

BRIDGEPOINT+

HEALTHCARE

07/28/2025

Sent via email 07/28/2025

Mrs. Kingsberry,
Program Manager
Office Of Healthcare Facilities Division
Health Regulation and Licensing Administration

RE: Form 2567 Plan of Correction and associated documents for April 13, 2025—05/05/2025
Annual certification Survey (Provider #095027),

We are submitting our Plan of Correction, Form CMS-2567 for April 13th, 2025, Annual certification survey. In addition, the following documents are also included:

- Form CMS-2567 for our April 13th, 2025, Annual survey.

If you have any questions, please feel free to contact me via email at ooyekoya@bridgepointhealthcare.com or call me at 202-546-5700 (ofc) or 813-476-5443 (cell).
Thank you.

Sincerely,



Olayinka Oyekoya, LNHA
Administrator
Bridgepoint Sub-Acute and Rehabilitation Capitol Hill

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Long Term Care Annual Recertification Survey was conducted at this facility April 13, 2025, through May 5, 2025. The survey activities consisted of a review of 49 sampled residents. The following deficiencies are based on observations, record reviews and resident and staff interviews. 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 resident census on the first day of the survey was 100 and the facilities license capacity is 117.

The following complaints were investigated during this survey: DC00012731, DC00012762, DC00012779, DC00012781, DC00012827, DC00012998, DC00013039, DC00013090, DC00013282, DC00013498, DC00013624 and DC00013628.

The following facility reported incidents were investigated during this survey: DC00012567, DC00012739, DC00012742, DC00012783, DC00012913, DC00013064, DC00013242, DC00013314, DC00013355, DC00013376, DC00013502, DC00013557, DC00013614, DC00013623, DC00013625, DC00013626 and DC00013635.

Federal and Local deficiencies were cited related to the investigation of: DC00012762, DC00012783, DC00012827, DC00013314, DC00013498, DC00013614, DC00013624, DC00013625 and DC00013626.

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

07/08/2025

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

TITLE

(X6) DATE

[Signature] ADMINISTRATOR 7/28/2025

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 During this survey, an Immediate Jeopardy (IJ) was identified at 42 CFR §483.25 Quality of Care (F689) on April 13, 2025, at 1:34 PM. The IJ was called on April 13, 2025, at 1:34 PM, the facility provided a plan of action to address the immediate concerns on April 13, 2025, at 5:04 PM and it was accepted at 5:04 PM. After the plan was verified, the IJ was removed on April 22, 2025, at 9:34 AM while the survey team was onsite. During this survey, an Immediate Jeopardy (IJ) was identified at 42 CFR §483.25 Quality of Care (F689) on April 17, 2025, at 3:00 PM. The IJ was called on April 17, 2025, at 3:36 PM, the facility provided a plan of action to address the immediate concerns on April 17, 2025, at 8:28 PM and it was accepted at 8:28 PM. After the plan was verified, the IJ was removed on April 24, 2025, at 1:50 PM while the survey team was onsite. 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 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	F 000			

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F 000 Continued From page 2

F 000

DCMR- District of Columbia Municipal
Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control
Program
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 canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident
Review
Peg tube - Percutaneous Endoscopic

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F 000 Continued From page 3

F 000

Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician 's order sheet
Pm - 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
TAR - Treatment Administration Record
Ug - Microgram

F 554 Resident Self-Admin Meds-Clinically Approp
SS=D CFR(s): 483.10(c)(7)

F 554 Tag: F 554- Resident Self-Administer
Medications (pgs. 4-6)

§483.10(c)(7) The right to self-administer
medications if the interdisciplinary team, as defined
by §483.21(b)(2)(ii), has determined that this
practice is clinically appropriate.
This REQUIREMENT is not met as evidenced by:

Based on observation, record review and resident
and staff interview, the Interdisciplinary Team (IDT)
failed ensure a resident was safe to self-administer
an Albuterol inhaler for one (1) of 1 sampled
resident who self-administer medicine. (Resident
#46).

The findings included:

Resident #46 was admitted on 09/27/22 with
multiple diagnoses including Pulmonary Chronic
Obstructive Disease, Bipolar, Schizophrenia, and

Corrective Action for Identified
Resident(s):
1. Resident #46 was assessed by the
DON on 4/15/2025 and found not to be
clinically appropriate for
self-administration of Albuterol due to
cognitive impairment. BIMS Score is 11.
2. The medication was removed from
the resident's room on 4/15/25 by the
unit nurse.
3. The physician and the responsible
party were notified on 6/16/2025 by the
unit nurse.
4. The care plan on medication
administration and the physician's
orders were updated on 6/16/2025 by
the floor nurse.

7/8/2025

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F 554	Continued From page 4 Anxiety. A policy titled, "Self-Administering Medications" with a review date of 05/24/24 instructed, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so... The staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medication is clinically appropriate for the resident...the nursing staff will determine who will be responsible (the resident or nursing staff) for document that medications were taken...medications must be stored in a safe and secure place, which is not accessible by other residents..." A physician order dated 02/21/25 instructed, "Albuterol -Budesonide Inhalation Aerosol 90-80 micrograms/actuation give 2 puffs by mouth every hour hours as need for shortness of breath." A quarterly Minimum Data Set assessment dated 03/21/25 documented that the resident had a Brief Interview for Mental Status summary score of "11" indicating that the resident had a moderately impaired cognitive status. The resident was also coded for requiring supervision from staff with activities of daily living and having a diagnosis of Chronic Obstructive Pulmonary Disease. During an observation on 04/14/25 at approximately 2:30 PM, the resident was observed sitting up in bed watching tv. At the time of the observation, the resident showed the surveyors an Albuterol inhaler that she had in her purse. The employee then stated that she uses	F 554	Cont. Tag: F 554- Resident Self-Administer Medications (pgs. 4-6) Identification of Other Residents Who Could Be Affected: 1. All residents with current orders for self-administration of medications were reviewed by 6/30/2025 by the Unit Manager via electronic medical record audits, direct observation, and staff interviews to verify clinical appropriateness and documentation accuracy. 2. An audit of all current residents was completed on 6/30/2025 by the Unit Manager to identify other residents who may have been self-administering medications without a physician's order. 3. Any additional residents that were identified during the audits were assessed for safety. Orders and care plans were updated according to their ability to safely administer their own medications. Systemic Changes Put in Place to Ensure Non-Recurrence: 1. The facility's policy on self-administration of medications was reviewed and revised by the DON on 6/16/2025. 2. The interdisciplinary team, licensed staff, were re-educated by the educator/designee on the revised medication self-administration policy by 7/8/2025.		

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F 554 Continued From page 5

her Albuterol inhaler at least 2 times a day (2 puffs) daily for shortness of breath. The resident said, "I can take my own medicine like I did at home. I don't want to answer any more questions."

A review of the April 2025 Medication Administration Record (MAR) lacked documented evidence that the resident used her Albuterol inhaler from 04/01/15 to 04/14/15.

During a face-to-face interview on 04/15/25 at approximately 9AM, Employee #38 (assigned LPN) stated that the resident keeps her Albuterol at the bedside, so she can administer it herself. The employee said that the resident used to "complain a lot" that she wanted to keep her Albuterol at the bedside like she did when she was home. When asked who documents in the MAR when it is administered, the employee failed to provide an answer.

During a face-to-face interview on 04/15/25 at approximately 10 AM, Employee #2 (DON) stated that the resident had not been assessed by the IDT to self-administer medication. The employee said she will ensure the Albuterol is removed from the resident's room.

F 578 Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir
SS=E CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive

Cont. Tag: F 554- Resident Self-
F 554 Administer Medications (pgs. 4-6)

3. Education for at least 80% of licensed staff was completed by the facility educator/designee by 7/8/2025.

Monitoring of Corrective Actions to Ensure Effectiveness:
The Director of Nursing (DON) or designee will audit 20 residents with self-administration medication orders weekly for 4 weeks, then monthly for 3 months, to ensure compliance with the self-administration of medications policy and guidelines. Any deficiencies will be corrected upon discovery. Findings of audits will be reviewed at monthly QAPI meetings. Any trends identified will prompt further education or systems adjustments.

Tag: F 578- Right to
Request/Refuse/Discontinue Treatment;
F 578 Formulate Advance Directives (pgs. 6-8)

Corrective Action for Identified Resident(s):
1. Residents #87, #56, #91, #74, and #73, and or their representatives have been provided with information regarding their rights to formulate or refuse an advance directive. This was completed on 6/13/2025 by the social worker.

7/8/2025

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F 578	Continued From page 6 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, five (5) of 49 residents sampled, facility staff failed to have documented evidence that they provided information to the residents and/or their representatives (RP) regarding their right to	F 578	Cont. Tag: F 578- Right to Request/Refuse/Discontinue Treatment; Formulate Advance Directives (pgs. 6-8) (cont.) Corrective Action for Identified Resident(s): 2. The medical records were reviewed and updated by the social worker to ensure the accurate documentation of the provision of information regarding their rights to formulate or refuse an advance directive. 3. The social worker and administrator were re-educated by the Regional Director of Operations on 7/8/2025. Identification of Other Residents Who Could Be Affected: 1. A facility-wide audit of current residents' medical records was completed by the Social Service Director on 6/16/2025 to ensure documentation of the provision of information regarding rights to formulate or refuse an advance directive. 2. No additional residents were identified without documentation of the provision of advance directives. A notification was sent to all current resident/families about their right to formulate an advanced directive via PCC by 07/8/2025 by Administrator in Training.		

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F 578	Continued From page 7 formulate or refuse an advanced directive. Residents #87, #56, #91, #74, and #73. The findings included: Review of the facility's "Advanced Directives" policy dated 05/24/24 documented: - Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. - If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. - Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. - If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. 1. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia. Review of the resident's medical record revealed the following: A face sheet that showed that listed the resident's daughter as her responsible party (RP), care conference person, emergency contact #1 and next of kin. A care plan focus area, last revised on 03/11/25	F 578	Cont. Tag: F 578- Right to Request/Refuse/Discontinue Treatment; Formulate Advance Directives (pgs. 6-8) Systemic Changes Put in Place to Ensure Non-Recurrence: 1. The Social Worker and administrator were re-educated on the facility's policy related to treatment refusal, resident rights, and advance directives on 7/8/2025 by the Regional Director of Operations. 2. Verification of the resident's right to request/refuse/discontinue treatment; formulation of advance directives was integrated into the admissions process, quarterly care plan reviews, and upon change in condition. Monitoring of Corrective Actions to Ensure Effectiveness: The Social Services Director or designee will audit 25 resident records monthly for 3 months to ensure consistency between resident preferences, physician orders, and care plans. Any deficiencies will be corrected upon discovery. Findings will be reported to the QAPI Committee for further action as needed. Any trends identified will prompt further education or systems adjustments.		

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F 578	Continued From page 8 documented: [Resident #87] end of life wishes to remain a full code. Goal(s): Interdisciplinary team (IDT) team will honor [Resident #87's] wishes for end-of-life care. Interventions: Assist with pre-burial needs upon request; Honor spiritual and cultural wishes Inform resident of memorial services within the facility via flyer; Offer "5 Wishes (the facility's advanced directives form)" quarterly. Review of Resident #87's medical record on 04/14/25 showed no documented evidence that the facility staff offered Resident #87's RP information to formulate or refuse to formulate an Advanced Directive. 2. Resident #56 was readmitted to the facility on 06/11/24 with multiple diagnoses that included: Amyotrophic Lateral Sclerosis (ALS) and Chronic Respiratory Failure with Hypoxia. Review of the resident's medical record revealed the following: A face sheet that listed the resident's sister listed as her RP, care conference person and emergency contact #1. 01/14/25 at 12:20 PM Care Conference Note: - Care plan meeting was held for the resident. - The resident is alert, oriented, and communicates using an assistive device. - The resident's sister participated by phone. - Will remain full code. - "Five Wishes" were offered to resident and placed in her room per her request. A care plan focus area last revised on 03/14/25 documented: [Resident #56] end of life wishes	F 578			

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F 578 Continued From page 9

are to remain a full code.
Goal(s): IDT team will honor [Resident #56's]
wishes for end-of-life care.
Interventions: Honor spiritual and cultural wishes;
Offer "5 Wishes" quarterly.

Review of Resident #56's medical record on
04/14/25 showed no documented evidence that the
facility staff offered Resident #56 or her RP
information to formulate or refuse to formulate an
Advanced Directive.

3. Resident #91 was admitted to the facility on
01/29/25 with multiple diagnoses that included:
Interstitial Pulmonary Disease, Type 2 Diabetes
Mellitus and Chronic Respiratory Failure.

Review of the resident's medical record revealed
the following:

A face sheet that showed that she was her on
responsible party.

An Admission Minimum Data Set (MDS)
assessment dated 02/04/25 showed that facility
staff coded: adequate hearing; clear speech; makes
self-understood; understands others; and a Brief
Interview for Mental Status (BIMS) summary score
of 13, indicating intact cognitive response.

A care plan focus area revised on 03/17/25,
[Resident #91] end of life wishes to be a full code,
had interventions that included: assist with
pre-burial needs upon request; honor spiritual and
cultural wishes; and offer "5 Wishes" quarterly.

Review of the resident's medical record on

F 578

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page 10 04/14/25 showed no documented evidence that the facility staff offered Resident #91 information to formulate or refuse to formulate an Advanced Directive. 4. Resident #74 was admitted to the facility on 04/16/24 with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure with Hypoxia and Type 2 Diabetes Mellitus. Review of the resident's medical record revealed the following: A face sheet that listed the resident's daughter as her RP, care conference person and emergency contact #1. A care plan focus area revised on 04/07/25 documented: Family wishes for [Resident #74] to be a do not resuscitate (DNR). Goal: IDT team will honor family end of life wishes as a communicated by family. Interventions: Provide advanced care planning information to family; Provide spiritual care in accordance with family's faith; Review "5 Wishes" with resident and family quarterly. Review of the resident's medical record on 04/14/25 showed no documented evidence that facility staff offered Resident #74's RP information to formulate or refuse to formulate an Advanced Directive. 5. Resident #73 was admitted to the facility on 04/04/24 with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure, and Adult Failure to Thrive. Review of the resident's medical record revealed	F 578			

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F 578 Continued From page 11
the following:

A face sheet that listed that she had a had a legal guardian who is her RP and emergency contact #1.

A care plan focus area, last revised on 0317/25 documented: Guardian end of life wishes for the resident to remain a full code.
Goal: IDT team will honor the wishes for end of life care.
Interventions: Honor spiritual and cultural wishes;
Offer "5 Wishes" quarterly.

Review of Resident #73's medical record on 04/14/25 showed no documented evidence that the facility staff offered the resident's guardian information to formulate or refuse to formulate an Advanced Directive.

During a face-to-face interview on 04/14/25 at 12:17 PM, Employee #18 (Director of Social Services) acknowledged the findings and stated, "I leave the advanced directive form (5 wishes) in the room for the resident or their RP. Once it's filled out, the resident or the family will give us (Social Services Department) a call to come get it." When asked who follows up if the advanced directive is not returned to the Social Services Department, Employee #XX stated that there is no follow-up done by him or anyone else in the Social Services Department if the Advanced Directive forms are not completed by the resident or their family/representative.

Cross Reference 22B DCMR Sec. 3231.12

F 600 Free from Abuse and Neglect
SS=D CFR(s): 483.12(a)(1)

F 578

Tag: F 600 Free from Abuse and Neglect (see pgs.12-14)

Corrective Action for Identified Resident(s):

1. Upon receiving the allegation, an immediate investigation was initiated to investigate the situation involving Resident #158. The investigation was completed on 5/6/2024 and documented in the abuse investigation folder.
2. Employee #39 was immediately removed from the schedule pending the outcome of the investigation.
3. Records of alleged abuse investigations are currently secured at the Administrator's office.

F 600

07/8/2025

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F 600 Continued From page 12

F 600 Cont. Tag: F 600 Free from Abuse and
Neglect (see pgs.12-14)

§483.12 Freedom from Abuse, Neglect, and
Exploitation
The resident has the right to be free from abuse,
neglect, misappropriation of resident property, and
exploitation as defined in this subpart. This
includes but is not limited to freedom from corporal
punishment, involuntary seclusion and any physical
or chemical restraint not required to treat the
resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or
physical abuse, corporal punishment, or involuntary
seclusion;
This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff and family
interviews, the facility failed to have documented
evidence that verbal abuse of resident did not occur
after receiving an allegation of staff-to-resident
verbal abuse for one (1) of 1 sampled residents.
(Resident #158)

The findings included:

Resident #158 was admitted on 03/06/24 with
multiple diagnoses including Altered Mental Status,
Muscle Weakness, and Psychotic Disorder.

During a telephone interview related to different
concern (Complaint DC~12827) on 04/25/25 at
approximately 10 AM, the resident daughter
(complainant) stated that Employee #39 (CNA) said,
"My mom was pistol in front of my mom. After the
employee said my mom was afraid and wanted to
go home." The resident's daughter

Identification of Other Residents Who
Could Be Affected:

1. All allegations of abuse in the past 4
weeks were reviewed by the
Administrator and DON by 6/30/2025 to
assure investigations are complete and
noted in the medical records. No
additional deficiencies were noted.
2. All abuse investigation records are
currently secured at the Administrator's
office.

Systemic Changes:

1. The facility abuse prevention policy
was reviewed and updated by 6/30/2025
by the Administrator/DON to ensure
clarity in reporting and documentation
procedures.
2. At least 80% of the current facility
staff will be provided training on the
abuse prevention policy by the
educator/designee.
3. A checklist has been developed to
ensure completion and documentation
of the abuse investigation, reporting,
and documentation process.

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F 600	Continued From page 13 then said, "I told her [Employee #39] that I would not tolerate any mistreatment of my mom. And then the employee said that she could tell I was from the streets." Additionally, the resident's daughter said that she made the Administrator aware and she never saw Employee #39 again. It should be noted that the resident's daughter could not remember the specific date of the incident. On 04/24/25 at approximately 11 AM, a review of Resident #158's medical record and the facility's incident binder lacked documented evidence of alleged incident of verbal abuse. During a face-to-face interview on 04/29/25 at 6:20 AM, Employee #39 stated that the Administrator and Human Resource Director called her into a few months. The meeting was held because Resident #158's daughter said, "I verbally abused her and her mom." The employee stated that she did not verbally abuse anyone. She was suspended for 2 day during the investigation and moved to a different floor when she returned to work. During a face-to-face interview on 04/29/25 at approximately 10 AM, Employee #1 (Administrator) stated that he remembered the incident. The employee said that they conducted an investigation and could not substantiate that staff-to-resident verbal abuse occurred. However, the employee said that the Human Resource's Director who no longer works for the facility had the investigation documents. And he was not able to locate them. Additionally, the employee said that Employee #39 (CNA) was suspended while the investigation was conducted, and she was moved to another floor when she returned to	F 600	Cont. Tag: F 600 Free from Abuse and Neglect (see pgs.12-14) Monitoring of Corrective Actions: 1. The Administrator or designee will review 50% of all alleged abuse investigations weekly for 4 weeks and monthly for 3 months for documented evidence of investigation and conclusion. Any deficiencies will be corrected upon discovery. 2. The Abuse Coordinator will monitor for unreported concerns. 3. Trends and outcomes will be reviewed by the QAPI Committee. Any trends identified will trigger further education or systems adjustments.		

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F 600	Continued From page 14 work.	F 600			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews for one (1) of 49 sampled residents,	F 604	Tag: F 604- Right to be Free from Physical Restraints (pgs. 15-16) Corrective Action for Identified Resident(s): 1. Resident #308 was assessed by therapy services 6/16/25, and it was determined that the bedrails were not medically necessary. 2. The bedrails were secured on 4/23/2025 by the Biomed staff. 3. The physician and responsible party were notified, and the resident's bedside screen and physician's orders were updated to reflect alternative safety interventions. Identification of Other Residents: 1. A facility-wide audit was completed by the unit managers/supervisors for residents with bedrails or other devices that could constitute restraints. Additional physical audits of our beds were completed on-4/23/2025 by Biomed and included in-room observations (of the beds). 2. For residents identified with 4-bed rails, an assessment was completed on 4/23/2025 for appropriateness of use of bedrails, and care plans were revised as indicated. 3. Any additional residents identified during the audit will be reviewed for the appropriateness of bedrails, and a corrective action will be implemented. Any deficiencies noted will be corrected upon discovery.		07/8/2025

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F 604	Continued From page 15 facility staff failed to provide documented evidence that one resident's bedrails were not being used as a restraint for a non-ambulatory, cognitively impaired resident who required extensive assistance with bed mobility and transfers. Resident #308. The findings included: A facility document titled 'Physical Restraint Application' with a review date of October 2010 documented the following: "Definition - Physical restraints are defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body" "Documentation - The following information should be recorded in the resident's medical record: 1. The date and time the restraint was applied. 2. The name and title of the individual(s) who applied the restraint. 3. The type of physical restraint applied. 4. The specific reason the restraint was applied. 5. The length of time the restraint will be used. 6. Each time the device is released for resident exercise, toileting, and position change. 7. Each time the resident is monitored, per facility policy. 8. All assessment data (e.g., bruises, rashes, sores, etc.) observed during the procedure. 9. If and how the resident participated in the procedure or any changes in the resident's ability	F 604	Cont. Tag: F 604- Right to be Free from Physical Restraints (pgs. 15-16) Systemic Changes: 1. The facility's restraint use policy was reviewed by the DON, and at least 80% of licensed staff, clinical team, therapy, and nurse aides were re-educated by the educator/designee on residents' rights to be free from physical restraints. 2. A bedrail assessment form was implemented as part of admission evaluations and quarterly reviews. 3. The IDT now reviews all bedrail use at least quarterly to ensure continued clinical necessity and documentation accuracy. Monitoring of Corrective Actions: 1. The Director of Nursing or designee will audit 25 residents with bedrails weekly for 4 weeks, and then monthly for 3 months to ensure restraint use is clinically justified and documented. Any deficiencies noted will be corrected upon discovery. 2. Findings will be reviewed during QAPI meetings. Any trends identified will prompt further education or systems adjustments. Any deficiencies noted will be corrected upon discovery.		

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F 604 Continued From page 16

F 604

to participate in the procedure.
10. Any problems or complaints made by the resident related to the restraint application.
11. If the resident refused the treatment and the reason(s) why.
12. The signature and title of the person recording the data."

A review of Resident #308's medical record revealed:

A siderail assessment dated 04/04/22 documented, "Yes - Involuntary or voluntary movement where it is observed that body parts are able to touch or roll into side rails with a 2 person turn and reposition; Yes - Resident unable to maintain positioning in bed as placed by staff with the use of regular pillows."

A physician's order dated 02/12/25 documented, "SIDE RAILS 1/4 (one quarter) EVERY SHIFT AS ENABLER TO PROMOTE BED MOBILITY every shift."

A Quarterly Minimum Data Set (MDS) Assessment dated 02/27/25 documented: facility staff marked "No" that indicated that they were "unable to conduct the brief interview for mental status." It should also be noted that the MDS revealed that the resident had impairment on both sides to upper and lower extremities; was dependent on staff for rolling left and right; and required 2+ person assist for bed mobility, transfers, and toileting.

During an observation conducted of the resident's room on 04/13/25 at approximately 9:00 AM, the resident was observed lying in bed with all four (4) bedrails in the upward position.

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F 604	Continued From page 17 During a subsequent observation conducted on 04/22/25 at approximately 12:00 PM, the resident was observed lying in bed with all four (4) bedrails in the upward position. It should be noted that there was no documented evidence in Resident #308's medical record stating that the resident should have all four (4) bedrails in use and in the upward position. During a face-to-face interview conducted on 04/23/25 at approximately 8:45 AM, Employees' #1 (Administrator) and #2 (Director of Nursing) both acknowledged the findings. Employee #1 stated, "We don't have a bedrail policy, because the standard is that we only use two (2) siderails up for all of the beds, otherwise it is entrapment and also a restraint" and Employee #2 stated, "He was transferred here from LTACH (Long-Term Acute Care Hospital) in that bed to accommodate his size, but he shouldn't have the two (2) siderails at the bottom because four (4) siderails would be a restraint. He doesn't get up all, he can't move."	F 604	Tag: L 609- Reporting of Alleged Violations (pgs. 18-20) Corrective Action for Identified Resident(s) 1. The incident of alleged abuse of residents #62, #40 was reported to the administrator on 4/22/25 and to the state on 4/22/25 by state and federal law requirements. Both residents were seen by psych on 4/28/25 with no negative outcomes noted. 2. Employees #28, #29, and #32 were immediately removed from the schedule on 4/22/25 pending the outcome of the internal investigation. 1 employee is no longer at BridgePoint Capitol Hill. The other 2 employees received training on Abuse Reporting prior to returning to work.		7/8/2025
F 609	Reporting of Alleged Violations SS=D CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609			

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F 609 Continued From page 18

that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews for two (2) of 49 sampled residents, facility staff failed to report an incident of alleged staff-to-resident verbal abuse to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Residents #62 and #40

The findings included:

A facility policy titled 'Abuse Investigation and Reporting' with a review date of 05/24/24 documented the following:

"Policy Statement - All reports of resident abuse, neglect, exploitation, misappropriation of resident

F 609 Cont. Tag: L 609- Reporting of Alleged Violations (pgs. 18-20)

Identification of Other Residents:

1. A facility-wide a random interview of 10% of employees was conducted by the Administrator or designee by 6/20/2025 of all resident incident reports for the past 30 days to identify any unreported allegations of abuse.
2. Interviews were initiated with staff to ensure no other incidents have gone unreported.
3. For any allegations of abuse identified during the auditing process, the facility ensured reporting was completed to the administrator of the facility and other officials, including state survey agencies and adult protective services, according to state and federal requirements. Any deficiencies noted were corrected upon discovery.

Systemic Changes:

1. At least 80% of all staff will receive mandatory re-education by the educator/designee by 6/30/2025 on the facility's policy for reporting alleged violations, including the obligation to report immediately to the Administrator and the State Survey Agency.
2. The reporting policy was reviewed and revised by the Regional Director of Operations by 06/30/25 to reflect state and federal expectations on abuse reporting.
3. Anonymous reporting protocols were reinforced

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F 609	Continued From page 19 property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." "Reporting - 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." 1. Resident #62 was admitted to the facility on 02/06/24 with diagnoses that included: Chronic Respiratory Failure with Hypoxia, Atrial Fibrillation, Morbid (Severe) Obesity, Type 2 Diabetes Mellitus, Acute Kidney Failure, Anxiety Disorder and Schizophrenia. A review of Resident #62's medical record revealed: A PASRR (Pre-Admission Screen/Resident Review) Level II determination letter dated 01/19/24 that justified the resident's nursing home placement in the facility. A significant change minimum data set (MDS) assessment dated 01/31/25 that documented that the Resident had a Brief Interview for Mental Status (BIMS) of, "11" indicating that the Resident had moderately impaired cognition. In addition, the assessment documented that the Resident experienced hallucinations, displayed verbal		Cont. Tag: L 609- Reporting of Alleged Violations (pgs. 18-20) Monitoring of Corrective Actions 1. The Administrator or designee will audit 5 incident and grievances weekly for 4 weeks and monthly for 3 months to ensure proper identification and timely reporting of allegations. Any deficiencies noted will be corrected upon discovery. 2. Audit outcomes will be reviewed during monthly QAPI meetings. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustments.		

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F 609	Continued From page 20 behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) for 1 to 3 days, rejected care daily, was independent with most ADLs (activities of daily living), was occasionally incontinent and received supplemental oxygen. A review of physician's orders dated 02/12/25 that directed: "Please document exact behavior exhibited under behavior note, every shift," and "Psych Consult and PRN." A Psych Progress Note dated 02/19/25 that documented: 1. Mood and behavior: Upon today's evaluation in my opinion his symptoms of irritability and frustration tolerance are due to underlying anxiety and depression associated with poor self-control declined health, and long hospital stay. The patient is exhibiting episodic flares of depression and anxiety. Denies active passive SI (suicidal ideation). He is future-oriented and wants to get better." A review of a care plan initiated on 02/12/24 that documented: Focus: [Name of Resident # 62]:is dependent on staff etc, for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Physical Limitations; Interventions included: All staff to converse with resident while providing care. A review of a care plan initiated on 02/16/24 that documented: "Focus: [Name of Resident # 62] is/has potential to be verbally aggressive r/t (related to) ineffective coping skills; Goal: [Name of Resident # 62] will verbalize understanding of need to control verbally abusive behavior through the review date. Interventions ... When the	F 609			

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F 609	Continued From page 21 resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. A review of a care plan initiated on 02/16/24 that documented: "Focus: [Name of Resident # 62] is resistive to care r/t (related to) non adherent to medication and refusal of care; Goal: [Name of Resident # 62] will cooperate with care through next review date; Interventions: ... Give clear explanation of all care activities prior to an as they occur during each contact.; Praise the resident when behavior is appropriate. " A review of a facility reported incident (DC~13626) dated 04/22/25 that documented: " . A review of the facility's investigation packet for the incident revealed the following: written statement by Employee #32/Certified Nurse Aide: "The CNA [Employee #28] was passing trays, [Resident #62's Room #] came to the door. The CNA said, 'Oh you scared me. The resident said, "I didn't do anything. The CNA said you crazy you talk to yourself. The resident said, yes, that's why I take medicine.' She [CNA/Employee #28] laughed and the resident said if it's a problem, don't come back to my room. The CNA 's name is [Name of Employee #28]. The resident's name is [Name of Resident #62]." A further review of the facility's investigative documents showed no documented evidence per the facility's policy that Employee#32 reported the alleged incident of verbal abuse immediately to the Administrator, DON, or a nurse or nursing supervisor in her department. Knowledge of the	F 609			

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F 609	Continued From page 22 incident came as a result of the facility's ongoing investigation of a separate incident of alleged verbal abuse between Employee #28 and another resident on the unit. During telephone interview on 04/28/25 02:14 PM, Employee #32 stated: "I was passing meal trays with the CNA who was training me. Resident #62 was standing at his door, Employee #28 said something like," Oh you scared me, you were talking to yourself. You're crazy. It was my first day and I was just trying to learn and do my job. I had received abuse training during orientation before I was allowed to work on to the unit, but I didn't think to report the incident with Resident #62 until I was questioned about an incident that involved Employee #28 and another resident. After the incident I never saw the CNA on the floor again, and I was told that I should not report to work until I was notified by my supervisor. During a face-to-face interview on 04/28/25 at 9:44 AM, Employee #2 Director of Nursing, she acknowledged the finding and stated that Employee #32 had been given a written and verbal warning for not reporting the alleged incident of staff-to-resident verbal abuse. 2. Resident #40 was admitted to the facility on 12/17/21 with multiple diagnoses that included: Dementia, Encephalopathy, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Anoxic Brain Damage and Epilepsy. A review of Resident #40's medical record revealed:	F 609			

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F 609	Continued From page 23 A Quarterly Minimum Data Set (MDS) Assessment dated 01/23/25 documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '01,' indicating the resident was severely impaired. Functional abilities that documented the resident required 1+ person assist with bed mobility and 2+ person assist with transfers and toilet use. During a review of Employee #28's (Certified Nursing Assistant, CNA) employment file, it revealed an 'Employee Warning Notice' dated 04/17/25 that documented, "Removed from Schedule pending investigation 4/19/25, 4/20/25, 4/22/25" and "On 4/17/25, in [room number] the RP (Responsible Party) for Resident #81 alleged that the person that brought her mother's tray called her a [expletive]. Employee #28 was assigned to the resident's room and was responsible for delivering the tray. [The] Employee was suspended pending investigation." A facility reported incident dated 04/22/25 at 6:32 PM documented, "During an ongoing abuse investigation on 4/22/25 at about 12:25 PM it was discovered that Employee #29 (CNA) alleged that she witnessed [Employee #28's name] verbally abused [Resident #40's name]." A care plan dated 04/22/25 documented, "Focus: A CNA alleged that [Resident #40's name] was verbally abused by another CNA on 04/22/25. Goal: Resident will be safe through the review date. Intervention: Resident will be treated with respect and dignity that he deserves during care." A review of Employee #29's (CNA) employment file showed an 'Employee Warning Notice' dated 04/22/25 that documented, "Removed from	F 609			

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F 609	Continued From page 24 schedule pending investigation and Violation of Policy/Procedure (Reference Policy HR (human resources) 401)" and "During the course of an abuse investigation [Employee #29's name] stated that she witnessed the alleged verbal abuse but failed to report it. The investigation is ongoing." During a face-to-face interview conducted on 04/24/25 at approximately 2:41 PM, Employee #3 (Nurse Supervisor) acknowledged the findings and stated, "It didn't happen that day (04/22/25). We were investigating an incident with [Resident #81's name]. There was a new CNA, [Employee #29's name], we were just asking the staff about any issues of abuse with residents, and she stated she saw [Resident #40's name] being verbally abused by [Employee #28's name], but she said that it had happened a long time ago. We educated her on reporting right away and she should not wait even if she is a new employee. I don't know how long she has worked here or when she was hired. So that's being investigated to try to figure out when that happened. I don't know when that (verbal abuse) happened." During a telephone interview conducted on 04/25/25 at approximately 10:14 AM, Employee #29 stated, "I just started at this job, and [Employee #28's name] was training me. On my last week of two (2) week orientation, I witnessed her talking to [Resident #40's name]. He can be disrespectful, but I don't pay him know mind. He said, 'Get the [expletive] away, leave me the [expletive] alone, leave me alone I'mma (I'm going to) [expletive] you up.' Then [Employee #28's name] said to '[Resident #40's name] if you touch me I'mma (I'm going to) [expletive] you up, I don't have time for this.' Employee #29 further	F 609			

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F 609	Continued From page 25 stated that, "They (facility staff) have me under her training me and this is what they have me trained under. They came to me with a paper; it was a paper with questions about if I have ever witnessed [Employee #28's name] and I said Yes and that's when I told them what I witnessed. I have talked to [other staff] people in the workspace, and they just say things like 'I don't see nothing, I don't know nothing.' They don't care about the residents here. I was afraid of retaliation if I said anything and the [other staff] people here going against me, it's not confidential. Everybody was watching me, it was so uncomfortable because everyone knew what I [had] reported." During a Face-to-face interview conducted on 04/28/25 at approximately 11:40 AM, Employee #28 stated, "There was an incident with the 'B' [expletive] word. I was passing the trays I went to [Resident #81's name] room first. I had worked with her before, and she would use the 'B' word, but I didn't call her that." Employee #28 was asked about her interaction with Resident #40 and she stated, "Yes, I've worked with him before. He gets agitated when he's really wet or wants to eat. He has always said the 'B' word to me, but I have never been abusive to him." During a telephone interview conducted on 05/01/25 at approximately 2: 49 PM, Employee #30 (Nurse Educator) acknowledged the findings and stated, "If there is a report of abuse allegation, the staff are informed to contact the charge nurse who will reach out to the nurse supervisor immediately. If the allegation is about an employee and the employee is working with the resident, then the employee will be sent home. It's repeated during my education and the	F 609			

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F 609	Continued From page 26 facility's [Abuse] policy is also included in the education. What I say to the staff is if a resident reports abuse, even if you believe it's true or not, it must be reported within two (2) hours. The expectation if it's witnessed by another staff, they should tell the charge nurse and nurse supervisor and provide a statement before they leave for the day."	F 609			
F 610	Investigate/Prevent/Correct Alleged Violation SS=D CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for two (2) of 49 residents sampled, facility staff failed to have documented evidence that they conducted thorough investigations for one resident's missing cellphone and one resident's allegation of staff-to resident verbal abuse. Residents #87 and #81.	F 610	Tag: 610- Investigation of Alleged Abuse, Neglect, Exploitation (pgs. 27-29) Corrective Action for Identified Resident(s): 1. Resident #87 was discharged on 6/12/2025. The administrator reached out to the family on 6/16/25 to request that they provide a receipt so the cellphone could be replaced. A follow-up investigation was initiated on 6/16/25 by the administrator to ensure additional staff on the 5th floor who worked on 12/2/2024 were interviewed, and completed on 6/19/25. The results of the incident were documented, and the findings were shared with the resident and the responsible party. 2. Resident #81 was involved in an allegation of staff-to-resident abuse. The staff member was removed from duty immediately. Resident #81 was interviewed and assessed; no physical injury was observed. The resident was seen by psych on 4/28/25 with no negative outcomes noted.	7/8/2025	

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F 610	Continued From page 27 The findings included: Review of the facility's "Abuse Investigation and Reporting" policy dated 05/24/24 documented: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. -The role of the investigator includes interviewing staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. 1. Facility staff failed to conduct a thorough investigation for Resident #87's missing cellphone. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia, Asthma, Muscle Weakness. Review of the resident's medical record revealed the following: A Significant Change Minimum Data Set (MDS) assessment dated 11/21/24 showed that facility staff coded: clear speech; makes self understood; clear comprehension of others; adequate vision; a Brief Interview for Mental Status (BIMS) summary score of 12, indicating mild cognitive impairment; no behavioral symptoms; and no functional impairment in range of motion in upper extremities.	F 610	Cont. Tag: 610- Investigation of Alleged Abuse, Neglect, Exploitation (pgs. 27-29) A thorough investigation was conducted, including interviews with involved parties, documentation review, and submission of findings to the State Agency on 6/17/25. Identification of Other Residents: 1. 100% of residents with documented allegations of abuse or incidents over the past 30 days were reviewed by 6/30/25 to ensure investigations were completed thoroughly and on time. 2. The review included audits of abuse logs, grievance records, and 24-hour reports. 3. Any deficiencies noted were corrected upon discovery. Any additional allegations found during the audit process will be reviewed for thoroughness and completeness. Systemic Changes: 1. The facility's policy and procedure for conducting and documenting investigations was reviewed by 07/8/25 with the Interdisciplinary Team and all department heads by the educator/designee. 2. A standardized abuse/neglect investigation tool was implemented on 5/24/25 to ensure all elements (timelines, documentation, interviews of staff) are consistently followed.		

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F 610 Continued From page 28

A Facility Reported Incident (FRI), DC~13314, submitted to the State Agency on 12/03/24 documented,
-On December 2nd, 2024, at approximately 4:30 PM, [Resident #87] complained that she could not find her Samsung cell phone when she woke up from sleep at around 4:00 PM.

A follow-up to FRI DC~13314, submitted to the State Agency on 12/09/24 documented:
-This is the conclusion of the self-report that was sent on 12/03/2024.
-During the investigation, staff were interviewed.
-Based on the facility investigation, facility was unable to substantiate how the cell phone went missing.

Review of the facility's investigation documents on 04/23/25 showed that not all the staff listed on the 5th floor assignment on the date of the incident (12/02/24) were interviewed or provided a statement, to include housekeeping and activities personnel, as part of the facility's investigation.

The evidence showed that the facility staff failed to conduct a thorough investigation of Resident #87's missing cellphone.

During a face-to-face interview on 04/23/25 at 11:44 AM, Employee #1 (Administrator/Abuse Coordinator) and Employee #2 (Director of Nursing/DON) reviewed the investigation documents and acknowledged the findings.

Cross Reference 22B DCMR Sec. 3232.2

F 610 Cont. Tag: 610- Investigation of Alleged Abuse, Neglect, Exploitation (pgs. 27-29)

3. The abuse coordinator was re-educated on the standardized abuse investigation tool by the Regional Director of operations by 07/8/25.

Monitoring of Corrective Actions
1. The Administrator or designee will audit 100% of new abuse/neglect investigations weekly for 4 weeks and monthly for 3 months to ensure timely notification, initiation of investigation, thorough documentation, and resolution of all allegations of abuse.
2. Audit outcomes will be reviewed during monthly QAPI meetings. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustments.

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F 610	Continued From page 29 2. Resident #81 was admitted to the facility on 05/30/24 with diagnoses that included: Cerebral Infarction, Hemiplegia and Hemiparesis, Facial Weakness, Aphasia, Epilepsy, Chronic Respiratory Failure, Tracheostomy Status, Gastrostomy Status, Altered Mental Status, and Anxiety. A review of Resident #81's medical record revealed: A Quarterly minimum data set (MDS) assessment dated 03/17/25 that documented that the Resident had a Brief Interview for Mental Status (BIMS) of, "07" indicating that the Resident had severely impaired cognition. A physician's order dated 03/10/25 that directed: "Psych Consult and PRN one time only for Evaluation/ Reassessment for 3 Days A Psych Progress Note dated 03/12/25 that documented: "1. Mood, and behavior...the patient is not a good historian and exhibits a combination of thought blocking and confusion. Given memory impairment, she remains vulnerable to agitation and care issues. No exacerbation of agitation was noted. The precipitating and perpetuating factors are a decline in health and memory. No evidence of active or passive SI (suicidal ideation) was noted. The patient denied overt s/s (signs and symptoms) of depression or psychosis. No evidence of mania or psychosis was noted ..." A physician's order dated 03/16/25 at 7: 00 AM that directed: "Behaviors - Monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement,	F 610			

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F 610	Continued From page 30 stealing, delusions, hallucinations, psychosis, aggression, refusing care. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift." A physician's order dated 03/17/25 at 9:00 PM that directed: "Trazodone HCl Oral Tablet 50 mg (milligrams). Give 1 tablet by mouth at bedtime for anxiety and difficulty sleeping." A physician's order dated 03/25/25 at 1:00 PM that documented: "Clonazepam Oral Tablet 0.5 mg. Give 1 tablet by mouth three times a day for anxiety for 15 days." A review of a facility reported incident (DC~13619) dated 04/17/25 that documented: " Initial report: At approximately 7:25 PM, Resident son in [Resident 381's room] stated that while using the bathroom in the patient(s) room that he heard someone used the word [expletive] on his mother. investigation is ongoing... A follow-up report dated 04/23/25 documented; "This is the follow-up of the self-report that was submitted on 04/17/2025. On 04/17/2025, at around 07:25 PM, [Resident # 81's son] reported that while he was in (his) mother (s) bathroom, A nurse came in to bring my/his mom her food, the nurse called her a girl, and my mom said she wasn't a girl and rejected her food. The nurse then called her [expletive] and walked out "... Staff were interviewed, and statements were obtained ... "Her son, who initially reported the incident, confirmed that he overheard the comment from the bathroom but was unable to identify the specific staff member involved. During	F 610			

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a follow-up on April 20, 2025, he maintained that he could not confirm who made the comment. Based on the statements and staff interviewed, none of the staff reported witnessing or hearing anyone referring to the resident using derogatory language on 04/17/2025. Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...This is the final report."

A review of the facility's investigation packet included the written statements of two CNAs, in response to the question: Was there any incident at all that you witnessed a staff member named [Employee #28/alleged perpetrator] (Nursing Assistant) treated any of the residents in any way that may indicate any form of abuse. Example: involuntary seclusion, financial, neglect physical, verbal, sexual, mental, or emotional abuse?

1) Employee #32 written statement response to the question dated 04/21/25 was: "Answer: Yes" "Comments: The CNA was passing trays, [Room of alleged victim/resident] came to the door. The CNA said, 'Oh you scared me. The resident said, "I didn't do anything. The CNA said you crazy you talk to yourself. The resident said, yes, that's why I take medicine.' She laughed and the resident said if it's a problem, don't come back to my room. The CNA 's name is [Name of Employee #28/alleged perpetrator]."

2) Employee #29's written statement/response: dated 04/22/25 was: "Answer: Yes." "Comments: I overheard her talk to {Name of alleged victim/resident] any kind of way. The words were. 'I don't have time [expletive], [Name of alleged victim/resident]. I will [expletive] you up if you touch me."

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The facility's final report was submitted to the state agency on 04/23/25 and concluded, " ...Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...This is the final report."

The facility's investigation lacked documented evidence that all alleged violations of the incident were thoroughly investigated. The two CNA statements dated 04/21/25 and 04/22/25 respectively, were new findings of alleged verbal abuse toward two other residents by Employee #28, that were not documented in the final report of the incident.

During a face-to-face interview on 04/28/25 at 9:44 AM, Employee #2/ Director of Nursing stated that the facility was in receipt of the two CNA responses which alleged that Employee #28, had verbally abused two other residents before submitting the final report of the alleged incident of verbal abuse between Employee #28 and Resident #81 to the State agency on 04/23/25. Employee #2 further stated that as a result of the CNA statements, two new investigations alleging that Employee #28 had verbally abused two other residents were initiated. Employee #2, then acknowledged that although the facility stated that " ...Based on interviews and documentation, the investigation did not yield sufficient evidence to substantiate the allegation of abuse ...,on 04/26/25 the facility initiated two new investigations of Employee #28's alleged verbal abuse toward two other residents. Employee #2 then acknowledged that final report of the alleged incident of verbal abuse between Employee #28 and Resident #81, was not complete, and should

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F 610	Continued From page 33 have included the fact that two new investigations of Employee #28's alleged verbal abuse toward two other residents were initiated. Cross Reference 22B DCMR Sec. 3232.2	F 610	Tag: L 656- Develop/Implement Comprehensive Care Plan (pgs. 34-37)		07/8/2025
F 656 SS=E	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 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.	F 656	Corrective Action for Identified Resident(s): 1. The care plan for resident # 38 was updated on 6/13/25 to address the resident's mechanically altered diet. 2. Resident #65 orthotic foot brace was discontinued on 5/21/2025 3. The care plan for resident #68 was updated on 6/12/2025 to reflect the resident's preference for interpreter services, ensuring communication services are met. 4. The care plan for resident #84 was updated on 5/2/2025 for the management of an indwelling urinary catheter, including monitoring and care interventions. 5. The central line IV for resident # 91 was discontinued on 4/13/25 Identification of Other Residents: 1. The facility unit managers/supervisors conducted a comprehensive audit of residents with specialized diets, indwelling catheters, IV lines, language barriers, and the use of orthotics to identify similar deficiencies by 6/30/25. 2. Any additional residents identified during the audit process had their care plans reviewed and revised by the unit managers/supervisors upon discovery.		

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F 656	Continued From page 34 (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 observations, interviews, and record reviews, for five (5) of 49 sampled residents, the facility staff failed to develop and/or implement care plans with goals and interventions to address: (1) Resident 38's use of a mechanically altered diet; (2) Resident #65's use of an orthotic foot brace for immobilization after the resident fractured his right foot; (3). Resident #68's preference to use an interpreter when communicating with a doctor or health care staff; 4) Resident #84's use of an indwelling urinary catheter; and (5) Resident # Resident #91's use of a left upper arm central intravenous (IV) line. . (Residents #38, #65, # 68, #84, and #91) The findings included: 1. Resident #38 was readmitted to the facility on 09/11/24 with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Hemiplegia, Oropharyngeal Disease.	F 656	Cont. Tag: L 656- Develop/Implement Comprehensive Care Plan (pgs. 34-37) Systemic Changes: 1. All IDT members were re-educated by the educator/designee on the care planning process on 6/30/2025, including care plan updates upon discovery of changes in condition or resident preferences. 2. The care plan review process was reviewed by the DON to ensure individualized care plans for residents with similar deficiencies were updated upon discovery. 3. The MDS Coordinator will review resident care plans for verification during the quarterly MDS completion. Monitoring of Corrective Actions: 1. The MDS Coordinator or designee will audit 10 charts of newly initiated or revised care plans weekly for 4 weeks and monthly for 3 months to ensure individualization and completeness. 2. Results will be presented at QAPI meetings for trend analysis and follow-up. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustments.		

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Physician order dated 02/12/24 for Resident #38 instructed, "Pleasure Feed Diet-Soft and Bite-Sized Texture (mechanically altered diet)...Assist feed, small bites/sips, slow rate intake, alternating consistencies."

A Quarterly Minimum Data Set (MDS) assessment dated 03/01/25 documented in part that the resident has a Brief Interview for Mental Status (BIMS) summary score of "01", indicating that the resident cognitive status was severely impaired.

Review of resident's care plans lacked documented evidence that the facility's staff developed a care plan to address the resident's mechanically altered diet and instruction for feeding assistance from staff.

During an observation on 04/22/25 at approximately 11:30 AM, Resident #38 was sitting in bed at a 90- degree with a lunch tray in front of him on a bedside table. Additionally, Employee # 11 (assigned CNA) was standing by the side of the resident's bed preparing to feed the resident.

During a face-to-face interview on 04/22/25 at approximately 11:30 AM, Employee #10 (RN/Nursing Supervisor) stated that she did not see that a care plan had been developed to address the resident's mechanically altered diet.

2. Resident #65 was admitted to the facility on 01/22/24 with diagnoses that included: Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, Chronic Respiratory Failure; Traumatic Spinal Cord Dysfunction;) Quadriplegia, Contracture of the Knee

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F 656	Continued From page 36 (Unspecified), Contracture of the Foot (Unspecified); Neuromuscular Dysfunction Of Bladder; Urinary Tract Infection; Encounter for Attention to Gastrostomy; Encounter for Attention to Tracheostomy, Anxiety Disorder and Depression. A review of Resident #48's medical record revealed: An admission MDS (Minimal Data Set) assessment dated 01/24/24 that documented the Resident had a Brief Interview for mental Status (BIMS) summary score of, "14" indicating that the Resident had intact cognition. In addition, the resident was coded for: impairment status on both sides to the upper and lower extremities; dependent status on for all (activities of daily living skills (ADLs) including turning and repositioning, having a fall in the last month prior to admission, having recent spinal surgery, having a gastrostomy tube, having a tracheostomy, and receiving speech and occupational therapies. An SBAR dated 01/02/25 that documented: "Situation: Rt (Right) plantar foot swollen. Order for X-Ray of Rt plantar foot; Assessment (Registered Nurse/RN) or Appearance (Licensed Practical Nurse/LPN): Swollen Rt plantar foot; Request/Nursing Notes: Order given by NP (Nurse Practitioner) on duty for X-ray of the right plantar foot to rule out fracture. Resident aware, RP/Friend [Name of resident representative] notified ..." An X ray Report dated 01/02/25 that documented: "Clinical History: [Resident] presents for fracture. Technique: 3 views of the right foot Comparison:	F 656			

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F 656	Continued From page 37 None. Findings: Diffuse soft tissue swelling about the right foot. Diffuse osteopenia. Cannot exclude an acute fracture on this ..." A General Progress Note dated 01/03/25 at 6:57 PM that documented: "Resident lab result received findings stated " 'Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study. Suggestion of a fracture of the distal fibula. No dislocation.' [Name of Medical Director] was called by the 4th floor unit manager ... She stated 'We need to send him to orthopedics. I don't think that is acute. [An] elective consultation arrangement will be made. I will contact [Rehab Director's Name] to put a boot on it." A care plan initiated on 01/03/25 that documented: "[Name of Resident #68] has Diffuse osteopenia. Cannot exclude an acute fracture on this limited osteopenic study No dislocation." Goal: Resident will verbalized reduction of pain by the next review date. Interventions initiated 01/04/25: Elective consultation arrangement will be made by MD ; Log roll resident during transfer and observe foot precaution; MD will follow up with rehab for boot... " A revised care plan dated 01/03/25 that documented: "[[Name of Resident #68] has diffuse osteopenia and at risk for fracture r/t x-tray of the right foot dated 01/03/2025 Date Intervention included: ". Orthopedic consult; Provide with pillows, etc. to help maintain comfortable position; PT (Physical Therapy) evaluation and treatment as ordered." 01/06/25 physician's order that directed: "PT	F 656			

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F 656	Continued From page 38 (Physical Therapy) Consult and pm (as needed), right foot boot for immobilization, distal fibula fracture. A Physical Therapy Encounter Note dated 01/09/25 that documented: " ... Pt was seen in room and was given foot brace to wear to immobilize ankle. 01/09/25 Physical Therapy Encounter Note: " ... Pt (Patient) was seen in room and was given foot brace to wear to immobilize ankle. Pt tolerated foot brace well and NP (Nurse Practitioner) also said it was good for patient ..." A further review of Resident# 65's comprehensive care plan showed no documented evidence that facility developed or implemented a care plan with a focus, goals or interventions for the resident's right foot boot for immobilization. During a face-to-face interview on Employee #21, Director of Rehab stated that the Resident was given the immobilization boot on 01/09/25 from physical therapy, and a care plan for the boot should have been implemented then. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 Director of Nursing (DON) stated that the Unit supervisors, unit managers, and the DON and all members of the disciplinary team were responsible for implementing the care plans. She further commented that since the fourth floor had currently had no unit Manager, implementing and updating resident care plans was primarily her responsibility. The Employee then acknowledged that a care plan for Resident # 65's right foot immobilization boot should have been implemented.	F 656			

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3. Resident #68 was admitted to the facility on 03/25/24 with diagnoses that included: History of Falling; Acute Respiratory Failure; Displaced Intertrochanteric Fracture of Right Femur, Atrial Fibrillation; Chronic Hepatitis, Orthostatic Hypotension, Restlessness and Agitation.

A review of Resident #68's medical record revealed:

An admission annual MDS (Minimal Data Set) assessment dated MDS 03-11-24 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, "05" indicating that the Resident had severely impaired cognition. In addition the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to communicate with a doctor or health care staff.

An annual MDS (Minimal Data Set) assessment dated MDS 02-28-25 which documented that the Resident had a Brief Interview for mental Status (BIMS) summary score of, "13" indicating that the Resident had intact cognition. In addition, the assessment documented that Resident's preferred language was Spanish and the Resident needed and wanted an interpreter to communicate with a doctor or health care staff.

During an initial tour of the 4th floor unit on 04/13/25 at 8:09 AM, a face-to-face interview was conducted with Resident #68 and a Spanish speaking interpreter (via the facility's language interpreter phone line service), the Resident stated he spoke very little English and he preferred to speak Spanish. The resident added

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F 656	Continued From page 40 that he could communicate with the staff, but sometimes he didn't understand what the staff and he was not sure if they could understand him. When asked if facility staff offered use of via Spanish interpreter via the language line he said, "No, not so much. My brother speaks English, so if something happens I let my brother know. He talks to the facility staff." During an initial tour of the 4th floor unit on 04/13/25 at 8:25 AM, a face-to-face interview was conducted with Employee #46 /Licensed Practical Nurse assigned to Resident #68. When asked if the Employee used the language line to communicate with the Resident, she stated, " No. The Resident is Spanish, but he understands and speaks English." A review of Resident #68's comprehensive care plan lacked documented evidence that facility staff implemented a care plan for the resident's preference to use a Spanish speaking interpreter when communicating with a doctor or health care staff. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then stated and acknowledged that although Resident #68 understands and speaks some English, a care plan for the Resident's preference to use an interpreter when communicating with a doctor or health care staff should have been developed, implemented and included in the resident's person-centered comprehensive care plan.	F 656			

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F 656	Continued From page 41 4. Resident #84 was admitted to the facility with the following diagnoses: Metabolic Encephalopathy; Quadriplegia; Traumatic Spinal Cord Dysfunction; Chronic Respiratory Failure; Dependence On Respirator [Ventilator] Status; Encounter for Attention to Tracheostomy; Dysphagia; Encounter for Attention to Gastrostomy, Anxiety Disorder and Depression. A Quarterly Minimum Data Set (MDS) assessment dated 01/15/25 documented that Resident #84 had a Brief Interview for Mental Status (BIMS) of, "15" indicating that the Resident had intact cognition. In addition, the resident was coded as having impairment s on both sides for the upper and lower extremities, limited range of motion; was dependent on staff for all ADLs (activities of daily living) including, had an indwelling urinary catheter, had a urinary tract infection within past 30 days of the assessment and had received antibiotic treatment. An SBAR Communication Form dated 01/02/25 that documented: Situation: Resident was noted with blood in Foley bag ...Request/Nursing Notes: Patient was noted with blood in Foley bag, he denied pain or discomfort on the lower abdomen, abdomen soft, non-distended, temp of 98.0. MD (Medical Director) notified, after assessment, new order for UA (urinalysis) C/S (culture and specimen). RP (Representative) at the bedside made aware A physician's order dated 01/04/25 that directed: "Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet via PEG-Tube (percutaneous endoscopic gastrostomy) every 12 hours for UTI (urinary tract infection)for 7 Days."	F 656			

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F 656	Continued From page 42 A physician's order dated 01/07/25 that directed: "Change 18Fr Foley catheter, tubing and drainage bag monthly. every night shift starting on the 7th and ending on the 7th every month." A physician's order dated 02/10/25 that directed: "Foley catheter care q shift and record out put. every shift." An SBAR Communication Form dated 02/11/25 that documented: Situation: Sediments in urine ...Request/Nursing Notes: Sediment noted in the urine bag, resident denied pain or abdominal discomfort. NP notified, order for Urinalysis Complete, urine culture. A review of Resident #84's comprehensive care plan lacked documented evidence that facility staff developed and implemented a comprehensive patient centered care planned that included a focus, goal, and interventions for the Resident's indwelling urinary catheter. During a face-to-face interview on 05/01/25 at 1:25 PM Employee #2 stated since the fourth floor had currently had no unit Manager, she was primarily responsible for implementing and updating resident care plans. The Employee then acknowledged that a care plan for the Resident #84's indwelling urinary catheter care should have been developed, implemented, and included in the resident's person-centered comprehensive care plan. 5. Resident #91 was admitted to the facility on 01/29/25 with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure. Review of the resident's medical record revealed the following:	F 656			

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F 656	Continued From page 43 An Admission Minimum Data Set (MDS) assessment dated 02/04/25 showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. Physician's orders dated 02/10/15 directed, "Established [central] line - Change dressing Q (every) 7 days, every night shift every Monday for IV-line care; Change dressing as needed if not intact or soiled as needed for IV care; Observe insertion site every shift for redness, warmth, swelling, drainage, coldness or irritation, every shift for IV care." Review of the April 2025 Treatment Administration Record (TAR) showed that on 04/07/25, facility staff documented a check mark and their initials to indicate that the resident's central IV-line dressing was changed during the night shift. During an observation on 04/13/25 at 2:28 PM, Resident #91 was noted with a left upper arm central IV line with a dressing that was dated "04/03/25". Review of the resident's medical record on 04/18/25 showed no documented evidence that facility staff developed a care plan with goals and interventions to address Resident #91's use of a left upper arm central IV line. During a face-to-face interview on 04/18/25 at 11:32 AM, Employee #6 (6th Floor Unit Manager) reviewed the resident's medical record, acknowledged the findings and stated that a care plan address Resident #91's use of a left upper	F 656			

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F 656	Continued From page 44 arm central IV line will be developed. Cross reference 22B DCMR Sec. 3210.4(a)	F 656	Tag: F 657- Care Plan Timing and Revision (pgs. 45-46) Corrective Action for Residents Affected: The care plan for Resident #38 was reviewed and updated on 6/19/2025 by the unit manager/designee to reflect current needs and preferences. This was completed with the interdisciplinary team, including clinical staff, social worker, and a dietitian.		7/8/2025
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 49 sampled residents, the facility staff	F 657	Identification for other Residents: 1. An audit of all care plans for residents with a quarterly, annual and change in condition MDS in the last 30 days was completed by the MDS Coordinator/designee. This was completed by 6/30/2025 to identify any other residents who may have been affected by similar deficiencies. Any deficiencies noted were corrected upon discovery. 2. Care plans for any identified residents were reviewed and updated by the Unit Manager/designee to ensure compliance with person- centered care requirements by 07/8/2025. Systemic Changes: 1. The facility's policy on care plan updates was reviewed by the DON, and education was provided to the IDT team by the educator/designee by 6/30/2025 to reinforce timelines for revisions post- admission, quarterly, annually, and upon significant change.		

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F 657	Continued From page 45 failed to review the comprehensive person-centered care plan as required. (Resident #38) The findings included: Resident #38 was admitted on 07/07/22 with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Hemiplegia and Oropharyngeal Disease. A review of medical records for Resident #38 revealed that there were no care plans reviewed and implemented after MDS assessments were completed on the following dates: 04/01/24 (Quarterly), 07/02/24 (Annual) and 11/29/24 (Quarterly). During a face-to-face interview on 04/24/25 at approximately 2:50pm, Employee #18 (Director of Social Work) stated that the resident's care plans were not reviewed by the Inter-Disciplinary Team (IDT) after the quarterly MDS dated 04/01/24 and 11/29/24, the annual MDS dated 07/02/24. Cross Reference 22B DCMR Section 3210.4	F 657	Cont. Tag: F 657- Care Plan Timing and Revision (pgs. 45-46) 2. A tracking system was implemented by 6/30/2025 to flag pending updates following a change in condition assessments to be monitored and audited by the IDT team. Any deficiencies noted will be corrected upon discovery. Monitoring of Corrective Actions 1. The MDS Nurse or designee will audit 10 charts of all quarterly, annual, and significant change MDS weekly for 4 weeks and monthly for 3 months, to verify timely care plan revisions. 2. Outcomes will be reported at QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will trigger further education or systems adjustments. Tag: F 677- ADL Care Provided for Dependent Residents (pgs. 46-47)		7/8/2025
F 677	ADL Care Provided for Dependent Residents SS=D CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of 49 residents sampled, facility staff failed to ensure that residents, who	F 677	Corrective Action for Residents Affected: 1. Resident #87 and Resident #86 were immediately provided with comprehensive grooming and personal hygiene services. 2. Resident #86 was seen by the podiatrist on 6/16/2025. Resident #87's fingernails were cleaned and trimmed on 4/13/2025. Resident #87 was discharged on 6/12/2025.		

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F 677	Continued From page 46 are unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. Residents #87, and #86. The findings included: Review of the facility's "Activities of Daily Living (ADLs), Supporting" policy dated 05/24/24 documented: - Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. - Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). 1. Facility staff failed to ensure that Resident #87, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Encephalopathy, Chronic Respiratory Failure with Hypoxia and Hypercapnia, and Muscle Weakness. Review of the resident's medical record revealed the following: A Quarterly Minimum Data Set (MDS) assessment dated 02/21/25 showed that facility staff coded: clear speech and comprehension of others; a Brief Interview for Mental Status (BIMS)		F 677	Cont. Tag: F 677- ADL Care Provided for Dependent Residents (pgs. 46-47) 3. A visual assessment was conducted for both residents by the unit manager/designee to identify additional specific needs and preferences related to personal hygiene and grooming on 04/13/25. No additional needs were identified. 4. ADL Care plan for Residents #86 were updated on 6/16/2025 by the unit manager/designee. Identification for other Residents: 1. A facility-wide audit to identify other residents who may be unable to carry out activities of daily living and require assistance with grooming and personal hygiene was completed by 6/30/2025 by the unit manager/designee. Any deficiencies noted were corrected upon discovery. 2. Care plans for identified residents were completed by Unit Manager/designee to ensure they received the necessary services to maintain good grooming and personal hygiene, including podiatry services by 06/30/25. 3. Any resident identified during the audit will be provided with immediate grooming and hygiene services upon discovery.	

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F 677	Continued From page 47 summary score of 11, indicating mild cognitive impairment; no functional impairment in range of motion in upper extremities; and required extensive assistance of one person physical assist for ADLs. A care plan focus area last revised on 03/17/25 documented: [Resident #87] has an ADL self-care performance deficit with interventions that included to "check nail length and trim and clean on bath day and as necessary, report any changes to the nurse." During an observation on 04/13/25 at 6:50 AM, Resident #87 was observed lying in bed. The resident's fingernails were noted to be long and appeared dirty, with a brown substance underneath seven out of 10 nailbeds. The resident stated, "I have asked for them (fingernails) to be cut." During a face-to-face interview at the time of the observation, Employee #5 (Licensed Practical Nurse/LPN) was asked about Resident #87's fingernails. The employee admitted that she had noticed the resident's nails prior to this observation. However, when asked why she did not clean and trim Resident #87's nails, Employee #5 did not provide an answer. The evidence showed that facility staff failed to ensure that Resident #87, who is unable to carry out ADLs, received the necessary services to maintain good grooming and personal hygiene. 2. Facility staff failed to ensure that Resident #86, who is unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene.		Cont. Tag: F 677- ADL Care Provided for Dependent Residents (pgs. 46-48) Systemic Changes: 1. At least 80% licensed staff will be re-educated by the educator/designee on expectations for providing complete ADL care, including grooming and nail hygiene, according to the resident's plan of care. The education will be completed by 6/30/2025. 2. Introduced daily random checks for nursing staff to ensure that all residents receive necessary grooming and personal hygiene services. Monitoring of Corrective Actions: 1. The Unit Manager or designee will observe 10 residents dependent on staff for ADLs daily for 7 days and weekly for 4 weeks to ensure appropriate grooming and hygiene. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be discussed during QAPI. Outcomes will be reported at QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustments.		

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F 677	Continued From page 48 Resident #86 was admitted to the facility on 07/26/24 with multiple diagnoses that included: Need for Assistance with Personal Care, Encephalopathy, and Chronic Respiratory Failure with Hypoxia. A physician's order dated 02/10/25 documented, "Podiatry Consult and PRN (as needed)." A Significant Change Minimum Data Set (MDS) Assessment dated 04/07/25 documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 'No' for the question, 'Should Brief Interview for Mental Status (C0200-C0500) be Conducted?' that indicated the resident was severely impaired. Functional abilities that documented that the resident was dependent on staff for all ADL (Activities of Daily Living) care. During an observation conducted of the resident's room on 04/13/25 at approximately 9:30 AM, the resident was observed lying in bed and an observation of the resident's feet revealed that Resident #86 had long toenails. During a subsequent observation conducted on 04/30/25 at approximately 10:00 AM, the resident was observed lying in bed and an observation of the resident's feet revealed that Resident #86's toenails had not been addressed by facility staff. During a face-to-face interview conducted on 04/30/25 at approximately 11:38 AM, Employee #10 (Nurse Supervisor) stated that she entered the verbal order for a podiatry consult on 02/10/25 and further stated, "If [it's a] podiatry consult you can call them in the morning or depending on the	F 677			

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F 677	Continued From page 49 situation if urgent, we call right away because podiatry is in-house. If [it's a] verbal order then I put [the] order in PCC (Point Click Care-facility's electronic health record system) then call the consult doctor. The consult[ing] doctor will let us know what date he can make it to assess the resident. If there is a delay, then we call the primary doctor to see if another consult[ing] provider is available sooner. The same day the order is given by the primary doctor you [are] supposed to reach out to the Podiatrist. We have a book that list[s] the Podiatrist; it's just one Podiatrist that covers all three (3) floors, four (4), five (5) and six (6). A general progress note should be written whenever the consult[ing] provider is notified. The names of [the] residents are entered in[to] the [Podiatry] book by the nurse who puts the order in PCC, or the unit secretary if she is aware of the consult order. It's the unit manager's job to make sure that the consult[ation] is done; it's also on 24-hr (hour) report and there's a step-down meeting as well. During an observation conducted on the sixth-floor unit on 04/30/25 at approximately 12:13 PM, it revealed a White binder labeled 'Podiatry Book' and inside the Podiatry book it documented, "You must place a Podiatry Consult Order in PCC for anyone you add to this list. It should read: "Podiatry Consult for Nail Care" one time only and print the order and place it in this book. All Care Foot and Ankle." It should be noted that for the months of February 2025 through April 2025, there was no documented evidence of Resident #86's name listed in the Podiatry book for a Podiatry consult or documented evidence that the resident was seen by the Podiatrist.	F 677			

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F 677	Continued From page 50 During a telephone interview conducted on 04/30/25 at approximately 12:28 PM, Employee #27 (Facility's Podiatrist) stated, "I've never seen that patient" and "There's a [Podiatry] book on each floor, the staff write down the names of the residents that need to be seen and I will see them, or they can call the office. That number is listed on the book as well and they can leave a message or speak with someone at my office if a resident has a consult [order] to be seen by me. I know of the [Podiatry] consults by checking the Podiatry consult book on each floor. I have never seen that resident and not aware of a [Podiatry] consult for that resident." During a face-to-face interview conducted on 04/30/25 at approximately 1:03 PM, Employee #2 (Director of Nursing) acknowledged the findings and stated, "The Podiatrist comes into the building. We put the consult[ation] order in the [Podiatry] book and Podiatry [the Podiatrist] goes to each floor. The Podiatrist will look in the book to ensure the resident is seen. I don't know how a resident would not get seen by Podiatry if there's an order because the name should be in the book."	F 677			
F 684	Quality of Care SS=D CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684	Tag: F 684- Quality of Care (pgs. 51-53) Corrective Action for Residents Affected: 1. Employee #16 was immediately retrained on the correct procedure for preparing and administering subcutaneous injections, including the selection of appropriate needle gauge and length on 4/18/2025 by the Unit manager. 2. The care plan for resident # 74 was reviewed and updated on 4/18/2025 by the unit manager/designee to ensure compliance with the physician's orders for turning and repositioning.		07/8/2025

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interview, for two (2) of 49 sampled resident's the facility's staff failed to follow: (1) Professional Standards of Practice when preparing to administer a subcutaneous injection as evidenced by Employee #16 prepared who a Heparin [anticoagulant] injection using an intramuscular (IM) gauge and length needle instead of a subcutaneous (SQ) gauge and length needle. It should be noted that the surveyor intervened before Employee #16 administered Heparin with the IM gauge and length needle. And (2) failure to follow physician's orders and care plan for turning and repositioning Resident #74 every two (2) hours.

The Findings included:

Resident # 75 was admitted on 06/21/24. The resident had a history of Deep Vein Thrombosis (DVT).

According to Pfizer medication information leaflet titled, "Heparin Sodium Injection, Solution Hospira, Inc. with a revision date of 05/2021 documented in part, "Administer Heparin Sodium Injection by intermittent intravenous injection, intravenous infusion, or deep subcutaneous (intrafat, i.e., above the iliac crest or abdominal fat layer) injection. Do not administer Heparin Sodium Injection by intramuscular injection because of the risk of hematoma at the injection site ..."
<https://labeling.pfizer.com/ShowLabeling.aspx?id=4313>

F 684 Cont. Tag: F 684- Quality of Care (pgs. 51-53)

Identification for other Residents:

1. A facility-wide medication pass audit by the unit manager/designee was conducted to identify any other residents receiving subcutaneous injections to ensure proper needle selection and administration techniques were being followed by the licensed staff. The audit was completed by 6/30/2025 to identify additional areas of non-compliance. Corrective action will be implemented upon discovery.
2. Facility-wide audit of residents requiring turning and repositioning every 2 hours was completed by the unit manager/designee by 6/30/2025 to ensure compliance with the physician's orders.
3. A least 80% of the licensed staff was provided immediate retraining for areas of noncompliance identified during the audit process by the educator/designee by 07/8/25.

Systemic Changes:

1. The facility's policy on Medication Administration was reviewed and revised by the DON on 6/30/2025.
2. The interdisciplinary team, licensed staff, was re-educated by the educator/designee on the revised Medication Administration policy by 6/30/2025.

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F 684 Continued From page 52

A policy titled, "Subcutaneous Injections" with a review date of 05/24/24 documented in part, "The following equipment ...will be necessary when performing this procedure ...Needle (25 to 27 guage, 3/8 to 5/8 inch) ..."

A policy titled, "Intramuscular Injections" with a review date of 05/24/24 documented in part, "The following equipment ...will be necessary when performing this procedure ...Needle (19 to 23 guage, 1 to 1 1/2 inch) ..."

A physician order dated 04/20/25 instructed, "Heparin Sodium [anticoagulant] Injection Solution 5000 units/milliter. Inject 1 ml subcutaneously every 8 hours for DVT."

A review of the employee's personnel file revealed the employee date of hire was 01/10/25. The employee received a training titled, "Anticoagulant Therapy and Risk Reduction" on 01/22/25.

During a medication administration observation on 04/18/25 starting at 8:55 AM, Employee #16 (RN) revealed the employee aspirated Heparin Sodium Injection Solution 5000 units per one (1) milliter into a syringe. The employee aspirated the medication using a 1 inch, 1 guage needle. After aspirating the medication, the employee capped the needle and took the medication into the resident's room to administer. When the employee was preparing to administer Heparin, the surveyor asked what site she was administering Heparin? The employee said subcutaneously at the left lower abdomen. The surveyor intervened and asked the employee not to administer the Heparin and step outside the

F 684 Cont. Tag: F 684- Quality of Care (pgs. 51-53)

Monitoring of Corrective Actions:
1. The Director of Nursing (DON) or designee will audit 20 resident's with subcutaneous injection medication orders weekly for 4 weeks, then monthly for 3 months, to ensure compliance with the Medication Administration policy and guidelines.
2. Findings of audits will be reviewed at monthly QAPI meetings. Any deficiencies noted will be corrected upon discovery. Any trends identified will trigger further education or systems adjustments.

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F 684 Continued From page 53

resident's room. The employee was then asked what was the appropriate needle for administering a subcutaneous injection? The employee failed to provide an answer. At the time of the interview, Employee #6 (RN/Unit manager) stated that the employee should use a tuberculin (28 guage, 1/2 inch - equivalent to 4/8 of an inch) syringe to administer the Heparin. The needle that the employee had was for IM injections. It should be noted the employee was later observed by the surveyor administering Heparin using the tuberculin syringe.

2. Resident #74 was admitted to the facility on 04/16/24, with multiple diagnoses that included: Anoxic Brain Injury, Chronic Respiratory Failure with Hypoxia and Type 2 Diabetes Mellitus.

Review of the resident's medical record revealed the following:

A face sheet that listed the resident's daughter was her Responsible Party/RP, care conference person and emergency contact #1.

A physician's order dated 02/10/25 that directed, "Turn and repositioning every two hours using wedges or pillows for pressure redistribution every shift."

A Quarterly MDS assessment dated 03/01/25 showed that facility staff coded: functional limitations in range of motion on both sides for upper and lower extremities and was totally dependent on staff for all activities of daily living (ADLs).

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F 684	Continued From page 54 A care plan focus area revised on 04/07/25 documented, "[Resident #74] has an ADL self-care performance deficit", and had interventions that included, "The resident is totally dependent on 2 staff for repositioning and turning in bed Q2H (every two hours) and as necessary." During a face-to-face interview on 04/13/25 at 7:28 AM, Resident #74's daughter/RP stated, "The staff are not turning my mother when I am not here, leaving her soiled for long periods of time." During an observation on the 6th floor on 04/24/25 starting at 11:30 AM, Resident #74 was observed lying in bed, positioned on her left side, with pillows on the right side of her body for pressure redistribution. During a second observation on the 6th floor on 04/24/25 at 1:31 PM, Resident #74 was observed lying in bed, positioned on her left side, with pillows on the right side of her body for pressure redistribution. During a third observation on the 6th floor on 04/24/25 at 2:33 PM, Resident #74 was observed lying in bed, still positioned on her left side, with pillows on the right side of her body for pressure redistribution. A face-to-face interview was conducted on 04/24/25 at 2:35 PM, at Resident #74's bedside with Employee #23 (her assigned Certified Nurse Aide/CNA) and Employee #6 (6th floor Unit Manager). When asked, Employee #23 stated that she repositioned Resident #74 at 1:30 PM. Employee #23 was further asked why Resident #74 was still positioned on the same side (the	F 684			

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			(X5) COMPLETION DATE

F 684 Continued From page 55
left) as when first observed by the surveyor at 11:30 AM (three hours prior), if she in fact had repositioned the resident. The employee did not respond and proceeded to reposition Resident #74 on her right side, with pillows on the left side of her body for pressure redistribution, with help from Employee #6.

F 684

The evidence showed that for three hours, facility staff failed to turn and reposition Resident #74 as instructed by the physician's order and her comprehensive care plan.

F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer
SS=G CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:

Based on observation, record reviews and staff interviews for one (1) of 39 sampled residents, facility staff failed to consistently assess and document changes in the skin of Resident #47 who developed an in-house, acquired pressure injury/ulcer that was first identified at an advanced stage (Stage 3). (Resident #47)

Tag: F 686- Treatment/Prevention of Pressure Ulcers (pgs. 59-60)

F 686

Corrective Action for Residents:
1. Resident #47 was immediately assessed by the wound care team on 6/13/2025, and a comprehensive treatment plan was initiated, including appropriate wound care interventions and consultations with a wound care specialist.
2. The resident's care plan was updated on 6/13/25 by the wound nurse to reflect the current status and treatment of the pressure injury, with documentation of the wound's progress.

Identification for other Residents:
1. A facility-wide skin sweep and assessment was completed for all residents by the wound team on 6/9/25 to identify any other potential pressure injuries. No additional pressure injuries were noted; other identified skin issues were immediately addressed.
2. Residents at risk for pressure ulcers will be identified and their care plans individualized to include preventive measures. Any deficiencies noted will be corrected upon discovery.

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F 686	Continued From page 56 These failures resulted in actual harm to Resident #47. The findings include: A policy titled, "Prevention of Pressure Ulcers/Injuries" with a revision date of 05/24/24 instructed staff to, "Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (activities of daily living); Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) ...Moisturize dry skin daily; and Reposition resident as indicated on the care plan ..." 1. Resident #47 was admitted to the facility on 10/26/22 with multiple diagnoses including Quadriplegia, Encephalopathy, Chronic Respiratory Failure (Hypoxia) and Muscle Weakness. A quarterly Minimum Data Set assessment dated 10/25/24 documented that the Brief Interview for Mental Status summary score was "blank" indicating that the resident did not respond to the test questions. The resident was coded for bilateral impairment of upper and lower extremities and being totally dependent on staff for all activities of daily living, being at risk for developing pressure ulcers, being on a turning and repositioning program, and using a pressure reducing bed. Also, the resident's height was documented as 74 inches [6.1 feet] and weight was 176 pounds."	F 686	Systemic Changes: 1. At least 80% of Licensed staff and nursing assistants, and nursing staff will receive re-education on wound care protocols, including identification and treatment protocols for residents at risk of developing pressure injuries by the educator/designee by 6/30/2025. 2. The wound care director implemented skin checks by licensed staff on shower/bed bath days by 07/8/25. Nursing assistants are expected to call the nurse to complete a head-to-toe assessment after a shower or bed bath. 3. CNA assignments will be updated to include visual skin check reminders during ADLs by 07/8/25. Monitoring of Corrective Actions: 1. The Wound Nurse or designee will audit 20 charts of residents of at-risk residents for developing pressure ulcers. Audits will be completed weekly for 4 weeks and then monthly for 3 months to ensure compliance with the skin check protocol. Any deficiencies noted will be corrected upon discovery. 2. Compliance and Outcomes will be reported and discussed during QAPI. for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 686	Continued From page 57 A physician order dated 11/06/24 instructed, "Aquaphor External Ointment (Emollient) apply to bilateral lower extremities topically two times a day for wound care. Off-load bilateral heel with off-loading device every shift for pressure redistribution ...Turn and reposition every two hours using wedges or pillows for pressure redistribution every shift." A care plan with a review date of 11/07/24 documented in part, "Focus- [Resident #47] is activity of daily living dependent secondary to Quadriplegia with incontinence of bladder and bowel with inability to communicate needs ...Interventions - assess, record, report and treat for any abnormality to skin during incontinent care, dependent on 2 staff to provide bath/shower and turning and repositioning every 2 hours and as necessary ...totally dependent on 1 staff for personal hygiene ..." A physician order dated 11/08/24 instructed, "Perform skin assessments on shower days twice a week and notify MD of any new changes every Tuesday and Friday. A quarterly Braden Scale for Predicting Pressure Score Risk dated 11/21/24 documented that the resident had a score of "15" indicating that the resident was at risk for developing pressure ulcers. Progress notes dated 11/22/24 to 01/07/25, lacked documented evidence of an alteration in the skin integrity of Resident #47's left foot. Treatment Administration Records dated 11/22/24 to 01/07/25, licensed nursing staff documented	F 686			

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F 686	Continued From page 58 that the following tasks were performed for the resident: Skin assessments (head-to-toe) conducted by licensed staff twice a week on shower days; Aquaphor ointment was applied to bilateral lower extremities twice a day; Turned and repositioned daily, every two hours; Bilateral heels were off loaded (elevated) with off-loading devices (wedges/pillows) daily, every shift. However, the facility staff failed to identify the resident's left foot pressure ulcer until 01/08/25 when it was an advanced stage (Stage 3). A Situation, Background, Assessment, Request (SBAR) form dated 01/08/25 at 7:29 PM signed by Employee #14 (LPN) documented in part, "Discovery of wound on left lateral aspect of the left foot started on 01/08/25 ... resident properly repositioned and turned every 2 hours for purpose of proper weight distribution and prevention of further skin injury. Nurse Practitioner notified of wound and wound consult placed and order obtained for treatment of wound ..." A wound care nurse practitioner progress note dated 01/09/25 at 7:23 PM documented in part, "Reason for visit: new skin and wound consult ...Patient with new stage 3 pressure injury to the left lateral distal foot ... Lower Extremity Exam ...Texture: dry, flaky, thickened, Perfusion: diminished pedal pulses, left foot cool to touch, Sensation: Bilateral lower extremity insensate, Associated Findings: generalized dryness ... Wound Status: Odor Post Cleansing: None, Size: 1 cm (centimeters) x 0.8 cm x 0.2 cm. Calculated area is 0.8 sq (square) cm, Wound Base: 20% epithelial, 70% granulation, 10% slough, 0% eschar, Wound Edges: Attached Periwound: Fragile, Callous, Exposed Tissues:	F 686			

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F 686	Continued From page 59 Subcutaneous, Exudate: Moderate amount of Serosanguineous ...Treatment- cleanse wound with wound cleanser, apply Iodosorb (topical antiseptic ointment) to base of wound, secure with boarder gauze, change daily ..." An observation with the wound nurse on 04/22/25 at approximately 12:30 PM showed the resident lying in bed, awake, non-verbal, and well groomed. The resident had a dressing to the left foot. The dressing was dry and intact. When the wound nurse practitioner removed the dressing, the wound had no smell, was approximately 1 inch in width and no depth, red tissue in center with pink surrounding tissue. During a face-to-face interview on 04/22/25 at approximately 12:30 PM, Employee #35 (Nurse Practitioner - Wound Specialist) stated that staff informed him on 01/08/25 that the resident had a new wound on his left foot. On 01/09/25, he assessed the resident and determined that he had a Stage 3 pressure wound to the left lateral foot. Also, Employee #35 said that he requested a longer bed for the resident because the resident's left foot was pressing against the bed's footboard which likely contributed to pressure at the site of the pressure injury. As a result, Resident #47 subsequently was issued a new bed with an extended footboard. During a face-to-face interview on 04/30/25 at approximately 3 PM, Employee #14 (assigned LPN) stated that he should have documented the characteristics of the resident's wound (size, depth, color, odor) on the SBAR dated 01/08/25. Additionally, the employee said that he conducts head-to-toe-assessments skin assessments twice a week and as needed. And he ensures	F 686			

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F 686	Continued From page 60 that the resident is turned and reposition every-two-hours daily and heels are always elevated off the mattress to prevent pressure. During a face-to-face interview on 04/30/25 at approximately 3:30 PM, Employee #10 (RN/Nurse Supervisor) reviewed the resident's medical record and said that she did not see documentation of a skin integrity issue with the resident's left foot before 01/08/25. During a face-to-face interview on 05/01/25 around 3:30 PM, Employee #36 (Central Supply Technician) indicated that he had received an electronic work order for a longer bed for Resident #47. According to the employee, he did not keep a copy of the work order and could not recall the exact date when he received it. However, he remembered that he provided the resident with a bed that extended at the foot portion on 02/18/25. Cross reference 22B DCMR Sec.3211.1(b)	F 686	Tag: F 689- Space Heaters and Unsafe Smoking Practices (pgs. 61-63) Corrective Action for Identified Resident (s): 1. Residents #10, #48, #87, and #92 had unauthorized portable space heaters in their rooms. All heaters were removed within 15 minutes of the Immediate Jeopardy notification on 04/13/2025. 2. Residents #10, #46, #80, #92, and #48 were identified as smokers engaging in unsafe practices. Each resident was reassessed using the facility's Smoking Safety Assessment. Smoking aprons and any needed aids were offered, and care plans were updated to reflect supervision requirements and safe storage of paraphernalia. 3. Residents were educated on the updated Smoking Policy beginning 04/18/2025.		07/8/2025
F 689	Free of Accident Hazards/Supervision/Devices SS=K CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for six (6) of 49 sampled residents,	F 689			

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F 689	Continued From page 61 facility staff failed to ensure that resident environments were free of accident hazards as evidenced by: (1) Four portable space heaters observed in Residents' #10, #48, #87, and 92 rooms; and (2) Inadequate supervision and unsafe smoking practices for Residents' #10, #46, #80, and #92 who were identified by staff as smokers. An Immediate Jeopardy, related to space heaters in resident rooms, was identified on 04/13/25 at 1:34 PM. The facility provided a plan of action to address the immediacy on 04/13/25 at 5:04 PM that was accepted. After the plan was verified, the IJ related to space heaters was removed on 04/22/25 at 9:34 AM, while the survey team was onsite. After the removal of immediacy, the deficient practice remained at a scope and severity of "E." An Immediate Jeopardy, related to inadequate supervision and unsafe smoking practices were identified on 04/17/25 at 3:36 PM. The facility provided an acceptable Plan of Removal to address the immediate concerns on 04/17/25 at 8:28 PM. While on site the State Survey Team, verified that the facility's Plan of Removal interventions for inadequate supervision and unsafe smoking practices were implemented. The IJ was then removed on 04/24/25 at 1:50 PM. After removal of the immediate concerns, the deficient practice remained at a scope and severity of "D." The findings included: 1. Review of the facility's "Electrical Appliances" policy dated 05/24/24 documented: "Portable space heaters are not allowed in resident areas."	F 689	Cont. Tag: F 689- Space Heaters and Unsafe Smoking Practices (pgs. 61-63) Identification of Other Residents: 1. On 04/13/2025, a facility-wide environmental sweep was conducted by the Maintenance Director and Administrator to identify any other rooms with space heaters or unauthorized appliances. 2. Any additional hazards found were removed immediately. 3. Beginning 04/18/2025, the facility conducted a comprehensive audit to identify all residents who are active smokers. All identified smokers were assessed for safety and had care plans updated accordingly. Systemic Changes: 1. Policy Revisions: a. The Electrical Appliance Policy was revised on 04/13/2025 to prohibit portable space heaters in all resident care areas. b. The Smoking Policy was revised on 04/18/2025 to enforce safety procedures, supervision, and designated smoking times/areas. 2. Resident & Family Education: a. Education began on 04/13/2025 regarding prohibited items and fire risks. Robo-calls were made to families/POAs.		

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F 689	Continued From page 62 1a. Resident #87 was admitted to the facility on 08/27/24 with multiple diagnoses that included: Chronic Respiratory Failure with Hypoxia and Hypercapnia, Asthma, and Muscle Weakness. Review of the resident's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated 02/21/25 which showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "11", indicating mild cognitive impairment. There was no functional impairment in range of motion and in upper extremities that was noted. During a unit tour of the 5th floor on 04/13/25 at 6:50 AM, a portable space heater was observed in use and blowing hot air on Resident #87. The space heater was noted to be approximately less than one foot away from the resident's bed, on top of a gray, plastic wash basin, that was sitting on top of the bedside drawer. During a face-to-face interview at the time of the observation, Employee #5 (assigned Licensed Practical Nurse/LPN) was asked why there was a space heater in the resident's room. The employee responded, "[Resident #87] was transferred to this room with the space heater about three (3) days ago. She gets cold. I think her family bought it for her." When asked if she was aware that space heaters were not permitted in resident care areas, the employee did not respond. During subsequent observations of all resident rooms, on all floors, portable space heaters were noted plugged in for use on the fourth and fifth floors respectively for the following residents:	F 689	Cont. Tag: F 689- Space Heaters and Unsafe Smoking Practices (pgs. 61-63) cont. Systemic Changes: 3. Staff Training: a. All on-duty staff were educated on the revised appliance policy 04/13/2025 regarding appliance restrictions. Starting 04/18/2025, 70% of staff received training on the updated and revised smoking policies and supervision, with a goal of 100% compliance. 4. Smoking Supervision Protocol: a. Designated outdoor smoking area equipped with a fire extinguisher and signage. b. Residents may only smoke during supervised, scheduled times (10 AM, 1 PM, 4 PM, 7 PM, 10 PM). c. Staff-supervised sign-in/out log and use of smoking aprons offered. Monitoring of Corrective Actions: 1. Daily: Room audits for electrical appliances and contraband smoking materials. 2. Smoking Supervision: Logs are reviewed daily to ensure adherence to scheduled times and supervision. 3. Monthly: Audit findings reported to the QAPI Committee for review and action as needed. Any deficiencies noted will be corrected upon discovery. 4. Smoking Binders: Maintained on each unit and at the security desk for rapid identification of residents who smoke.	7/8/2025	

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F 689	Continued From page 63 #92, #10, and #48. 1b. Resident #10 was admitted to the facility on 12/22/23 with multiple diagnoses that included: Muscle Weakness, Paraplegia, and Nicotine Dependence. Review of the resident's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated 04/02/25 that showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "15", indicating intact cognition and had functional limitation impairment in range of motion on one side for upper extremities. 1c. Resident #92 was admitted to the facility on 11/01/24 with multiple diagnoses that included: Paraplegia, Polyneuropathy, Generalized Muscle Weakness, and Need for Assistance with Personal Care. Review of the resident's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated 02/07/25 that showed facility staff coded: a BIMS summary score of "15," and functional limitation impairment in range of motion on both upper extremities. 1d. Resident #48 was admitted to the facility on 11/16/22 with diagnoses that included Quadriplegic C5-C7 and Vascular Myelopathy. Review of Resident #48's medical record revealed the following a Quarterly Minimum Data Set (MDS) assessment dated 04/11/25 that showed facility staff coded a BIMS summary score of, "15," and impairments in functional limitations in range of motion impairment on both	F 689	Tag: F 693- Tube Feeding Management/Restore Eating Skills (see pg. 79)		

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F 689	Continued From page 64 sides for upper and lower extremities. It should be noted that Residents' #87, #48, #84, #10 were non-ambulatory. A face-to-face interview was conducted on 04/13/25 at 10:22 AM with Employees #3 (Registered Nurse/RN Supervisor) and Employee #4 (Plant Operations Supervisor). Employee #3 stated that she was not aware that space heaters were not allowed in resident rooms. Employee #4 acknowledged the findings and stated that space heaters are not allowed in resident rooms. These findings resulted in determination of Immediate Jeopardy on 04/13/25 at 1:34 PM. The facility's Administrator provided a plan of action to address the immediacy on 04/13/25 at 5:04 PM that was accepted and included: 1. Immediate Removal of Hazard Facility staff will be sent to each unit simultaneously to the rooms identified by surveyors to remove the portable space heaters within 15 minutes of notification of the Immediate Jeopardy. All other resident rooms will be checked and any portable space heaters found will be removed immediately on 04/13/25. 2. Environmental Sweep A facility-wide sweep will be conducted by the Maintenance Director and Administrator within 1 hour to identify any other unauthorized electrical appliances or hazards. Documentation of the sweep, including date, time, and rooms assessed, will be completed and placed in the IJ response binder on 04/13/25. Any additional hazards found will be removed immediately, and residents will be educated as	F 689			

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F 689	Continued From page 65 needed. 3. Policy Enforcement The facility's "Electrical Appliances" policy will be reviewed and updated to explicitly prohibit portable space heaters in all patient care areas on 04/13/2025. 4. Resident and Family Education All residents and their responsible parties will be provided with written and/or verbal education on prohibited appliances, including portable space heaters, starting on 4/13/2025. A robo call will be sent to every family member/POA on 04/13/25 regarding the prohibition of portable space heaters. 5. Staff Education All staff present here today on 04/13/25 including housekeeping, maintenance, dietary, nursing, and respiratory therapy will be educated on identifying and reporting unsafe resident practices and prohibited electrical appliances as of 4/13/2025. All other staff will be educated upon arrival before the start of their next shift on prohibited electrical appliances to include portable space heaters starting on 04/13/2025. We will complete at least 80% compliance by Wednesday, April 16, 2025, with a goal of 100%. 6. Date of Compliance April 16, 2025 The Survey Team verified that the plan of action to address the immediacy was in place. The Immediate Jeopardy related to space heaters in resident rooms was lifted on 04/22/25 at 9:34 AM while the survey team was onsite. 2. A policy titled, "Smoking Policy" with a review date of 12/2024 instructed in part, "To protect the health, safety, and comfort of our residents,	F 689			

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F 689 Continued From page 66

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visitors, medical staff and employees ... Bridge Point is a smoke free facility. Smoking may not occur with the facility. This policy is applicable to all employees, staff, visitors, and residents, both smokers and non-smokers. The information in this policy will be reviewed with all staff during orientation and on an annual basis ...Residents receive information regarding policy during the admission process ...Residents and visitor compliance with the policy is a shared responsibility of all Bridge Point employees and staff ...The nursing facility acts to minimize the smoke (sp) to the greatest extent possible. The nursing facility will provide smoking jackets for resident use for safety ..."

2a. Resident #80 was admitted on 07/15/24 with multiple diagnoses including Chronic Respiratory Failure, Muscle Weakness, and Difficulty Walking.

A quarterly Minimum Data Set assessment dated 01/21/25 documented in part, "Brief Interview for Mental Status summary score of "15" indicating that the resident had an intact cognitive status. The resident was coded for having impaired bilateral lower extremities and requiring partial to maximum assistance from staff with activities of daily living."

A review of a list of residents in the facility who smoke on 04/15/25 at approximately 3:45 PM, revealed Resident #10 and Resident #92 were identified by staff as smokers. At the time of review, Employee #1 (Administrator) and Employee #2 (DON) stated that they were a "Non-Smoking Facility." Staff do not provide residents with assistance with smoking. The facility does not have a designated area for

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F 689	Continued From page 67 smoking. And all residents who smoke go outside and up the street away from the building when they smoke. On 04/15/25 starting at approximately 3PM, the State Survey Team conducted a tour of the facility that included observations, resident interviews, and staff interviews. The tour revealed that the facility had two additional residents who smoke (Residents #46 and #80). An observation on 04/15/25 at 3:45 PM revealed a designed smoking area sign posted on the wall to the left of the facility's main entrance door. At the time of the observation, Employee #1 (Administrator) stated the sign was an "old sign," and that the area was not a designated smoking area. During an observation on 04/15/25 at approximately 4:45 PM, Resident #80 was lying in bed, alert and orientated to name, time, place, and situation. At the time of the observation, the resident stated that he started smoking again a few weeks ago. He said that he smokes daily outside of the building near the wheelchair ramp that's close to the entry door. Additionally, the resident said, "I would never smoke in the building. It is a hospital, and everyone knows you don't smoke in a hospital." When asked if he had access to cigarettes and matches, the resident showed the surveyors an opened pack of cigarettes and a green butane lighter. Also, the resident said he was not provided with information about the facility's smoking policy. A review of Resident #80's medical record on 04/15/25 at approximately lacked documented evidence of a care plan addressing the resident	F 689			

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F 689	Continued From page 68 smoking. During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #80 was identified by staff as a smoker. The facility's protocol is that all residents who smoke have a care plan in place to address the resident smoking. The employee then said she reviewed Resident #80's medical record and did not see a smoking care plan. Additionally, the employee said that a smoking assessment would not be done unless the resident triggers for new behavior of smoking. During a face-to-face interview on 04/17/25 at approximately 9 AM, Employee #11 (assigned CNA) stated that she was not aware that Resident #80 was a smoker. Additionally, the employee said she did not know if residents were allowed to keep cigarettes and lighters in their person or in their rooms. And that she was not aware of the facility's smoking policy. During a face-to-face interview on 04/17/25 at approximately 9:15 AM, Employee #12 (assigned LPN) stated that Resident #80 is a smoker. The resident lets staff know when he is going out to smoke. Staff do not assist him with smoking. And she was not aware of the facility's policy with residents keeping their cigarettes, matches, or lighter on their person or in their room. She believed that Resident #80 is allowed to keep his cigarettes and lighter with him. 2b. Resident #46 was admitted on 09/27/22 with multiple diagnoses to include Chronic Obstructive Pulmonary Disease, History of Falls, Generalized Muscle Weakness, Schizophrenia, Bipolar and	F 689			

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F 689	Continued From page 69 Anxiety. A Smoke-Safety Screen dated 12/04/23 documented in part, "Resident had cognitive loss, visual deficits and dexterity problems. The resident smokes 2-2.5 cigarettes daily ...has received cigarettes from other residents, possible new behavior ...safe to smoke with supervision ...unsafe for resident to smoke related to impaired decision making and limited mobility ..." Please note review of the resident medical record to include assessments and progress notes from 01/01/25 to 04/14/25 lacked documented evidence that the facility's staff monitored the resident for receiving cigarettes from other residents. A review of an annual Minimum Data Set (MDS) assessment dated 12/29/24 documented a Brief Interview for Mental Status summary score of "12" indicating that the resident had a moderately intact cognitive status. Additionally, the resident was not coded for using tobacco products. A care plan with a revision date of 01/16/25 documented in part, "Focus- [Resident #46] has a history of smoking related to lifestyle ...Interventions - [Resident #46] was educated about the facility policy on smoking. The facility non-smoking facility and she verbalized understanding. Notify charge nurse immediately if it suspected that resident has violated facility smoking policy. Smoking cessation was offered." A quarterly MDS assessment dated 03/31/25 documented in part that the resident had a Brief Interview for Mental Status summary score of "11" indicating the resident had a moderately impaired cognitive status. Also, the resident was	F 689			

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F 689	Continued From page 70 coded for requiring supervision to maximum assistance from staff with activities of daily living and independently using a manual wheelchair for mobility. During a face-to-face interview on 04/15/25 at approximately 4:50 PM, Resident #46 stated that she smokes outside the building near the wheelchair ramp. She also keeps her cigarettes or black and mild (cigar) on her person. She will ask residents who are outside smoking with her for a lighter or match. The resident stated that, "I'm grown. I don't need no one to supervise me while I'm smoking." The resident also stated that when she goes outside, she does not announce that she is going out to smoke. During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #46 was identified by staff as a smoker. Additionally, the employee stated that she had reviewed the resident record it did not see that the resident was being monitored for the behavior of asking other residents for cigarettes, as indicated on the smoking evaluation dated 12/04/23. During a face-to-face interview on 04/17/25 at approximately 9:30 AM, Employee #11 (assigned CNA) stated that Resident #46 was a smoker. She informs the nurses when the resident wants to smoke. She pushes the resident in her wheelchair outside (in front of the building) to smoke. Additionally, the employee said that she does not assist the resident with lighting light her cigarettes. And she does not know where the resident keeps her cigarettes, lighters or matches. Additionally, the employee said that she was not aware of the facility's smoking policy.	F 689			

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During a face-to-face interview on 04/17/25 at approximately 9:40 AM, Employee #12 (assigned LPN) stated that Resident #46 is a smoker. The CNA accompanies her while she smokes. Also, the CNA is responsible for lighting the resident's #46's cigarette because the resident was not safe to do that task.

2c. Resident #92 was admitted on 11/01/24 with multiple diagnoses including Paraplegia, Muscle Weakness, Depression, Bipolar, and Anxiety.

A review of the resident's medical record lacked documented evidence of a smoking care plan.

A quarterly Minimum Data Set assessment dated 02/07/25 documented that the resident had a Brief Interview for Mental Status summary score of "15" indicating the resident had an intact cognitive status. The resident was also coded for impairment of upper extremities (both sides), impairment of lower extremities (both sides), requiring partial to maximum staff assistance with activities of daily living, and independently using a motorize wheelchair for mobility."

During a face-to-face interview on 04/15/25 at approximately 5:30 PM, Employee #10 (RN/Nursing Supervisor) stated that Resident #80 was identified by staff as a smoker. The facility's protocol is that all residents who smoke should have a smoking care plan in their medical record. The employee then said she reviewed Resident #92's medical record and did not see a smoking care plan. Additionally, the employee said that the resident would not have a smoking assessment unless they trigger for a new behavior of smoking.

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During a face-to-face interview on 04/17/25 at approximately 10 AM, Resident #92 stated that he was a smoker and goes outside and to the street to the corner to smoke. The resident was asked if he had any smoking paraphernalia such as cigarettes and a lighter on his person and the resident stated, "No, I don't have nothing [anything] on me, and my lighter is broke." When asked how he would light his cigarettes if he didn't have a lighter, the resident stated, "I would just get a light from somebody else that's outside smoking."

During a face-to-face interview on 04/17/25 at 10:20 AM, Employee #33 (CNA) stated that she was not aware of any residents that smoke. The employee also said that she was not aware where residents store their smoking paraphernalia.

2d. Resident #10 was admitted on 12/22/23 with multiple diagnoses including Nicotine Dependence, Paraplegia, Epilepsy, Lack of Coordination, Muscle Weakness, and Bipolar.

A review of a care dated 01/04/24 documented in part, "Focus - [Resident #10] is a cigarette smoker and does not wish to stop during the hospital stay ...Interventions: Explore smoking apron, Educated about the facility policy on smoking. The Facility Non-smoking Facility and he verbalized understanding, Offer a nicotine patch. Offer smoking cessation classes. Resident able to smoke unsupervised per the smoking assessment. Resident smokes off [the] Facility premises."

An annual Minimum Data Set (MDS) assessment dated 11/06/24 documented that the Brief Interview for Mental Status (BIMS) summary

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F 689	Continued From page 73 score of "15" Brief Interview for Mental Status (BIMS) summary score of "15" indicating that the resident had an intact cognitive status. Additionally, the resident was coded for having an impairment of the upper extremity (one-side), impairment of lower extremities (both sides), requiring set-up to partial staff assistance from staff with activities of daily living, independent with using his motorized wheelchair, and using tobacco products ..." A quarterly Smoking Safety Screen assessment dated 11/28/24 documented that the resident had a score of "1.0" indicating that the resident was safe to smoke without supervision. The assessment also documented in part, "Smokes 5- 10 cigarettes per day, Can light his own cigarettes, Does not need the facility to store lighters and cigarettes, Adaptative equipment needed - cigarette holder, Safe to smoke independently..." A quarterly Smoking Safety Screen assessment dated 02/28/25 documented that the resident had a score of "1.0" indicating that the resident was safe to smoke without supervision. The assessment also documented in part, "Smokes 5- 10 cigarettes per day, Can light his own cigarettes, Does not need the facility to store lighters and cigarettes, Adaptative equipment needed - smoking apron and cigarette holder, Safe to smoke without supervision." A quarterly MDS assessment dated 04/02/25 documented that the resident had a Brief Interview for Mental Status (BIMS) summary score of "15" indicating that the resident had an intact cognitive status. Additionally, the resident was coded for having an impairment of the upper	F 689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
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F 689	Continued From page 74 extremity (one-side), bilateral impairment of lower extremities, requiring set-up to partial staff assistance with activities of daily living, and independent with using motorized wheelchair." During a face-to-face interview on 04/17/25 at 9:50 AM, Resident #10 stated, "I go smoke my cigarettes around the corner. I never got no smoking apron or cigarette holder. I would like to have a smoking apron." When asked where he stores his smoking paraphernalia (cigarettes and lighter), the resident stated, "I get it from someone I know outside." When asked about the facility's smoking policy or smoking contract, Resident #10 stated, "I don't know nothing about a policy or contract, they just tell us don't smoke." During a face-to-face interview on 04/17/25 at 11:33AM, Employee #31 (assigned LPN) stated that she did not know Resident #10 was a smoker. "I have never seen cigarettes on him. I know the resident goes downstairs but I don't know what he does there." When asked about the facility's smoking policy the employee stated, "I don't know the specifics. I know that the residents are not allowed to smoke." During a face-to-face interview on 04/17/25 at 11:35 AM, Employee #32 (assigned CNA) stated, "I am not aware if [Resident #10] is a smoker. I have never found or seen any smoking materials in his possession." When asked about the facility's smoking policy, the employee stated that she was not aware of one. During a face-to-face interview on 04/17/25 at approximately 12:00 PM, Employee #2 (DON) acknowledged that Resident #10 is a known cigarette smoker and that facility staff failed to	F 689			

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F 689	Continued From page 75 ensure that he was smoking safely as evidenced by not providing the resident with the required adaptative equipment needed (smoking apron and cigarette holder). These findings resulted in an Immediate Jeopardy being called on 04/17/25 at 3:36 PM. On 04/17/25 at 8:28 PM, the facility's Administrator provided the State Agency Survey Team with an acceptable Plan of Removal that addressed the immediate concerns with residents' smoking. The plan included the following interventions: Resident-Specific Interventions - Resident #10: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 - Resident #46: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25 - Resident #80: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25	F 689			

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F 689 Continued From page 76

F 689

- Resident #92: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25

- Resident #48: Will be reassessed using smoking safety assessment; smoking apron and /or any identified smoking aid will be offered; care plan will be updated to reflect supervision needs and proper storage of paraphernalia. The residents will be educated on the revised smoking policy. This will be started on 4/18/25

Facility-Wide Interventions

- We will conduct a facility-wide audit of all residents to identify active smokers starting 4/18/25. Smoking Policy will be revised as of 4/18/25.

- We will complete the Smoking Safety Assessment on all identified smokers starting 4/18/25. We will update and individualize the care plans for each smoker to reflect supervision needs, location, and supplies needed to assure safe smoking based on their assessment findings starting 4/18/25. If smoking paraphernalia is found, we will immediately attempt to confiscate all smoking paraphernalia. If unable to confiscate the smoking materials, social services, recreation services, ombudsman and/or the police will be involved. All items confiscated will be labeled and logged.

- We will reinforce the prohibition of smoking materials in resident rooms or on persons with residents and staff. This will be started 4/18/25.

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F 689	Continued From page 77 - Residents identified as smokers will be educated starting 4/18/25 on the updated smoking policy, smoking process and a smoking contract. Staff Education and Competency Validation - 70 percent of current staff (clinical, non-clinical, and agency staff) will receive in-service training on the smoking policy, safe smoking practices, resident supervision, and emergency response protocols starting 4/18/25. The goal will be 100% of staff to receive training. - Training will include the revised smoking policy and procedure. Nursing staff or designee will be assigned to monitor known smokers in the designated smoking area - Smoking binders will be placed on all floors and the security desk to help identify residents who smoke. Implementation of Systems and Monitoring Processes - We will develop a daily room audit tool that includes permission to inspect for smoking paraphernalia (lighter, cigarettes, etc.). This will be completed by nurse aide or designee. - We will establish and enforce a smoking materials storage protocol; only designated staff will have access. - We will create a resident smoking log and supervision documentation tool that includes time in/out, safe smoking supplies offered/accepted or declined. - We will assign a designated Smoking Safety Supervisor per shift. - We will complete monthly audits added to the QAPI Committee agenda for compliance tracking.	F 689			

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F 689 Continued From page 78

F 689

Designated Smoking Area Protocols

- We will enforce the use of a designated smoking area (outside to the left of the main entrance on the ground level)- Smoking area will include a fire extinguisher (in close proximity), fire blanket, will post no-smoking signage, and will have locked cart for smoking materials at the security desk).
- All residents who smoke will have to sign in/out and will be supervised by a nursing assistant or other clinical staff.
- Smoking aprons will be offered and documented on the smoking log. Return of smoking materials will also be documented on the log.
- Residents will only be able to access smoking materials during scheduled supervised times. (10am, 1 pm, 4pm, 7pm and 10pm).

Completion date for Immediate Jeopardy
Compliance - 4/21/25

After the plan was verified, the IJ was removed on April 24, 2025, at 1:50 PM while the survey team was onsite.

F 693 Tube Feeding Mgmt/Restore Eating Skills
SS=D CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to

F 693

Tag: F 693- Tube Feeding
Management/Restore Eating Skills
(pgs. 79-81)

Corrective Action for Resident(s):

1. Resident #38 received the prescribed water flushes via PEG tube immediately on 4/18/2025.
2. The attending physician was notified immediately upon discovery of the oversight.
3. A dehydration risk screen was completed on 6/11/25.
4. The resident's care plan was reviewed and updated on 6/16/25 with the frequency of water flushes.

07/8/2025

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F 693	Continued From page 79 eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility staff failed to provide a resident with water flushes via Percutaneous Endoscopic Gastrostomy (PEG) tube as prescribed for one (1) of 49 sampled residents. (Resident #38) The findings included: Resident #38 was admitted on 07/07/22 with multiple medical diagnoses that included Dysphagia following Cerebral Infarction and Gastrostomy Tube. A care plan with a review date of 09/13/24 documented in part, "Focus - [Reside#38] requires tube feeding related to Dysphagia...Interventions -The resident is dependent with [gastrostomy] tube feeding and water flushes ..." A physician order dated 02/12/25 instructed, "hydration water flushes 300 milliliters every four (4) hours via gastrostomy tube."	F 693	Cont. Tag: F 693- Tube Feeding Management/Restore Eating Skills (pgs. 79-81) Identification of Other Residents: 1. A facility-wide audit was conducted on 4/18/2025 by unit manager/designee to identify other residents with PEG tubes and ensure compliance with the prescribed frequency of water flushes. 2. All identified residents with PEG tubes were checked to ensure they were receiving prescribed flushes. Any discrepancies were immediately corrected upon discovery. Systemic Changes: 1. At least 80% of Licensed nursing staff were re-educated on PEG tube care, including pump usage, water flush administration, and documentation by the educator/designee. 2. The facility's enteral nutrition protocol was reviewed with staff by the educator/designee by 07/8/25. 3. A protocol was implemented, requiring nursing staff to document PEG tube flushes in the electronic health record immediately after administration by 7/8/25. 4. The dietitian and nurse managers began reviewing tube feeding compliance during weekly clinical meetings by 07/8/25.		

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F 693	Continued From page 80 A quarterly Minimum Data Set (MDS) assessment dated 03/01/25 documented in part that the resident had a Brief Interview for Mental Status (BIMS) summary score of "01", indicating that the resident cognitive status was severely impaired. The resident was also coded for using a feeding tube. During an observation on 04/18/25 at approximately 11:00 AM, Resident #38 was lying in bed, alert and oriented to name. The resident was receiving enteral water flush hydration via gastrostomy tube. The resident's feeding pump for water flushes was set at 300 milliliters every six (6) hours. During a face-to-face interview with on 4/18/25 at approximately 11:00 am, Employee #14 (assigned LPN) stated that the feeding pump's water flush frequency setting of every six hours was incorrect. The resident has a order for water flushes every (4) hours. The employee immediately changes the setting to every four (4) hours. When asked, did he check the tube feeding setting when he started his shift, the employee stated, "No."	F 693	Cont. Tag: F 693- Tube Feeding Management/Restore Eating Skills (pgs. 79-81) Monitoring of Corrective Actions: 1. The Director of Nursing or designee will audit 20 charts of residents receiving tube feedings weekly for 4 weeks and monthly for 3 months to ensure compliance with water flushes and care protocols. Any deficiencies noted will be corrected upon discovery. 2. Compliance and Outcome will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment. Tag: F694- Parenteral/IV Fluids (pgs. 81-83)		07/8/2025
F 694	Parenteral/IV Fluids SS=D CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:	F 694	Corrective Action for Resident(s): 1. The central line for resident #91 was discontinued on 4/13/2025 by the unit nurse with no signs of infection or complications noted. 2. The dressing was replaced on 4/28/2025 by the unit nurse, and the physician was notified. 3. The central line for resident #53 was discontinued on 6/4/2025 by the unit nurse with no signs of infection or complications noted. 4. The care plan and physician's orders were reviewed and updated by the unit nurse on 6/16/2025.		

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F 694	Continued From page 81 Based on observations, record reviews and staff interviews, for two (2) of 49 residents sampled, facility staff failed to ensure that the residents received care and services, consistent with professional standards of practice, for their central intravenous (IV) lines. Residents' #91 and #53. The findings included: Review of the facility's "Central Venous Catheter Dressing Changes" dated 05/24/24 documented: - The purpose of this procedure is to prevent catheter-related infections - After the original insertion of CVAD (central venous access device), change transparent semi-permeable membrane (TSM) dressings at least every 5-7 days and PRN (as needed). According to the National Institute of Health (NIH): - Per Centers for Disease Control (CDC) guidelines and nursing standards of practice, central line dressings should be changed at a minimum of every seven (7) days and as needed. - Label the dressing with the date, time, and your initials, as well as the date the dressing should be changed again. - Labeling is a quality measure to promote ongoing adherence to agency policies and recommendations. https://www.ncbi.nlm.nih.gov/books/NBK594495/ 1. Resident #91 was admitted to the facility on 01/29/25 with multiple diagnoses that included: Interstitial Pulmonary Disease, Type 2 Diabetes Mellitus and Chronic Respiratory Failure.	F 694	Cont. Tag: F694- Parenteral/IV Fluids (pgs. 81-83) Identification of Other Residents 1. A comprehensive review of all residents with central IV lines was completed by unit managers/designee by 6/30/25, to identify any additional cases of non-compliance. 2. Any additional residents with central lines identified during the audit with undated dressing or untimely dressing changes will be immediately addressed upon discovery by the unit manager or unit nurse, and the staff re-trained by the educator/designee. Systemic Changes; 1. Nursing staff responsible for both residents will be re-educated on central line care and documentation standards by the educator/designee by 6/30/2025. 2. Additionally, at least 80% of licensed nurses were re-educated on central line care, including sterile technique, frequency of dressing changes, flushing protocols, and site assessments as ordered by the physician by the educator/designee by 07/8/25. 3. Nurse managers now validate central line care weekly, and documentation accuracy is reviewed during clinical rounds (implemented by 7/8/25).		

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F 694	Continued From page 82 Review of the resident's medical record revealed the following: An Admission Minimum Data Set (MDS) assessment dated 02/04/25 showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact cognitive response. Physician's orders dated 02/10/15 directed, "Established [central] line - Change dressing Q (every) 7 days, every night shift every Monday for IV-line Care; Change dressing as needed if not intact or soiled as needed for IV care; Observe insertion site every shift for redness, warmth, swelling, drainage, coldness or irritation, every shift for IV care." Review of the April 2025 Treatment Administration Record (TAR) showed that on 04/07/25, facility staff documented a check mark and their initials to indicate that the resident's central IV-line dressing was changed during the night shift. During an observation on 04/13/25 at 2:28 PM, Resident #91 was noted with a left upper arm peripheral inserted central catheter (type of CVAD) with a dressing that was dated "04/03/25". During a face-to-face interview at the time of the observation, Employee #16 (Registered Nurse/RN) acknowledged that the central line dressing had not been changed in over seven days, and that the facility's policy is to change the dressing at least every seven days. The evidence showed that facility staff failed to ensure that Resident #91 received care and	F 694	Cont. Tag: F694- Parenteral/IV Fluids (pgs. 81-83) Monitoring of Corrective Actions: 1. The unit manager or designee will audit 10 residents with central line dressings weekly for 4 weeks and then monthly for 3 months to ensure adherence to dressing change protocols and documentation. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 694	Continued From page 83 services, consistent with professional standards of practice for her left upper arm peripheral inserted central catheter IV site. 2. Resident #53 was admitted to the facility on 10/29/24 with multiple diagnoses that included: Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Anoxic Brain Injury. Review of the resident's medical record revealed: A Quarterly MDS assessment dated 04/10/25 showed that facility staff coded that the resident had an IV access. A physician's order dated 04/15/25 directed, "Established [central] line, change dressing every 7 days, every night shift, every Sunday for midline dressing change." Review of the TAR for April 2025 showed that facility staff documented a check mark and their initials to indicate that the resident's midline central IV site dressing was completed on 04/26/25. During an observation on 04/28/25 at 10:00 AM, Resident #53 was observed lying in bed, the dressing on his midline IV site was noted with a transparent dressing that had no date on it to show when the central line catheter dressing was last changed. During a face-to-face interview at the time of the observation, the Employee #6 (6th Floor Unit Manager) acknowledged the finding and stated, "There's no date visible to say when the dressing was changed so it will get changed today."	F 694			

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F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 49 residents sampled, facility staff failed to ensure that Resident #53's attending physician evaluated his total program of care as evidenced by failing to have documented evidence that the physician reviewed the pharmacist recommendations for four (4) months. The findings included: Review of the facility's "Medication Regimen Review" policy dated 06/21/17 documented: - The pharmacist must report any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing (DON), and these reports must be acted upon in a manner that meets the needs of the residents. - For non-urgent recommendations, the facility, and attending physician must address the	F 711	Tag: F 711- Physician Visits (pgs.85-86) Corrective Action for Resident(s): 1. The attending physician completed a review of Resident #53's total program of care, including all pharmacist recommendations from the past four months by 6/30/2025. 2. Documentation of the physician's review and any subsequent actions taken was completed and added to Resident #53's medical record by 6/30/2025. Identification of Other Residents: 1. A facility-wide audit was conducted by the unit manager/designee by 6/30/25 to identify any other residents whose pharmacist recommendations had not been reviewed by their attending physicians. 2. For any identified cases, immediate reviews were scheduled and completed by the respective attending physicians, with documentation added to each resident's medical record.		07/8/2025

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			(X5) COMPLETION DATE

F 711 Continued From page 85

recommendation(s) in a timely manner, no later than their next routine visit.

Resident #53 was admitted to the facility on 10/29/24 with multiple diagnoses that included: Chronic Pain, Schizophrenia, Anxiety Disorder, and Anoxic Brain Injury.

Review of the resident's medical record revealed the following:

Physician's orders dated 10/29/24 that directed, "Lidocaine External Patch (topical pain reliever) 4% (Lidocaine), apply to left lower leg topically one time a day for leg pain; Olanzapine (Antipsychotic medication) oral tablet 2.5 MG (milligrams), give 2.5 mg via G (gastrostomy) -tube two times a day; Quetiapine Fumarate (Antipsychotic medication) oral tablet 150 MG, give 150 mg via G-tube every 12 hours; and Acetaminophen (pain reliever) oral tablet, give 650 mg via G-tube every 6 hours as needed (PRN) for Pain."

A physician's order dated 11/20/24 that directed, "Oxycodone (narcotic pain reliever) HCl (hydrochloride) oral tablet 5 MG, give 1 tablet enterally every 4 hours as needed for Pain." It should be noted that this medication was discontinued (d/c) on 01/30/25.

11/21/24 at 5:50 PM Pharmacy Progress Note:
- Consultant pharmacist medication regimen review (MRR) report.
- Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include

Cont. Tag: F 711- Physician Visits
F 711 (pgs.85-86)

Systemic Changes:

1. The facility's policy on physician review of pharmacist recommendations was updated by the Regional Director of Operations to require monthly documentation of such reviews in each resident's medical record as of 06/30/25.

2. A protocol was established by 07/8/25 where the unit managers will maintain a monthly report of pharmacist recommendations for each resident in a binder to be reviewed and signed off by the attending physician.

3. The binder will be reviewed monthly by the unit managers for physician compliance and follow-up.

4. The Medical Director, Director of Nursing, Unit Managers, and Consultant Pharmacist were educated by the Administrator by 7/8/25.

Monitoring and Quality Assurance:

1. The Director of Nursing or designee will conduct monthly audits of resident records for 3 months to ensure compliance with the updated policy on physician visits. Any deficiencies noted will be corrected upon discovery.

2. These audits will focus on verifying that all pharmacist recommendations are reviewed and documented by the attending physician.

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F 711	Continued From page 86 clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via G-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via G-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS (Centers for Medicare and Medicaid) with antipsychotic drug utilization, recommend review and clarify indication. - Lidocaine Patch 4%, apply to left lower leg topically one time a day for leg pain at 9:00 AM. Patch can be applied for up to 12 hours. There shall be a drug-free period of 12 hours. To avoid medication administration errors, clarify directions with prescriber to include "12 hours on and 12 hours off." Kindly update PointClickCare (PCC/facility's electronic) and document lidocaine patch removal at 9:00 PM on the Medication Administration Record (MAR). Review of the MRR for November 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 12/19/24 at 1:41 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G (gastrostomy) - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide		3. Compliance and outcome will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 711	Continued From page 87 appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). Review of the MRR for December 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 01/22/25 at 3:45 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. A physician's order dated 01/30/25 that directed, "Oxycodone HCl oral tablet 5 MG, give 1 tablet enterally every 6 hours as needed for Pain." Review of the MRR for January 2025 and Resident #53's medical record showed no	F 711			

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F 711	Continued From page 88 documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 02/16/2025 at 7:15 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. Review of the MRR for February 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 03/12/25 at 11:05 AM Care Conference Note: - [Resident #53] had a care conference held on 03/11/25 with the interdisciplinary team (IDT) team and niece to discuss the plan of care. - The plan of care was reviewed and will continue. A care plan focus area, reviewed on 03/11/25,	F 711			

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F 711 Continued From page 89

F 711

documented, "[Resident #53] is at risk for adverse reaction r/t (related to) polypharmacy" with interventions that included, "Request physician to review and evaluate medications; review pharmacy consult recommendations, and follow up as indicated."

Review of Resident #53's physician's orders showed that on 03/25/25 is when the resident's primary care doctor reviewed and acted upon the consultant pharmacist's recommendations and identified irregularities from November 2024, December 2024, January 2025 and February 2025.

The evidence showed no documented evidence that from November 2024 through February 2025, four (4) months, the physician reviewed Resident #53's total program of care, to include medication management, as evidenced by the consultant pharmacist's identified irregularities and recommendations not being acted upon.

During a face-to-face interview on 04/28/25 at 2:55 PM, Employee #2 (DON) was asked why Resident #53's medication regimen reviews were not reviewed or acted upon from November 2024 - February 2025. Employee #2 stated, "[Resident #53's] primary doctor was also the medical director, who left abruptly, without notice on 01/27/25. Her residents were then picked up by [Physician's name], who also became the Medical Director. Once reviewed and acted upon, the forms are given back to the clinical team to file. I am not sure why the doctors did not review the MRRs for [Resident #53] for those months."

Cross Reference 22B DCMR Sec. 3207.10

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F 726 F 726 SS=D	Continued From page 90 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 §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, for two (2) of 49 residents, sampled, facility staff failed to demonstrate appropriate competencies and skills sets to provide safe	F 726 F 726	Tag: F726-Competent Nursing Staff (pgs. 91-92) Corrective Action for Residents Affected 1. Resident #73, the alarm was reviewed and resolved by the unit nurse on 4/13/25. The unit manager assigned to the floor provided immediate retraining to the assigned nursing staff on 4/13/25 on nurse aides not trained to troubleshoot issues related to G-tubes. 2. For resident #209, no harm resulted from the deficiency. Immediate corrective training was provided to the nurse responsible for the SBAR documentation. Identification of Other Residents: 1. Residents with a change in condition and hospital transfers in the last 7 days were reviewed by the DON/designee to ensure an accurate and thorough completion of the SBAR. This will be completed by 6/30/2025. No additional deficiencies were noted. 2. An audit of all nursing assistants will be completed to validate understanding of not troubleshooting medical devices such as G-Tubes. No additional deficiencies were noted.		7/8/2025

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F 726	Continued From page 91 nursing services. Residents #73 and #209. The findings included: Review of the facility's "Change in a Resident's Condition or Status" policy dated 05/24/24 documented: - The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; need to transfer the resident to a hospital/treatment center. - Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR Communication Form. 1. Resident #73 was admitted to the facility on 04/04/24 with multiple diagnoses that included: Encounter for Attention Gastrostomy, Anoxic Brain Injury, and Adult Failure to Thrive. Review of the resident's medical record revealed the following: A physician's order dated 03/05/25 directed, "Enteral feed order every shift for dysphagia, Glucerna 1.5 at 46 ml (milliliters)/hr(hour) X 24 hours via PEG (Percutaneous Endoscopic Gastrostomy)." An Annual Minimum Data Set (MDS) assessment dated 04/11/25 showed that facility staff coded that the resident received nutrition via a feeding tube.	F 726	Systemic Changes: 1. The Facility HLOC report will be reviewed daily by the unit manager/designee to identify residents with a change in condition and thorough completion of the SBAR and to ensure that only current information is documented in the resident's medical record. Any deficiencies noted will be corrected upon discovery. 2. Nursing supervisors will be responsible for reviewing the SBAR for accuracy and completion before physician notification. Any deficiencies noted will be corrected upon discovery. 3. At least 80% of licensed staff received training on accurately completing the SBAR before physician notification and documentation of current information in the resident's medical record. Monitoring and Quality Assurance: 1. The unit manager/designee will conduct audits of the SBARs in PointClick Care after a change in condition or resident transfer to the hospital, daily for 7 days, weekly for 4 weeks, and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance and outcome will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 726

During an observation on 04/13/25 at 8:50 AM, Resident #73 was observed lying in bed. The machine with the resident's tube feeding was alarming with the following error message, "Flow error. Clog in line down stream of pump." The surveyor pushed the resident's call light in order to alert the staff. At 9:19 AM, Employee #8 (Certified Nurse Aide/CNA) entered the room. The employee performed hand hygiene, donned gloves, and proceeded to push the restart button on the machine. When asked if he's been trained in the care of gastrostomy tubes, the employee stated, "No. CNAs are not trained to troubleshoot G (gastrostomy)- tubes."

During a face-to-face interview on 04/13/25 at approximately 9:30 AM, Employee #2 (Director of Nursing/DON) was made aware of the observation and stated, "If the G-tube is alarming, the CNA should've made the nurse aware, they are not to restart it themselves."

2. Resident #209 was admitted to the facility on 04/14/25 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Injury, and Metabolic Encephalopathy.

Review of the resident's medical record revealed the following:

A Situation Background Assessment and Request (SBAR) Communication Form completed by Employee #34 (assigned Registered Nurse/RN) 04/21/25 at 5:59 PM documented:
- Situation - Tachycardia with a pulse of 135 and an oxygen saturation of 85%.
- This started on: 04/21/25 at 9:00 AM.
- Most Recent Vital signs: blood pressure: 108/73

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F 726 Continued From page 93

F 726

- date: 04/21/25 at 1:36 AM; respiration: 18.0
(Breaths/min) date - 04/21/25 at 1:36 AM;
temperature: 98.3 (°F) date - 04/21/25 at 1:36 AM,
route: axillary.

- Comments: In the morning the resident had a
pulse of 135 and his oxygen saturation was 85%, I
informed Nurse Practitioner (NP), and she said to
call 9-1-1, the resident was transferred via
Emergency Medical Services to [Hospital name].

Review of the SBAR form and the progress notes
showed that the nurse failed to gather all relevant
and pertinent information for the provider prompted
by the SBAR Communication Form as evidenced by
the lack of documentation that Resident #209's
blood pressure, respirations or temperature were
assessed at the time of his change in condition.

A face-to-face interview was conducted on 04/23/25
at 4:15 PM, with Employee #34 and Employee #2
(DON). Employee #34 stated, "There was a lot
going on at the time. I saw that he [Resident #209]
was tachycardic and his saturations were low, so I
called the doctor, who said to transfer the resident
to the hospital. He left the facility around 9:00 AM."
Employee #2 stated, "The protocol is to do a
complete assessment, including all vital signs, when
there is a change in condition and document them
in the SBAR form to relay to the doctor."

F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records
SS=D CFR(s): 483.45(a)(b)(1)-(3)

§483.45 Pharmacy Services

The facility must provide routine and emergency
drugs and biologicals to its residents, or obtain them
under an agreement described in

Tag: F 755- Pharmacy
Services/Procedures/Pharmacist
Responsibilities (pgs. 94-96)

Corrective Action for Resident(s):

1. The missing medication for Resident #75 was immediately procured from the pharmacy on 4/18/2025 and administered as per the physician's order.
2. An assessment of Resident #75 was completed by a licensed staff member on 4/18/2025 to ensure no adverse effects resulted from the missed medication dose.

7/8/2025

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§483.70(f). 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 observation, record review, and staff interview, the facility's staff failed to ensure a resident's medication recently received from pharmacy was available for administration for one (1) of 49 sampled residents. (Resident #75)

The findings included:

Resident #75 was admitted on 06/21/24 with multiple diagnoses including Epilepsy, Spastic

F 755 Cont. Tag: F 755- Pharmacy Services/Procedures/Pharmacist Responsibilities (pgs. 94-96)

Identification of Other Resident(s):

1. A review of all residents' medication records was completed by 6/30/2025 by the DON or designee to identify any other instances of unavailable medications.

2. No other deficiencies were noted.

Systemic Changes:

1. Licensed staff are now required to notify the physician when resident medications are unavailable for administration.

2. Training for at least 80% of licensed staff by the educator/designee will be completed by 6/30/2025 on the updated medication process, emphasizing the importance of timely medication availability and physician notification.

3. The facility has implemented a communication protocol between the nursing staff and pharmacy to ensure timely notification and resolution of any medication supply issues (effective by 7/8/25).

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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
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F 755 Continued From page 95
Quadriplegia, Ventilator Dependent and
Gastrostomy Tube.

A policy titled, "Medication Ordering and Receipt"
with a review date of 01/03/25 instructed, "The
nurse ...will sign the packing slip ...indicating the
correct medication has been delivered to the correct
medication cart ..."

A physician's order dated 03/31/25 instructed,
"Levetiracetam (anti-epileptic drug) 100
milligrams/milliliters solution administer 10 milliliters
(1000 milligrams) via gastrostomy tube every 12
hours to prevent seizures.

A pharmacy request form dated 04/11/25 revealed
that the facility reordered Resident #75's
Levetiracetam 100mg/ml solution on 04/11/25 and it
was delivered to the facility on that same day.

A medication observation on 04/18/25 at
approximately 9:30 AM, Employee #16 (RN) was
unable to locate Resident #75's Levetiracetam after
looking on all three (3) medication carts and the
medication room. When the employee attempted to
use another resident's Keppra (10 milliliters) to
administer to Resident # 75, the surveyor
intervened.

During a face-to-face interview on 04/18/25 at
approximately 9:40 PM, Employee #16 stated that
she was using another resident's Levetiracetam
because she could not find Resident #75's
medication. When asked, is it the facility's policy to
use another resident's medication? The employee
said, "No" and then said she would make the nurse
practitioner aware, so she could an order to
administer the tablet (crush) form that they had on
hand as stock medication.

F 755 Cont. Tag: F 755- Pharmacy
Services/Procedures/Pharmacist
Responsibilities (pgs. 94-96)

Monitoring and Quality Assurance:

1. Audits will be completed weekly for 4
weeks and monthly for 3 months by the
unit managers to identify medications
requiring re-ordering and missed
medications. Any deficiencies noted
will be corrected upon discovery.
2. At least 80% of Licensed staff will be
educated by the educator/designee on
notifying the nursing supervisor of
delayed receipt of medications from
the pharmacy by 7/8/25.
3. Compliance will be reported and
discussed during QAPI meetings for
continued oversight. Any deficiencies
noted will be corrected upon discovery.
Any trends identified will prompt
further education or systems
adjustment.

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F 755 Continued From page 96

F 755

During a face-to-face interview on 04/18/25 at approximately 10 AM, Employee #6 (RN/Unit Manager) stated that an employee signed a pharmacy slip indicating that Resident #75's Levetiracetam was delivered on 04/11/25. The employee said that facility's protocol is that when the nurse signs for the medication they then put on the correct medication cart. Additionally, the employee said she could not explain why the medication was not available. Also, the employee stated that Employee #16 should not have used another resident's Levetiracetam for Resident #75.

F 756 Drug Regimen Review, Report Irregular, Act On
SS=D CFR(s): 483.45(c)(1)(2)(4)(5)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,

F 756 Tag: F 756- Drug Regimen Review (pgs. 97-98) 07/8/2025

Corrective Action for Resident(s):
1. The attending physician for Resident #53 was immediately contacted by a licensed nurse to review the pharmacist's identified irregularities.
2. Documentation of the physician's review and actions taken was completed and added to Resident #53's medical record by 6/30/25.

Identification of Other Resident(s):
1. A comprehensive audit of all current residents' medical records will be conducted by the consulting pharmacist by 6/30/25 to identify any other instances where pharmacist-identified irregularities were not reviewed by the attending physician. For any additional residents identified, immediate action was taken to ensure physician review and documentation of actions taken.

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F 756	Continued From page 97 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (1) of 49 residents sampled, facility staff failed to have documented evidence that the attending physician reviewed and acted upon identified irregularities noted by the pharmacist. Resident #53. The findings included: Review of the facility's "Medication Regimen Review" policy dated 06/21/17 documented: - The pharmacist must report any irregularities to the attending physician, the facility's Medical Director, and Director of Nursing (DON), and these reports must be acted upon in a manner that meets the needs of the residents. - For non-urgent recommendations, the facility, and attending physician must address the recommendation(s) in a timely manner, no later than their next routine visit. Resident #53 was admitted to the facility on	F 756	Cont. Tag: F 756- Drug Regimen Review (pgs. 97-98) Systemic Changes A meeting was held with the medical director and administrator by 6/20/2025 to require that all pharmacist-identified irregularities be reviewed by the attending physician within 48 hours of receiving the report, with documentation of the review and any actions taken. The Consulting pharmacist will be in-serviced by the administrator to notify unit managers of medication irregularities to ensure follow-up with attending physicians by 07/8/25. Monitoring and Quality Assurance: 1. Weekly audits of medical records will be conducted by the unit managers/designee for 2 weeks and monthly for 3 months to ensure compliance with the updated policy and process for notifying physicians of medication irregularities. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 756	Continued From page 98 10/29/24 with multiple diagnoses that included: Chronic Pain, Schizophrenia, Anxiety Disorder, and Anoxic Brain Injury. Review of the resident's medical record revealed the following: Physician's orders dated 10/29/24 that directed, "Lidocaine External Patch (topical pain reliever) 4% (Lidocaine), apply to left lower leg topically one time a day for leg pain; Olanzapine (Antipsychotic medication) oral tablet 2.5 MG (milligrams), give 2.5 mg via G (gastrostomy)-tube two times a day; Quetiapine Fumarate (Antipsychotic medication) oral tablet 150 MG, give 150 mg via G-Tube every 12 hours; and Acetaminophen (pain reliever) oral tablet, give 650 mg via G-Tube every 6 hours as needed (PRN) for Pain." A physician's order dated 11/20/24 that directed, "Oxycodone (narcotic pain reliever) HCl (hydrochloride) oral tablet 5 MG, give 1 tablet enterally every 4 hours as needed for Pain." It should be noted that this medication was discontinued (d/c) on 01/30/25. 11/21/24 at 5:50 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review (MRR) report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN	F 756			

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F 756	Continued From page 99 moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via G-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via G-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS (Centers for Medicare and Medicaid) with antipsychotic drug utilization, recommend review and clarify indication. - Lidocaine Patch 4%, apply to left lower leg topically one time a day for leg pain at 9:00 AM. Patch can be applied for up to 12 hours. There shall be a drug-free period of 12 hours. To avoid medication administration errors, clarify directions with prescriber to include "12 hours on and 12 hours off." Kindly update PointClickCare (PCC/facility's electronic) and document lidocaine patch removal at 9:00 PM on the Medication Administration Record (MAR). Review of the MRR for November 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 12/19/24 at 1:41 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G (gastrostomy) - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN opioid pain medication orders must include clearly defined circumstances for use. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10).	F 756			

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F 756	Continued From page 100	F 756			
	Review of the MRR for December 2024 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 01/22/25 at 3:45 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. A physician's order dated 01/30/25 that directed, "Oxycodone HCl oral tablet 5 MG, give 1 tablet enterally every 6 hours as needed for Pain." Review of the MRR for January 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon.				

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F 756	Continued From page 101 02/16/2025 at 7:15 PM Pharmacy Progress Note: - Consultant pharmacist medication regimen review report. - Acetaminophen 325 mg, give 650 mg via G - tube every 6 hours for pain; Oxycodone 5mg, give 1 tablet enterally every 4 hours PRN for pain, neuropathic for pain. There is high scrutiny with opioid drug utilization. PRN pain orders must include clearly defined circumstances for the use of opioid. To provide appropriate treatment, kindly clarify and add pain scale number parameters to distinguish each PRN pain regimen: i.e. PRN mild pain (1-3), PRN moderate pain (4-6) or PRN severe pain (7-10). - Olanzapine 2.5 mg, give via g-tube two times a day for antipsychotic; Quetiapine Fumarate 150mg, give via g-tube every 12 hours for antipsychotic. Because there is a high level of scrutiny from CMS with antipsychotic drug utilization, recommend review and clarify indication with an appropriate indication. Review of the MRR for February 2025 and Resident #53's medical record showed no documented evidence that this report was reviewed by the resident's primary care doctor or that the identified irregularities were acted upon. 03/12/25 at 11:05 AM Care Conference Note: - [Resident #53] had a care conference held on 03/11/25 with the interdisciplinary team (IDT) team and niece to discuss the plan of care. - The plan of care was reviewed and will continue. A care plan focus area, reviewed on 03/11/25, documented, "[Resident #53] is at risk for adverse reaction r/t (related to) polypharmacy" with interventions that included, "Request physician to review and evaluate medications;	F 756			

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F 756	Continued From page 102 review pharmacy consult recommendations, and follow up as indicated." Review of Resident #53's physician's orders showed that on 03/25/25 is when the resident's primary care doctor reviewed and acted upon the consultant pharmacist's recommendations and identified irregularities from November 2024, December 2024, January 2025 and February 2025. The evidence showed that from November 2024 through February 2025, four (4) months, identified irregularities for Resident #53 were not reviewed or acted upon by the resident's attending physician. During a face-to-face interview on 04/28/25 at 2:55 PM, Employee #2 (DON) was asked why Resident #53's medication regimen reviews were not reviewed or acted upon from November 2024 - February 2025. Employee #2 stated, "[Resident #53's] primary doctor was also the medical director, who left abruptly, without notice on 01/27/25. Her residents were then picked up by [Physician's name], who also became the Medical Director. Once reviewed and acted upon, the forms are given back to the clinical team to file. I am not sure why the doctors did not review the MRRs for those months."	F 756	Tag: F 759- Unnecessary Drugs (pgs. 103-104) Corrective Action for Identified Resident (s): The nurses responsible for the medication error were re-educated on the 5 Rights of Medication Administration by the educator/designee by 07/8/25. Identification of Other Resident(s): A med pass audit will be completed by unit managers/designee by 6/30/25 to identify any potential issues of non- compliance. For any additional residents identified, immediate action will be taken by the DON/designee to ensure staff education on medication administration protocols.		07/8/2025
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759			

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F 759	Continued From page 103 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to ensure that the medication error rate was 5% or less. Subsequently, the facility had a 16% medication error rate. The findings included: During eight (8) medication administration observations conducted from 04/15/25 through 04/25/25 showed (4) errors out 25 opportunities. The medication error rate was 16%. During a face-to-face interview on 04/25/25 at approximately 3PM, Employee #2 stated that staff are provided with education on medication administration and medication management. She will ensure they receive additional education. Cross Reference F554, F684, F755, F761, and F880		F 759	Tag: F 759- Unnecessary Drugs (pgs. 103-104) Systemic Changes: 1. At least 80% of licensed nurses will be provided a mandatory retraining by the educator/designee on the 5 Rights of Medication Administration, and Medication pass audits will be increased to daily for 14 days. 2. A competency validation process will be implemented by 6/30/25 for at least 80% of licensed staff, including observation and competency validation completed by the educator/designee. Monitoring of Corrective Actions: 1. The Unit Manager or designee will complete direct observation audits of 10 medication passes weekly for 4 weeks on all shifts and monthly for 3 months. Any deficiencies noted will be corrected upon discovery.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper		F 761	2. In addition to facility medication pass audits, the Consultant Pharmacist will also conduct random medication pass audits monthly to validate compliance and track error rates. Any deficiencies noted will be corrected upon discovery. Trends and findings will be reported in QAPI to sustain a facility-wide error rate below 5%. 3. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.	

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F 761	Continued From page 104 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, facility staff failed to ensure safe and secure storage of residents' medications as evidenced by storing: three (3) opened and undated vials of insulin for three residents in the medication refrigerator, two, opened, expired insulin vials for two (2) residents in the medication refrigerator, and by failing to remove one Resident's insulin pen from the medication refrigerator after the Resident was discharged from the facility. Residents #9, # 64, #77, #209, and #259. The findings included: 1. On 04/23/25 at 12:03 PM, during an observation of the 5th Floor Medication Storage Room, one opened, expired vial of Humalog Mix 75/25 insulin for Resident #9 was observed in the medication room refrigerator. A handwritten date was observed in the box that the vial of insulin came in, indicating that the insulin vial had been opened on 03/20/25. Per manufacturers' (Eli Lilly) the guidelines for	F 761	Tag: F 761- Label/Store Drugs and Biologicals (pgs. 105-106) Corrective Action for Resident(s): 1. The identified insulin products for Residents #9, #64, #77, #209, and #259 were immediately removed and discarded according to facility policy by 06/30/25. 2. Each resident's medication administration record was reviewed by the unit manager/designee by 07/8/25 to confirm no missed or duplicated doses. 3. The nursing staff responsible was re-educated on proper labeling, dating, and removal procedures for medications by the educator/designee by 07/8/25. Identification of Other Resident(s): 1. A comprehensive audit of all medication storage areas will be completed by the unit manager/designee by 6/30/2025 to identify any other instances of improper storage of insulin vials, pens, and injectable medications. Any deficiencies noted will be corrected upon discovery. 2. Ensured all medications were properly labeled with open dates and checked for expiration. This was completed by the unit manager/designee by 6/30/2025. 3. Unit managers/designee verified that medications belonging to discharged residents were removed promptly upon discharge by 6/30/2025.	07/8/2025	

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F 761	Continued From page 105 Humalog Mix 75/25 (https://uspl.lilly.com/humalog7525.html#ug), stated, "Opened Humalog mix 75/25 vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin." this applies whether the vial is stored in the refrigerator or at room temperature." A review of Resident #9's medication record revealed the following: Resident #9 was admitted to the facility on 04/01/16 with diagnoses that included: Diabetes Mellitus, Atrial Fibrillation; Heart Failure; Hypothyroidism; and Gastroesophageal Reflux Disease (GERD). A physician's order dated 04/09/25 that directed: "Humalog Mix 75/25 Suspension (75-25) 100 units/ml, (units per milliliter) (Insulin Lispro Protamine and Lispro) Inject 20 units subcutaneously in the morning for diabetes AC (before a meal) Breakfast." An April 2025 medication administration record (MAR) which documented that facility staff administered expired Humalog Mix 75/25 insulin to the Resident from 04/21/25 to 04/22/25. A review of Resident #9's blood sugar readings from 04/21/25 to 04/23/25 showed: 4/24/2025 08:47 88.0 mg/dL (milligram per deciliter) 4/23/2025 23:33 133.0 mg/dL 4/23/2025 16:52 127.0 mg/dL 4/23/2025 14:23 126.0 mg/dL 4/23/2025 14:18 89.0 mg/dL 4/23/2025 04:12 120.0 mg/dL	F 761	Cont. Tag: F 761- Label/Store Drugs and Biologicals (pgs. 105-106) Systemic Changes: - At least 80% of licensed nurses were re-educated by 6/30/2025 on labeling and dating insulin vials and proper procedures for removing medications upon resident discharge by the educator/designee. - The DON initiated updated procedures to ensure medications are checked for expiration dates and dated according to the manufacturer's recommendations by 06/30/25. At least 80% of licensed nurses were re-educated by 6/30/2025 on the updated procedures. Monitoring of Corrective Actions: - The Unit Manager/designee will audit all medication storage areas for expired medications and correct labeling of insulin weekly for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. - Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 761 Continued From page 106

F 761

4/22/2025 15:43 83.0 mg/dL
4/22/2025 11:33 99.0 mg/dL
4/22/2025 08:30 94.0 mg/dL
4/21/2025 22:57 135.0 mg/dL
4/21/2025 15:19 198.0 mg/dL
4/21/2025 12:28 200.0 mg/dL
4/21/2025 10:14 245.0 mg/dL

During a face-to-face interview on 04/09/25 with Employee # 45, a Licensed Practical Nurse assigned to Resident #9, he stated that he had not noticed that Resident #9's insulin expired. He further said that he had not removed the insulin from the refrigerator and did not administer insulin to the Resident on 04/24/25 because his blood sugar before breakfast was 88 mg/dl.

During a face-to-face interview with Employee #3/5th floor Unit Manager/Registered Nurse, she stated, "I take the responsibility for checking the refrigerator for expired medications." She then acknowledged the finding and said that she would discard the expired Humalog Mix 75/25 insulin from the refrigerator and order a new vial of insulin for Resident #9.

2. On 04/24/25 at 12:48 PM during an observation of the 6th Floor Medication Storage Room, in the medication refrigerator, the following was observed: one(1) vial of Aspart (Novolog) insulin opened on 03/17/25 with no expiration date for Resident #64; one opened vial of Lantus insulin with no date for Resident #209; one opened vial of Lantus insulin with no date for Resident #77, and one opened Lantus insulin pen that showed approximately 20 units had been used with no date on it for Resident #259, who was discharged from the facility on 02/28/25.

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F 761	Continued From page 107 A. Resident #64 was re-admitted to the facility on 01/31/25 with diagnoses that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus; End-Stage Renal Disease; Seizures, and Encounter for Gastostomy. A review of Resident #64's medication record showed the following: A physician's order dated 02/10/25 that directed: "Check Blood Sugar one time a day *Use Per Sliding Scale and Inject Subq (subcutaneously) * 1-150=0 units; 151-200=1 units; 201-250=2 units; 251-300=3 units; 301-350=4 units; 351-400=5 units; Call Physician (for) Blood Sugar greater than 400 for Diabetes Mellitus." The order was discontinued on 02/17/25. A physician's order dated 02/18/25 that directed: "Insulin Aspart Injection Solution (Insulin Aspart) Inject as per sliding scale: if 1 - 150 = 0 unit; 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units BS>400, Call MD (Physician), subcutaneously one time a day for diabetes, The order was discontinued on 02/18/25 and was never renewed. Per manufacturers' (Novo Nordisk) guidelines for Novolog (insulin Aspart injection), (https://www.novolog.com/taking-novolog.html), opened vials of Novolog should be disposed after 28 days, even if there is insulin left in the pen or vial. A review of Resident #64's February 2025 medication administration records showed that facility staff had not administered Aspart to Resident #64 after 02/18/25.	F 761			

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			(X5) COMPLETION DATE

F 761 Continued From page 108

F 761

B. Resident #209 was admitted to the facility on 04/14/25 with diagnoses that included: Anoxic Brain Damage, Not Elsewhere Classified Metabolic Encephalopathy, Epilepsy and Type 2 Diabetes Mellitus Without Complications.

A review of Resident #209's medical record showed:

A physician's order dated 04/15/25 that documented: "Insulin Glargine Solution 100/ml. Inject 40 units subcutaneously two times a day for hyperglycemia." The physician discontinued the order on 04/22/24 and did not renew it. On 04/24/25, the Resident was discharged to the hospital and did not return to the facility. Two days later, the insulin was observed in the medication refrigerator.

Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (<https://products.sanofi.us/lantus/lantus.html>), stated, "In-use (opened) Lantus vials or pens can be used for 28 days whether stored in the refrigerator or at room temperature."

A review of Resident#209's April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 04/15/25 to 04/22/25. Of note, the Resident's vial of Lantus insulin had no date indicating when it was opened or expired during this period.

C. Resident #77 was admitted to the facility on 05/30/24 with diagnoses that included: Metabolic Encephalopathy; Type 2 Diabetes Mellitus Without Complications; Obstructive Hydrocephalus and Chronic Respiratory Failure.

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F 761	Continued From page 109 A review of Resident #77's medical record showed: A physician's order dated 03/23/25 that documented: "Lantus 100 unit/ml Solution. Inject 20 units subcutaneously two times a Day for Diabetes Mellitus." Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, "In-use (opened) Lantus vials can be used for 28 days whether stored in the refrigerator or at room temperature." A review of Resident #77's March and April 2025 medication administration records showed that facility staff administered Lantus insulin to the Resident from 03/23/25 to 04/24/25. Resident #77's vial of Lantus insulin was observed on 04/24/25 stored in the medication refrigerator with no date indicating when facility staff opened it or when it expired. D. Resident #259 was admitted to the facility on 02/07/25 with diagnoses that included: Quadraplegia; Type 2 Diabetes Mellitus Without Complication; Chronic Respiratory Failure; Anemia, Dysphagia, and Depression. A review of Resident #259's medical record showed: A physician's order dated 02/10/25 that documented: "Lantus SoloStar 100 UNIT/ML Solution pen-injector Inject 15 units subcutaneously one time a day at bedtime for Diabetes Mellitus Type 2,"	F 761			

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F 761	Continued From page 110 Per manufacturers' (Sanofi) the guidelines for Lantus (insulin glargine injection) (https://products.sanofi.us/lantus/lantus.html), stated, "In-use (opened) Lantus Solostar pens should be used for 28 days, even if there is still insulin left in the pen." On 02/28/25, the Resident was transferred to the hospital and did not return to the facility. Approximately 57 days later, on 04/24/25, the Resident's insulin was observed in the medication refrigerator. During a face-to-face interview on 04/24/25 at 1:55 PM, Employee #6, 6th Floor Unit Manager was made aware of the open, undated, and expired insulin stored in the medication refrigerator in the Medication Storage Room. The Employee commented that each nurse is responsible for ensuring that all medications are in date before removing them from the medication refrigerator and certainly before administering the medication to the Resident. She added that the nurses are also responsible for ensuring that all medications for residents who have been discharged from the facility are removed from the medication refrigerator and sent back to the pharmacy immediately. She further commented that if the nurse observes no date on an opened insulin vial or pen, the nurse is responsible for discarding the insulin and ordering a new vial or pen. The Employee then acknowledged the findings and stated that they would have an in-service meeting with the nurses on the unit about medication storage immediately after the interview. Cross reference 22B DCMR Sec 3227.12	F 761			

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F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews, the facility staff failed to ensure that food was prepared in a form designed to meet the individual needs for one (1) of six (6) sampled residents who was prescribed a mechanically altered diet. Subsequently, Resident #38 was served roast beef that was not mechanically altered to bite size as prescribed. (Resident #38) The findings included: Resident #38 was admitted on 07/07/22 with multiple medical diagnoses that included Dysphagia following Cerebral Infarction, Oropharyngeal Disease, Gastrostomy Tube, Gastro-Esophageal Reflux, and Loss of Teeth. A physician's order dated 02/12/25 instructed "Pleasure diet -soft and bite sized texture ...upright 90-degree positioning, assist feed, small bites/sips, slow rate ..." Please note: This is a pleasure diet, the resident received gastrostomy tube feeding daily to meet nutritional needs, per physician order. A quarterly Minimum Data Set dated 03/01/25 documented in part that the resident had a Brief Interview for Mental Status summary score was blank indicating the resident did not answer the test questions. Also, the resident was coded for	F 805	Tag: F 805- Food in Form to Meet Individual Needs (pgs. 112-113) Corrective Action for Resident(s): 1. Upon identification, the meal was removed, and the appropriate mechanically altered meal was provided on 4/22/2025. 2. The nurse and dietary staff involved were re-educated by the speech therapist on the resident's diet order on 4/22/2025. Identification of Other Residents: 1. A review of dietary orders for all residents on mechanically altered diets by the dietary manager and dietician was completed by 6/30/2025 to identify any other residents potentially affected by similar issues. No other issues were noted. 2. Resident meal observations by the dietary manager/designee were completed by 6/30/2025 to ensure consistency with prescribed diets. No issues were noted during the audit. Systemic Changes: 1. Dietary and nursing staff were re-educated by the dietary manager/designee on verifying diet orders and matching them to tray tickets. 2. The dietary policy was reviewed by the dietary manager to include a mandatory double-check system for meal preparation, ensuring that all mechanically altered diets are prepared according to individual resident needs. Dietary staff were re-educated on the policy by 6/30/2025.	07/8/2025	

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F 805 Continued From page 112

impairment of bilateral upper extremities, required maximum assistance with eating, required assistance with oral hygiene, received enteral bolus tube feedings for nutrition and hydration, and received an altered diet.

A speech therapy evaluation and plan of treatment dated 03/31/25 - 04/29/25 documented in part, "Treatment of swallowing dysfunction ...evaluation of oral and pharyngeal swallowing function ... Goal-Patient will consume soft/bite sized solids ...Risk Factors-due to physical impairment and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for aspiration ..."

During an observation on 04/22/25 at approximately 1:30 PM, Resident #38 was observed awake, sitting in bed with head of bed elevated at a 90-degree angle. A bedside table with a lunch tray was positioned directly in front of the resident. The lunch tray consisted of a small bowl of roast beef chunks in gravy and one cup of juice. At the time of the observation, Employee # 11 (assigned CNA) was standing to the left of the resident's bed stating that she was getting ready to feed the resident. When asked, was the roast beef the appropriate diet for the resident, the employee failed to answer. The surveyor asked the employee not to feed the resident until Employee #15 (Speech Pathologist) could view the tray. Also noted during the observation was Feeding Protocol that was posted on the left wall of the resident's bed. The Feeding Proctol documented in part, "Soft and bite-sized pleasure diet ...maintain upright posture (90-degree angle) during po (by mouth) intake ..."

During a face-to-face interview conducted outside

F 805 Cont. Tag: F 805- Food in Form to Meet Individual Needs (pgs. 112-113)
3. The protocol was reiterated to dietary staff by the dietary manager/designee requiring them to verify meal modifications against dietary orders before serving. Nursing staff were instructed by the educator/designee to visually verify diets at mealtime for the correct diet by 7/8/25.

Monitoring of Corrective
The Dietary Manager or designee will audit 25 diet trays weekly for 4 weeks and then monthly for 3 months. Audits will include visual tray checks and interviews with staff to confirm meal accuracy. Any deficiencies noted will be corrected upon discovery. Compliance will be discussed during QAPI. Outcomes will be reported at QAPI meetings for continued oversight. Any trends identified will trigger further education or systems adjustment

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F 805	Continued From page 113 in the resident's room 04/22/25 at approximately 1:35 PM, Employee #15 (Speech Pathologist) viewed the lunch tray and stated that the roast beef appeared to be larger than bite sized. The employee then stated, "This is unsafe for the resident. Bite sized is no larger than 1.5 centimeters. I will go down and talk to dietary." During a face-to-face interview on 04/22/25 at approximately 1:40 PM, Employee #17 (Dietician) stated that she was not sure if the roast beef was bite sized. She would talk with dietary staff to find out. During a face-to-face interview on 04/23/25 at approximately 9 AM, Employee #37 (Director of Food and Nutrition) stated that her staff made an error with the resident's lunch tray on 04/22/25. The employee then said, "They sent the resident a regular diet instead of bite sized."	F 805			
F 812 SS=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 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.	F 812	Tag: F 812- Food Procurement, Store/Prepare/Serve – Sanitary (pgs. 114-116) Corrective Action for Identified Deficiencies: 1. Upon identification, the kitchen was inspected by the Dietary Manager and Maintenance Director on 4/13/2025. 2. Immediate corrections were made on 4/13/25: unlabeled and expired food was discarded, the curtain was replaced on 4/21/25, fans were cleaned on 4/14/25, ceiling light covers were cleaned 4/20/25, the eyewash solution was replaced on 4/13/25, and missing ceiling tiles were reported and repaired on 4/14/2025. 3. Non-functioning steamers and food warmers were removed from the kitchen on 6/11/2025. The garbage disposal was repaired 4/13/25.		07/8/2025

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F 812 Continued From page 114

§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 interview, during a tour of the kitchen on April 13, 2025, at approximately 6:30 AM, facility staff failed to store and distribute food under sanitary condition as evidenced by one (1) of one (1) open bag of shredded carrots that was stored in the walk-in freezer undated, two (2) of five (5) torn air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, six (6) of six (6) ceiling lights above the three-compartment sink that were soiled with dust, one (1) of two (2) open eyewash solution bottle that was stored by the tray line for use, one (1) of two (2) garbage disposals that was inoperative, two (2) of two steamers with an 'out of service since May 8, 2023' sign, one (1) of two food warmers that has been inoperative since June 1, 2023. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 ceiling lights were missing a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced.

The findings included:

1. An open bag of shredded carrots was stored in one (1) of one (1) refrigerator/freezer unit with no label to indicate when it was opened.
2. Two (2) of five (5) air/strip curtains in one (1) of one (1) walk-in refrigerator/freezer unit, were torn.

F 812 Identification of Other Areas:
1. An audit of all food storage areas by the dietary manager/designee to identify any other undated or expired items was completed on 4/13/25. All identified items were discarded.

2. An inspection of all equipment and lighting in the kitchen and storage areas was completed by the maintenance manager on 4/14/2025, to ensure functionality and cleanliness. No additional deficiencies were noted.
3. Additional light fixtures were replaced by 6/30/2025.

Systemic Changes:

1. All dietary staff were re-educated by the dietary manager/designee on food labeling, storage, and cleaning responsibilities by 7/8/25.
2. Plant Operations was instructed to coordinate with dietary services for regular cleaning of high surfaces and fans. Equipment maintenance logs are now updated monthly, and any malfunctioning items are reported to the work order system.
3. The dietary manager reviewed the food storage policy to ensure dating of all opened food items and regular checks for expired products by 06/30/25.
4. The maintenance and dietary manager revised equipment maintenance protocols to include monthly checks and immediate repair or replacement of non-functional equipment.

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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
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F 812	Continued From page 115 3. Six (6) of six (6) ceiling light covers above the three-compartment sink were soiled with dust. 4. One (1) of two (2) bottles of eyewash solution stored for use near the tray line, was stored open, with a broken sterility seal, and needed to be discarded. 5. One (1) of two (2) garbage disposal units was inoperative. 6. Two (2) of two (2) steamers have been out of service since May 8, 2023. 7. One (1) of two (2) food warmers has been out of service since June 1, 2023. 8. In the dry storage room, one (1) of five (5) 33.8 fluid ounces of Twocal, calorie & protein nutritional drink expired as of April 1, 2025, three (3) of 18 ceiling lights did not have a light bulb tube guard, and a ceiling tile that had been removed, needed to be replaced. Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.	F 812	Cont. Tag: F 812- Food Procurement, Store/Prepare/Serve – Sanitary (pgs. 114-116) 5. The dietary manager established a routine inspection process for all kitchen and storage areas to ensure compliance with sanitary standards. Monitoring of Corrective Actions: 1. The Dietary Manager or designee will complete weekly sanitation and equipment audits of 100% of kitchen zones for weekly for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment	07/8/2025	
F 836 SS=D	License/Comply w/ Fed/State/Local 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	F 836	Tag: F 836- Personnel Policies/ Handbook (pgs. 116-118) Corrective Action for Identified Deficiency: 1. Upon identification, the Administrator and Director of Nursing conducted an immediate staffing review and adjusted schedules to ensure compliance on 5/5/2025. 2. Agency staff were brought in to cover open shifts, and part-time employees were offered additional hours.		

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F 836	Continued From page 116 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 a review of the facility's records and a staff interview, the facility failed to comply with the State Regulation (22B DCMR sect. 3211.5) for daily staffing ratios, as evidenced by not providing the minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, with at least six tenths (0.6) hours being provided by a registered nurse for seven (7) of 35 sampled days. The findings included:	F 836	Cont. Tag: F 836- Personnel Policies/ Handbook (pgs. 116-118) 3. The staffing schedule was reviewed, and state-required postings were updated by 7/8/25. Identification of Other Areas or Resident(s): 1. 100% of staffing records for the past 30 days were audited against state minimum staffing requirements by the administrator to identify any additional days of noncompliance. This was completed by 6/30/2025. 2. The audit included shift logs and assignment sheets. If areas of non-compliance is identified during the audit they were immediately addressed. Systemic Changes: 1. The scheduling coordinator, Administrator, and DON were re-educated by the Regional Director of Operations on 06/30/25 on daily staffing minimums and the requirement to comply with the state regulation (22B DCMR sect. 3211.5) and facility staffing patterns. 2. A staffing matrix was developed by the corporate and facility leadership team and implemented to guide shift assignments based on census and acuity by 7/8/25. 3. The facility has initiated a proactive recruitment campaign. 4. The Administrator and staffing coordinator now conduct a daily staffing huddle to confirm compliance with the minimum staffing requirement.		

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F 836	Continued From page 117 A review of the facility's daily staffing sheets revealed the following: On 10/19/24 the facility's resident census was 110. In addition, residents received 3.9 hours of direct nursing care. On 11/24/24 the facility's resident census was 105. In addition, residents received 3.8 hours of direct nursing care. On 12/21/24 the facility's resident census was 110. In addition, residents received 3.3 hours of direct nursing care with 0.50 of those hours being provided by a registered nurse. On 12/22/24 the facility's resident census was 110. In addition, residents received 3.6 hours of direct nursing care. On 12/29/24 the facility's resident census was 109. In addition, residents received 4.0 hours of direct nursing care. On 04/18/25 the facility's resident census was 106. In addition, residents received 3.9 hours of direct nursing care. On 04/26/25 the facility's resident census was 104. In addition, residents received 4.0 hours of direct nursing care. During a face-to-face interview on 05/05/25 at approximately 10:00 AM, Employee #22 (Staffing Coordinator) stated that they were short of staff on the previously mentioned days because they were in the process of hiring additional staff. Additionally, the employee said that she was not aware of the staffing requirements.	F 836	Cont. Tag: F 836- Personnel Policies/ Handbook (pgs. 116-118) Monitoring of Corrective Actions: 1. The Administrator or designee will review staffing levels daily for 14 days, then weekly for 4 weeks, and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment		

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	Tag: F 842- Residents' Rights/ Exercise of Rights (pgs. 119-120) Corrective Action for Resident(s): 1. Resident #209's was at the hospital at the time the issue was identified. 2. The staff involved in the documentation of Resident #209's medical record is no longer employed at Bridgepoint Capitol Hill. Identification of Other Residents: The medical records of 100% of residents discharged within the past 7 days were reviewed by the DON by 6/30/2025 to ensure vital signs, discharge summaries, and documentation were complete and timely. Any discrepancies found during the audit were addressed immediately. Systemic Changes: 1. At least 80% of licensed staff were re-educated by the educator/designee on discharge documentation requirements for residents no longer in the facility, including mandatory vital signs before discharge by 07/8/25. 2. Nursing management now reviews all discharge information prior to resident discharge and after discharge for completeness and accuracy. 3. PCC will be disabled for discharged residents.	07/8/2025	

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F 842 Continued From page 119
by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview for one (1) of 49 residents sampled, facility staff failed to have accurate documentation in Resident #209's medical record.

The findings included:

Resident #209 was admitted to the facility on 04/14/25 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Injury, and Metabolic Encephalopathy.

F 842 Cont. Tag: F 842- Residents' Rights/
Exercise of Rights (pgs. 119-120)

Monitoring of Corrective Actions:

1. The Director of Nursing or designee will audit 100% of all resident discharges weekly for 4 weeks and monthly for 3 months to ensure compliance with documentation standards. Any deficiencies noted will be corrected upon discovery.

2. Audit results will be reviewed during QAPI and used to identify training needs or process gaps.

3. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.

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F 842 Continued From page 120

F 842

Review of the resident's medical record revealed
the following:

04/21/25 at 5:59 PM Situation Background
Assessment and Request (SBAR):
- Situation - Tachycardia with a pulse of 135 and an
oxygen saturation of 85%
- Comments: In the morning the resident had a
pulse of 135 and his oxygen saturation was 85%, I
informed Nurse Practitioner (NP), and she said to
call 9-1-1, the resident was transferred via
Emergency Medical Services to [Hospital name].

A physician's order dated 04/21/25 directed,
"Transfer to hospital."

Review of the Medication and Treatment
Administration Record for April 2025 showed that on
04/21/25, night shift (7:00 PM - 7:00 AM), the nurse
documented a check mark and their initials to
indicate that they took vital signs (including a blood
glucose level), administered medications and
treatments to Resident #209, who was no longer in
the facility.

During a face-to-face interview on 04/23/25 at 4:15
PM, with Employee #34 (assigned RN on 04/21/25)
stated that Resident #209 left the facility around
9:00 AM on 04/21/25.

The evidence showed that facility staff failed to have
accurate documentation in Resident #209's medical
record.

During a face-to-face interview on 04/23/25 at 4:20
PM, Employee #2 (DON) reviewed Resident 209's
medical record and acknowledged the findings.

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F 842	Continued From page 121 Cross Reference 22B DCMR Sec. 3231.11	F 842	Tag: F 880- Infection Prevention and Control Program (pgs. 122-123)	07/8/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880	Corrective Action for Resident(s): 1. Employee number 3 assigned to resident # 20 was re-educated on Enhanced Barrier Precautions on 4/13/2025 by the IP. All necessary personal protective equipment (PPE) was provided and properly utilized. 2. Employee number 44 assigned to resident # 78 was re-educated on Enhanced Barrier Precautions on 4/13/2025 by the IP. All necessary personal protective equipment (PPE) was provided and properly utilized. 3. Employee number 14 assigned to resident # 38 was re-educated on Enhanced Barrier Precautions on 4/21/2025 by the IP. All necessary personal protective equipment (PPE) was provided and properly utilized. 4. Employee #47 was re-educated on performing hand hygiene before and after insulin administration secondary to failing to do so with resident #38. Identification of Other Residents: 1. Will conduct a facility-wide audit by the Infection Preventionist/designee to identify any other residents requiring Enhanced Barrier Precautions by 7/8/25. 2. Staff observations were completed by the Infection Preventionist/designee by 6/30/25 to assure compliance with EBP requirements. No additional issues were identified during the audit.		

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F 880 Continued From page 122

to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

Based on observation, record reviews and staff interviews, for three (3) of 49 sampled residents the facility staff failed to: (1) provide a safe, sanitary and comfortable environment; (2) follow acceptable standards of precautions of Resident #78's Enhanced Barrier Precautions; and (3) follow acceptable standards of precautions for Resident #38's Enhanced Barrier Precautions

F 880 Systemic Changes:
1. At least 80% of clinical staff will receive mandatory re-education by the educator/designee on the facility's infection prevention and control policies, including hand hygiene, PPE use, standard precautions, and contact isolation protocols by 7/8/25.
2. Competency validation by the Infection Preventionist/designee included the weekly infection control rounding observation of staff entering rooms and performing procedures for residents on EBP and hand hygiene after medication passes by 7/8/25.

Monitoring of Corrective Actions:
1. The Infection Preventionist or designee will complete weekly audits of 10 residents with Enhanced Barrier Precautions to ensure acceptable standards of precautions are followed. Any deficiencies noted will be corrected upon discovery.

2. Audits will be completed daily for 7 days, then weekly for 4 weeks, then monthly for 3 months. Any deficiencies noted will be corrected upon discovery.

3. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.

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F 880	Continued From page 123 and failed to follow acceptable Infection Control practices by not performing hand hygiene after administering Resident #38's insulin. (Residents #20, #78, and #38) The findings included: 1) Resident #20 was admitted to the facility on 12/12/24 with diagnoses that included: Metabolic Encephalopathy; Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side; Dysphagia; Chronic Obstructive Pulmonary Disease, Unspecified and Colostomy Status. During an initial tour on 04/13/25 at 6:49 AM, an Enhanced Barrier Precaution sign was observed, posted on the wall to the left of Resident #20 room door. The sign directed all visitors to wash/sanitize their hands before entering and exiting the resident's room and directed providers and staff to put on new gloves and a new gown when performing high-contact Resident care activities (i.e. personal hygiene, changing briefs or assisting with toileting, device care use: central line, urinary catheter feeding tube, tracheostomy, wound care, etc.) for the Resident. The Resident was observed resting in bed lying on his back. On the left side of the resident's bedrail was an ileostomy drainage container. Employee #43 Registered Nurse assigned to the Resident entered the Resident room and stated, "I was just about to empty his (ileostomy) container. It gets emptied every 4-8 hours." The Employee then went to the sink in the resident's room, washed her hands, applied a new pair of gloves, and but failed to put on a gown before emptying the resident's ileostomy container. The Employee emptied the bag, removed her gloves, and	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUBACUTE AND REHAB CAPITOL HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 223 7TH STREET NE WASHINGTON, DC 20002		
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F 880 Continued From page 124

F 880

washed her hands in the sink before exiting the room.

During a face-to-face interview immediately after the observation, when asked what Enhanced Barrier Precautions means, She stated that you wash your hands, apply gloves and a gown if you are within close contact to the Resident. When asked what stopped her from putting a gown on, the Employee replied I don't know. I was just trying to empty the Resident's ileostomy container. The Employee then acknowledged that a gown should have been worn when she changed the resident's colostomy and made no further comment.

2) Resident #78 was admitted to the facility on 06/03/24 with diagnoses that included: Intraspinal Abscess and Granuloma; Metabolic Encephalopathy; Resistance to Multiple Antimicrobial Drugs; Chronic Respiratory Failure, Functional Quadriplegia, and Dependence on Respirator [Ventilator] Status.

During an initial tour on 04/13/25 at 07:05 AM an Enhanced Barrier Precaution sign was observed, posted on the wall to the left of Resident #78's room door. The sign directed all visitors to wash/sanitize their hands before entering and exiting the resident's room, and directed providers and staff to put on new gloves and a new gown when performing high -contact Resident care activities (i.e. personal hygiene, changing briefs or assisting with toileting, device care use: central line, urinary catheter feeding tube, tracheostomy, wound care, etc.) for the Resident. The Resident was observed asleep, lying in bed on his back. On the right side of the

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F 880	Continued From page 125 resident's bedrail was a urinary catheter drainage container. Employee #44 Certified Nurse Aide/CNA assigned to the Resident#78 entered the Resident's room, washed her hands., and applied a new pair of gloves. The Employee did not put on a gown before emptying the resident's urinary catheter container. The Employee emptied the urinary container, removed her gloves, and washed her hands in the sink before exiting the room. During a face-to-face interview immediately after the observation, when asked what Enhanced Barrier Precautions means, She stated that it means you wash your hands, apply gloves and a gown. When asked what stopped her from putting a gown on, the Employee replied I don't know. I always put on a gown I forgot this time. The Employee then acknowledged the finding. 2. Resident #38 was admitted on 07/07/22 with multiple medical diagnoses that included Gastrostomy tube. A physician order dated 2/12/25 instructed "Glucerna 1.5 bolus 220 milliliters every 4 hours via gastrostomy tube". A quarterly Minimum Data Set (MDS) assessment dated 03/01/25 documented in part that the resident had a Brief Interview for Mental Status (BIMS) summary score of "01", indicating that the resident cognitive status was severely impaired. The resident was also coded for using a feeding tube. During observation of Unit 4 on 04/21/25 at	F 880			

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F 880	Continued From page 126 approximately 2:45 PM showed a Enhanced Barrier Precautions (EBP) sign posted on Resident #38's door. The signage included the following directives: "STOP - ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, before entering and when leaving the room..." At the time of the observation, Employee #14, (Licensed Practical Nurse/LPN), was observed entering Resident #38's room and troubleshoot a sounding error alarm on display panel for the feeding tube pump alarm. The employee did this task without performing proper hand hygiene before entering and after exiting the resident's room. During a face-to-face interview on 04/21/25 at 2:45 PM, Employee #14 (LPN) stated that because the resident was on EBP, he should have performed hand hygiene before entering and exiting the Resident #38's room . However, the employee stated, " I forgot." Based on observation and staff interview, for one (1) of two (2) sampled residents that were administered insulin, the facility's staff failed to follow acceptable Infection Control practices. As a result Employee #47 (RN) failed to perform hand hygiene after administering insulin. (Resident #38) Resident #38 was admitted on 09/11/24 with multiple diagnoses including Type 2 Diabetes Mellitus. A policy titled, "Subcutaneous Injections" with a review dated of 05/24/24 instructed on part, "Put	F 880			

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F 880	Continued From page 127 on gloves ...Select appropriate injection site ... slowly inject medications ...with drawn needle quickly ...discard equipment ...remove gloves ...perform hand antiseptic [hand hygiene] ..." A physician order dated 02/12/25 instructed, "Humalog 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 0 - 150 = 2unit; 151 - 200 = 4unit; 201 - 250 = 6unit; 251 - 300 = 8unit; 301 - 350 = 10unit; 351 - 400 = 12unit Call Md If Blood sugar is less than 60mg/dl (milligram per deciliter) or more than 400mg/dl, subcutaneously every 6 hours for Type 2 Diabetes Mellitus." During a medication administration observation on 04/22/24 starting at 6:30 AM, showed Employee #47 performing a fingerstick glucose test for the resident. The resident's blood sugar level was 194 mg/dl. Additionally, Employee #47 administered the resident Humalog Insulin 4 units subcutaneously, per sliding scale. After administering insulin, the employee removed and discarded her gloves in the trash can, walked out of the resident's room, and started documenting on the electronic health record. During a face-to-face interview on 04/22/25 at approximately 6:40 AM, Employee #47 stated that she should have performed hand hygiene after removing her glove. The employee said that she was nervous and forgot.	F 880			
F 925	Maintains Effective Pest Control Program SS=D CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, and interview, facility	F 925	Tag: F 925- Maintains Effective Pest Control Program (pgs. 128-130) Corrective Action for Resident(s): 1. The mouse droppings were cleaned from the cook line and dishwashing machine room on 4/13/2025. 2. The areas were thoroughly cleaned and sanitized on 4/14/2025 by EVS. 3. A professional pest control service was contacted and conducted an immediate inspection and treatment of the affected areas to eliminate any existing pest issues on 4/14/2025. Any deficiencies noted were corrected upon discovery.	07/8/2025	

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F 925 Continued From page 128

staff failed to ensure that the environment remains free of pest as evidenced by three (3) of three (3) mouse traps that were observed around the cook line, one (1) of one (1) mouse trap and mouse droppings in the dishwashing machine room, and flying pest in the three-compartment sink area.

The findings included:

1. Three (3) of three (3) mouse traps were observed around the cook line, behind one (1) of one (1) grill and one (1) of one (1) gas stove, and one (1) of one (1) mouse trap and mouse droppings were seen in a corner area of the dishwashing machine room.

2. Flying insects that appear to be gnats were observed in the area where the three-compartment sink is located, and sporadically throughout the kitchen.

Employee #37 acknowledged the findings during a face-to-face interview on April 17, 2025, at approximately 3:00 PM.

F 942 Resident Rights Training
SS=F CFR(s): 483.95(b)

§483.95(b) Resident's rights and facility responsibilities.
A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively.
This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews,

Cont. Tag: F 925- Maintains Effective
F 925 Pest Control Program (pgs. 128-130)

Identification of Other Resident(s):

1. A comprehensive inspection of the kitchen and dishwashing area was conducted on 4/14/2025 to identify any other areas that may be affected by pest issues. No additional areas were identified.

2. Additional pest control measures were implemented throughout the facility on 4/14/2025, including sealing potential entry points and increasing the frequency of pest control treatments.

Systemic Changes:

1. The facility reviewed its pest control contract to ensure scope and frequency met best practice standards. The contract meets standards, however the facility chose to increase the frequency of visits.

2. Environmental Services and Dietary staff were re-educated on pest prevention practices by the educator/designee, including food storage, trash handling, and cleaning protocols by 7/8/25.

F 942
3. A pest control log was implemented in the kitchen for real-time reporting.
4. Preventative pest control service frequency was increased from monthly to weekly.

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F 942	Continued From page 129 facility staff failed to ensure that staff members were educated on the resident's rights and the facility's responsibilities to properly care for its residents, as set forth at §483.10, respectively. The findings included: A review of the Facility's Assessment updated 12/03/24, that documented: " ...Section 3.4 Staff Training/Education and Competencies. We only hire individuals that are eligible to work in The District of Columbia, currently using temporary nursing assistant(s). Department and job specific competencies are completed during orientation and reviewed annually. Competencies follow a pattern of requirements for certification and licensure renewal and trends of events within the facility and industry as a whole ...List of competencies include- tracheostomy, ventilator, Enteral Tube feeding, ostomy, IVs (intravenous), TPN, (total parenteral nutrition) vital signs, weight taking, height measuring, oxygen, suctioning, systems assessment, turning and repositioning, SBAR (Situation, Background, Assessment, Request) Communication Forms, Care plan, change in condition communications, computer documentation and changes in condition and reporting, complaint management, drains, referrals, appointment making, assistance with ADLs (activities of daily living skills), wound care, IDT (interdisciplinary team) assessments and isolation." A review of the facility's policy entitled, "Resident Rights," (revised 05/24/24) documented " ...Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our residents' rights.	F 942	Cont. Tag: F 925- Maintains Effective Pest Control Program (pgs. 128-130) Monitoring of Corrective Actions: 1. The Maintenance Director or designee will perform weekly environmental inspections of all resident care and storage areas for 4 weeks and monthly for 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment Tag: F 942- Training Requirements – General (see pgs. 130-132) Corrective Action for Identified Deficiency: 1. Review of personnel records showed incomplete annual training modules for several staff, including orientation topics, resident rights, and general care expectations. 2. Staff identified were immediately removed from the assignment until training was completed. 3. All missing training was completed by 6/30/2025. No adverse resident outcomes were linked to the training lapses.		7/8/2025

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F 942	Continued From page 130 On 05/05/25, the facility's education and training records for Residents' Rights were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, "2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including Resident Rights and Facility Responsibilities. In the column next to Residents Rights were the comments, "Review and packet and HealthStream. Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence that showed what the HealthStream education/training for Residents Rights consisted of and there was no documented evidence to show that the educator provided a review and packet for Resident Rights to facility staff as part of their education and training. In addition, there was no documented evidence that staff who were not present for the September 19-20, 2024, skills fair, received the training. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/Regional Director of Operation stated, "All staff receive education and training on Residents Rights that they during orientation before they are assigned to the floor and as part of the staff skills fair training annually". Employee #48 then reviewed the facility's staff education and training binder, and	F 942	Cont. Tag: F 942- Training Requirements – General (see pgs. 130-132) Identification of Other Staff or Residents: 1. 100% of employee training records were audited by the educator/designee by 6/30/2025 to verify completion of required general training modules. 2. Staff with missing or outdated training were removed from the schedule until fully compliant. Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding resident rights and responsibilities to include mandatory annual training sessions. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Education developed a structured training program on resident rights and facility responsibilities, to be completed by all new hires and annually by existing staff. 3. Education implemented a new protocol for documenting staff training sessions, including attendance records and training materials, to ensure accountability and traceability.	07/8/2025	

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F 942	Continued From page 131 the facility's administrative records, and stated that all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets. She commented further that she could not substantiate what specific information the staff educator provided for review or in the education packet for Resident Rights. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator, "The staff is not getting the education to the extent needed; the Director of Nursing and myself (Administrator) provide some of the education PRN (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it." Cross reference 22B DCMR Sec 3214.4	F 942	Cont. Tag: F 942- Training Requirements – General (see pgs. 130-132) Monitoring of Corrective Actions: 1. The educator or designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment		
F 944	QAPI Training SS=F CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews,	F 944	Tag: F944- Training Requirements – QAPI (pgs. 132-134) Corrective Action for Identified Staff and Resident(s): The Educator and Administrator were provided training on QAPI on 6/30/2025 by the Regional Director of Operations.	07/8/2025	

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F 944	Continued From page 132 facility staff failed to provide training that outlined and informed staff of the elements and goals of the facility's QAPI program. The findings included: On 05/05/25, the facility's education and training records were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, "2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including QAPI (Quality Assurance and Performance Improvement Plan and Participation. In the column next to QAPI were the comments, "Review and packet." Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence to show that the educator provided a review or a packet for QAPI to facility staff as part of their education and training. In addition, there was no documentation to show that staff who were not present for the September 19-20, 2024, skills fair, received QAPI training. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records for staff. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/Regional Director of Operations, stated that, "All staff are required to receive QAPI training. QAPI training is usually	F 944	Cont. Tag: F944- Training Requirements – QAPI (pgs. 132-134) Identification of Other Staff or Residents: 1. An audit of 100% of current employee training records was conducted by 6/30/2025 by administrator to verify completion of the required QAPI training. 2. Staff identified were immediately removed from the assignment until training was completed. Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding QAPI and responsibilities to include mandatory annual training sessions. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Education developed a structured training program on QAPI training to be completed by all new hires and annually by existing staff. 3. Education implemented a new protocol for documenting staff training sessions, including attendance records and training materials, to ensure accountability and traceability.		

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F 944	Continued From page 133 completed during staff orientation and as part of the staff skills fair training that the facility has annually." Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets for QAPI training. She commented further that she could not substantiate that the staff educator provided training that outlined and informed staff of the elements and goals of the facility's QAPI program, or how to facility staff could communicate concerns, problems or opportunities for improvement to the facility's QAA (Quality Assessment and Assurance Committee). During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator, stated: "The staff is not getting the education to the extent needed. The Director of Nursing (DON) and myself [Administrator] provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it."	F 944	Cont. Tag: F944- Training Requirements – QAPI (pgs. 132-134) Monitoring of Corrective Actions: 1. The educator or designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment. Tag: F 946- Training Requirements – Compliance and Ethics (pgs. 134-136) Corrective Action for Identified Deficiency: 1. The educator's review of personnel records showed incomplete annual training modules for several staff, including compliance and ethics training. 2. Staff identified were removed from the assignment by 6/30/2025 until training is completed. 3. All missing training was completed by 6/30/2025. No adverse resident outcomes were linked to the training lapses.	7/8/2025	
F 946 SS=F	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85-	F 946			

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F 946	Continued From page 134 §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to provide a training program or another practical manner to effectively communicate the standards, policies, and procedures of the compliance and ethics program to its entire staff. The findings included: On 05/05/25, the facility's education and training records for its Compliance and Ethics program were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. Inside of the binder was a table of education topics with the heading, "2024 SNF (Shared Nursing Facility) Skills Fair Training. In the first column of the table was a list of several training topics including Compliance and Ethics. In the column next to Compliance and Ethics, were the comments, "Review and packet." Attached to the Skills Fair Training document was a September 19-20-2024, 24-page sign-in sheet with the signatures of some staff who attended the skills fair training, however there was no documented evidence to show that the educator provided a training program or another practical manner to effectively	F 946	Cont. Tag: F 946- Training Requirements – Compliance and Ethics (pgs. 134-136) Identification of Other Staff or Residents: 1. 100% of employee training records was audited by 6/30/2025 by the educator to verify completion of required compliance and ethics training. 2. Staff identified were immediately removed from the assignment until training was completed. Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding compliance and ethics training to include mandatory annual training sessions. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Education developed a structured training program on compliance and ethics training to be completed by all new hires and annually by existing staff. 3. Education implemented a new protocol for documenting staff training sessions, including attendance records and training materials. to		

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F 946	Continued From page 135 communicate the standards, policies, and procedures of the compliance and ethics program to its entire staff. In addition, there was no documentation to show that staff who were not present for the September 19-20, 2024, skills fair, received education and training for the facility's Compliance and Ethics program. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee#48/ Regional Director of Operations stated that "The Compliance and Ethics training is usually completed during staff orientation and as part of the staff skills fair training that the facility has annually." Employee #48 then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that all she could find was the list of training topics for the 2024 SNF Specific Skills Fair Training and the sign-in sheets for Compliance and Ethics training. She commented further that she could not substantiate that the staff educator provided training on the facility's Compliance and Ethics program. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1/Administrator stated, " The staff is not getting the education to the extent needed; The Director of Nursing (DON)and myself [Administrator] provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff,	F 946	Cont. Tag: F 946- Training Requirements – Compliance and Ethics (pgs. 134-136) Monitoring of Corrective Actions 1. The educator or designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.	7/8/2025	

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F 946	Continued From page 136 and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it."		Tag: F 947- In Service Training Requirements for Nurse Aides -12-hour training for nurse aides not completed (see pg. 137)	07/8/2025	
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to show documented evidence of its Required In-Service Training for Nurse Aides. The findings included: A review of the Facility's Assessment updated 12/03/24, that documented: " ...Section 3.4 Staff	F 947	Corrective Action for Identified Deficiency: 1. A list of nurse aides was obtained to verify completion of the 12-hour required training. 2. Identified staff received training by 06/30/25 to ensure compliance with the training requirements. Identification of Other Staff or Residents: 1. 100% of nurse aide employee training records was audited by 6/30/2025 by the educator to verify completion of required nurse aide mandatory training. 2. Staff identified were immediately removed from the assignment until training was completed.		

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F 947	Continued From page 137 Training/Education and Competencies. We only hire individuals that are eligible to work in The District of Columbia, currently using temporary nursing assistant(s). Department and job specific competencies are completed during orientation and reviewed annually ..." On 05/05/25, the facility's education and training records for the required in-service training for Nurse Aides were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. The binder contained the following education and training provided by the educator for the facility's Certified Nurse Aides (CNAs) in 2024: 1) "Documentation" news article and monthly test; No staff sign-in sheet was attached: (June); 2) "Reporting to the Nurse," news article and monthly test; No staff sign-in sheet was attached (July); and, 3) "Skin and Wound Observation news article and monthly test; No staff sign-in sheet was attached (August). Of note, the facility's education and training binder showed documented evidence of its required in-service training for Nurse Aides for only three (3) months out of 12. The facility's educators were not available for interview on 05/05/25 to answer questions about the facility's education and training records. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee# 48/Regional Director of Operations stated, "The the CNAs receive the required in-service training during staff orientation before they are assigned to the floor and annually at the SNF Specific Skills Fair." Employee #48	F 947	Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding 12-hour required mandatory annual training for nurse aides to include mandatory annual training sessions on documentation, reporting to the nurse, and skin and wound observations. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Education developed a structured training program to be completed by all new hires and monthly for 12 months. 3. Education implemented a new protocol for documenting staff training sessions in Health Stream, including attendance records and training materials, to ensure accountability and traceability. Monitoring of Corrective Actions: 1. The educator or designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		

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F 947	Continued From page 138 then reviewed the staff education and training binder, and the facility's administrative records, and stated that all she could find was the training that the educator provided for June, July and August, 2024. She commented further that she could not substantiate that the staff educator provided all of the required in-service training for the CNAs. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1 stated, "The staff is not getting the education to the extent needed; The Director of Nursing and the Administrator provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it."	F 947			
F 949 SS=F	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility staff failed to show documented evidence of an effective training program for all staff, which includes, at a minimum, training on behavioral health care and services for its residents.	F 949	Tag: F 949- Training Requirements – Behavioral Health (pgs. 139-141) Corrective Action for Identified Deficiency: 1. Review of personnel records by the educator/designee showed incomplete annual training modules for several staff, including behavioral health training. 2. Staff identified were removed from the assignment by 6/30/2025 until training is completed. 3. All missing training was completed by 6/30/2025. No adverse resident outcomes were linked to the training lapses.		

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F 949	Continued From page 139 The findings included: On 05/05/25, the facility's education and training records for were reviewed as part of an extended survey. The facility provided a binder from the educator that included the education and training records for staff in the facility for review. The binder showed no documented evidence of an effective training program for all staff, which included, at a minimum, training on behavioral health care and services for its residents. During a face-to-face interview on 05/05/25 at 9:15 AM, Employee #48/ Regional Director of Operations, stated that the behavioral health care and services for residents is usually completed during staff orientation and as part of the staff skills fair training that the facility has annually. Employee #48, then reviewed the facility's staff education and training binder, and the facility's administrative records, and stated that she did not see where the behavioral health care and services for residents was included as part of the annual SNF Specific Skills Fair. She commented further that she could not substantiate the staff educator provided education and training on the behavioral health care and services for its residents. During a face-to-face interview on 05/05/25 at 11:36 AM with members of the QAA Committee Employee #1 stated: The staff is not getting the education to the extent needed; The Director of Nursing and the Administrator provide some of the education prn (as needed). A new facility educator was hired. The Employee has been here a few weeks and has done some training, but only remotely. We need to do a better job with our education of staff, and we need more	F 949	Cont. Tag: F 949- Training Requirements – Behavioral Health (pgs. 139-141) Identification of Other Staff or Residents: 1. 100% of employee training records was audited by the educator/designee by 6/30/2025 to verify completion of required behavioral health training. 2. Staff identified were immediately removed from the assignment until training was completed. Systemic Changes: 1. The Regional Director of Operations revised the facility's policy on staff education regarding behavioral health training to include mandatory annual training sessions. The leadership team, including the Administrator, Director of Nursing, Educator, and department heads were trained on the staff education policy by the Regional Director of Operations by 7/8/25. 2. Developed a structured training program on Behavioral Health training to be completed by all new hires and annually by existing staff. 3. Implemented a new protocol for documenting staff training sessions, including attendance records and training materials, to ensure accountability and traceability.		

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F 949	Continued From page 140 availability of the training from the educator. We will look back into having an Educator onsite and meeting the needs of the facility to address it.	F 949	Cont. Tag: F 949- Training Requirements – Behavioral Health (pgs. 139-141) Monitoring of Corrective Actions: 1. The educator or designee will audit 100% of employee training records monthly for 3 months, then 25% monthly for an additional 3 months. Any deficiencies noted will be corrected upon discovery. 2. Compliance will be reported and discussed during QAPI meetings for continued oversight. Any deficiencies noted will be corrected upon discovery. Any trends identified will prompt further education or systems adjustment.		7/8/2025