Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: С B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 000-Preparation and/or execution of this plan 06/20/22 L 000 Initial Comments L 000 of correction do not constitute admission or agreement by provider of the truth of the facts An unannounced Complaints/Facility Reported alleged or conclusions set forth in the statement Incidents survey was conducted at BridgePoint of deficiencies. The plan of correction is Subacute & Rehabilitation Capitol Hill facility from prepared and/or executed solely because the May 19, 2022 to May 23, 2022. Survey activities provisions of federal and state law require it. consisted of observations, record reviews, This plan is submitted as evidence of our resident and staff interviews and Infection compliance. 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 District of Columbia Municipal DCMR-Regulations

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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	, -	•			
	D/C Discontinue				
	DI - deciliter				
	DMH - Department	of Mental Health			
	EHR - Electronic I	lealth Record			
	EKG - 12 lead Elec	trocardiogram			The state of the s
	EMS - Emergen	cy Medical Services (911)			
	ESRD - End Stage F				
	G-tube Gastrostom	y tube			
	HR- Hour HSC - Health Service Center				
	HVAC - Heating ventilation/Air conditioning				
	ID - Intellectual				
	IDT - interdiscipli				
	L- Liter	nary tourn			
		nit of mass)			
	`	Administration Record			
	MD- Medical Do				
	MDS - Minimum D	===:			
		(metric system unit of mass)			
	,	netric system measure of			
	volume)				
	mg/dl - milligrams i				
	_	s of mercury			
	MN midnight				
	Neuro - Neurologic		-		
	NP - Nurse Prac	titioner			
	O2- Oxygen				
		ion screen and Resident			
	Review				
	Peg tube - Percutane	ous Endoscopic			
	Gastrostomy				
		rotective Equipment			
	PO- by mouth				
		order sheet			
	Prn - As needed				
	Pt - Patient				
	Q- Every				
	RN - Registered	Nurse			
	ROM Range of			1	
	Rp, R/P - Responsib				

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ С B. WING_ HFD02-0024 05/23/2022

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	SCC Special Car	e Center						
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	Ug - Microgram							
770004	5							
L 051	3210.4 Nursing Facilitie	∋s		L 051	L 051			
лалана английн англий	A shares are a shall be				1.	Corrective action for resident		
	A charge nurse shall be following:	e responsible for the			1.	Confective action for resident		
					Residen	nts #3 and #4 will have their		
	(a)Making daily resident visits to assess phys and emotional status and implementing any		sical		E .	hensive care plans reviewed and		
						by 06/20/22. There were no ill		į
	required nursing interve					esidents.		
	<u>-</u>	·						
	(b)Reviewing medication				2.	Identify other residents		
	completeness, accurac	-						
	physician orders, and a	ndherences to stop-or	der			it of all current residents' care pla		
	policies;			-	ſ	conducted and all current resider		
	(n) Douglassing	Inlana of ++ f-				eir care plans reviewed and upda	ated by	
	(c)Reviewing residents appropriate goals and a		ina		06/20/22	۷.		
	them as needed;	zpprodones, and revis	m 19		2	Cuntomia ahanasa		
	anom do noodou,				3.	Systemic changes		
	(d)Delegating responsi	bility to the nursing sta	aff for		The ID7	Γ team will be educated on the		
	direct resident nursing					nce of ensuring that comprehens	sive care	
	_	·				e created for each resident and		
	(e)Supervising and eva			-	updated	/revised as needed. The Directo		
	employee on the unit; a	ınd	1			rsement will be responsible for	ensuring	
ĺ	/DI/ /	7.14 · · ·	.			residents have updated/revised		
	(f)Keeping the Director				comprel	hensive care plans.		
	or her designee informe	ed about the status of	ļ					
	residents.							
	This Statute is not met		'nr					
	Based on record review	•			-			
	two (2) of six (6) sample							
	failed to revise Resider high fall risks after sust							
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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NAME OF PROVIDER OR SUPPLIER

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:
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WASHINGTON, DC 20002

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L 051 Continued From page	•3	L 051	4. Monitor corrective actions	
#4's activities of daily I The findings include: Review of the facility p Interdisciplinary Team "The care plan is ba comprehensive asses Review of the facility p Protocol" revised 11/0 Based on the precedir and physician will iden to try to prevent falls of clinically significant 1. Facility staff failed to plan to reflect high fall Resident #3 was admi 07/13/21 with multiple Muscle Weakness, He Respiratory Failure with Review of Resident #3 following: A Quarterly Minimum 04/13/22 that showed Resident #3 with seve A Care Plan with a foc 07/27/21, "[Resident # falls r/t (related to) con subdural hemorrhage. 03/03/22 at 11:00 AM Assessment Request Form] "Patient acquire	policy titled, "Care Planning- "revised 11/02/21, stated, used on the resident's used on the resident #3 clinical 19/21 documented, " used assessment, the staff unity pertinent interventions as and to address the risks used to address the risks used to address the risks used to revise Resident #3's care of the revise Resident #3's care of the used to the facility on the diagnoses that included: used the resident provided the used to address the used to the used to address the used to the used to address the used to use use used to use use used to use use used to use use use used to use	L 051	The MDS nurses will complete monthly of comprehensive care plans to ensure the residents have updated/revised comprehensive care plans. Audits will be completed duresident MDS completion. The results reported to the QAPI Committee month months for review and recommendation. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action complet. The facility's date of alleged compliance 20, 2022.	nat all ensive uring will be ly x 3 s. the on-

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PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI WASHINGTON, DC 20002 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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.

Health Regulation & Licensing Administration

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.

50 Category High Risk for Falling ... "

03/28/22 at 9:18 PM [Morse Fall Scale] "... Score

03/29/22 (Revision date) [Care Plan focus area]

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

MANE OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI (A) ID PREPIX TAG SUMMARY STATEMENT OF DEFICIENCISS (EACH DEFICIENCY MUST BE PRECEDED BY PULL PREPIX TAG CONTINUED FROM IS CONTINUED FROM INCIDENTIFYING INFORMATION) LOS1 Continued From page 5 "Resident #41 page an ADL self-care performance deficit rit (related to) fatigue, impaired balance [Resident #41] 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 02/H (every 2 hours) and as necessary." An Admission Minimum Dasa Set dated 04/04/22 revealed that facility staff coded the following: cognitively infact, no behavior issues, for all ADL care (including bed mobility and transter) - 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) norm, resident noted out of the bed on the floor." 04/15/22 at 8:09 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 too and vital signs takenTransferred 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."		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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"[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 takenTransferred 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
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	L 051	"[Resident #4] has ar deficit r/t (related to) for [Resident #4] require with bathing/showerin necessary is totally for repositioning and hours) and as necess. An Admission Minimur revealed that facility is cognitively intact, no care (including bed madependence with two and weighed 192 pour respiratory called by AM), up on arriving to resident noted out of "Called into patient's taking care of patient patient laying face do Patient was assessed signs takenTransfelift. 2 cm X 0.1 skin ct 0.2 cm old scar reope officer and supervisor patient to hospital for 04/15/22 at 11:14 AM Summary] "CT (Comp Exam: noncontrast he spine CT no acute	ADL self-care performance ratigue, impaired balance s assistance of one (1) staffing as scheduled and as dependent on one (1) staffiturning in bed Q2H (every 2 stary." Im Data Set dated 04/04/22 staff coded the following: behavior issues, for all ADL hobility and transfer) - total (2) persons physical assist ands. 4's medical record revealed General Progress Note] CNA around 0620 (6:20 the pt (patient) room, the bed on the floor." General Progress Note] room by CNA who was On arrival, nurse observed who on the floor next to bed. If from head to toe and vital erred back to bed via hoyer at above left eyebrow. 0.2 X and to right hand House notified. Order to send evaluation." [Hospital Discharge outed Tomography) Scan and CT, noncontrast cervical fracture is present or skull	L 051	DEFICIENCY)		

Health Regulation & Licensing Administration

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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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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L 051	should say 2 people of involved and all the of reeducated about using turning and reposition ventilators." 3211.1 Nursing Facility Sufficient nursing time resident to ensure that receives the following: (a) Treatment, medical supplements and fluid rehabilitative nursing of the resident is comforted to the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair; (d) Protection from active involved in the resident is comforted by freedom and trimmed nails, and well-groomed hair;	he standard. The care plan furing ADL. The CNA her nursing staff have beening 2 people especially for ing residents on lies shall be given to each the resident in the reside	L 051	1. Corrective action for resident Resident #4's care plan will be revised reflect the number of staff required to perform ADLs. 2. Identify other residents An audit of other resident care plans who completed by 06/20/22. 3. Systemic changes Licensed nursing staff and MDS staff where deducated on the importance of ensuring residents have their care plans revised staff know how to care for them. The of Nursing will be responsible for ensure residents care plans are revised to accurreflect their currently functional status. 4. Monitor corrective actions The Director of Nursing/Designee will weekly audits of 10% of residents care plans are revised to the QAI Committee monthly x 3 months for revised monitoring for compliance. 5. Date correction action compless.	complete plans.
	his or her own clothing which shall be clean a	g; and shoes or slippers,		The facility's date of alleged compliant 20, 2022.	e is June

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L 052	(3)Participate in mear recreational activities; (g)Prompt, unhurried requires or request he (h)Prescribed adaptiv him or her in eating independently; (i)Assistance, if neede including oral acre; and j)Prompt response to for help. This Statute is not me Based on record revisione (1) of six (6) sample failed to revise the act care plan to reflect the required to provide AD resulting in a fall with the findings include: Review of the facility plater disciplinary Team	assistance if he or she elp with eating; assistance if he or she elp with eating; e self-help devices to assist ed, with daily hygiene, ad an activated call bell or call et as evidenced by: ew and staff interview, for pled residents, facility staff tivities of daily living (ADL) e number of persons et care to Resident #4, injury. policy titled, "Care Planning- i" revised 11/02/21, stated, ased on the resident 's	L 052	DEFICIENC	Υ)	
	Protocol" revised 11/0 Based on the precedir and physician will ident to try to prevent fall of clinically significant Resident #4 was admit	ng assessment, the staff http:// pertinent interventions is and to address the risks consequences of falling"				

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLE	TED	
		**************************************			l c	
	HFD02-0024		B. WING			/2022
		*			00/20	" LULL
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND F	REHAB CAPITOL HI	TREET NE		•	
	****	WASHING	STON, DC 2000	2		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	1	COMPLETE DATE
		•	.,,,	DEFICIENCY)		
L 052	Continued Every page	- 0	L 052			
£ 002	Continued From page	. 9	L 032			
		pirator (Ventilator) Status,				
	Muscle Weakness, H	emiplegia and Hemiparesis.				
	,	[Morse Fall Scale] " Score				
	50 Category High Ris	k for Falling"				
	03/20/22 (Revision de	ate) [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 necess	ary."				
		m Data Set dated 04/04/22				
		staff coded the following:				
		behavior issues, for all ADL nobility and transfer) - total				
		(2) persons physical assist				
	and weighed 192 pou					
	Review of Resident #	4's medical record revealed				
	the following:					
		General Progress Note]				
		CNA around 0620 (6:20				
		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					
		On arrival, nurse observed				
		wn on the floor next to bed.				
		from head to toe and vital				
	_	erred back to bed via hoyer				
		it above left eyebrow. 0.2 X				
		ened to right hand House	:			
		notified. Order to send				
	patient to hospital for	evaluation."				

Health Regulation & Licensing Administration

STATE FORM

	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	
		UEDOS SOS	B. WING		C	
·		HFD02-0024	D. 14110		05/2	3/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	NTE, ZIP CODE		
ppinces	OINT GUD ACUTE AND	223 7TH S	TREET NE			
אפטעואם	OINT SUB-ACUTE AND F		STON, DC 2000	2		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	7N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
L 052	Continued From page	10	L 052			
	j					
	044500	*** ***		-		
	04/15/22 at 11:14 AM			PARAMETER		
		outed Tomography) Scan				
		ead CT, noncontrast cervical				
	•	fracture is present or skull				
		cture or static subluxation of				
		dhesive 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"					
		[General Progress Note] "				
		left forehead laceration site				
	glued with no signs a	nd symptoms of infection				
	noted"	•				
	During a telephone in					
	05/20/22 at 9:54 AM,	• • •				
	_	#4 the day if the incident)				
	_	ng him (Resident #4) by				
	=	ed to the side on the left				
		linen under him and was		**************************************		
		linen on. First his feet fell		Toponomia		
		egs. I was on the opposite				
	_	re was only one upper bed				
		ldn't pull him back. His	at a second			
,		vn 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 b	een times where I have help				
		have help and the workload				
		for help, I don't always get				
	it. But I understand it's					
		•				
		that facility staff failed to				
	revise the ADL care p	lan to address the number			Ì	
	of persons required to	care for Resident #4 which				

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PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 052 Continued From page 11 L 052 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 上 080 Nursing) acknowledged the findings and stated. "On this unit (6th floor, ventilator unit), all the residents require 2 assist for turning and 1. Corrective action for resident repositioning. That 's the standard. The care plan should say 2 people during ADL. The CNA Resident #2 was released from the restraint involved and all the other nursing staff have been immediately upon identification. The reeducated about using 2 people especially for resident was assessed with no adverse turning and repositioning residents on effects noted. The resident has been ventilators." assessed by psychiatry to address his agitation. The nurse involved no longer L 080 3216.1 Nursing Facilities L 080 works at the facility and was reported to the board of nursing on 05/06/22. Each resident has the right to be free from physical and chemical restraints. 2. Identify other residents This Statute is not met as evidenced by: Based on record review and staff interview, for An audit of all residents did not reveal any one (1) of six (6) sampled residents, facility staff residents that were being inappropriately failed to ensure that Resident #2 was free from a restrained or untreated for agitation or physical restraint. restlessness. There were no additional findings related to this citation. The findings include: Review of the facility's policy, "Use of Restraints" 3. Systemic changes

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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

prevent resident mobility are considered

tucking sheets so tightly that a bed bound-resident cannot move..."

restraints and are not permitted, including ...

Resident #2 was admitted to the facility on

staff convenience or for the prevention of falls ...

practices that inappropriately utilize equipment to

Nursing staff have been educated on the

importance of ensuring that residents are not

Nursing will be responsible for ensuring that

residents are not inappropriately restrained.

inappropriately restrained or untreated for agitation or restlessness. The Director of

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ С B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Monitor corrective actions L 080 L 080 Continued From page 12 12/27/21 with multiple diagnoses that included: The Director of Nursing/Designee will Repeated Falls, Encephalopathy, Hemiplegia and complete weekly audits of all residents to Hemiparesis Following Cerebral Infarction ensure that no restraints are being used Affecting Left Non-Dominant Side. inappropriately. The results will be reported to the OAPI Committee monthly x 3 months Review of a facility reported incident (FRI) for review and recommendations. received on 05/03/22 documented, "On 4/30/2022 @ (at) around 0830 (8:30 AM) the Therapeutic Recreation Specialist Director reported that she The QAPI Committee is responsible for the observed [Resident #2] sitting in a recliner at the on-going monitoring for compliance. Nursing Station and tied to the recliner. This initial report, Investigation is in progress..." 5. Date correction action completed Review of Resident #2's medical record revealed The facility's date of alleged compliance is the following: June 20, 2022. 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

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Physical Limitations..."

Seizure activity..."

accepted by patient every shift"

ml intramuscularly every 6 hours as needed for

04/06/22 [Physician's Order] "Frequent rounding and toileting every 2 hours as tolerated and

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,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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HFD02-0024			B. WING		05/2) !3/2022	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND R	REHAR CAPITOL HI	223 7TH ST	REET NE			
WASHIN			WASHING	TON, DC 2000	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 080	Continued From page	: 13		L 080			
	"Patient is stable. He Patient was constant! importance of not tryir himself, to prevent him	[General Progress Note] was less agitated today. y reminded on the ng to get up and walk by n from falling. He verbaliz ing 'I will try to be a good					
	"Resident found lying room by the bed on th	•	s				
	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 5149"	Order] "Room transfer to)				
	04/29/22 [Physician's Order] "Patient is a High Fall risk, monitor, cue and redirect as needed every shift"						
	plan related to recent remain (Alarm, roundi mat, bed in lowest pos apparent injuries note reviewed with IDT (int	Plan of Care Note] "Care fall events. Interventions ing redirection/cues, fall sition and activities). No d from fall. Interventions erdisciplinary team). ith P.O.C. (plan of care).					
	very agitated, trying to	Behavior Note] "Residen o stand and get out of ger et by staff CNA (Certified he is clean and dry."	ri				

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PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) L 080 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

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was not interviewable.

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

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 080 Continued From page 15 L 080 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."

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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

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 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.

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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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		,		DEFICIENCY)		
L 080	Continued From page	17	L 080			
	10 PM. 1 . 1					
		as taken immediately. The				
	nurse and CNA were	suspended at first then fired		L 200		
	and reported to the bo	pards. Education was				
	provided to all the oth	er nursing staff on abuse		1. Corrective action for resident		
	and use of restraints."			Consecute action for resident		
				Baridant #2 has bed their NADO on date		
				Resident #3 has had their MDS update		
L 200	3231.11 Nursing Facil	lities	L 200	accurately reflect their condition on 5/2		
ŀ				There were no ill effects to the resident		
	Each entry into a med	lical record shall be legible,				
-	current, in black ink, dated and signed with full			2. Identify other residents		
	signature and discipline identification.					
				An audit of all current residents MDS	e did not	
	This Statute is not me	•				
		ew and staff interview, one		reveal any addition concerns. There		
		residents, facility staff failed		additional findings related to this citation	on.	
	to ensure that Reside	nt #3's Minimum Data Set				
	(MDS) accurately refle	ected the resident's status.		3. Systemic changes		
	•					
	The findings include:			The IDT team has been educated on the	e .	
	The initiality of the day			importance of ensuring that resident's		
	Decident #2 was adm	itted to the facility on		correctly documented in the MDS. The		
	Resident #3 was adm					
	•	diagnoses that included:		of Reimbursement will be responsible f		
		eart Failure and Chronic		ensuring that resident's MDSs accurate	ly reflect	
	Respiratory Failure wi	ith Hypoxia.		their status.		
				4. Monitor corrective actions	ļ	
	Review of Resident #3	3's medical record showed				
	the following:			The Director of Reimbursement/Design	nee will	
				complete random weekly audits of 10%		l
	A Ouartarly Minimum	Data Sat (MDS) datad		resident's MDSs to ensure that their sta		j
		Data Set (MDS) dated		!	E	
		facility staff coded the		documented correctly. The results will		
		paired cognition, in Section		reported to the QAPI Committee month		
		nobility devices and was		months for review and recommendation	ıs.	
	coded as no falls sinc	e admission/entry or reentry				
		whichever is more recent		The QAPI Committee is responsible for	r the on-	
	under section J1800.			going monitoring for compliance.		
				Barred mile voi combination.		
	It should be noted the	t the prior Quarterly MDS		Doto name -titi 1	4.0.4	
				5. Date correction action comple	icu	
	assessment was date	U UZ/UZ/ZZ.			_	
				The facility's date of alleged compliance	ce is	
	01/12/22 [Physician's	Order] "Fall precaution		June 20, 2022.	***************************************	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HFD02-0024	B. WING		C 05/23/2022
	ROVIDER OR SUPPLIER OINT SUB-ACUTE AND F	EHAB CAPITOL HI	DDRESS, CITY, STA STREET NE GTON, DC 2000:		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 200	every shift" 03/03/22 at 11:00 AM Assessment Request Form] "Patient acquire today @ (at) 11am. Sl with minor skin abrasi posterior arm. Treatm patient report, Patient with the walker and he the fall. Patient was for room by staff along wi Patient stated that he his arm (patient show right posterior arm)" 03/03/22 [Physician's days s/p (status post) The evidence showed Resident #3's fall. During a face-to-face 05/20/22 at 1:33 PM, Rehabilitation) stated, walker for ambulation time. [Resident #3] or and with the nursing s The evidence showed had a documented or use of a rolling walker these in the resident's During a face-to-face 05/20/22 at approxima #11 (MDS Coordinato	[Situation Background (SBAR) Communication ed a fall Patient had fall infit nurse assessed patient on and redness to right ent applied as ordered. Per stated that he was walking a turned back and acquired bund sitting on the floor in the Restorative assistant. did not hit his head but hit ed order] "Neurochecks X 3 fall" I documented evidence of interview conducted on Employee #10 (Director of "[Resident #3] has a rolling the's had it for quite some by uses it during therapy taff." If that although Resident #3 in 03/03/22 and documented in facility staff failed to code in MDS. interview conducted on ately 3:00 PM, Employee	L 200		

neam R	nealth Regulation & Licensing Administration						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATIONNUMBER:	A. BUILDING:		COMPLETED		
					С		
		HFD02-0024	B. WING		05/23/2022		
.		111 502-0024			03/23/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST.	ATE, ZIP CODE			
BBIDGED	OINT SUB-ACUTE AND R	223 7TH S	STREET NE				
BRIDGER	OINT SUB-ACCTEAND		STON, DC 2000	02			
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)		
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE		
				DEFICIENCY)			
L 201	Continued From page	: 19	L 201	L 201			
L 201	3231.12 Nursing Facil	lities	L 201	1. Corrective action for resident			
	Each medical record	shall include the following		Resident #1's no longer resides in the	facility as		
}	information:			of 5/10/22. We could not go back			
				retrospectively to correct the issue.			
	(a)The resident's nam	ne,age, sex, date of birth,					
	race, martial status ho	ome address, telephone		2. Identify other residents			
	number, and religion;						
	•			An audit of other residents with trachs	will be		
	(b)Full name, addresses and telephone numbers			completed by 06/20/22.			
	of the personal physician, dentist and interested						
	family member or sponsor;			3. Systemic changes			
	talling matrix of operator,						
	(c)Medicaid, Medicare	e and health insurance		Nursing and Respiratory staff will be e	ducated		
	numbers;			on the importance of ensuring that resident			
	•			records are accurate. The Director of 1			
	(d)Social security and	other entitlement numbers;		will be responsible for ensuring that re			
	,	,		records are complete and accurate.			
	(e)Date of admission,	results of pre-admission		1			
	screening, admitting of			4. Monitor corrective actions			
	diagnoses;						
	• • • • • • • • • • • • • • • • • • • •			The Director of Nursing/Designee will	complete		
	(f)Date of discharge, a	and condition on discharge;		monthly audits of 25% of residents wit	h trachs		
	· · · · · · · · · · · · · · · · · · ·			records to ensure that their records are	complete		
	(a)Hospital discharge	summaries or a transfer		and accurate. The results will be repor	^		
	form from the attendir			QAPI Committee monthly x 3 months	for		
		(3 p)		review and recommendations.			
	(h)Medical history and	d allergies:					
	, ,	U ,		The QAPI Committee is responsible for	or the on-		
	(i)Descriptions of phys	sical examination, diagnosis	1	going monitoring for compliance.			
	and prognosis;	and and and and					
	and progressio,			5. Date correction action comple	eted		
	(j)Rehabilitation potential;						
	(I)rvenabilitation potential;			The facility's date of alleged complian	ce is June		
	(k)Vaccine history, if applicable, and other			20, 2022.			
		about immune status in		,,			
	relation to vaccine pre						
	rolation to vaccine pre	vonable diocase,					
	(I)Current status of re-	sident's condition:					
		:,	1	E .	i i		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ARER-		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		OOM ELIED	
HFD02-0024		HFD02-0024	B. WING		C 05/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATI	E, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND R	REHAB CAPITOL HI	STREET NE			
			IGTON, DC 20002			
(X4) ID PREFIX TAG			PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE COMPLETE	
L 201	Continued From page	20	L 201			
	significant changes in when medication or trachanged or renewed of condition remains state condition; (n) The resident's medischarge, which shall attending physician are diagnoses, course of the essential information of discharge and location discharged; (o) Nurse's notes which accordance with the reassessment and the preservice; (p) A record of the resiongoing reports of phystherapy, speech theratherapeutic recreation services; (q) The plan of care; (r) Consent forms and	observation to describe the resident's condition, eatment orders are or when the resident's ble to indicate a status quo lical experience upon I be summarized by the nd shall include final treatment in the facility, of illness, medications on n to which the resident was the shall be kept in esident's medical policies of the nursing dent's assessment and rysical therapy, occupational py, podiatry, dental, n, dietary, and social advance directives; and				
		et as evidenced by: w and staff interview, for pled residents, facility staff				

	FOF DEFICIENCIES OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				A. BUILDING:				
		HFD02-0024		B. WING		1	C 23/2022	
	ROVIDER OR SUPPLIER	PEHAR CADITOL HI	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DIVIDULI	OINT GOB-ACOTE AND N	CHAB CAPITOE III	WASHINGT	TON, DC 2000	2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
L 201	failed to ensure Resident #1's medical record accurately documented the right type and size or			L 201				
	The findings include:							
	Nondramatic Subarac	diagnoses that include hnoid Hemorrhage fron Chronic Respiratory Fai	n					
	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.		aled					
			ded					
	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"		5 MG					
	05/10/22 "Suction as r	needed every shift"						
	05/10/22 "Trach site inspected for redness, swelling, pain, drainage and intactevery shift							
	05/10/22 "Tracheostor (as needed) every shirt	my care every shift and ft"	prn					
	05/10/22 "Trach-collar of Inspired Oxygen) e	r (t/c) at 28% FIO2 (Frac very shift"	ction					
	Respiratory Treatmen	t Care Assessment:						

Health Regulation & Licensing Administration
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NOWBER:	A. BUILDING:		COMPLETED	
HFD02-002		HFD02-0024	B. WING		C 05/23/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
BRIDGEP	OINT SUB-ACUTE AND F	REHAR CAPITOL HI	STREET NE			
			NGTON, DC 2000	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
L 201	Continued From page	⊋22	L 201			
	suctionpre (before) post (after) RR: 19; pi post breath sounds: c (endotracheal tube) S (Extended-Length); tr (oxygen saturation): S breathing effort: norm on 28% trach collar, r noted." 05/10/22 at 4:05 PM ' suctionpre RR: 19, sounds: rhonchi, post Trach ET/Size 8 porte SPO2: 99%; trach interests	Size 7 XLT rach intact: yes; pre SPO2 99%; post SPO2: 99%; aal resting patient is stable				
	Therapist) who docum respiratory assessme her (Resident #1) trac cannula's are never of don't remember what	Employee #5 (Respiratory nented the aforementioned ent) stated, "I did not change ch. Trachs or the inner hanged during the night. I I wrote but it was a The XLT is the correct size."				
	inaccurately documer tracheostomy type an	nted Resident #1's				
L 204	3232.2 Nursing Facility	ties	L 204			
	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					

Health Regulation & Licensing Administration

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
UED02 0024		B, WING		C		
HFD02-0024			1 2		05/23/2	2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
BBIDGED	ONT CUD ACUTE AND F	223 7TH S	TREET NE			
BRIDGEP	OINT SUB-ACUTE AND F		TON, DC 200	02		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	is.	PROVIDER'S PLAN OF CORRECTION	.1	OVE)
PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
L 204	Continued From page	23	L 204	L 204	:	
	shall include the follow	wing:		1. Corrective action for resident		
					or programme	
	(a)The date, time, and	d description of the incident;		The incident for resident #2 has been		
	4			investigated by the DOH during the co		
	(b)The name of the w	itnesses;		survey. The facility failed to report the		
				prior to the survey. There were no adv	erse	
	(c)The statement of the	ne victim;		effects related to the incident.		
	/ 15 A / 4 / 15 / 15					
		ting whether there is a		2. Identify other residents		
	pattern of occurrence	; and			****	
	(a) A description of the	corrective action taken		An audit of other incidents in the past	3 months	
	(e)v describrion or me	corrective action taken.		ve been		
	This Statute is not me	at se avidanced hv:		reported as required.		
		ev and staff interview, for		*		
		oled residents, facility staff		3. Systemic changes		
		policies and procedures for				
	reporting and conduct			Leadership will be educated on the im	nortance	
	Residents' #2 and #3.			of ensuring that all concerns and incidents are		
	reducine ne and no.			investigated appropriately and reported as		
	The findings include:			required to ensure that residents are not		
	The indings morace.			subjected to potential abuse. The Adm		
	Review of the facility i	policy "Abuse Investigation		will be responsible for ensuring that residents		
		d in July 2017 stated, "All		are not subjected to potential abusive situations		
		se, neglect, exploitation,		secondary to the failure to properly inv		
:		esident property, mistreat		and report allegations of abuse.		
		nown source ("abuse") shall		or actions of access		
	be promptly reported			4. Monitor corrective actions		
		management Role of the				
		w any witnesses to the	The Administrator will complete weekly audits		ly audits	
		taff members (on all shifts)	of all Incidents Reported by the Facility to			
		t with the resident during the		ensure that all incidents are investigate		
	period of the alleged i			thoroughly and reported as required.		
	,	· · · · · · · · · · · · · · · · · · ·		will be reported to the QAPI Committee		
	1. Facility staff failed t	to report an allegation of		monthly x 3 months for review and		
	abuse made by Resid			recommendations.		
	, , , , , , , , , , , , , , , , , , , ,	—-				
	Resident #2 was adm	itted to the facility on		The QAPI Committee is responsible for	or the on-	
		diagnoses that included:		going monitoring for compliance.	, alo on-	
		phalopathy, Hemiplegia and		Bomb moments for compilance.		

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Date correction action completed L 204 Continued From page 24 L 204 Hemiparesis Following Cerebral Infarction The facility's date of alleged compliance is June Affecting Left Non-Dominant Side. 20, 2022. 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.

Health Regulation & Licensing Administration

unsubstantiated."

During a face-to-face interview conducted on

(Administrator) acknowledged the finding and stated, "The allegation was investigated thoroughly and it was found to be

2. Facility staff failed to interview and or obtain

05/20/22 at 3:09 PM, Employee #1

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI** WASHINGTON, DC 20002 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 204 Continued From page 25 L 204 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

Health Regulation & Licensing Administration

mother present. Patient mother reported that patient informed her that patient had a fall Monday morning (04/18/22). Per Mother, Patient reported it vesterday 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

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
				С				
	IFD02-0024	8. WING		05/23/2022				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
BRIDGEPOINT SUB-ACUTE AND REHAB C	BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI WASHINGTON, DC 20002							
(X4) ID SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	OF DEFICIENCIES PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE				
L 204 Continued From page 26 patient's head. No abnormaliti asked how the patient fell. Per patient wanted to get out of be push chair away. Patient then the floor" 04/20/22 at 1:32 PM [Situation Assessment Request (SBAR) Form] " Fall At 12pm write resident room, RP (represente that, Tuesday evening the reshe fell Tuesday morning (04/1 the resident, he stated that was [of] the bed. Manager made a went to the room. Head to toe 2 abrasions noted on the left of the No c/o pain. MD notified" 04/20/22 [Physician's Order] "(every) shift x 3 days" 04/20/22 [Physician's Order] "/report PRN (as needed) x 72 for s/sx (signs and symptoms) change in mental status, new sleepiness, inability to maintait every shift for 3 Days" 04/21/22 [Physician's Order] "skin abrasions for changes. Nodoctor) for any signs of irritation infection, or change in skin into 5 Days" Review of the facility's investig showed no documented evide employees assigned to Reside and 04/19/22 were interviewed statements to get their recolle of the alleged fall.	r verbal report ed and was trying to a slid out of bed onto n Background o Communication er walked in ative informed writer dident told her that 19/22): writer asked as trying to get out aware and both of us assessment done, upper back noted. Whonitor/document h (72 hours) to MD b: Pain, bruises, onset: confusion, in posture, agitation Monitor left scapula lotify MD (medical on, signs of legrity every shift for gation packet ence that the ent #3 on 04/18/22 d or provided written	L 204	DETROITION OF THE PROPERTY OF					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
HFD02-0024			B. WING		C 05/23/2022	
BRIDGEP	ROVIDER OR SUPPLIER	REHAB CAPITOL HI WASHING	DRESS, CITY, ST STREET NE GTON, DC 200	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)				
L 204	Continued From page		L 204	F 610 1. Corrective action for resident		
	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.			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.		
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 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.			
			The Administrator will complete week of all Incidents Reported by the Facilitiensure that all investigations are invest thoroughly. The results will be reported QAPI Committee monthly x 3 months review and recommendations. The QAPI Committee is responsible for going monitoring for compliance. 5. Date correction action completes the facility's date of alleged compliant 20, 2022.	y to igated ed to the for or the on-		

PRINTED: 05/27/2022 FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ С B. WING HFD02-0024 05/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HI WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) 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

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 Health Regulation & Licensing Administration

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD02-0024	B. WING		C 05/23/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 206	/report PRN (as need for s/sx (signs and syr change in mental stat sleepiness, inability to every shift for 3 Days' 04/21/22 [Physician's skin abrasions for chasigns of irritation, signs skin integrity every sh Review of the facility's showed no document employees assigned that and 04/19/22 were int statements to get their of the alleged fall. During a face-to-face 05/20/22 at 1:54 PM,	ed) x 72h (72 hours) to MD mptoms): Pain, bruises, us, new onset: confusion, o maintain posture, agitation Order] "Monitor left scapula anges. Notify MD for any us of infection, or change in ift for 5 Days"	L 206			