STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL	223 7TH STREET NE WASHINGTON, DC 20002

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F 000	INITIAL COMMENTS An unannounced Recertification Survey was conducted at this facility from January 10, 2024 to January 25, 2024. Survey activities consisted of observations, record reviews, and resident, family and staff interviews. The facility's census on the first day of the survey was 105 and the survey sample included 42 residents. The following Complaints were investigated: DC~12510, DC~12493, DC~12126, DC~11644, DC~11580, DC~11171, DC~[10908] The following Facility Reported Incidents were investigated: DC~12458, DC~12366, DC~12187, DC~12171, DC~12066, DC~11939, DC~11799, DC~11761, DC~11682, DC~11633, DC~11550, DC~11492, DC~11463, DC~11432, DC~11433, DC~11418, DC~11412, DC~11405, DC~12165, DC~11259, DC~11237, DC~11204, DC~11196, DC~12026, DC~11178, DC~12429, DC~11110, DC~10982, DC~10941, DC~10867, DC~10835 Citations are being cited for: DC~11682, DC~11412, DC~11405, DC~12366, and DC~12066. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administration 2/28/24

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

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F 000	Continued From page 1 and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP - Infection Prevention and Control Program	F 000		

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F 000	Continued From page 2 LPN - Licensed Practical Nurse 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) M - Minute ML - milliliters (metric system measure of volume) Mg/dl - milligrams per deciliter Mm/Hg - millimeters of mercury MN - midnight N/C - nasal cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for two (2) of 42 sampled residents, facility staff failed to implement its policy as evidenced by: 1) not having documented evidence they conducted a background check or that an employee received abuse education and 2) not removing	F 607		

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F 607	Continued From page 4 the alleged perpetrator (facility staff) from the facility to protect the alleged victim (resident) from further abuse pending an investigation. Residents' #70 and #31. The findings included: Review of the facility policy "Abuse Prevention Program" revised on 12/01/22 documented: - As part of the resident abuse prevention, the administration will conduct employee background checks - Require staff training/orientation programs that include such topics as abuse preventions, identification, and reporting abuse 1. Facility staff failed to implement its policy by not having documented evidence they conducted a background check or that an employee received abuse education. Resident #70 was admitted to the facility on 11/16/22 with multiple diagnoses that included: Quadriplegia, Spinal Stenosis and Muscle Weakness. An Admission Minimum Data Set (MDS) assessment dated 12/19/22 showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A Facility Reported Incident (FRI), DC~11412, submitted to the State Agency on 12/27/22 documented: - [Resident #70] reported to the nursing supervisor that the assigned RN (Registered Nurse/Employee #20) screamed at him because he refused to be turned.	F 607	**Corrective action** Employee # 14 was removed from the schedule on 10/14/23. Resident #31 and resident # 70 did not have any adverse effects from not removing employee # 14 from the schedule on 10/12/23 to protect resident # 31 and resident # 70. Employee # 20 is no longer employed by Bridgepoint Capitol Hill therefore a background check cannot be completed at this time. Employee # 20 is no longer employed by Bridgepoint Capitol Hill therefore she cannot be in-serviced on abuse at this time.	

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F 607	Continued From page 5 During an onsite investigation and review of the facility's investigation documents on 01/22/24 at approximately 9:30 AM, the surveyor asked to see the human resources (HR)/administrave record for Employee #20, Employee #1 (Administrator) and Employee #3 (Director of Human Resources) stated that they both looked but there is no file for that employee and would keep looking. During a face-to-face interview on 01/22/24 at 1:20 PM, Employee #3 stated, "She (Employee #20) is an agency nurse. We don't have a file or any documentation for her. [RN/alleged perpetrator] worked at the facility from January 2021 to December 2022. I am not sure if there are any previous allegations of abuse made against this employee or any disciplinary actions. It appears that she was terminated in December 2022 after the alleged incident with [Resident #70]. Since I started working here in March 2023, I have made sure that all employees, agency or not, have a file with HR that includes all the required information." The evidence showed that facility staff failed to have documented evidence of a background check or that Employee #20received training/orientation that included such topics as abuse preventions, identification, and reporting abuse. 2. Facility staff failed to remove the alleged perpetrator (facility staff) from the facility to protect the alleged victim (resident) from further abuse pending an investigation. A review of the facility' policy entitled, "Abuse Investigation and Reporting," revised on 04/14/23	F 607		

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F 607	Continued From page 6 documented: "Policy Interpretation and Implementation, Role of the Administrator ...4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation ..." A review of the facility's policy entitled, "Abuse Policy: Prevention/Recognizing Signs of Abuse and Neglect," revised on 04/23/24 documented, "...Protection 1. Once an allegation of abuse is made the alleged abuser will be escorted from the premises by the supervisor to ensure the protection and safety of the resident." Resident #31 was admitted to the facility on 10/29/20 19 with diagnoses that included the following: Hemiplegia, Chronic Respiratory Failure, Muscle Wasting, Major Depressive Disorder, Generalized Anxiety Disorder, Dysphasia, Paranoid Personality Disorder and Vascular Dementia. A Quarterly Minimum Data Set assessment dated 08/25/23 documented that facility staff coded the Resident as having a Brief Interview for Mental Status Summary (BIMS) score of 15 indicating intact cognition, being totally dependent for all ADL (assisted daily living) skills including eating and receiving anti-anxiety antidepressant and anti-psychotic medications for seven (7) days of the assessment. A Facility Reported Incident (FRI), DC~12366, submitted to the State Agency on 10/12/2023 documented: "On 10/12/2023, [Resident #31] reported that on 10/09/2023, Employee #14, the day shift CNA assigned to her, allegedly said to her, "You are pathetic," This is an initial report,	F 607	Identifying other residents All residents involved in the allegations of abuse could be affected. The Director of Nursing and Administrator will ensure that all staff involved in allegations of abuse will be removed immediately from the schedule to protect the resident from further abuse. The Director of Nursing and the facility Administrator will ensure that all staff involved in allegations of abuse will be educated about abuse before they can return to work. Human Resource Director or designee will review all employee files that are involved in allegation of abuse 30 days prior to survey, from December 10, 2023 to ensure that a background check was completed prior to being hired.	

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F 607	Continued From page 7 investigation is on-going. DC police department was informed. CNA was removed from the unit. MD (Medical Director) was notified, [Name of Resident's] daughter] was notified, RP (Representative) is aware. During initial tour of the facility on 01/11/24 at 10:37 AM, Resident #31 was observed in bed watching TV. During an interview at the same time as the observation, the Resident stated that the incident occurred during the daytime shift. The CNA assigned to me was very combative --- every little thing I'd say she had to get the last word in. I can't remember exactly what she was assisting me with at the time, but she told me I was pathetic. Facility staff initiated an investigation of the incident between Resident #31 and Employee #14 on 10/12/23. A review of the facility's investigative documents for the incident revealed the following: A Resident Concern/Complaint Form dated 10/12/23 documented that facility staff received Resident #31's complaint that on 10/09/23, Employee #14 (Resident's assigned CNA) called the Resident pathetic. A review of a care plan initiated on 10/12/2023 documented: "Focus: Allegation of verbal abuse on 10/9/2023 reported by a resident on 10/12/2023, Goal: [Name of Resident #31] will feel safe through the review date with the target date of 03/14/2024. Interventions: Employees will continue to communicate with [Name of Resident #31] respectfully and treat her with dignity; [Name of Physician] was notified 10/12/2023. Rep	F 607	Systemic Changes Regional Director of Clinical Operations will In-service the Director of Nursing and the facility Administrator on ensuring that all staff that are involved in allegation of abuse are immediately removed from the schedule to protect the resident from further abuse. If the allegation of abuse is not founded, the staff will be re-educated prior to returning to work and will be re-assigned to another floor. The Regional Director of Clinical Operations will in-service the Director of Nursing and the facility administrator on ensuring that all staff that are involved in allegations of abuse are educated on abuse before returning to work. The facility Administrator will in-service the Human Resource Director on ensuring that all staff involved in allegation of abuse had a background check prior to being hired, if there is an allegation of abuse another background check will be done immediately.	

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F 607	Continued From page 8 (representative)/daughter were notified on 10/12/2023. Investigation is ongoing; Initial DOH (Department of Health) self-report done 10/12/2023; DC Police Department was notified 10/12/2023 ..." A written statement dated 10/12/23 from Employee #14 documented," (Every time) I enter Resident # 31's room she verbally abuses me. I simply say ' Hi, I am your aide. This is the task I'm here for. She then proceeds with rude comments which I simply ignore and go tell the RN (Registered Nurse). Had to notify Employee #15 (Registered Nurse assigned to Resident #31) and Employee #16 (Licensed Practical Nurse) that this happens every day. A written statement dated 10/12/23 from Employee #15 documented, "On 10/09/23 assigned CNA working with Resident #31 complained that the resident was shouting at her while giving ADL care. Writer went to resident's room and educated not to shout while CNA giving care and resident verbalized understanding and would not do it anymore." A typed telephone statement from Employee #14 documented on 10/16/23: What was your interaction with Resident #1 when you provided care for her? Response: When I went into Resident #31's room. I introduced myself as her CNA today. Resident #31 replied "I don't have time for your [expletive] today. I immediately left the room and reported the incident to Employee #15. I and Employee #15 returned to Resident #31's room, Employee #15 then explained to Resident #31 that I was there to take care of [pronoun] and assist with meals and that [pronoun] should be nice to me. Resident #31	F 607	Monitoring corrective actions The Director of Nursing and or the facility administrator will complete an audit weekly x three months to ensure that all staff involved in allegations of abuse are removed from the schedule immediately. They will be in-serviced on abuse before returning to work. The Human Resource Director or designee will audit all employee records involved in allegation of abuse weekly x three months to ensure that they have a background check completed prior to being hired.	

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F 607	Continued From page 9 agreed for me to take care of her. Resident #31 has always been rude to me. I will always ignore her comments and just do my job. During a telephone interview conducted on 01/19/24 at 12:16 PM, Employee #14 stated, "I told management that Resident #31 was always nasty towards me. The Resident would cuss at me every day and I would tell the nurse. This occurred every single day for four months. The day of the incident she was verbally abusive to me. She said I don't want you to feed me [expletive]. I told the Nurse and Management, but they never switched my team. I told the Administrator about this. He asked Employee #15 if I ever complained about the Resident. She stated, "Yes, I had." He then asked why would you keep her assigned to the Resident if you knew there were problems. She stated she went to speak with the Resident who then agreed that I could feed her, so the assignment was not changed. The Employee also stated, "I continued to work with the Resident the rest of her shift and over the next 2-3 days and when she returned to the facility after the investigation was over, she was assigned to the 5th floor." A review of Employee #14's timecard showed that the Employee continued to work at the facility from 10/12/23 through 10/14/23. She returned to work on 10/18/23 and worked until 10/20/23. During a telephone interview conducted on 01/24/24 at 12:00 PM, Employee #15 stated, "When there is a big concern or when an allegation of resident abuse involving staff occurs, the staff should be removed from assisting the Resident. The day of the incident I remember going with the CNA to the resident's room. I	F 607	All findings will be reported monthly to the QAPI committee for 3 months for review recommendations, monitoring and education as needed. Any deficiencies will be corrected immediately. Date of compliance will be February 21, 2024.	2/21/2024

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F 607	Continued From page 10 asked the Resident to allow the CNA to assist with feeding and the Resident agreed. I should have re-assigned the CNA since there was an allegation of abuse." The evidence showed that the facility staff failed to remove or suspend Employee #14 (alleged perpetrator) from the schedule from 10/12/23 to 10/14/23 to ensure the protection and safety of Resident #31 (alleged victim), during an investigation of abuse per the facility's policies.	F 607		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625	Corrective action Resident #310 was discharged on 2/15/23 therefore, an updated 6-108 with bed hold days and bed hold policy cannot be given to resident or their responsible party.	

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F 625	Continued From page 11 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) out of 42 sampled residents, the facility staff failed to provide written information to the resident or resident representative that stated the duration of the State Agency's bed-hold policy before the facility transferred the Resident to the hospital. Residents' #2, #310, and #34. The findings included: 1. Resident #2 was admitted to the facility on 07/01/00 with diagnoses that included: Metabolic Encephalopathy, Apraxia, Contracture of the Left Hand, Presence of an Artificial Eye, and Obsessive Compulsive Disorder. A review of Resident #2's medical record revealed: Resident #2's face sheet indicated that her primary Payor was Medicaid. A Quarterly Minimum Data Set (MDS) assessment dated 06/28/23 documented that the facility staff coded the Resident in the following manner: Brief Interview for Mental Status (BIMS) score of, "02," indicating severely impaired cognition. An SBAR (Situation, Background, Assessment and Recommendation/Request) Communication Form and Progress Note dated 07/03/23 at 8:45 PM, documented: "Situation: Charge nurse found	F 625	Resident # 2 and resident # 34 responsible party were given an updated 6-108 with bed hold days on 2/16/2024. Bed hold policy was provided to resident # 2 and resident # 34 on 2/16/2024.	

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F 625	Continued From page 12 resident on the floor, 911 was called and resident was transferred to the hospital... The charge nurse assessed the resident, [pronoun] was alert and oriented x 2, B/P (Blood Pressure) 130/98, Heart rate 118, Respiration 20, Oxygen 98% on room air, Temperature 98.0. Resident sustain(ed) injury to the right eye. The injury was clean and a 4 x 4 dressing applied. EMS (Emergency Medical System) transferred Resident to [Name of local hospital]." A review of a Department of Health (DOH) Complaint/Incident Report Form dated 07/04/23 at 2:26 AM documented: "On July 3, 2023, at approximately 8.30 PM, Charge nurse was making rounds to [Resident#2 's Room] and met patient on the floor faced down. patient sustained injury to the right upper eye, no change in mental status compared to [pronoun] baseline. [Physician's Name] was called, order given to transfer resident to the nearest hospital via 911, Patient was picked up by 911 crew at approximately 9.07 pm to [Name of Local Hospital] Family member [Name of Resident's representative] was notified, Investigation is in progress." A review of a DOH Notice of Discharge Transfer or Relocation Form dated 07/05/23 at 9:35 AM documented; " ...(1)The proposed action is: a) Transfer- Hospital/Rehab facility /Nursing home; Transfer type: Hospital; (2) Must list specific reason for this action: Transferred to hospital ... (3) You are scheduled to be discharged, transferred or relocated on or by date: July 03, 2023 ..." Of note the facility staff submitted the Notice of Discharge Transfer or Relocation Form on 07/05/23, two days after the resident ' s discharge to the hospital."	F 625	Identifying other residents All residents transferred to the hospital could be affected. All 6-108 completed within 30 days prior to the survey which will be December 10, 2023 will be audited by the Director of Social Services to ensure they include the bed hold days. All residents transferred to the hospital within 30 days prior to survey which will be December 10, 2023 that are currently in the facility will be provided a copy of the bed hold policy by the Director of Nursing or designee.	

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	095027	A. BUILDING _____ B. WING _____	C 01/25/2024

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F 625	Continued From page 13 A review of the resident's medical record lacked documented evidence that the facility staff provided Resident #2's representative with written notice of the resident's bed hold days before the resident transferred to the hospital on 07/03/23. During a face-to-face interview on 01/23/24 at 1:51 PM Employee #17 (Social Worker) stated "I filled out the notice of transfer form when I first came (to the facility). The Resident had bed hold days left and was allowed to come back to the facility, to the same room. I should have completed the form the same day as the Resident's transfer, and I should have included the number of the Resident's bed hold days." Cross Reference 22B DCMR Sec. 3270.1 2. Resident #310 was admitted to facility on 01/21/23 with multiple diagnoses that included: Atrial Fibrillation, Heart Failure, Hypertension, End Stage Renal Disease, Arthritis and Other Fracture. An Admission Minimum Data Set (MDS) Assessment dated 01/27/23 showed the resident had a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. A review of Resident #310's face sheet documented that the resident was his own representative. A Physician note dated 02/15/23 at 19:27 (7:27 PM) documented, "Resident is alert and oriented x 4 able to make needs known. At 17:30 pm (5:30 pm) resident was observed lying on the floor in	F 625	**Systemic Change** The facility administrator will in-service the Director of Social Services on completing the 6-108 within 24 hours of resident Discharging to hospital to include the bed hold days. The Director of Social Services will in-service the social service staff on accurately completing the 6-108 within 24 hours to include the bed hold days. The Director of Social Services or designee will review all completed 6-108 forms weekly to ensure that they are completed with 24 hours of resident discharging to the hospital, and they include the bed hold days. The Director of Nursing or designee will in-service all Licensed Nurses on ensuring that they provide a copy of the bed hold policy to the resident or resident representative by providing a hard copy or by email whichever is applicable prior to discharge to the hospital. The Director of Nursing or designee will review all copies of bed hold policy provided to the resident representative weekly to ensure that a copy was provided to the resident or resident representative prior to	

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F 625	Continued From page 14 his room close to his bed, face down. When asked, resident stated that, he was coming back from the bathroom when he felt dizzy and loss his balance and fell. He was observed with a deep cut underneath his chin and a cut on the lower lip." Further review of the progress note dated 02/15/23 showed, "[Doctor's name] made aware at 5.40 pm. Order given to transfer resident to the ER for further evaluation. Resident left the facility to [Hospital's name] via stretcher at 18:40 pm (6:40 pm)." A Physician order dated 02/15/23 documented, "Transfer resident to the nearest ER due to bleeding from the chin as a result Fall." During a face-to-face interview conducted on 01/18/24 at 3:26 PM Employee #8 (Social Worker) stated, "We do the 6-108's if the 6-108 is not in the electronic record, we have a book that we keep it in. I'll go see if I can find it." Employee #8 returned with a book labeled 6-108 and the document was not found for the resident's transfer to the hospital on 02/15/23. During a face-to-face interview conducted on 01/19/24 at 2:53 PM Employee #4 (Director of Social Services) stated, "We have a book for the 6-108, ...I know you had requested documents from prior dates, and we didn't have it [the 6-108]." Cross Reference 22B DCMR Sec. 3270.1 3. Resident #34 was admitted to the facility on 03/07/22 with diagnoses that included: Cognitive Communication Disorder, Urinary Incontinence	F 625	Monitoring and corrective action The Director of Social Servies and or designee will audit 6-108 weekly x 3 months to ensure that they are completed within 24 hours and they include the bed hold days. The Director of Nursing or designee will audit all copies of bed hold policy provided to the resident or their representative to ensure that the resident or the resident representative are given a copy on the day of discharge to the hospital. Any deficiencies will be corrected immediately. All findings will be reported monthly to the QAPI committee for three months for review recommendation, monitoring and education as needed. – Date of compliance will be February 21, 2024.	

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F 625	Continued From page 15 and Muscle Wasting and Atrophy. Review of Resident #34's medical record revealed the following: A face sheet that showed that the resident is her own representative. A Quarterly Minimum Data Set (MDS) assessment dated 11/26/23 showed facility staff coded: clear speech, makes self understood and able understand others; a Brief interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A physician's order dated 12/30/23 that directed, "Transfer resident to nearest hospital via 911 due c/o (complaint of) chest pain" A Progress Note dated 12/30/23 at 8:40 AM: - Around 4:15 AM, resident called 911 that she was feeling shortness of breath - Emergency team arrived and took her to [Hospital name] A Progress Note dated 01/05/24 at 6:26 AM: - Resident was readmitted alert and responsive from [Hospital name] A Social Services Progress Note dated 01/05/24 at 7:35 AM documented: "6-108 form was completed and faxed to the ombudsman office for the transfer to the hospital that occurred on 12-3-23 [12/30/23]." Review of the "Notice of Discharge, Transfer or Relocation Form" dated 01/05/24 showed facility staff documented: - This proposed action is a transfer	F 625		

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F 625	Continued From page 16 - Type- hospital - You are scheduled to be transferred on 12/30/23 - Your available number of bed hold days - 18 The evidence showed that facility staff failed to provide Resident #34 with written information that specified the duration of the state bed-hold days before or within 24 hours of transfer to the hospital. The evidence further showed that this notice was provided upon being readmitted back to the facility on 01/05/24. During a face-to-face interview on 01/22/24 at 9:39 AM, Employee #4 (Director of Social Services) stated, "Notice of transfer forms should be done as soon as possible or within a day (24 hours) after the resident goes to the hospital. This one (Resident #34's) was done late. I don't know what happened; it was around the New Year's holiday." Cross Reference 22B DCMR Sec. 3270.1	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656	**Corrective action** Resident # 54 foley catheter was discontinued on 1/14/2024 therefore there was no need to revise the comprehensive care plan with goals and approaches for the use of an indwelling foley catheter.	

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F 656	Continued From page 17 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for one (1) of 42 sampled residents, the facility staff failed to develop a resident's person-centered comprehensive care plan with goals and approaches for the use of an indwelling Foley catheter. Resident #54.	F 656	**Identifying other residents** All residents with foley catheter could be affected. An audit for comprehensive care plans for all current residents with foley catheters will be completed by Unit Managers or designee by 2/21/2024 to ensure their comprehensive care plans is revised with goals and approaches for the use of foley catheters. **Systemic Changes** The Director of Nursing or designee will educate all License Nurses on developing resident comprehensive care plan for residents with foley catheter to ensure that they have developed a comprehensive care plan for the use of a foley catheter. **Monitoring corrective actions** Monthly audits of care plans for residents with foleys will be conducted by the director of nursing or designee monthly for three months to ensure that all residents with foleys have a comprehensive care plan developed	

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F 656	Continued From page 18 The findings included: Resident #54 was admitted to the facility on 11/27/23. The resident had a history of Cerebral Palsy, Asthma, Seizure, Anemia, Atrial Fibrillation, and Sepsis. A review of a physician's order dated 11/27/23 at 1900 [7:00 PM] directed: "Foley catheter care q shift every shift." A review of an Admission Minimum Data Set (MDS) assessment dated 12/05/23 revealed that facility staff coded Resident #54 had a severe cognitive impairment. The resident was dependent on staff for bed mobility, transfers, toilet use and the resident had an indwelling catheter. A review of Resident #54's comprehensive care plans lacked documented evidence that the facility staff developed a care plan with goals and approaches for his use of an indwelling urinary catheter. During a face-to-face interview on 01/24/24 at approximately 1:00 PM, Employee #2 (Director of Nursing) reviewed Resident #54's care plan and stated that she did not see a care plan to address the resident's use of an indwelling urinary catheter.	F 656	Any deficiencies will be corrected immediately. All findings will be reported monthly to the QAPI committee for 3 months for review recommendations, monitoring and education as needed. . Date of compliance February 21, 2024.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		

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F 690	Continued From page 19 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, for one (1) of 42 sampled residents, the facility's staff failed to ensure Resident #362 was provided appropriate care to prevent the resident's suprapubic catheter from becoming dislodged during care. Resident #362.	F 690	Corrective action Resident # 362 did not suffer any adverse effects from the dislodged suprapubic catheter on 2/15/22. Assigned C.N.A The employee is no longer at Bridgepoint Capitol Hill	

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F 690	Continued From page 20 The findings included: Resident #362 was admitted to the facility on 08/29/22 with multiple diagnoses including Functional Quadriplegia, Neuromuscular Dysfunctional Bladder, Urogenital Implants, and Calculus Ureter. It should be noted the resident was discharged home on 02/03/23. A review of a care plan dated 08/29/22 documented the following but not limited to: Focus Area - [Resident's name] has an indwelling suprapubic catheter (Neurogenic bladder). Goal - [Resident's name] will be free from catheter-related trauma through review date. Interventions -Catheter: [Resident's name] has 24fr indwelling suprapubic Catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. -Check tubing for kinks each shift. -Monitor and document intake and output as per facility policy. A review of a physician order dated 12/07/22 instructed, "Suprapubic cateter r/t (related to) neurogenic bladder every shift." A Situation, Background, Assessment, Request Form dated 12/21/22 at 5:30 AM documented, "Writer was called to room 6133 by resident 'sitter regarding resident suprapubic catheter at 0515 (5:15 AM). Upon assessing resident, his suprapubic catheter was noted dislodged out of his bladder and intact with small bleeding at stoma site. Resident sitter stated that pt's (patient's) suprapubic catheter got dislodged while care was being rendered by assigned CNA	F 690	Identifying other residents All residents with foley catheters could be affected. Random observations of the C N A caring for residents with Foley catheter will be conducted weekly by the unit managers of current resident with foley catheters to ensure that the C.N.A caring for residents with foleys catheter are gentle when providing care to prevent dislodgment of foley catheters, also to ensure that the resident foley catheter is secured with a leg strap to prevent dislodgement. C N A will be educated immediately if any deficient practice(s) are observed Systemic changes The Director of nursing or designee will in-service all C.N.A 's and License Nurses on ensuring that they are gentle when providing care for residents with Foley catheter to prevent dislodgement.	

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F 690	Continued From page 21 (Certified Nurse's Aide). Resident denied pain upon assessment, new suprapubic catheter 24fr (French)/10cc (millimeters) available was inserted aseptically per facility guideline, procedure well tolerated and suprapubic catheter draining expectedly." A Root Cause Analysis and Action Plan dated 12/21/22 at 5:45 AM documented the following but not limited to, "Root Cause Analysis findings as possible improper handling of the catheter." A review of a State Survey Agency Intake Form (DC~11405) dated 12/28/23 documented, "Suprapubic catheter dislodge at 0515 (5:15 AM) during morning (sic) care. Upon assessing resident, suprapubic catheter noted out of his bladder and intact with small bleeding at stoma site. Resident 'sitter stated that pt's suprapubic catheter got dislodged while care was being rendered by assigned CNA. Resident denied pain upon assessment, new suprapubic catheter 24fr/10cc available was inserted aseptically per facility guideline, procedure well tolerated and suprapubic catheter draining expectedly. Mother called and informed at 0645 (6:45 AM). MD called and gave order for urology consult." During a face-to-face interview on 01/16/24 at 1:39 PM, the Director of Nursing (DON) stated that the resident's catheter should not have been dislodged during care. Additionally, the employee said that the Certified Nursing Assistant involved was re-inserviced on handling durable medical equipment gently when providing care at the time of the incident. In addition, the employee stated that staff are always instructed to handle durable medical equipment gently.	F 690	Monitoring corrective actions Monthly random observations of 5 residents with foley catheter that C N A are providing care for will. be completed by Unit Managers or shift supervisors monthly for 3 months to ensure that C.N.A's and License Nurses when providing care for resident with foley catheters are being gentle when providing care for Residents with foley catheter and that their foley catheter is secured to prevent dislodgment of foley catheters by Any deficiencies will be corrected immediately. All findings will be reported monthly to the QAPI committee for 3 months for review recommendations, monitoring and education as needed. Date of compliance will be February 21,2024.	

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F 697 F 697 SS=D	Continued From page 22 Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, for one (1) of 42 sampled residents, Employee #5 (Licensed Practical Nurse/LPN), failed to ensure that Resident #46 received effective pain management in accordance with the physician's orders and the comprehensive care plan. The findings included: Resident #46 was admitted to the facility on 11/02/23 with diagnoses that included: Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease (COPD) and Retention of Urine. A physician's order dated 11/02/23 that directed, "Acetaminophen (pain reliever) Tablet 325 MG (milligrams), give 2 tablets by mouth every 6 hours as needed for pain, do not exceed 3-4gm (grams) in 24 hours." A care plan focus area: "[Resident #46] has acute pain r/t (related to) medical procedure abdominal surgical site. Date Initiated: 11/02/2023." Interventions included: - Administer analgesia medication as per orders - Give 1/2 (half) hour before treatments or care - Anticipate the resident's need for pain relief and	F 697 F 697	Corrective action Resident # 46 did not suffer any adverse effect from the staff not providing effective pain management that was consistent with the physician order and the comprehensive care plan. Resident #46 was assessed for pain on 2/.16/2024 by Director of Nursing, Resident denied pain as at that time. Employee #5 was educated on 2/16/2024 by Director of Nursing to ensure that she administer pain medication to resident that complained of pain effective pain management that was consistent with the physician order and the comprehensive care plan.	

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F 697	Continued From page 23 respond immediately to any complaint of pain A physician's order dated 11/06/23 that directed, "Vital signs every shift" An Admission Minimum Data Set (MDS) assessment dated 11/08/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition; received PRN pain medications; experienced pain almost constantly; and that pain almost constantly interfered with therapy and day-to-day activities. Resident #46's vital signs and Medication Administration Record (MAR) showed the following: - 01/01/24 at 12:33 PM, staff documented pain level "9" on the numerical scale - 01/01/24 at 4:35 PM, staff documented pain level "9" on the numerical scale However, the MAR and progress notes lacked documented evidence that the resident was medicated for pain for the previously mentioned dates and times. It should be noted that the resident's next documented pain assessment was "0" on 01/01/24 at 6:23 PM. Resident #46's vital signs and Medication Administration Record (MAR) on 01/08/24 showed the following: - 01/08/24 at 12:22 PM, staff documented pain level "10" on the numerical scale - 01/08/24 at 3:24 PM, staff documented pain level "10" on the numerical scale - 01/08/24 at 6:20 PM, staff documented pain	F 697	**Identifying other residents** All residents with orders for pain medication and care plan related to pain management could be affected. All current residents receiving pain medications in the last 30 days prior to survey will. be audited by Unit Managers and or shift supervisor to ensure that they received effective pain management that was consistent with the physician orders and the comprehensive care plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING _____ B. WING _____	C 01/25/2024

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F 697	Continued From page 24 level "9" on the numerical scale However, the MAR and progress notes lacked documented evidence that the resident was medicated for pain for the previously mentioned dates and times. It should be noted that the resident's next documented pain assessment was "0" at 11:23 PM on 01/08/24. Review of the progress notes dated on 01/01/24 and 01/08/24 showed no documented refusal of Acetaminophen by Resident #46. Review of the 5th floor nursing assignment sheet showed that Employee #5 (Licensed Practical Nurse/LPN), was the nurse assigned to Resident #46 on the dates 01/01/24 and 01/08/24, day shift (7:00 AM - 7:00 PM). During a face-to-face interview on 01/16/24 at 9:45 AM, Employee #5 stated, "When a resident reports pain, I have to assess where the pain is and use the 1 to 10 scale to get the level. Then, whatever PRN (as needed) or regular medication they can get at that time, I would give it to them and then reassess half an hour later. If a resident refuses medications, I would let the doctor know and document it in PCC (Point Click Care, facility's electronic health record system)." The employee was shown Resident #46's vital signs record, MAR and progress notes for January 2024 and asked where was the documented evidence that the resident either received or was offered and refused pain medications on 01/01/24 and 01/08/24 when he reported numerical pain levels of "9" and "10". The employee replied, "I did give him [Resident #46] the PRN medication. I	F 697	**Systemic Changes** The Director of Nursing or designee will in-service all License Nurses on ensuring that all residents receive effect pain management that was consistent with the physician orders and the comprehensive CP. **Monitoring corrective action** The Director of Nursing will audit 5 residents a weekly x 3 months that are receiving pain medication to ensure that they are receiving effective pain management consistent with the physician orders and the comprehensive care plan. Any deficiencies will be corrected immediately All findings will be reported Monthly x three months to the QAPI committee for review recommendations, monitoring, and education as needed. Date of compliance will be February 21, 2024.	

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F 697	Continued From page 25 don't know why it didn't show up on the MAR." The evidence showed that on 01/01/24 and 01/08/24 during the day shift, 7:00 AM - 7:00 PM, Employee #5 failed to provide Resident #46 with effective pain management that was consistent with the physician's orders and the comprehensive care plan. Cross Reference 22B DCMR Sec. 3211.1	F 697	**Corrective Action** Employee # 5 was educated by the Director of Nursing on 2/16/2024 on ensuring enteral medication are administered separately then flushed with 5-10 ml of water after each medication per policy. Resident # 4146, # 4153, #4156, # 4155 and # 4150 did not suffer any adverse effects from their enteral medications combined and administered at the same time as indicate on assessment completed by unit manager on 1/10/2024	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		

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F 726	Continued From page 26 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on one (1) of five (5) observations and staff interview, facility staff failed to demonstrate competency to provide appropriate nursing services to assure resident safety. The findings included: According to the "National Library of Medicine-National Center for Biotechnology Information", - If multiple medications must be administered enterally, they should be administered separately, ideally after flushing the feeding tube with 5-10 mL of water, due to the unpredictable stability and compatibility of crushed drug mixtures and the potential for serious drug-drug interactions - Guidance documents from CMS (Centers for Medicare and Medicaid Services) state that the crushed medications should not be combined and given all at once via feeding tube https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10511598/ According to the "Long-Term Care Nursing: Medication Pass", - Do not, under any circumstances, try to pre-pour medications to save time - Pre-pouring medications are against regulations - In addition, it increases the risk of making mistakes https://ceufast.com/course/long-term-care-nursin	F 726	**Identifying other residents** All residents that are receiving enteral feeding could be affected. All medications carts were audited on 1/10/24 on all units by Unit Managers no other medication carts had any pre poured medications in them, **Systemic changes** Director of Nursing or designee will in-service all License Nurses not to combine enteral medications when administering them to prevent unpredictable stability and compatibility of crushed drug to drug interactions.	

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F 726	Continued From page 27 g-medication-pass#:~:text=More%20specifically%2C%20do%20NOT%2C%20under,the%20risk%20of%20making%20mistakes. During an observation on 01/10/24 at 9:25 AM of "Medication Cart C" on the 4th floor with Employee #5 (Licensed Practical Nurse/LPN), the surveyor noted plastic cups with a substance that appeared to be crushed medications in water in the medication compartments for residents in rooms #4146, #4153, #4156, #4155 and #4150 (5 in total). When asked about the cups, Employee #5 stated that those were resident medications in the cups. "I checked the medications against the [physician] orders first but I have not signed them off. I will sign them off once I give the resident their medications. I did that to let the medications soak so the G-tube (gastrostomy) tubes don't get clogged." When asked is that the standard of practice for medication administration, Employee #5 stated "No." During a face-to-face interview on 01/10/24 at 9:34 AM, Employee #6 (4th floor Unit Manager) stated that medications are not to be crushed or pre-poured ahead of time. "We are supposed to go to each resident, administer the medications as ordered and then sign off." The evidence showed that Employee #5 failed to demonstrate competency to provide appropriate nursing services to assure resident safety.	F 726	**Monitoring corrective actions** The unit manager and or shift supervisors will conduct weekly audits x 3 months on resident receiving enteral feeding to ensure that their medications are administered separately and not combined to prevent drug to drug interactions. Any deficiencies will be corrected immediately. All findings will be reported monthly x 3 months to the QAPI committee for 3 months for review recommendations, monitoring and education as needed. - Date of compliance will be February 21,2024.	
F 755 SS=D	Cross Reference 22B DCMR Sec. 3226.4 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 28 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on one (1) of five (5) observations, record review and staff interviews, facility staff failed to ensure that the system to account for the reconciliation of controlled medications was followed. The findings included:	F 755	Corrective action Narcotic Books on all units were checked by unit managers on 1/11/2024 no other narcotic books had an issue with reconciliation of controlled medications. All license Nurses that worked on the 5th floor from 1/1/24 through 1/11/2024 were educated between 1/11/2024 to 2/16/2024 on ensuring that they count controlled medication at the beginning and end of their shift with the incoming and outgoing nurse and sign the narcotic reconciliation log to ensure no that the drug reconciliation is correct and there are no missing signatures.	

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F 755	Continued From page 29 During an observation on 01/11/24 at 8:44 AM of "Medication Cart B" on the 5th Floor with Employee #7 (Licensed Practical Nurse/LPN) the following was noted on the January 2024 "Controlled Medication Shift Change Log": - 01/01/24 - 7:00 AM "count correct"- left blank; "signature off-going nurse"- left blank; "signature on-coming nurse"- left blank - 01/01/24 - 7:00 PM "count correct"- left blank; "signature off-going nurse"- left blank; - 01/02/24 - 7:00 AM "count correct"- left blank; "signature off-going nurse"- left blank; - 01/06/24 - 7:00 AM - 7:00 PM "count correct"- left blank - No entry for 01/06/24 7:00 PM - 7:00 AM - 01/07/24 - 7:00 AM - 7:00 PM "count correct"- left blank - 01/07/24 - 7:00 PM - 7:00 AM "count correct"- left blank - 01/08/24 - 7:00 AM - 7:00 PM "count correct"- left blank; "signature on-coming nurse"- left blank - 01/08/24 - 7:00 PM - 7:00 AM "count correct"- left blank; "signature off-going nurse"- left blank; - 01/09/24 - 7:00 AM - 7:00 PM "count correct"- left blank; "signature on-coming nurse"- left blank - 01/09/24 - 7:00 PM - 7:00 AM "count correct"- left blank; "signature off-going nurse"- left blank; "signature on-coming nurse"- left blank - 01/10/24 - 7:00 AM - 7:00 PM "count correct"- left blank; "signature off-going nurse"- left blank; "signature on-coming nurse"- left blank - 01/10/24 - 7:00 PM - 7:00 AM "count correct"- left blank; "signature on-coming nurse"- left blank; - 01/11/24 - 7:00 AM - 7:00 PM "count correct"- left blank; "signature off-going nurse"- left blank. When asked about the narcotic count from this	F 755	Identifying other residents All residents receiving controlled medications have the potential to be affected. The unit managers and or shift supervisor will review the narcotic book on every unit for the last 30 days prior to survey to ensure that License Nurses are following the control medication reconciliation process. Systemic Changes The Director of Nursing or designee will in-service all License Nurses on the control count reconciliation process. The unit managers and shift supervisors will review all narcotic books weekly to ensure that the control count reconciliation process is followed.	

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F 755	Continued From page 30 morning (01/11/24 at 7:00 AM - 7:00 PM) where there was no documentation of if the reconciliation was count was correct and was missing the signature of the off-going nurse, Employee #7 stated, "I did [narcotic] count with the off-going nurse and it was correct, I forgot to circle 'yes' on the sheet. I'm not sure why she (off-going nurse) did not sign out." During a face-to-face interview on 01/11/24 at 9:12 AM, Employee #2 (Director of Nursing/DON) was shown the 5th floor January 2024 Controlled Medication Shift Change Log. The employee acknowledged the findings and stated, "Out-going and in-coming nurses are supposed to do [narcotic] count and make sure it is correct by circling yes or no and signing their name, that is the process." The evidence showed that facility staff failed to ensure that the system to account for the reconciliation of controlled medications was followed.	F 755	Monitoring corrective actions The unit managers and shift supervisor will audit all narcotic books weekly x 3 months to ensure the narcotic count reconciliation process is followed. Any deficiencies will be corrected immediately. All findings will be reported monthly to the QAPI committee for 3 months for review recommendations, monitoring, and education as needed. - Date of compliance will be February 21, 2024 Corrective action The cup of pineapples and pears were removed from the 4th floor test tray on 1/11/2024 and 1/12/2024 because the temperature was not at or below 41 degrees Fahrenheit. No residents were affected, new cooling bowls were delivered on 1/22/2024 to maintain proper temperature range.	
F 812 SS=D	Cross Reference 22B DCMR Sec. 3224.3 (d) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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F 812	Continued From page 31 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to serve cold food (pineapples and pears) at or below 41 degrees Fahrenheit for two (2) of 2 opportunities. The findings included: On 01/11/24 at 1:19 PM, a test tray on the 4th floor revealed a cup of pineapples that had a temperature of 51 degrees Fahrenheit. During a face-to-face interview on 01/11/24 at 1:20 PM, Employee #18 (Chef) acknowledged the findings. On 01/12/24 at 12:59PM, a test tray on the 4th floor revealed a cup of pears that had a temperature of 53 degrees Fahrenheit. During a face-to-face interview on 01/12/24 at 1:00 PM, Employee #18 acknowledged the findings. During a face-to-face interview on 01/12/24 at 1:30 PM, Employee #19 (Food Service Director) stated that moving forward they will order cooling bowls with lids to serve cold food.	F 812	Identify other residents. All residents in the facility could be affected. Director of food and nutrition services will check temperature on test trays once weekly on the units. ensure that cold items to include the fruit cup temperatures are at or below 41 degrees Fahrenheit. Systemic Changes The Director of food and nutrition services will educate all dietary staff to ensuring that cold items to include the fruits temperatures are at or below 41 degrees Fahrenheit. The Director of food and nutrition will also in-service dietary staff on ensuring fruits are placed in the cooling bowls. Monitoring and corrective actions The director of food services and or designee will have weekly temp checks on the test trays on the unit for three. months to ensure that fruit cup temperatures are at or below 41 degrees Fahrenheit. Any deficiencies will be corrected immediately. All findings will be reported monthly to QAPI committee for 3 months for review recommendations, monitoring and education as needed. . Date of compliance will be February 21,2024.	

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F 836 F 836 SS=D	Continued From page 32 License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 42 sampled residents, facility staff	F 836 F 836	**Corrective action** Resident # 70 did not have any adverse effects from employee # 20 administrative record not being created or retained for al least five years while providing services in the facility. Employee # 20 is no longer a staff at Bridgepoint Capitol Hill. **Identifying other residents** All residents could be affected. An audit of employee files will be completed by human resource director or designee to ensure that all agency employee hired within the last 30 days prior to the survey December 10, 2023 to ensure that all agency staff have documented evidence that an administrative record was created or retained for at least 5 years.	

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F 836	Continued From page 33 failed to operate and provide services in compliance with applicable State regulations regarding professionals providing services in the facility. Resident#70. The findings included: According to 22B DCMR sec. 3203.7, "Each administrative record shall be retained for at least five (5) years from the date of creation." Resident #70 was admitted to the facility on 11/16/22 with multiple diagnoses that included: Quadriplegia, Spinal Stenosis and Muscle Weakness. An Admission Minimum Data Set (MDS) assessment dated 12/19/22 showed facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognition. A Facility Reported Incident (FRI), DC~11412, submitted to the State Agency on 12/27/22 documented: [Resident #70] reported to the nursing supervisor that the assigned RN (Registered Nurse) screamed at him because he refused to be turned. During an onsite investigation and review of the facility's investigation documents on 01/22/24 at approximately 9:30 AM, the surveyor asked to see the human resources (HR)/administrave record for the RN/alleged perpetrator, Employee #1 (Administrator) and Employee #3 (Director of Human Resources) stated that they both looked but there is no file for that employee and would keep looking.	F 836	**Systemic changes** The human resource director will educate all staff in the human resource department to review all agency staff records upon hire to ensure that agency staff have documented evidence that an administrative record is created or retained for at least 5 years. **Monitoring corrective actions** Monthly audits of employee records will be reviewed by the Director of human resources or designee monthly x 3 months to ensure that all agency staff have documented evidence that administrative records are created and retained for at least 5 years. Any deficiencies will be corrected immediately. All findings will be reported monthly to the QAPI committee for 3 months for review recommendations, monitoring and education as needed. - Date of compliance will be February 21, 2024.	

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BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL	223 7TH STREET NE WASHINGTON, DC 20002

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F 836	Continued From page 34 During a face-to-face interview on 01/22/24 at 1:20 PM, Employee #3 stated, "She (Employee #20) is an agency nurse. We don't have a file or any documentation for her. [RN/alleged perpetrator] worked at the facility from January 2021 to December 2022. I am not sure if there are any previous allegations of abuse made against this employee or any disciplinary actions. It appears that she was terminated in December 2022 after the alleged incident with [Resident #70]. Since I started working here in March 2023, I have made sure that all employees, agency or not, have a file with HR that includes all the required information." This showed that facility staff failed to have documented evidence that an administrative record was created or retained for at least five (5) years for Employee #20, who was providing services in the facility. Cross Reference 22B DCMR sec. 3203.7	F 836		