trying to push chair away. Patient then slid out of bed onto the floor..."

04/20/22 at 1:32 PM [Situation Background Assessment Request (SBAR) Communication Form] "... Fall ... At 12pm writer walked in resident room, RP (representative informed writer that, Tuesday evening the resident told her that he fell Tuesday morning (04/19/22): writer asked the resident, he stated that was trying to get out [of] the bed. Manager made aware and both of us went to the room. Head to toe assessment done, 2 abrasions noted on the left upper back noted. No c/o pain. MD notified ..."

04/20/22 [Physician's Order] "Neurochecks Q (every) shift x 3 days"

04/20/22 [Physician's Order] "Monitor/document /report PRN (as needed) x 72h (72 hours) to MD for s/sx (signs and symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation every shift for 3 Days"

04/21/22 [Physician's Order] "Monitor left scapula skin abrasions for changes. Notify MD (medical doctor) for any signs of irritation, signs of infection, or change in skin integrity every shift for 5 Days"

Review of the facility's investigation packet showed no documented evidence that the

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	095027	A. BUILDING ______ B. WING ______	C 05/23/2022

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F 607 Continued From page 13

employees assigned to Resident #3 on 04/18/22 and 04/19/22 were interviewed or provided written statements to get their recollection or knowledge of the alleged fall.

During a face-to-face to interview conducted on 05/20/22 at 1:54 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.

F 609 SS=D Reporting of Alleged Violations
CFR(s): 483.12(c)(1)(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the

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F 607

F 609

F 610

1. Corrective action for resident

The incident for resident #2 has been investigated by the DOH during the complaint survey. The facility failed to report the incident prior to the survey. There were no adverse effects related to the incident.

2. Identify other residents

An audit of other incidents in the past 3 months will be reviewed to ensure that they have been reported as required.

3. Systemic changes

Leadership will be educated on the importance of ensuring that all concerns and incidents are investigated appropriately and reported as required to ensure that residents are not subjected to potential abuse. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate and report allegations of abuse.

4. Monitor corrective actions

The Administrator will complete weekly audits of all Incidents Reported by the Facility to ensure that all incidents are investigated thoroughly and reported as required. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

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F 609	Continued From page 14 incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 report an allegation of physical abuse of Resident #2. The findings include: Review of the facility policy "Abuse Investigation and Reporting" revised in July 2017 stated, "All report of resident abuse, neglect, exploitation, misappropriation of resident property, mistreat and or injuries of unknown source ("abuse") shall be promptly reported..." 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. Review of Resident #2's medical record revealed the following: A Significant Change in Status Minimum Data Set (MDS) dated 03/18/22 that showed facility staff coded the following: severely impaired cognition, no presence of behavioral symptoms or rejection of care; extensive assistance with two persons physical assistance with activities of daily living (ADLs); functional impairment/limitations in range of motion (ROM) in both upper and lower extremities, and no use of physical restraints. 05/11/22 at 5:08 PM [General Progress Note] "Patient reported today that he was hit on the	F 609	5. Date correction action completed The facility's date of alleged compliance is June 20, 2022.	

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F 609	Continued From page 15 right side of head in the elevator. Patient stated that someone walked him to the elevator placed a bag over his head and hit him in the back of his head (points to right side of head). Patient stated that the man held him down but he got back up and walked from the elevator and back to his room. Patient stated that he could not see the person but knew it was a man and could not recall what the man looks like." Review of the facility's investigation packet showed no documented evidence that the allegation was ever reported to the state agency. During a face-to-face interview conducted on 05/20/22 at 3:09 PM, Employee #1 (Administrator) acknowledged the finding and stated, "The allegation was investigated thoroughly and it was found to be unsubstantiated."	F 609	F 610 1. Corrective action for resident Investigations were completed/reviewed and/or reinvestigated and appropriate actions taken to resolve the concerns for all residents. Resident #3 will have their fall re-investigated. 2. Identify other residents An audit of other resident's concerns and falls from the past 3 months will be completed. 3. Systemic changes Nursing staff and Leadership will be educated on the importance of ensuring that all falls are investigated appropriately. A new process for monitoring and investigating falls will be put in place. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate falls.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610	4. Monitor corrective actions The Administrator will complete weekly audits of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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F 610	Continued From page 16	F 610	5. Date correction action completed	

Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Facility staff failed to interview and or obtain staff interviews from all employees who took care of Resident #3 after an alleged fall.

Resident #3 was admitted to the facility on 07/13/21 with multiple diagnoses that included: Muscle Weakness, Heart Failure and Chronic Respiratory Failure with Hypoxia.

Review of Resident #3's medical record the following:

A Quarterly Minimum Data Set (MDS) dated 04/13/22 that showed facility staff coded the following: severely impaired cognition, no potential indicators of psychosis, no behavior issues, for bed mobility and transfers, extensive assistance with two person physical assist, for walk in room and corridor, limited assistance with one person physical assist, for surface-to-surface transfer (transfer between bed and chair or wheelchair), not steady, only able to stabilize with staff assistance, functional limitation/impairment in range of motion in both upper and lower extremities, does not use any mobility devices and has had no falls since admission/entry of reentry to the facility.

04/20/22 at 12:30 PM [General Progress Note] "C.N.A was asked to patient's room. Patient's mother present. Patient mother reported that patient informed her that patient had a fall Monday morning (04/18/22). Per Mother, Patient reported it yesterday afternoon. Patient mother

The facility's date of alleged compliance is June 20, 2022.

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F 610	Continued From page 17	F 610		

stated that she did not report it. Head to toe shin check performed. Patient has two abrasions to his left scapula/ back region ...Writer asked patient what had happened of which he confirmed what was already reported by his mother. Writer asked if he had hit his head during the fall, patient stated "yes". Writer assessed the back of patient's head. No abnormalities noted. Writer asked how the patient fell. Per verbal report patient wanted to get out of bed and was trying to push chair away. Patient then slid out of bed onto the floor..."

04/20/22 at 1:32 PM [Situation Background Assessment Request (SBAR) Communication Form] "... Fall ... At 12pm writer walked in resident room, RP (representative informed writer that, Tuesday evening the resident told her that he fell Tuesday morning (04/19/22): writer asked the resident, he stated that was trying to get out [of] the bed. Manager made aware and both of us went to the room. Head to toe assessment done, 2 abrasions noted on the left upper back noted. No c/o pain. MD notified..."

04/20/22 [Physician's Order] "Neurochecks Q (every) shift x 3 days"

04/20/22 [Physician's Order] "Monitor/document /report PRN (as needed) x 72h (72 hours) to MD for s/sx (signs and symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation every shift for 3 Days"

04/21/22 [Physician's Order] "Monitor left scapula skin abrasions for changes. Notify MD (medical doctor) for any signs of irritation, signs of infection, or change in skin integrity every shift for

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F 610	Continued From page 18 5 Days" Review of the facility's investigation packet showed no documented evidence that the employees assigned to Resident #3 on 04/18/22 and 04/19/22 were interviewed or provided written statements to get their recollection or knowledge of the alleged fall. During a face-to-face to interview conducted on 05/20/22 at 1:54 PM, Employee #2 (Director of Nursing) acknowledged the findings and made no comment.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, one (1) of six (6) sampled residents, facility staff failed to ensure that Resident #3's Minimum Data Set (MDS) accurately reflected the resident's status. The findings include: Resident #3 was admitted to the facility on 07/13/21 with multiple diagnoses that included: Muscle Weakness, Heart Failure and Chronic Respiratory Failure with Hypoxia. Review of Resident #3's medical record showed the following: A Quarterly Minimum Data Set (MDS) dated 04/13/22 that showed facility staff coded the	F 641	F 641 1. Corrective action for resident Resident #3 has had their MDS updated to accurately reflect their condition on 5/20/22. There were no ill effects to the resident. 2. Identify other residents An audit of all current residents MDSs did not reveal any addition concerns. There were no additional findings related to this citation. 3. Systemic changes The IDT team has been educated on the importance of ensuring that resident's status is correctly documented in the MDS. The Director of Reimbursement will be responsible for ensuring that resident's MDSs accurately reflect their status.	

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following: severely impaired cognition, in Section G600, does not use mobility devices and was coded as no falls since admission/entry or reentry or prior assessment...whichever is more recent under section J1800.

It should be noted that the prior Quarterly MDS assessment was dated 02/02/22.

01/12/22 [Physician's Order] "Fall precaution every shift"

03/03/22 at 11:00 AM [Situation Background Assessment Request (SBAR) Communication Form] "Patient acquired a fall ... Patient had fall today @ (at) 11am. Shift nurse assessed patient with minor skin abrasion and redness to right posterior arm. Treatment applied as ordered. Per patient report, Patient stated that he was walking with the walker and he turned back and acquired the fall. Patient was found sitting on the floor in room by staff along with the Restorative assistant. Patient stated that he did not hit his head but hit his arm (patient showed
right posterior arm)..."

03/03/22 [Physician's order] "Neurochecks X 3 days s/p (status post) fall"

The evidence showed documented evidence of Resident #3's fall.

During a face-to-face interview conducted on 05/20/22 at 1:33 PM, Employee #10 (Director of Rehabilitation) stated, "[Resident #3] has a rolling walker for ambulation. He's had it for quite some time. [Resident #3] only uses it during therapy and with the nursing staff."

F 641

4. Monitor corrective actions

The Director of Reimbursement/Designee will complete random weekly audits of 10% of the resident's MDSs to ensure that their status is documented correctly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is June 20, 2022.

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F 641	Continued From page 20 The evidence showed that although Resident #3 had a documented on 03/03/22 and documented use of a rolling walker, facility staff failed to code these in the resident's MDS. During a face-to-face interview conducted on 05/20/22 at approximately 3:00 PM, Employee #11 (MDS Coordinator) acknowledged the findings and stated that she would make the modifications.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	F 657 1. Corrective action for resident Residents #3 and #4 will have their comprehensive care plans reviewed and updated by 06/20/22. There were no ill effects to the residents. 2. Identify other residents An audit of all current residents' care plans will be conducted and all current residents will have their care plans reviewed and updated by 06/20/22. 3. Systemic changes The IDT team will be educated on the importance of ensuring that comprehensive care plans are created for each resident and updated/revised as needed. The Director of Reimbursement will be responsible for ensuring that all residents have updated/revised comprehensive care plans.	

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F 657	Continued From page 21 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of six (6) sampled residents, facility staff failed to revise Resident #3's care plan to reflect high fall risks after sustaining a fall and Resident #4's activities of daily living (ADL) care plan. The findings include: Review of the facility policy titled, "Care Planning-Interdisciplinary Team" revised 11/02/21, stated, "...The care plan is based on the resident's comprehensive assessment..." Review of the facility policy titled, "Falls- Clinical Protocol" revised 11/09/21 documented, "... Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent ... falls and to address the risks of clinically significant consequences of falling..." 1. Facility staff failed to revise Resident #3's care plan to reflect high fall risks after sustaining a fall. Resident #3 was admitted to the facility on 07/13/21 with multiple diagnoses that included: Muscle Weakness, Heart Failure and Chronic Respiratory Failure with Hypoxia. Review of Resident #3's medical record the following: A Quarterly Minimum Data Set (MDS) dated 04/13/22 that showed facility staff coded the Resident #3 with severely impaired cognition.	F 657	4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have updated/revised comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is June 20, 2022.	

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F 657	Continued From page 22 A Care Plan with a focus area revised on 07/27/21, "[Resident #3] is a Moderate risk for falls r/t (related to) confusion and traumatic subdural hemorrhage..." 03/03/22 at 11:00 AM [Situation Background Assessment Request (SBAR) Communication Form] "Patient acquired a fall ... Patient had fall today @ (at) 11am. Shift nurse assessed patient with minor skin abrasion and redness to right posterior arm. Treatment applied as ordered. Per patient report, Patient stated that he was walking with the walker and he turned back and acquired the fall. Patient was found sitting on the floor in room by staff along with the Restorative assistant. Patient stated that he did not hit his head but hit his arm (patient showed right posterior arm)..." 03/03/22 at 11:38 AM [Morse Fall Scale] "... Score 75 Category High Risk for Falling..." 04/20/22 at 12:58 AM [Morse Fall Scale] "... Score 75 Category High Risk for Falling..." Review of the comprehensive care plan on 05/20/22 revealed that Resident #3's care plan focus area had not been revised to reflect "high risk for falling", it documented resident as a "moderate falls risk". During a face-to-face interview conducted on 05/50/22 at 1:50 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated, "It (the care plan) should've been updated." 2. Facility staff failed to revise the activities of daily living (ADL) care plan to reflect the number of persons required to provide ADL care to Resident #4, resulting in a fall with injury.	F 657		

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Resident #4 was admitted to the facility on 03/28/22 with multiple diagnoses that included: Dependence on Respirator (Ventilator) Status, Muscle Weakness, Hemiplegia and Hemiparesis.

03/28/22 at 9:18 PM [Morse Fall Scale] "... Score 50 Category High Risk for Falling..."

03/29/22 (Revision date) [Care Plan focus area] "[Resident #4] has an ADL self-care performance deficit r/t (related to) fatigue, impaired balance... [Resident #4] requires assistance of one (1) staff with bathing/showering as scheduled and as necessary... is totally dependent on one (1) staff for repositioning and turning in bed Q2H (every 2 hours) and as necessary."

An Admission Minimum Data Set dated 04/04/22 revealed that facility staff coded the following: cognitively intact, no behavior issues, for all ADL care (including bed mobility and transfer) - total dependence with two (2) persons physical assist and weighed 192 pounds.

Review of Resident #4's medical record revealed the following:

04/15/22 at 8:08 AM [General Progress Note] "respiratory called by CNA around 0620 (6:20 AM), up on arriving to the pt (patient) room, resident noted out of the bed on the floor."

04/15/22 at 9:30 AM [General Progress Note] "Called into patient's room by CNA who was taking care of patient. On arrival, nurse observed patient laying face down on the floor next to bed. Patient was assessed from head to toe and vital signs taken ...Transferred back to bed via hoyer

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 lift. 2 cm X 0.1 skin cut above left eyebrow. 0.2 X 0.2 cm old scar reopened to right hand ... House officer and supervisor notified. Order to send patient to hospital for evaluation." 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, "I was changing him (Resident #4) by myself. I had 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	F 657		

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F 657	Continued From page 25 it. But I understand it's a safety issue." The evidence showed that facility staff failed to revise the ADL care plan to address the number of persons required to care for Resident #4 which subsequently resulted in a fall with injury. During a face-to-face interview conducted on 05/20/22 at 10:24 AM, Employee #2 (Director of Nursing) acknowledged the findings and stated, "On this unit (6th floor, ventilator unit), all the residents require 2 assist for turning and repositioning. That's the standard. The care plan should say 2 people during ADL. The CNA involved and all the other nursing staff have been reeducated about using 2 people especially for turning and repositioning residents on ventilators."	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of six (6) sampled residents, facility staff failed to revise the activities of daily living (ADL) care plan to reflect the number of persons requred to provide ADL care to Resident #4, resulting in a fall with injury.	F 689	F 689 1. Corrective action for resident Resident #4's care plan will be revised to reflect the number of staff required to safely perform ADLs. 2. Identify other residents An audit of other resident care plans will be completed by 06/20/22. 3. Systemic changes Licensed nursing staff and MDS staff will be educated on the importance of ensuring that residents have their care plans revised so that staff know how to care for them. The Director of Nursing will be responsible for ensuring that residents care plans are revised to accurately reflect their currently functional status.	

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F 689

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The findings include:

Review of the facility policy titled, "Care Planning-Interdisciplinary Team" revised 11/02/21, stated, "... The care plan is based on the resident ' s comprehensive assessment..."

Review of the facility policy titled, "Falls- Clinical Protocol" revised 11/09/21 documented, "... Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent ... falls and to address the risks of clinically significant consequences of falling..."

Resident #4 was admitted to the facility on 03/28/22 with multiple diagnoses that included: Dependence on Respirator (Ventilator) Status, Muscle Weakness, Hemiplegia and Hemiparesis.

03/28/22 at 9:18 PM [Morse Fall Scale] "... Score 50 Category High Risk for Falling..."

03/29/22 (Revision date) [Care Plan focus area] "[Resident #4] has an ADL self-care performance deficit r/t (related to) fatigue, impaired balance ... [Resident #4] requires assistance of one (1) staff with bathing/showering as scheduled and as necessary ... is totally dependent on one (1) staff for repositioning and turning in bed Q2H (every 2 hours) and as necessary."

An Admission Minimum Data Set dated 04/04/22 revealed that facility staff coded the following: cognitively intact, no behavior issues, for all ADL care (including bed mobility and transfer) - total dependence with two (2) persons physical assist and weighed 192 pounds.

Review of Resident #4's medical record revealed

F 689

4. Monitor corrective actions

The Director of Nursing/Designee will complete weekly audits of 10% of residents care plans. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is June 20, 2022.

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F 689		F 689		

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the following:

04/15/22 at 8:08 AM [General Progress Note] "respiratory called by CNA around 0620 (6:20 AM), up on arriving to the pt (patient) room, resident noted out of the bed on the floor."

04/15/22 at 9:30 AM [General Progress Note] "Called into patient's room by CNA who was taking care of patient. On arrival, nurse observed patient laying face down on the floor next to bed. Patient was assessed from head to toe and vital signs taken ...Transferred back to bed via hoyer lift. 2 cm X 0.1 skin cut above left eyebrow. 0.2 X 0.2 cm old scar reopened to right hand ... House officer and supervisor notified. Order to send patient to hospital for evaluation."

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)

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F 689	Continued From page 28 stated, "I was changing him (Resident #4) by myself. I had 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." The evidence showed that facility staff failed to revise the ADL care plan to address the number of persons required to care for Resident #4 which subsequently resulted in a fall with injury. During a face-to-face interview conducted on 05/20/22 at 10:24 AM, Employee #2 (Director of Nursing) acknowledged the findings and stated, "On this unit (6th floor, ventilator unit), all the residents require 2 assist for turning and repositioning. That ' s the standard. The care plan should say 2 people during ADL. The CNA involved and all the other nursing staff have been reeducated about using 2 people especially for turning and repositioning residents on ventilators."	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726	F 726 1. Corrective action for resident Resident #2 was released from the restraint as 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 perform ADLs. There were no ill effects related to 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 and was reported to the Board of Nursing on 05/06/22. The CNA involved in resident #4's incident was suspended pending investigation. She was returned to work and 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.	

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F 726 Continued From page 29
resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, for two (2) of six (6) sampled residents, facility staff failed to have nursing staff with the appropriate skills sets to provide nursing and related services to assure resident safety as evidence by: (1) one facility staff using a sheet to restrain Resident #2 and (2) not revising Resident #4's activities of daily living (ADL) care plan, which resulted in a fall with injury.

The findings include:

F 726

3. Systemic changes

Nursing and IDT staff have been educated on the importance of ensuring that residents are not inappropriately restrained and have their care plans revised so that staff know how to care for them. The Director of Nursing will be responsible for ensuring that residents care plans are revised to accurately reflect their currently functional status.

4. Monitor corrective actions

The Director of Nursing/Designee will complete weekly audits of 10% of residents care plans and observations to ensure that residents are not inappropriately restrained. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is June 20, 2022.

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Review of the facility policy titled, "Care Planning-Interdisciplinary Team" revised 11/02/21, stated, "... The care plan is based on the resident's comprehensive assessment..."

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..."

1. Facility staff failed to ensure that Resident #2 was free from a physical restraint.

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.

Review of a facility reported incident (FRI) received on 05/03/22 documented, "On 4/30/2022 @ (at) around 0830 (8:30 AM) the Therapeutic Recreation Specialist Director reported that she observed [Resident #2] sitting in a recliner at the Nursing Station and tied to the recliner. This initial report, Investigation is in progress..."

Review of Resident #2's medical record revealed the following:

A Significant Change in Status Minimum Data Set (MDS) dated 03/18/22 that showed facility staff

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F 726	Continued From page 31 coded the following: severely impaired cognition, no presence of behavioral symptoms or rejection of care; extensive assistance with two persons physical assistance for activities of daily living (ADLs); functional impairment/limitations in range of motion (ROM) in both upper and lower extremities, and no use of physical restraints. 03/29/22 [Physician's Order] "Ativan (antianxiety) Solution 2 MG (milligram)/ML(milliliter) Inject 0.5 ml intramuscularly every 6 hours as needed for Seizure activity..." 04/06/22 [Physician's Order] "Frequent rounding and toileting every 2 hours as tolerated and accepted by patient every shift" Care Plan focus area revised on 04/08/22 "[Resident #2 is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t (related to) (if dependent) Cognitive deficits, Physical Limitations..." 04/20/22 at 11:08 PM [General Progress Note] "Patient is stable. He was less agitated today. Patient was constantly reminded on the importance of not trying to get up and walk by himself, to prevent him from falling. He verbalized understanding by saying 'I will try to be a good boy'..." 04/23/22 at 5:28 PM [General Progress Note] "Resident found lying down on the floor in his room by the bed on the floor mat .... No injuries noted, no bleeding, no open skin. Resident is able to move all extremities without pain or resistance. Resident assisted back to Geri chair..."	F 726		

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F 726	Continued From page 32 04/23/22 [Physician's Order] "Neuro check q (every) shift x 3 days every shift for s/p (status post) unwitnessed fall for 3 days" 04/28/22 [Physician's Order] "Room transfer to 5149" 04/29/22 [Physician's Order] "Patient is a High Fall risk, monitor, cue and redirect as needed every shift" 04/29/22 at 3:13 PM [Plan of Care Note] "Care plan related to recent fall events. Interventions remain (Alarm, rounding redirection/cues, fall mat, bed in lowest position and activities). No apparent injuries noted from fall. Interventions reviewed with IDT (interdisciplinary team). Nursing to continue with P.O.C. (plan of care)." 04/30/22 at 4:37 AM [Behavior Note] "Resident is very agitated, trying to stand and get out of geri chair. All ADL care met by staff CNA (Certified Nurse Aide) assigned he is clean and dry." 04/30/22 at 11:30 AM [Situation Background Assessment Request (SBAR)] "Situation... At 08:30 am, the Therapeutic Recreation Dir (director) reported that she observed resident sitting in a recliner at the Nursing station tied to the recliner... Assessment, Resident is alert and responsive verbally, no acute distress noted, skin condition intact with no redness, no bruises or discoloration observed, no swelling... no discomfort noted... MD (medical doctor)... made aware... Resident's RP (representative) was also informed..." 05/01/22 at 6:17 AM [General Progress Note Late Entry] "Resident had a quiet night. OOB (out of	F 726		

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F 726	Continued From page 33 bed) in Geri chair and brought to the nursing station for on observation. Refused to sleep in his bed..." 05/02/22 at 11:20 AM [General Progress Note Late Entry] "Writer was instructed by D.O.N. (Director of Nursing) to call Police related to incident that occurred 4/30/22. Police came to facility and spoke with writer and D.O.N. Patient was interviewed by Police officer in presences of writer. Patient was unable to recall incident, denies pain and stated that he was fine..." During a unit tour conducted on 05/19/22 at 12:45 PM, Resident #2 was observed sitting in a Geri chair in front of the 5th floor nurse's station. The Resident appeared neat, groomed and did not complain of pain or discomfort. Resident #2 was sitting up, with a bedside table over the chair, eating his lunch. There were no observed restraints or items that could be used as restraints on or around the resident. Resident #2 was not interviewable. During a face-to-face interview conducted on 05/19/22 at 3:10 PM, Employee #6 (Therapeutic Recreational Specialist) stated, "I came in on a Saturday (04/30/22), around 7:30 AM. I went to change and update the board by the nurse's station and saw [Resident #2] in his chair. While trying to reposition his feet, I saw a sheet tied around his chest to the back of the geri chair. There was also to bedside tables confining him. I called my superior immediately and reported it. She talked to the nursing staff." During a telephone interview conducted on 05/19/22 at 3:18 PM, Employee #7 (Director of Therapeutic Recreation) stated, "On April 30th	F 726		

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(2022), [Employee #6] and I came in for a class. We walked onto the unit (5th floor) together. I went to my office and she went to talk to [Resident #2]. She [Employee #6] then came running to me saying, 'He's [Resident #2] tied to the chair!' I immediately went to the nurse's station. I saw a sheet around [Resident #2's] chest. I looked at the back and saw that the sheet was tied. I then asked for the nurse assigned to come with me. We went to [Resident #2] and I told her you cannot tie a resident. She denied that he was tied and proceeded to untie the sheet from behind the Geri chair. I called the nursing supervisor, reported it to the Unit Manager and to the Administrator."

During a telephone interview conducted on 05/20/22 at 11:56 AM, Employee #8 (Licensed Practical Nurse-LPN) stated, "I was the only nurse working that night (11:00 PM on 04/29/22 to 7:00 AM on 04/30/22]. He [Resident #2] was in the Geri chair when I came. In the morning, I was at the desk charting when a lady (Employee #7) came and told me that [Resident #2] had a sheet tied to the back of the chair and that he shouldn't be restrained. I went and untied him (Resident #2). I don't feel that he was restrained. He was able to move around, there was no harm done. He (Resident #2) was a nuisance and high fall risks. It was hard to get work done. I did receive in-service on abuse and restraints but what they explained in the training as being abusive or confinement is not what I did. He was able to move his arms. After the fact, I met with the DON and Administrator and they said I could've gotten an order to give Ativan if he was that agitated. But that's worse, being chemically restrained."

During a telephone interview conducted on

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F 726	Continued From page 35 05/20/22 at 12:05 PM, Employee #9 (Certified Nurse Aide) stated, "I worked with [Resident #2] that night [from 11:00 PM 04/29/22 to 7:00 AM 04/30/22]. He's a high fall risk. He's usually in the Geri chair, in front of the nurse's station so someone always has an eye on him. I last changed the resident at 6:00 AM when he was soiled and put him back in the chair with just a sheet to cover his body. Later, a lady (Employee #7) passed by and asked who's in charge of the resident and said, 'This man [Resident #2] is tied to the chair.' The nurse came around and said no that he was not tied and started to untie him from the chair. I did not see him tied. The sheet I put on him was just to cover his body." Through record review and staff interview, the evidence showed that Employee #8 tied a sheet to physically restrain Resident #2 for the purpose of convenience. During a face-to-face interview conducted on 05/20/22 at 3:09 PM, Employee #1 (Administrator) and Employee #2 (DON) acknowledged the finding and stated, "Disciplinary action was taken immediately. The nurse and CNA were suspended at first then fired and reported to the boards. Education was provided to all the other nursing staff on abuse and use of restraints." 2. Facility staff failed to revise the activities of daily living (ADL) care plan to reflect the number of persons required to provide ADL care to Resident #4, resulting in a fall with injury. Resident #4 was admitted to the facility on 03/28/22 with multiple diagnoses that included: Dependence on Respirator (Ventilator) Status,	F 726		

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	095027	A. BUILDING ______ B. WING ______	C 05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 726	Continued From page 36 Muscle Weakness, Hemiplegia and Hemiparesis. 03/28/22 at 9:18 PM [Morse Fall Scale] "... Score 50 Category High Risk for Falling..." 03/29/22 (Revision date) [Care Plan focus area] "[Resident #4] has an ADL self-care performance deficit r/t (related to) fatigue, impaired balance ... [Resident #4] requires assistance of one (1) staff with bathing/showering as scheduled and as necessary ... is totally dependent on one (1) staff for repositioning and turning in bed Q2H (every 2 hours) and as necessary." An Admission Minimum Data Set dated 04/04/22 revealed that facility staff coded the following: cognitively intact, no behavior issues, for all ADL care (including bed mobility and transfer) - total dependence with two (2) persons physical assist and weighed 192 pounds. Review of Resident #4's medical record revealed the following: 04/15/22 at 8:08 AM [General Progress Note] "respiratory called by CNA around 0620 (6:20 AM), up on arriving to the pt (patient) room, resident noted out of the bed on the floor." 04/15/22 at 9:30 AM [General Progress Note] "Called into patient's room by CNA who was taking care of patient. On arrival, nurse observed patient laying face down on the floor next to bed. Patient was assessed from head to toe and vital signs taken ...Transferred back to bed via hoyer lift. 2 cm X 0.1 skin cut above left eyebrow. 0.2 X 0.2 cm old scar reopened to right hand ... House officer and supervisor notified. Order to send patient to hospital for evaluation."	F 726		

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F 726	Continued From page 37	F 726		

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, "I was changing him (Resident #4) by myself. I had 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."

The evidence showed that facility staff failed to revise the ADL care plan to address the number

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of persons required to care for Resident #4 which subsequently resulted in a fall with injury.

During a face-to-face interview conducted on 05/20/22 at 10:24 AM, Employee #2 (Director of Nursing) acknowledged the findings and stated, "On this unit (6th floor, ventilator unit), all the residents require 2 assist for turning and repositioning. That ' s the standard. The care plan should say 2 people during ADL. The CNA involved and all the other nursing staff have been reeducated about using 2 people especially for turning and repositioning residents on ventilators."

F 842 SS=D

Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential

F 726

F 842

F 842

1. Corrective action for resident

Resident #1's no longer resides in the facility as of 5/10/22. We could not go back retrospectively to correct the issue.

2. Identify other residents

An audit of other residents with trachs will be completed by 06/20/22.

3. Systemic changes

Nursing and Respiratory staff will be educated on the importance of ensuring that resident records are accurate. The Director of Nursing will be responsible for ensuring that resident records are complete and accurate.

4. Monitor corrective actions

The Director of Nursing/Designee will complete monthly audits of 25% of residents with trachs records to ensure that their records are complete and accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is June 20, 2022.

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F 842	Continued From page 39 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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F 842	Continued From page 40 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 Resident #1's medical record accurately documented the right type and size of her tracheostomy. The findings include: Resident #1 was admitted to the facility on 05/09/22 with multiple diagnoses that included: Nondramatic Subarachnoid Hemorrhage from Left vertebral Artery, Chronic Respiratory Failure with Hypoxia and Encounter for Attention to Tracheostomy. Review of Resident #1's medical record revealed the following: The Entry Tracking Record/Minimum Data Set dated 05/10/22 revealed that facility staff coded as the resident entering the facility on 05/09/22. Physician's Orders: 05/09/22 "Albuterol Sulfate (relaxes the muscles around the airways) Nebulization Solution 2.5 MG (milligram)/3ML(milliliter) 0.083% 3 ml via trach (tracheostomy) every 6 hours as needed for Shortness of Breath" 05/10/22 "Suction as needed every shift" 05/10/22 "Trach site inspected for redness,	F 842		

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swelling, pain, drainage and intact ...every shift

05/10/22 "Tracheostomy care every shift and prn (as needed) every shift"

05/10/22 "Trach-collar (t/c) at 28% FIO2 (Fraction of Inspired Oxygen) every shift"

Respiratory Treatment Care Assessment:

05/09/22 at 10:35 PM "28% t/c ... treatment type: suction ...pre (before) RR (respiratory rate): 19, post (after) RR: 19; pre breath sounds: rhonchi, post breath sounds: clear ... Trach ET (endotracheal tube) Size 7 XLT (Extended-Length); trach intact: yes; pre SPO2 (oxygen saturation): 99%; post SPO2: 99%; breathing effort: normal resting ... patient is stable on 28% trach collar, no respiratory distress noted."

05/10/22 at 4:05 PM "28% t/c ... treatment type: suction ...pre RR: 19, post RR: 19; pre breath sounds: rhonchi, post breath sounds: clear ... Trach ET/Size 8 portex; pre SPO2: 99%; post SPO2: 99%; trach intact: yes; breathing effort: normal resting ... patient remains stable on 28% trach collar."

During a telephone interview conducted on 05/24/22 at 4:43 PM, Employee #5 (Respiratory Therapist) who documented the aforementioned respiratory assessment) stated, "I did not change her (Resident #1) trach. Trachs or the inner cannula's are never changed during the night. I don't remember what I wrote but it was a documentation error. The XLT is the correct size."

The evidence showed that facility staff

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F 842	Continued From page 42 inaccurately documented Resident #1's tracheostomy type and size.	F 842		