STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: _____ B. WING _____	C 03/21/2024

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BRIDGEPOINT SUB-ACUTE & REHAB NATIONA	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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L 000	Initial Comments An unannounced Complaints/Facility Reported Incidents (FRI) Survey was conducted at this facility from March 19, 2024, to March 21, 2024. Survey activities consisted of observations, record reviews, and resident and staff interviews. The sample included 11 residents. The facility's census on the day of the survey was 124 residents. The following Complaint was investigated: DC~12580. Federal: 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. State: After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32 requirements for Long Term Care Facilities. 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	L 000	**L000**-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 deficiences. 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.	**5/01/2024**

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L 000	Continued From page 1	L 000		

CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C - Discontinue
Dl - Deciliter
DMH - Department of Mental Health
DOH - Department of Health
DON - Director of Nursing
ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association

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L 000	Continued From page 2 NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;	L 051	**1. Corrective action for resident** Resident # 2 care plan was updated and revised on 04/18/2024 to include the new interventions after the fall on 12/16/23.	**5/01/2024**

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L 051	Continued From page 3 (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 11 sampled residents, facility staff failed to update/revise a resident's care plan interventions after a fall. Resident #2. The findings included: Resident #2 was admitted to the facility on 09/12/13 with diagnoses that included: Hemiplegia/Hemiparesis, Seizure Disorder, Unspecified Psychosis, and Schizophrenia. Review of Resident #2's medical record revealed: A physician's order on 06/01/23 that directed, "Floor mats bilaterally to the resident's bedside when resident is in bed, to minimize fall related injuries. Licensed Nurse to check for placement when resident is in bed every shift to minimize fall related injuries." A Situation Background Assessment Request (SBAR) Communication Form and Progress Note dated 12/16/23 documented: - Situation: Resident was observed in a sitting position on the floor mat.	L 051	**2. Identify other residents** All residents with falls could be affected. An audit of care plans for all current residents with falls from 2/19/2024 will be conducted by the Director of Nursing or Designee by 4/30/24 to ensure that the care plan is revised to include new interventions after a fall. **3. Systemic changes** The Quality Assurance nurse or Designee will educate all Licensed Nurses on updating/revising care plans after a fall to include new interventions for a fall by 4/30/24. **4. Monitor corrective actions** A Monthly audit of care plans for residents that fall will be conducted by DON/ Unit Manager/ shift supervisors or designee x 3 months to ensure that all resident that fall have their fall care plan updated/revised to include interventions for falls. Any deficiencies will be corrected immediately. All findings will be reported to the QAPI committee for recommendation, monitoring and education as needed. **5. Date correction action completed** Date of compliance 05/01/24.	

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L 051	Continued From page 4 - Nursing notes - Resident was observed in a sitting position on the floor mat beside her bed facing the door. - Head to toe assessment done, no apparent injury or open area noted. Resident denies pain, no s/s of pain noted. Resident was assisted off the floor with 3 staff assistance. - Neuro check initiated. [Doctor's name] made aware. Review of Resident #2's comprehensive care plan on 03/20/24 showed that the last care plan review/revision was completed on 02/07/24. However, there was no documented evidence that from 12/16/23 to 02/07/24, facility staff revised Resident #2's fall care plan with new interventions after she had a fall on 12/16/23. During a face-to-face interview conducted on 03/20/24 at 2:28 PM, Employee #2 (Director of Nursing/DON) acknowledged that the facility staff failed to update or revise Resident #2's care plan interventions after the resident's fall on 12/16/23.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as	L 052	**L 052** **1. Corrective action for resident** Resident #1 was sent to the hospital on 3/14/24 after a fall. The following interventions were put in place: The care plan of resident #1 that fell on 3/14/2024 with close monitoring documented in the care plan has been revised to be supervised by staff when in the wheelchair in front of the nursing station on 3/25/24.	**5/01/2024**

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L 052	Continued From page 5 evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, and staff interviews, for one (1) of 11 sampled residents, the facility staff failed to ensure that Resident #1, who was at risk for falls, received adequate supervision during an episode of confusion with aggressive behavior as evidenced by the resident	L 052	She was evaluted on 4/29/24 by OT, recommendation of supervision while in wheelchair and evaluated on 4/29/24 by Therapeutic Recreation and recommendation for music and tabletop activities. Consultant pharmacy reviewed medications on 4/22/24 and no recommendations made. Completed labs were on 4/24/24 and reviewed by NP and no new recommendations. **2. Identify other residents** All residents that were attempting to get out of bed and brought to the nursing station for supervision by staff could be affected. DON and unit manager conducted rounds on 3/21/24 to ensure that all residents that are seated in their wheelchairs by the nurse's station were being supervised by staff. All residents sitting in their wheelchair by the nursing station were being supervised by the nursing staff. **3. Systemic Changes** The Director of Quality and or Designee will educate all Licensed Nurses and certified nursing assistants on ensuring that residents that are seated in their wheelchairs in front of the nurse's station are being supervised by staff by 4/30/24. Any deficiences will be corrected immediately.	

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L 052	Continued From page 6 having a witnessed fall with injury. Actual harm was determined for Resident #1 on 03/14/2024. The findings included: "Policy: Safety and Supervision of Residents last revised on July 2017, System Approach to Safety: - The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. - Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. - The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition." Resident #1 was admitted to the facility on 05/04/22 with multiple diagnoses including Age-Related Physical Disability, Unspecified Fall sequela, Unspecifid Fracture of Right Femur sequela, Hypertension, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of Resident #1's medical record revealed	L 052	**4. Monitor corrective actions** The Director of Nursing and or designee will conduct weekly random walking rounds x 3 months to ensure that residents are being supervised by nursing staff when seated in front of the nurse's station. All findings will be reported monthly to the QAPI committee monthly x 3 months for recommendations monitoring and education as needed. **5. Date correction action completed** Date of compliance 05/01/24	

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L 052	Continued From page 7 the following: A physician's order dated 05/05/22 directed, "Fall and safety precaution every shift." A focus care plan problem with a start date of 08/24/22 showed, "[Resident name] is risk for falls r/t (related to) Confusion, Incontinence, Unaware of safety needs. Resident had actual fall 09/12/23. Interventions included, "anticipate and meet the resident's needs." Morse Falls Risk Assessment dated 12/12/23 showed: "Resident#1 had fallen before. - Ambulatory aid: none/bedrest/wheelchair/nurse assistant. - Gait: Impaired (difficulty rising from chair, uses arms to get up, bounces to rise, keep head down when walking, watches the ground, - Grasps furniture, person or aid when ambulating - Mental status: overestimates or forgets limit." A Quarterly Minimum Data Set (MDS), with an Assessment Reference dated 02/02/24 documented the following: - Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "06", indicating severe cognitive impairment. - Section GG (Functional Status) - Mobility:01-Dependent (helper does all of the effort to complete the activity); Resident coded "01"for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a wheelchair); 88-Activity not attempted due to medical condition and safety; Resident coded "88" for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). - Section J (Health Conditions), "0" fall since	L 052		

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L 052	Continued From page 8 admission/entry/reentry (05/04/22). A focus care plan problem with a start date of 02/29/24 showed: "[Resident #1] had an episode of kicking and hitting," and had interventions that included, "frequent rounding with turning and repositioning every two hours." Review of a Complaint, DC~12580, received by the State Agency on 03/14/24 documented: - "I received a call from [Registered Nurse's name] reporting that grandma has fallen with bleeding head injuries." A Situation Background Assessment Request/Recommendation (SBAR) Communication Form dated 03/14/24 at 8:11 AM documented: "Mental status change: Increased confusion, new or worsening behavioral symptoms. Assessment: 'Writer observed getting out of the chair, writer quickly trying to catch up with resident, by the time I trying to reach, she already on the floor.' Nursing note: Resident was noted with increase[d] agitation at 6:00 am trying to get out of bed on multiple times, resident was transfer[ed] to the wheelchair and placed at the nursing station for close monitoring, while [writer was] on the computer documenting, resident was getting out of the chair again, writer quickly trying to catch up with, by the time I reached her she was already on the floor, with laceration on the right side of her forehead, ice pack and pressure dsg [dressing] was applied." A Nursing Progress Note dated 03/14/24 at 8:51 AM documented, "Writer received report from assign nurse, that resident fell on right forehead while sitting on wheelchair at 3 west nursing station' staff informed to follow facility protocol for fall. Resident observed with laceration on right	L 052		

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L 052	Continued From page 9 forehead clean and covered with 4x4, call place to [Dr. Name], order receive to transfer resident to ER (emergency room) for further evaluation, non-emergency van called unable to get appointment, 911 call and pick up resident to [hospital name] around 8am." A Nursing Progress Note dated 03/14/24 at 10:19 AM documented, "Resident was noted with increased agitation at 6:00am trying to get out of bed on multiple times. Resident was charged and offered water, and repositioned, Resident continued to yell and climbing out of bed. When asked what was going on? Resident continued to yell and kick. At 6:20am the resident was transferred to the W/C (wheelchair) and placed at the nursing station for close monitoring. Resident continued to get up from the wheelchair multiple times with anxiety. And was repositioned in the wheelchair so many times. At 6:30am, while the nurse was at the nursing station charting, resident got up the 4th time, before nurse could get to the resident, resident was on the floor on her right side, resident was noted with abrasion, pressure, icepack and dsg (dressing) applied. VS (vital signs) T (temperature) 97.6, P (pulse) 78, R (respirations) 18, B/P (blood pressure) 130/70, SPOX (oxygen saturation) 97, F/S (fingerstick) 152 MG/DL (milligrams/deciliter) taken, ROM (range of motion) exercise done able to follow command. Pain medication acetaminophen administered per order. Resident was assisted off the floor [Dr. Name] made aware order to transfer Resident to ER (Emergency Room) for evaluation RP [Responsible Party name] made aware." A Nursing Progress Note dated 03/14/24 at 12:19 PM documented, "Writer informed that resident was restless and agitated and repeatedly attempting to get out of bed. Staff reported they	L 052		

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L 052	Continued From page 10 brought resident to the nursing station for closer monitoring and had to repeated redirect resident to prevent fall. However, while staff was documenting at the end of shift, resident had a fall with a bruise/laceration to right side of head. Per reports, [Doctor's name] ordered resident to be transferred to the hospital and resident was transferred to (hospital name). Writer notified RP (responsible party name), that resident was transferred and was also updated that a CT (Computed Tomography) scan was negative. Nursing will continue monitoring resident upon return. Psych consult ordered for further evaluation." Radiology Report dated 03/14/24 at 3:41 PM documented, "XR [x-ray right/hand; Findings: There is an acute, minimally displaced fracture of the distal head of the 2nd metacarpal." A Nursing Progress Note dated 03/14/24 at 4:17 PM documented, "Resident returned from [hospital name] around 1500 (3:00 PM). Head-to-toe assessment done with primary nurse. Resident repositioned and made comfortable. Upon assessment, right hand in splint with laceration on right facial laceration. [RP Name], visiting and updated on interventions including [Dr. Name]'s notification to evaluate resident. Psych consult done. [Dr. Name], orthopedic consulted per d/c (discharge) recommendations. Wound consult done. He verbalized understanding but stated "don't give my grandmom pain medication unless she is screaming and only Tylenol." Resident states she does not have pain at rest, only when moved and on her right lower extremity. Resident on Tylenol PRN [as needed]. Nursing to continue monitoring and implementing fall precautions."	L 052		

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L 052	Continued From page 11 A Physician Progress Note dated 03/18/24 at 11:49 AM documented: - "S/p (status/post) fall on 3/14 (March 14, 2024). - Treated in ER for facial laceration and right minimally displaced fracture of 2nd metacarpal." During a facility tour on 03/19/24 at 10:30 AM, Resident #1 was observed in bed with a bruise/laceration to the right side of her forehead. During a face-to-face interview on 03/19/24 at 11:15AM Employee #2 (Director of Nursing/DON) stated that if a resident is at risk of falling or had a fall, they are placed on frequent monitoring. When asked what she meant by "Frequent monitoring", she stated, "Everyone including the housekeeping and EVS (environment service) staff looks and checks on the resident." During a face-to-face interview on 03/20/24 at 1:00 PM, Employee #5, (Certified Nursing Assistant/CNA) who was assigned to care for and monitor Resident #1, was asked where she documented that she was monitoring Resident #1. The employee brought three forms titled "Q (every) 2 hr (hour) Rounding Sheet" dated from 03/11/24 to 03/20/24 that did not document Resident #1's name. The first form displayed another resident's name. The second form displayed the same resident's name with a line drawn through it. The third form lacked documented evidence of a resident name. When asked why Resident #1's name on the frequent monitoring forms dated 03/11/24 to 03/19/24, Employee #5 failed to provide an answer. During a telephone interview conducted on 03/21/24 at 2:05 PM Employee #4 (Licensed Practical Nurse/LPN), who was assigned to	L 052		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 12 Resident #1, stated, "The resident's chair could not come into the nursing station where I was seated so, the resident was seated outside of the nursing station where she was being monitored. I was monitoring the resident when she got up from her wheelchair and fell on the floor before I could get to her. Blood was coming out from her right forehead. Other staff were in their assigned rooms taking care of other residents. I was by myself." An observation made by the Surveyor on 03/21/24 at 2:15 PM of the nurse's station where Employee #4 stated she was seated and where Resident #1 was seated, showed that the nurse and the resident were not within arm's length of each other. In order for the nurse to reach the resident, she would have had to get up from her chair, walk around the side of the nurse's station desk, to the front of the desk. During a face-to-face interview on 03/21/24 at 2:50 PM Employee #2 (DON) stated, "Resident #1 was on frequent monitoring and was moved to close monitoring when she became aggressive and was climbing out of the bed. We do not do 1:1 [one-to-one] monitoring. We do close monitoring. Close monitoring is when the at-risk resident's behavior threatens their safety, they are brought to areas such as the nursing station to be monitored. The employee further stated that close monitoring means that the resident and the facility staff are within arm's length of each other." Of note, the facility had no written policy relating to close monitoring. During a face-to-face interview conducted on	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: _____ B. WING _____	C 03/21/2024

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L 052	Continued From page 13 03/21/24 at 3:15 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "The resident was brought to the nursing station for close monitoring but where the nurse was seated, she could not reach the resident who stood up out of her wheelchair and fell to the floor. We will educate staff on the process for closely monitoring residents."	L 052		