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	HFD02-0024	A. BUILDING: _____ B. WING _____	C 05/23/2022

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

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L 000	Initial Comments An unannounced Complaints/Facility Reported Incidents 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 DCMR- District of Columbia Municipal Regulations	L 000	L 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

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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
RN - Registered Nurse
ROM Range of Motion
Rp, R/P - Responsible party

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L 000	Continued From page 2 SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: 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	L 051	L 051 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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L 051	Continued From page 3 #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. 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	L 051	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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L 051	Continued From page 4	L 051		

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.

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]

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L 051	Continued From page 5 "[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." 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..	L 051		

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L 051	Continued From page 6	L 051		

(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 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

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L 051	Continued From page 7 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."	L 051	L 052 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	
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and	L 052	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. 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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L 052	Continued From page 8 (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on 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. 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:	L 052		

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L 052	Continued From page 9 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 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."	L 052		

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L 052	Continued From page 10 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 of persons required to care for Resident #4 which	L 052		

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L 052	Continued From page 11 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."	L 052	L 080 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.	
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute 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	L 080		

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L 080	Continued From page 12 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 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..."	L 080	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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L 080	Continued From page 13 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..." 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."	L 080		

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L 080	Continued From page 14 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 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 beddside 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.	L 080		

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L 080	Continued From page 15 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 (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	L 080		

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L 080	Continued From page 16	L 080		

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 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,

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L 080	Continued From page 17 "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."	L 080		
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute 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 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	L 200	L 200 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. 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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L 200	Continued From page 18 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." 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.	L 200		

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L 201	Continued From page 19	L 201	L 201	
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition;	L 201	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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L 201	Continued From page 20 (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of six (6) sampled residents, facility staff	L 201		

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L 201	Continued From page 21 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, 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:	L 201		

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L 201	Continued From page 22 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 inaccurately documented Resident #1's tracheostomy type and size.	L 201		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and	L 204		

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L 204	Continued From page 23 shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (e)A description of the corrective action taken. This Statute 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: Repeated Falls, Encephalopathy, Hemiplegia and	L 204	L 204 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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L 204	Continued From page 24 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." 2. Facility staff failed to interview and or obtain	L 204	5. Date correction action completed The facility's date of alleged compliance is June 20, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	C 05/23/2022

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L 204	Continued From page 25 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 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	L 204		

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L 204	Continued From page 26 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 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.	L 204		

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L 204	Continued From page 27 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.	L 204	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.	
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute 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	L 206	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. 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. 5. Date correction action completed The facility's date of alleged compliance is June 20, 2022.	

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L 206	Continued From page 28	L 206		

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 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 (medical doctor) notified..."

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

04/20/22 [Physician's Order] "Monitor/document

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