STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	R-C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(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 Revisit survey was conducted at Bridge Point National Harbor from November 8, 2021 through November 10, 2021. Survey activities consisted of a review of 38 sampled residents. The facility's census on the first day of the was 109. The following complaints and facility reported incidences were investigated during this survey: DC00010184, DC00010364, DC00010362, DC00010351, DC00010337 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. 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	{F 000}	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.	12/08/2021

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

M Washington LNHA

TITLE: Interim Administrator

(X6) DATE: 12/13/21

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	{F 000}		

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
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

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{F 000}	Continued From page 2 Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey 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 000}		
{F 550} SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	{F 550}	F 550 1. Corrective action for resident Resident #S1 has been given a privacy bag. 2. Identify other residents An audit of other residents with urine collection bags did not identify any other residents affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been re-educated on the importance of resident's rights to include privacy. The Director of Nursing and Unit Managers will be responsible for validating privacy rounds/inspections and subsequent follow up on findings.	12/08/2021

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{F 550}	Continued From page 3 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview for one (1) of 38 sampled residents the facility's staff failed to ensure a resident was provided dignity and privacy due to not covering the urine catheter/collection bag. Resident #S1. The findings include: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey ending 09/16/2021 stipulated: ".....2. An audit of other residents with urine	{F 550}	4. Monitor corrective actions The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 550}	Continued From page 4 collection bags did not identify any other residents affected... 3. Staff have been educated on the importance of resident's rights to include privacy... 4. The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy." The facility's date of alleged compliance is 11/02/2021. Review of the facility's policy entitled "Patients' Rights" with a revision/review date of 9/2020, revealed," ...Personal privacy during personal hygiene activities (e.g., toileting, bathing, dressing) during medical/nursing treatments and when requested as appropriate ..." Resident #S1 was admitted to the facility on 11/03/2021 with multiple diagnoses including Diabetes Mellitus Type 2, Morbid Severe Obesity, Rheumatoid Arthritis, and Encounter for Attention to Gastrostomy. On 11/08/2021 at approximately 10:00 AM Resident # S1 was observed in her room, laying in bed with a urine collection bag hanging on the Resident's bedframe uncovered. Review of the physician's order dated 11/04/2021, directed "Foley Catheter care every shift ..." "Change foley bag every 2 weeks every night shift every 14 days ..." During a face-to-face interview conducted on 11/08/2021 at approximately 10:00 AM Employee #42 (Registered Nurse) stated "I will check it."	{F 550}		

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{F 550}	Continued From page 5 Employee #42 went to residents' room and later returned and stated, "It is covered".	{F 550}	F 584	12/08/2021
{F 584} SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	{F 584}	1. Corrective action for resident The floor tiles in room 343 have been cleaned. 2. Identify other residents An audit of other areas throughout the facility were inspected. There were no additional findings related to this citation. 3. Systemic changes Engineering/Environmental staff have been re-educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Engineering will notify the Director of Environmental Services if their facility improvement projects result in areas that need to be cleaned. The Director of Engineering and Director of Environmental Services will be responsible for maintaining a safe, clean, and comfortable environment. 4. Monitor corrective actions The Director of Environmental Services/Designee will complete random audits of floor tiles on each unit weekly and will follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed	

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{F 584}	Continued From page 6 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility's staff failed to provide housekeeping services necessary to maintain the interior of the facility in a safe, sanitary, orderly and comfortable manner. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, documented that the facility's engineering staff, "... have been educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Plant Operations will be responsible for maintaining a safe, clean, and comfortable environment." During a tour of unit 3 west on 11/08/2021 at 10:16 AM, a large, brown, soiled area was noted on the floor in room 343, on the right side, near the head of the resident's bed (bed A). During a face-to-face interview conducted at the time of the observation with Employee #51 (Painter), he stated, "There was a wardrobe there that was changed out last week. EVS (environmental services) has to clean the floor." During a face-to-face interview conducted on 11/08/2021 at 10:18 AM with Employee #52 (EVS Supervisor), she acknowledged the finding and	{F 584}	The facility's date of alleged compliance is December 8, 2021.	

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{F 584}	Continued From page 7 stated, "I didn't know they moved the wardrobe. I'm going to get the floor tech (technician) to take care of it now."	{F 584}		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation 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 observations, record reviews, resident staff interviews, for three (3) of 38 sampled residents, facility staff failed to complete a thorough investigation. Residents' #M1, #38 and #107. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, documented, "Staff and Leadership have been educated on the importance of ensuring that all	{F 610}	F 610 1. Corrective action for resident Investigations were completed/reviewed and/or reinvestigated and appropriate actions taken to resolve the concerns for all residents. Resident #M1 will have her concern reinvestigated. Residents #8 and #107 will have their falls investigated. 2. Identify other residents An audit of other resident's concerns and falls from November 3, 2021 to present will be completed. 3. Systemic changes Nursing staff and Leadership will be educated on the importance of ensuring that all concerns and incidents are investigated appropriately to ensure that residents are not subjected to potential abuse. A new process for monitoring and investigating falls will be put in place. The comment card box will be checked twice a day. Concerns will be given to the Administrator or designee for review and follow up. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse. 4. Monitor corrective actions The Administrator will complete weekly audits	12/08/2021

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{F 610}	Continued From page 8 allegations of abuse are reported and investigated appropriately to ensure that residents are not subjected to potential abuse. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse." Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, " ...The individual conducting the investigation will, as minimum... interview the resident (as medically appropriate) ... interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ... interview other residents to whom the accused employee provides care or services ..." 1. Facility staff failed to conduct a thorough investigation of an alleged violation of privacy to Resident #M1. Review of a comment card written by the Resident #M1's son given to the facility on 11/02/2021 documented, "[Resident #M1] feels uncomfortable with to[o] many people coming to view her bed sore like a sideshow!" During a face-to face-interview conducted with Resident #M1 on 11/08/2021 at 10:58 AM, she reported that a few weeks ago, while her female nurse was changing her incontinent brief and the dressing on her buttocks, a male nurse appeared in the doorway of the resident's room and started talking to the female nurse. When the resident asked the male nurse, why he was there, she reports that he said nothing to her. The resident stated that she spoke with the Unit Manager about the incident.	{F 610}	of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 610}	Continued From page 9 Resident #M1 was admitted to the facility on 10/15/2021, with diagnoses that included: Pressure Ulcer of Other site, Unstageable [pressure ulcer], Morbid Obesity and Weakness. According to the Quarterly Minimum Data Set (MDS) dated 10/22/2021, staff coded Resident #M1 as: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact cognition. In Section G (Functional Status), "Total dependence, one-person physical assist" for toilet use. In Section H (Bladder and Bowel), "Always incontinent" for urine and bowel. In Section M (Skin Conditions), "Yes" to question, "Does resident have unhealed pressure ulcers/injuries?" A review of the physician's orders revealed: 10/18/2021 at 11:00 PM, "Dakins (a dilute solution of sodium hypochlorite and other stabilizing ingredients, traditionally used to cleanse wounds to prevent infection), (1/4 strength) solution ...Apply to left upper buttock topically every 12 hours for Wound care ..." 10/18/2021 at 11:00 PM, "Dakins (1/4 strength) solution ... Apply to right upper buttock topically every 12 hours for Wound care ..." A review of the medication administration record	{F 610}		

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{F 610}	Continued From page 10 (MAR) from 11/02/2021 to 11/08/2021 documented that staff was applying Dakins solution for wound care every shift during this time. Review of a nursing progress note dated 11/02/2021 at 4:29 PM, documented the following, "Writer was made aware by patient advocate of resident concern regarding a male staff in her room while the female staff was changing her wound dressing. Writer went to talk to resident. Resident was very friendly expressing her concern no[t] to be change[d] or wound to be done by male staff or in present [presence] of male staff. Writer apologized to the resident and let her know she will take her concern in consideration and will communicate it to the staff." Review of an email correspondence dated 11/05/2021 at 12:01 PM documented, "I (Employee #1- Interim Administrator) spoke with daughter and son of [Resident's name]. My team spoke with the [Resident's Name] on 11/4/21. We addressed the concerns notes [noted] on the comment card: 1.The issue with looking at her wounds translated into the fact that she is uncomfortable having male caregivers. That has been addressed ..." Review of the facility's documents and the resident's medical record revealed that facility staff failed to, 1. Report the incident to the state agency and 2. Failed to thoroughly investigate the allegation (interview staff members on all shifts who have had contact with the resident during the period of the alleged incident). During a face-to-face interview conducted on	{F 610}		

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{F 610}	Continued From page 11 11/09/2021 with Employee #1(Interim Administrator) at 10:30 AM, she stated that she had received the comment card filled out by the Resident's son. The Employee further stated that she had contacted Resident #M1's son and daughter via email to address the issue. Moving forward the resident will not have any male staff to provide incontinent care or wound care. 2. Facility staff failed to conduct investigations of the unwitnessed falls of Residents' #8 and #107. A. Resident #8 was admitted to facility on 03/27/2021 with multiple diagnoses that included: Restlessness and Agitation, Aphasia, Anemia and Type 2 Diabetes Mellitus. Review of two (2) facility reported incidents documented the following: 10/09/2021 at 7:53 PM " ... Resident was observed on the floor by her bedside lying on her left side ... [Physician's Name] made aware, order given for start (sp) bi-lateral and femur X-ray ... neuro check in progress ..." 10/29/2021 at 6:08 PM "Writer was called to resident rom (sp) at 0947 AM ... Per residents charge nurse resident was observed in the floor matt (sp) at her bedside ... [Physician's Name] made aware ... order for neuro-check ..." Review of the Significant Change MDS dated 10/01/2021 revealed that facility staff coded the following: In Section C (Cognitive Patterns), a BIMS summary score of "04", indicating severe cognitive impairment.	{F 610}		

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{F 610}	Continued From page 12 In Section E (Behavior), "0" indicating that there was no behavior concerns. In Section G (Functional Status), bed mobility, "extensive assistance, one person physical assist", transfer, "total dependence, two persons physical assist", lower extremities, "impairment on both sides", mobility devices, "none of the above". Review of the care plan with the focus area, "[Resident #8's Name] has a communication problem ..." revised on 05/23/2021 had the following intervention(s): " ... ensure/provide a safe environment call light within reach, adequate low glare light, bed in lowest position and wheels locked ..." Review of the care plan with the focus area, "[Resident #8's Name] is a high risk for fall ..." revised on 10/12/2021 had the following intervention(s): "... review information on past falls and attempt to determine cause of falls. Record possible root causes ..." Review of the progress notes revealed: 10/09/2021 at 2:39 PM (Nursing Progress Note) "Writer's attention was called by housekeeper on the unit who had just left resident's room, she came back to empty the trash when she observed resident on the floor ... head to toe assessment was done, resident denies hitting head ..." 10/29/2021 at 12:04 PM (Nursing Progress Note) "Writer was called to resident rom (sp) at 0947 AM ... per the resident's charge nurse resident	{F 610}		

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{F 610}	Continued From page 13 was observed in the floor matt (sp) at her bedside. When asked what happened, resident was given conflicted answers due to confusion ..." 10/29/2021 at 1:00 PM (Nursing Progress Note) "Resident observed on the floor, full assessment done, no injury found, MD (medical doctor) and family notify." Review of the facility's investigations folder for the two (2) reported falls, revealed that there was no investigation or documented evidence of an investigation being conducted for either of the facility reported incidences (falls on 10/09/2021 and 10/29/2021). During a face-to-face interview conducted on 11/09/2021 at 10:57 AM, Employee #1 (Interim Administrator) stated, "Right now unless it is something unusual that happened, I would not do a full investigation. We did not investigate further because they were just falls." B. Resident #107 was admitted to the facility on 05/21/2021, with diagnoses that included: Unspecified Focal Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, Person Injured in Unspecified Motor -Vehicle Accident, Traffic, Parkinson's Disease, Anxiety Disorder, Unspecified Abnormalities of Gait and Mobility and Weakness. The Department of Health received a Complaint /Incident Report submitted electronically on 11/04/2021, at 4:32 PM that documented, " ... Writer was made aware by resident charge nurse of fall sustained around 11:20PM ...resident was returning from Physical therapy ... was observed sitting on the floor in front of his wheelchair.	{F 610}		

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{F 610}	Continued From page 14 When (asked) what happened resident stated he was trying to go to the bathroom. Resident did not initiate his call bell prior to the incident ... per charge nurse ..." Review of the Quarterly MDS, dated 09/15/2021, staff coded the following: In Section C (Cognitive Patterns), nothing was documented In Section G (Functional Status), "Total dependence", for locomotion on and off unit, dressing, toilet use and personal hygiene. In Section H (Bladder and Bowel), "Always incontinent" for urine and bowel continence. In Section O (Special Treatments, Procedures and Programs), Therapy start date for physical therapy is documented as: "08-01-2021". Review of the physician's orders revealed: 11/04/2021 at 12:12 PM "X-ray for back pain STAT (immediately) for S/P (status post) fall." 11/04/2021 at 12:45 PM "X-ray to lumbar spine/lower back one time only for back pain STAT (immediately) for S/P fall for 1 Day." An X-ray report dated 11/04/2021 revealed: "... presents with a history of low back pain associated with injury/fall; Technique: Lumbar spine, 2 views; Findings... Bones: Vertebral bodies and posterior elements appear intact. ... Conclusion: No acute fracture/malalignment identified ..."	{F 610}		

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{F 610}	Continued From page 15 Review of the progress notes revealed: 11/03/2021 at 11:01 PM (Nursing Progress Note) "Resident remain alert, oriented, and verbally responsive. At about 11: 20 am, resident was observed on the floor, resident "stated he is trying to go to the bathroom. Upon assessment ROM (range of motion) WNL (within normal limits), a small abrasion measured 0.1 x 0.1 cm (centimeters) noted on his sacral, area cleansed with soap and water, DON (Director of Nursing), Family member [Name of Resident Representative] and [Name of Physician] notified ...Denies pain. Nursing will continue to monitor this progress." Review of the facility's documents and the resident's medical record revealed that facility staff failed to thoroughly investigate the incident (... interview staff members on all shifts who have had contact with the resident during the period of the alleged incident ...) on 11/03/2021. During a face-to face interview conducted on 11/10/2021 at 10:41 AM with Employee #1 (Interim Administrator) stated, "Right now unless it is something unusual that happened, I would not do a full investigation."	{F 610}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	{F 656}	F 656 1. Corrective action for resident Resident #M1 will have their comprehensive care plans reviewed and updated. Resident #39 is not currently in the facility.	12/08/2021

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{F 656}	Continued From page 16 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. (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 38 sampled residents, facility staff failed to review resident's plans of care for	{F 656}	2. Identify other residents An audit of all current resident's care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. 3. Systemic changes IDT team has been re-educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The MDS coordinators will be responsible for ensuring that all residents have comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 656}	Continued From page 17 appropriate goals and approaches as needed. Residents' #39 and #M1. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "... IDT (interdisciplinary) team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The Director of Reimbursement will be responsible for ensuring that all residents have comprehensive care plans..." 1. During a tour of unit 3 west on 11/08/2021, Resident #39 was observed with a tan immobilizer (supportive garment worn around the wrist to reinforce and protect it against strains and sprains during strong use, or as a splint to help healing) applied to the left wrist. Resident #39 was admitted to the facility on 06/23/2021 with multiple diagnoses that included: Muscle Weakness, Lymphedema and Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) dated 09/30/2021 revealed: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) summary score of "15", indicating intact cognitive response. In Section G (Functional Status) for the area, "upper extremity (shoulder, elbow, wrist, hand)" , facility staff coded, "0", no impairment". Review of a physician's note dated 10/06/2021	{F 656}		

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{F 656}	Continued From page 18 documented, " ... Exam wrist is largely swollen ... pain severe persist ... P (plan) wrist immobilizer ..." Review of Resident #39's comprehensive care plan last revised on 10/26/2021, revealed no documented evidence that a care plan was developed (initiated) to address Resident #39's use a wrist immobilizer (wearing schedule, monitoring skin). During a face-to-face interview conducted on 11/09/2021 at 2:17 PM with Employee #56 (Vice President of Clinical Operations), she stated, "Care plans are initiated by supervisors or nurse managers." 2. Resident #M1 was admitted to the facility on 10/15/2021, with diagnoses that included: Acute Respiratory Failure with Hypoxia, Pressure Ulcer of Other site, Unstageable, Morbid Obesity, Weakness, Type 2 Diabetes Mellitus, Hypertensive Heart and Chronic Kidney Disease. According to the Quarterly MDS dated 10/22/2021, staff coded the following: In Section C (Cognitive Patterns), Resident #M1 had a Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact cognition. In Section G (Functional Status), "Total dependence" and "one-person physical assist" for toilet use. In Section H (Bladder and Bowel), "Always	{F 656}		

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{F 656}	Continued From page 19 incontinent" for urine and bowel. In Section M (Skin Conditions), "Yes," to the question, "Does resident have unhealed pressure ulcers/injuries?" Review of the medical record revealed the following: 10/18/2021 at 11:00 PM, (physician's order) "Dakins (wound cleanser) solution ...Apply to left upper buttock topically every 12 hours for Wound care ..." 10/18/2021 at 11:00 PM, (physician's order) "Dakins (1/4 strength) solution ... Apply to right upper buttock topically every 12 hours for Wound care ..." 11/02/2021 at 4:29 PM (Nursing Progress Note) "Writer was made aware by patient advocate of resident concern regarding a male staff in her room while the female staff was changing her wound dressing..." 11/05/2021 at 12:01 PM (Email Correspondence) "I (Employee #1- Interim Administrator) spoke with daughter and son of [Resident's name]. My team spoke with the [Resident's Name] on 11/4/21. We addressed the concerns notes [noted] on the comment card: 1.The issue with looking at her wounds translated into the fact that she is uncomfortable having male caregivers. That has been addressed ..." Review of the Medication Administration Record (MAR) from 11/02/2021 to 11/08/2021 documented that staff was providing wound care as ordered (Dakins solution).	{F 656}		

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{F 656}	Continued From page 20 Review of the Comprehensive Care Plan with a revision date of 10/29/2021, lacked documented evidence that the facility's staff developed a care plan with a focus area to address the Resident #M1's preference for privacy and no male employees to provide incontinent care and wound care. During a face-to face interview conducted with Employee #42 (Unit Manager) on 11/10/2021 at 12:55 PM, she stated that she had not documented Resident #M1's preference for female care providers during incontinent care and wound care in the comprehensive care plan.	{F 656}		
{F 686} SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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 record review and staff interviews, the facility failed to provide proper care to minimize pressure ulcers and to promote healing of ulcers evidenced by failure to ensure that skin	{F 686}	F 686 1. Corrective action for resident All residents have been assessed for changes in skin condition and all active licensed nursing staff have been educated on completing the entire assessment form. Training will be ongoing for prn, new staff, and staff on leave. 2. Identify other residents Facility will complete house wide skins assessments by 12-08-2021. Any new skin issues or toe nails that need to be trimmed will be referred to the wound care team or podiatrist respectively.	12/08/2021

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{F 686}	Continued From page 21 assessments (skin sheets) were completed twice a week, to include, head-to-toe skin assessments, toe-nail assessments, a license nurse signature and or a Unit Manager/Designee signature. The resident census on the first day of the revisit was 109. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "The assessments will be documented and stored in the departmental shower books and the DON (Director of Nursing)/Designee will audit for completion twice a week for two months." According to the directions listed on the facility's Skin Monitoring Sheet staff were to perform visual assessment of resident's skin...Repost any abnormal looking skin...to charge nurse immediately. Forward any problems to the Unit Manager/Designee for review use this form to show exact location and description of the abnormality. Review of 155 Skin Assessment Sheets for Units #1, #2, and #3 dated from 11/03/2021 to 11/08/2021 revealed the following: 1. Three (3) resident's skin sheets lacked documented evidence that a licensed nurse conducted a head-to-toe assessment. 2. One-hundred and eighteen (118) resident's skin sheets lacked documented evidence that licensed staff assessed the resident's toenails for the potential need for trimming.	{F 686}	3. Systemic changes Active licensed staff were educated on completing the skin assessment form in its entirety to include the proper review of completed forms. Skin assessments will be performed twice a week by the Licensed Nursing staff during the resident's showers/bed baths to document any changes in the resident' s skin condition. 4. Monitor corrective actions The DON/Designee will audit the skin assessment forms for completion twice a week for 3 months. The Administrative Assistant will do a second review to ensure that the assessment forms have been completed in their entirety. Incomplete forms will be returned to the managers for a re-assessment. Staff who are found to consistently fill out the skin assessment forms incorrectly will be addressed via the progressive disciplinary policy of the facility. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 686}	Continued From page 22 3. Forty-eight (48) resident's skin sheets lacked documented evidence that the DON or Designee audited the skin sheets for completion. During a face-to-face interview conducted on 11/10/2021 at approximately 2:00 PM, Employee #20 (Unit Manager/ Registered Nurse) stated that nursing staff should have conducted head-to-toe assessments including toenail assessments and signed the completed skin sheets. Additionally, the nursing supervisor (or designee) should have audited the skin sheets for completeness.	{F 686}		
{F 697} SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interview, for one (1) of 38 sampled residents, the facility failed to assess a resident's pain level pre and post the administration of pain medication residents. Residents #93. The findings include: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey ending 9/16/21 stipulated: "2. An audit of other residents with orders for pain medications was completed and residents were	{F 697}	F 697 1. Corrective action for resident Resident #93 is currently being assessed pre and post pain medication administration. 2. Identify other residents An audit of Pre and Post assessments of other residents with orders for pain medications will be completed. 3. Systemic changes Active licensed nursing staff have been educated on the importance of ensuring that residents are assessed pre and post pain medication administration. Training will be ongoing for prn, new staff, and staff on leave. The Director of Nursing will be responsible for ensuring that residents are assessed pre and post administration of pain medication.	12/08/2021

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{F 697}	Continued From page 23 assessed for indications and effectiveness. There were no additional findings related to this citation. Compliance date 11/2/21. 3. Nursing staff have been educated on the importance of ensuring that residents are given pain medication as ordered and assessed for indications and effectiveness of pain medication ...The Director of Nursing will be responsible for effectiveness of pain medication. Compliance date 11/2/21. 4. The Director of Nursing/Designee will complete weekly audits of 10%of residents receiving pain medication to ensure that the medication was given per physician's orders and has been effective...The facility's date of alleged compliance is 11/2/21." Review of the facility's policy entitled: "Pain Assessment and Management" revised March 2015, documented: "Assessing Pain 1. During the comprehensive pain assessment [staff is to] gather the following information as indicated from the resident (or legal representative): a. History of pain (as measured on a standardized pain scale); b. Characteristics of pain: (1) Intensity of pain (as measured on a standardized pain scale); (2) Descriptors of pain; (3) Pattern of pain (e.g. constant or intermittent); (4) Location and radiation of pain; and (5) Frequency, timing and duration of pain. c. Impact of pain on quality of life; d. Factors that precipitate or exacerbate pain; e. Factors and strategies to reduce pain; and	{F 697}	4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of 5 of residents receiving pain medication to ensure that assessments were completed pre and post administration of pain medication. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 697}	Continued From page 24 f. Symptoms that accompany pain (e.g., nausea, anxiety)... Implementing Pain Management Strategies: ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions. Monitoring and Modifying Approaches: ---2. Monitor the following factors to determine if the resident ' s pain is being adequately controlled: a. The resident's response to interventions and level of comfort over time; b. The status of the underlying cause(s) of pain, if identified previously; and c. The presence of adverse consequences to treatment." According to the facility's Pain Assessment and Management policy last reviewed May 2016 the pain scale rating is as follows:" 0= none; 1-3= mild; 4-6=moderate, 7-10=severe" 1. The facility staff failed to access Resident #93's pain level pre and post the administration of pain medication. Resident # 93 was admitted to the facility on 01/07/2021 with diagnoses that included: Unspecified Fracture of Lower End of Right Tibia, Anemia, Major Depressive Disorder, Schizoaffective Disorder, Bipolar Type, Unsteadiness of Feet and Vitamin D Deficiency. Review of the physician's order dated 09/24/2021 directed, "Oxycodone -acetaminophen (narcotic pain reliever) tablet 5-325 mg (milligram) one tablet by mouth every 8 hours as needed for mild to moderate pain".	{F 697}		

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	095024	A. BUILDING _____ B. WING _____	R-C 11/10/2021

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{F 697}	Continued From page 25 The November 2021 Medication Administration Record showed that Resident #93 received Oxycodone-acetaminophen tablet 5-325 mg one tablet by mouth every 8 hours as needed for mild to moderate pain on the following days: 11/01/21 at 2:22 AM 11/02/21 at10:01 AM and 6:47 PM 11/03/21 at 8:11 AM and 6:03 PM 11/04/21 at 1:11 PM and 9:22 PM 11/05/21 at 9:18 AM and 5:55 PM 11/06/21 at 12:32 AM, 11:32 AM and 8:10 PM 11/07/21 at 10:21 AM and 8:15 PM 11/08/21 at 8:41 AM 11/09/21 at 9:17 AM and 5:37 PM Review of the November 2021 Treatment Administration Record showed that facility staff recorded the resident's pain level as "0" indicating the resident did not have any pain. It is also not clear if staff were recording this pain level for the pre or post assessment of the resident's pain. Review of the progress notes for resident #93 from 11/01/2021 to 11/09/2021 shows the facility nurse recorded "PRN (as needed) Administration was: Effective" when the resident was administered pain medication. Facility staff failed to record the indications and or characteristics (rating, intensity descriptors, pattern or pain, location, and frequency) pre and post administration of pain medication. Review of the care plan entitled, " ...at risk for pain r/t (related to) Right Lower extremity ..." last updated 10/29/2021, had the following Interventions: "Evaluate the effectiveness of pain interventions. Review compliance, alleviating of symptoms, dosing schedules and resident	{F 697}		

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{F 697}	Continued From page 26 satisfaction with results, impact on functional ability and impact on cognition. Monitor probable cause for each pain episode ..." On 11/10/2021 at approximately 3:45 PM, a face-to-face interview was conducted with Employee #55. At this time, Employee #55 reviewed the resident's records and acknowledged that there were no pre and post pain assessments conducted for Resident #93 on the days that Oxycodone-Acetaminophen 5-325 mg was administered.	{F 697}	F 726 1. Corrective action for resident Resident #62 was assessed and findings were reported to the physician. The physician ordered a chest x-ray, CBC, and BMP. Based on the results, the resident was ordered an antibiotic for pneumonia. 2. Identify other residents Other residents with changes in their respiratory status have been audited. There were no additional findings related to this citation. 3. Systemic changes Active licensed nursing staff have been educated on lung assessments and changes in condition. Training will be ongoing for prn, new staff, and staff on leave. The Director of nursing will be responsible for ensuring that residents are properly assessed for changes in lung/other conditions. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly random audits on residents that have been reported as having a change in respiratory changes or status. Any concerns will be addressed immediately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed	12/08/2021
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	{F 726}		

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{F 726}	Continued From page 27 §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 observation, record review and staff interview, for one (1) of 38 sampled residents, facility staff failed to conduct a complete lung assessment. Resident #62. The findings include: During a face-to-face interview with Resident #62 on 11/08/2021 at 9:45 AM, the Resident was noted to have a productive cough. The Resident coughed into a towel and showed the surveyor red-tinged sputum and stated, "The same thing (productive cough with red-tinged sputum) happened a couple days ago. I showed it to the nurse." The surveyor immediately reported the observation to the Resident's nurse. Resident #62 was admitted to the facility on 09/28/2021 with multiple diagnoses that included: Long Term Use of Anticoagulants, Gastro-Esophageal Reflux Disease and Chronic Kidney Disease. Review of the Admission Minimum Data Set (MDS) dated 10/05/2021 revealed: In Section C (Cognitive Patterns), facility staff coded Resident #62 with a Brief Interview for Mental Status (BIMS) summary score of "10" indicating moderate impairment.	{F 726}	The facility's date of alleged compliance is December 8, 2021.	

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{F 726}	Continued From page 28 Review of the nursing progress notes revealed: 11/05/2021 at 6:51 PM " ... noted blood on sputum, [Physician's Name] made aware ..." 11/07//2021 at 4:02 PM " ... Upon morning assessment, noted napkin with dried blood ..." Review of the physician's orders revealed: 09/29/2021 "Vital signs every shift" Review of the Resident #62's medical record (medication administration record, treatment administration record, progress notes and vital signs) for dates 11/05/2021 and 11/07/2021 lacked documented evidence that nursing staff assessed the Resident's temperature, oxygen saturation, respiration rate and lung sounds. During a face-to-face interview conducted on 11/09/2021 at 2:20 PM with Employee #56 (Infection Preventionist), when asked what is the facility's standard for lung assessments, she stated, "When assessing the lungs, nurses should do a respiration rate (RR), listen to the lungs in all quadrants for any adventitious (abnormal) sounds and get an oxygen saturation." When asked about assessing a resident who had a productive cough of red-tinged or bloody sputum, Employee #56 stated, "A resident coughing up blood is considered a change in condition. A full set of vital signs (blood pressure, RR, temperature, pain measurement and lung sounds) and an SBAR (Situation, Background, Assessment, Request) should be done."	{F 726}		

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{F 755}	Continued From page 29	{F 755}	F 755	12/08/2021
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records 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 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics in two (2) of two (2)	{F 755}	1. Corrective action for resident The nurse signed out the medication that had been previously given and all counts were reconciled and correct. Active licensed nurses have been re-educated on completing the narcotic count as a part of nursing report/hand-off and the importance of accurate accounting of narcotic medications and documentation of medication administration. Training will be ongoing for prn, new staff, and staff on leave. 2. Identify other residents Narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation. 3. Systemic changes Active licensed nursing staff have been re-educated on the importance of accurate accounting of narcotic medications and documentation of medication administration and requirement to perform a narcotic count as a part of report/hand-off. Training will be ongoing for prn, new staff, and staff on leave. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits 5 narcotic count sheets and randomly observe shift report to ensure that narcotic counts occur at change of shift and anytime licensed nurses change units	

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{F 755}	Continued From page 30 observations. The findings include: According to the facility's Plan of Correction (POC), with a compliance date of 11/02/2021, the facility staff documented, "Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications." 1. During an observation on unit 3 west on 11/10/2021 at 9:19 AM, Employee #57 (Licensed Practical Nurse) was observed taking out a narcotic medication from the narcotic box. After popping the mediation into the medication cup, Employee #57 went into the room and administered the medication to the resident. The Employee then came out the resident's room and continued doing her work. Employee #57 failed to sign the narcotic book to reflect that a narcotic medication had been administered. During an observation later on that day at 11:49 AM, it was observed and noted that Employee #57 still had not signed the narcotic book to reflect that she had administered a narcotic medication. During a face-to-face interview conducted on 11/10/2021 at 11:49 AM, Employee #57 stated, "I haven't signed for any of the medications I've given this morning even the narcotic. I will go back and sign for them later." When asked to further explain, Employee #57 stated that is her normal practice even though it is not the standard	{F 755}	and take over the keys for the medication cart. In addition, the DON/designee will review if medication counts match the medication on hand correctly, and are documented when given. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 755}	Continued From page 31 of practice at the facility. 2. During a review of the, "Shift Verification of Controlled Substances Count" form for unit 3 west, side 1, on 11/10/2021 at 11:55 AM, it was observed that the nurse's signature in the section "on-going signature" did not reflect the name of the nurse who had the key for the narcotic box. During a face-to-face interview conducted with Employee #57 at the time of the observation, when asked about performing the narcotic count, she stated, "The nurse [off-going nurse] and I did not count. I had already started working on another unit when I was told I was being moved to this unit (3 west). The nurse met me on my unit and gave me the keys."	{F 755}	F 761 1. Corrective action for resident Medication carts are free of unopened bottles of insulin. 2. Identify other residents An audit of all medication carts was completed. There were no additional findings related to this citation. 3. Systemic changes Active licensed nursing staff have been educated on the importance of ensuring that no unopened bottles of insulin are left on medication carts. Training will be ongoing for prn, new staff, and staff on leave. The Director of Nursing will be responsible for ensuring that no unopened bottles of insulin are left in medication carts. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete random weekly audits of medication carts to ensure that no unopened bottles of insulin are in medication carts. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is	12/08/2021
{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 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	{F 761}		

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{F 761}	Continued From page 32 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 an observation and staff interviews, the facility's staff failed to properly store unopened insulin in the refrigerator. The findings include: During an observation of unit 3 east's Medication Cart #1 on 11/08/2021 at 11:39 AM, it revealed an unopened bottle of Novolog Insulin being stored at room temperature. During a face-to-face interview on 11/08/2021 at 11:40 AM, Employee #20 (Registered Nurse) stated that the unopened Insulin should be stored in the refrigerator and not in the cart. During a telephone interview conducted on 11/10/2021 at approximately 2:00 PM, Employee #55 (Pharmacist) stated, "All unopened Insulin should be stored in the refrigerator until opened and activated."	{F 761}	December 8, 2021.	
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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	{F 842}	F 842 1. Corrective action for resident Resident #48's therapy discharge summary has been corrected via an addendum to reflect the correct reason for discharge.	12/08/2021

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{F 842}	Continued From page 33 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(i) Medical records. §483.70(i)(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(i)(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 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	{F 842}	2. Identify other residents An audit of other residents discharged from therapy was completed to ensure that the correct reason for discharge was listed. 3. Systemic changes Licensed therapists and assistants (PT/OT/SLP/PTA/COTA) have been educated on the importance of ensuring that discharge summaries are accurate. The Director of Rehabilitation will be responsible for ensuring that therapy discharge summaries are complete and accurate. 4. Monitor corrective actions The Director of Rehabilitation/Designee will complete weekly audits of all residents discharged from therapy to ensure that discharge summaries are complete and accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 842}	Continued From page 34 §483.70(i)(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(i)(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 and staff interview for one (1) of 38 sampled residents, the Speech Therapist failed to accurately document Resident #48's discharge summary information in the residents' medical record. The findings include: Resident #48 was admitted to the facility on 04/19/2019, with multiple diagnoses including: Paraplegia, Aphasia, Dysphagia, Muscle Weakness, Other Muscle Spasm, Pain Unspecified, and Respiratory Failure. Review of the Quarterly Minimum Data Set (MDS) dated 06/13/2021, revealed that facility staff coded in Section B (Hearing Speech Vision),	{F 842}		

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{F 842}	Continued From page 35 B0600 Speech clarity "2" indicating "No Speech"; B0700 Makes self-understood "3", indicating "Rarely/never understood". In Section C (Cognitive Patterns), "Should a brief interview for mental status be conducted" "0", indicating "No". Review of the physician's orders revealed: 08/27/2021 "SLP (Speech Language Pathology) eval (evaluation) & (and) Treat (treatment) 2x/wk (week) x 30 days (two times per week for 30 days) for dysphagia tx (treatment) speech/language tx, therapeutic PO (by mouth) trials ..." Review of the document entitled "Speech Therapy SLP (Speech Language Pathology) Discharge Summary" dated 09/16/2021, revealed in the section labeled "D/C (discharge) Reason, facility staff documented "other". There was no additional information in the clinical record to describe what "other" meant. During a face-to -face interview conducted on 11/10/2021 at approximately 11:00 AM with Employee #13 (Director of Rehabilitation) stated, "She [The speech language therapist that signed the document] clicked the box for 'other' instead of documenting highest practical level achieved."	{F 842}		
{F 867} SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	{F 867}		

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{F 867}	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems as evidenced by failing to ensure that they developed plans of action to identify quality deficiencies. The resident census on the first day of the survey was 109. The findings include: A review of the facility's previous survey dated 08/23/2021 to 09/16/2021 showed that the facility was cited for the following deficiencies: F550 Resident Rights/Exercise of Rights F584 Safe/Clean/Comfortable/Homelike Environment F610 Investigate/Prevent/Correct Alleged Violation F656 Develop/Implement Comprehensive Care Plan F686- Treatment/Services to Prevent/Heal Pressure Ulcer F697- Pain Management F726 - Competent Nurse Staffing F755 - Pharmacy services/Procedures/Pharmacist/Records F761 - Discharge Summary F842 - Resident Records-Identifiable Information F867 - QAPI Program/Plan, Disclosure/ Good faith Attempt F880- Infection Prevention & Control F908 - Essential Equipment, safe Operating Condition	{F 867}	F 867 1. Corrective action for resident The QAPI Committee has reviewed all current citations and interventions. Recommendations for changes have been implemented. 2. Identify other residents A review of all outstanding citations have been reviewed and recommendations implemented. There were no additional findings related to this citation. 3. Systemic changes The Administrative team has been re-educated on the QAPI process and assessing progress of improvements and making changes to the plans to improve outcomes (including goals and metrics) and all areas of concern from this survey. The Administrator will be responsible for ensuring that the findings of this survey and other issues identified are reported to the QAPI committee and Governing Board and addressed appropriately in accordance with state and federal regulations. 4. Monitor corrective actions The Administrator/Designee will complete Monthly reviews of all findings of this survey and other issues identified to ensure appropriate follow up and interventions are in place and changes to the plan as needed for improved outcomes. The results will be reported to the QAPI Committee and Governing Board monthly x 3 months for review and recommendations.	12/08/2021

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{F 867}	Continued From page 37 The aforementioned deficiencies were cited again the Revisit Survey that ended on 11/10/2021. Based on the repeated deficiencies, there is no evidence that the facility staff continuously monitored their deficient practices from the prior survey and implemented the corrective actions as they indicated in their Plan of Correction from the recertification survey of 08/23/2021 with a compliance date of 11/02/2021. In addition, the facility failed to: Implement appropriate plans of action to correct identified deficiencies as outlined in their Plan of Corrections with a compliance date of 11/02/2021, as documented below: Under F550 -"4.Monitor Corrective Actions- The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance." Under F584 - "4. Monitor Corrective Actions- The Director of Plant Operations/Designee will complete random audits of ceiling tiles on one unit weekly and will follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance." Under F610 - "4. Monitor Corrective Actions -The Administrator will complete weekly audits	{F 867}	The QAPI Committee and Governing Board are responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 867}	Continued From page 38 of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance." Under F656 - "4. Monitor Corrective Actions -The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance." Under F686 - " 2. Identify Other Residents ... going forward skin assessments will be performed twice a week by the License Nursing staff during the residents showers/bed baths to document any changes in the resident' s skin condition. 3. Systemic Changes - The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. 4. Monitor Corrective Actions. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality Director and addressed in the weekly QAPI meetings." Under 697 -" 3. Systemic Changes - Nursing staff have been educated on the importance of ensuring that residents are given pain medication as ordered and assessed for indications and	{F 867}		

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{F 867}	Continued From page 39 effectiveness of pain medication and administration as prescribed. 4. Monitor corrective Actions - The Director of Nursing/Designee will complete weekly audits of 10% of residents receiving pain medication to ensure that the medication was given per physician orders and has been effective. The results will be reported to the QAPI Committee monthly. ..The QAPI Committee is responsible for the ongoing monitoring for compliance." Under 726 - "3. Systemic Changes - Nursing, Respiratory, Rehabilitation, Therapeutic recreation, Housekeeping, and Maintenance staff have been educated on Infection Control and enhanced barrier precautions. .. The Infection Preventionist will be responsible for ensuring that staff are adequately trained on Infection Control and Prevention practices. 4. Monitor Corrective Actions - The Infection Preventionist/Designee will complete weekly random audits on all units to ensure that infection prevention practices are being used by all staff .. Any concerns will be addressed immediately. The results will be reported to the QAPI Committee monthly. The QAPI Committee is responsible for the ongoing monitoring for compliance." Under 755 - "3. Systemic Changes -Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications. 4. Monitor Corrective Actions - The Director of Nursing/Designee will complete random weekly audits of 10 % of narcotic count	{F 867}		

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{F 867}	Continued From page 40 sheets to ensure that medication counts match the medication on hand correctly and are documented when given. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance." Under 842 - "3. Systemic Changes...The Director of Nursing, Dietician, Director of Cardiopulmonary Services, and Director of Social Services will be responsible for ensuring that medical records are complete for their respective disciplines. 4. Monitor Corrective Actions - The Unit Managers and Nursing Supervisors/Designee will complete weekly audits of 10% of residents to ensure that medical records are complete and accurate. The results will be reported to the QAPI Committee monthly...The QAPI Committee is responsible for the ongoing monitoring for compliance. Under 880- "3. Systemic Changes - Staff have been educated on the importance of ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, enhanced barrier precautions, proper use of PPE, wound care, and medication administration). Policies and procedures were reviewed and updated. The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices. 4. Monitor Corrective Actions -The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. The results will be reported to the QAPI Committee monthly...The QAPI Committee is	{F 867}		

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{F 867}	Continued From page 41 responsible for the ongoing monitoring for compliance." Under 908 - "3. Systemic Changes - Staff have been educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patient care equipment are in safe working condition. 4. Monitor Corrective Actions - Engineering/Designee will complete weekly audits of mechanical, electrical, and patient care equipment service requests to ensure that they are in safe working condition. The results will be reported to the QAPI Committee monthly... for review and recommendations. The QAPI Committee is responsible for the ongoing monitoring for compliance." According to the facility staff, the QAPI Team met on 10/18/2021. During a the exit interview on 11/10/2021 at 2:36 PM, Employee #1 (Interim Administrator) acknowledged the finding.	{F 867}		
{F 880} SS=E	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	{F 880}	F 880 1. Corrective action for resident All active staff have been re-educated on infection control practices to include hand hygiene, wearing PPE as appropriate, enhance barrier precautions, and not wearing (personal outdoor) hats during patient care. Training will be ongoing for prn, new staff, and staff on leave. 2. Identify other residents An initial audit of infection control practices was completed. All residents have the potential to be affected. There were no additional findings related to this citation.	12/08/2021

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{F 880}	Continued From page 42 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 §483.70(e) 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 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	{F 880}	3. Systemic changes All active staff have been re-educated on the importance of ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, wearing PPE as appropriate, enhance barrier precautions, and not wearing (personal outdoor) hats during patient care). Training will be ongoing for prn, new staff, and staff on leave. The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices. 4. Monitor corrective actions The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. Staff who are found to be non-compliant with proper infection control and prevention practices will be addressed through the facility's progressive disciplinary policy. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

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{F 880}	Continued From page 43 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 review and staff interview, the facility's staff failed to maintain Infection Control and Prevention Practices to minimize spread of infections. The findings include: According to the facility's Plan of Correction, with a compliance date of 11/02/2021, the facility documented that, " ... all staff would be in-serviced on the proper use of Personal Protective Equipment and the Infection Control Preventionist would be responsible for ensuring that staff utilize proper infection control and prevention practices." Review of the facility's policy entitled, "COVID-19	{F 880}		

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{F 880}	Continued From page 44 Guidelines for ...Healthcare Providers" with a revision date of 02/08/2021 documented under the Personal Protective Requirements section that staff are required to wear "eye shield (face shield) at all times when working with patients/residents..." 1. Employee #21 (Registered Nurse) failed to perform hand hygiene in between changing gloves. During an observation on unit 3 west on 11/08/2021 at 10:18 AM, Employee #21 (Registered Nurse) was observed wearing gloves, while cleaning an area on the floor in the hallway with paper towels. After she tossed the paper towels in the trash receptacle, she took off her gloves, donned a clean pair of gloves and went to start preparing medications to administer to a resident. The Employee was immediately stopped by the surveyor. Review of the facility's in-service entitled, "Donning and Doffing Personal Protective Equipment" dated 10/24/2021, revealed Employee #21's signature, indicating that she attended the training. During a face-to-face interview conducted at the time of the observation, Employee #21 acknowledged the break in infection control but made no comments about her actions. 2. Facility staff failed to properly wear Personal Protective Equipment (face shield) when entering a resident's room who was on Enhanced Barrier Precautions (EBP).	{F 880}		

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{F 880}	Continued From page 45 During an observation on 11/09/2021 at approximately 10:00 AM, Employee #54 (Certified Nurse's Aide) was observed walking into Room #317 with her face shield pointing upward, not covering her eyes or face mask. The Employee was within 6 feet of the resident when she was noted leaning over the resident (who was lying in bed) to pick up the food tray that was on the opposite (left) side of the resident's bed. It should be noted that the resident had a tracheostomy (medical device) and before entering the room, there was a sign indicating that the resident was on Enhanced Barrier Precautions. Review of the facility's in-service entitled, Donning and Doffing Personal Protective Equipment dated 10/24/2021 revealed Employee #54's signature indicating that she attended the training. The teaching tool documented that staff were to "apply eyewear (face shield) snugly around face and eyes ..." The teaching tool also documented, "As of 10/23/2021, all staff are required to wear face shields if they are going into the units or within 6 (six) feet of the resident". Enhanced Barrier Precautions are intended to provide an approach for gown/glove use that is based on resident risk factors and type of care, rather than based on MDRO [multidrug resistant organism] status, especially for residents at risk for acquisition (i.e., presence of indwelling medical devices or wounds). https://www.cdc.gov/hai/containment/faqs.html During a face-to-face interview on 11/09/2021 at 10:05 AM, Employee #54 was asked if there was	{F 880}		

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{F 880}	Continued From page 46	{F 880}		

a reason why her face shield was not covering her eyes and face mask. The Employee stated, "No, there is not a reason." The Employee then pulled her face shield down to cover her eyes and face mask and said to the surveyor, "Is that how you like it?" The surveyor replied by saying that the face shield should cover your eyes and face mask.

3. Employee #60 (Cosmetologist), failed to maintain Infection Control Practices while providing hair care services for Resident #37.

During an observation on 11/09/2021 at approximately 11:00 AM, Employee #60 was observed standing within 6 feet of Resident #37. Further observation showed the Employee was not wearing a gown or face shield while combing Resident #37's wet hair.

Resident #37 was re-admitted to the facility on 09/01/2020, with the following diagnoses: Muscle Weakness (Generalized), Hypertension, Diabetes Mellitus and Hyperlipidemia.

It should be noted that Resident #37 was on Enhanced Barrier Precautions.

A review of Employee #60's education transcript revealed that she completed the facility's education course entitled, "Isolation and Standard Precautions," on 11/14/2020.

During a face-to-face interview conducted on 11/09/2021 at 12:36 PM, Employee #60 stated that she was aware of the facility's policy for personal protective equipment requirements while in resident care areas. The Employee further

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{F 880}	Continued From page 47 stated that she removed the face shield and gown because they had gotten wet. 4. Employee #61 (Licensed Practical Nurse) failed to maintain Infection Control Practices while providing activity daily living (ADL) care for Resident #M2. During an observation on 11/08/2021 at 9:25 AM, Employee #61 was observed coming out of Resident #M2's room into the hallway, while wearing her personal outdoor hat. It should be noted that Resident #M2 was on Enhanced Barrier Precautions. During a face-to-face interview conducted on 11/08/2021 at 9:30 AM, Employee #61 stated that she was aware of the facility's policy for wearing (personal outdoor) hats during patient care and that she had forgotten to remove her hat before providing resident care. When asked about providing care to other residents, Employee #61 said she had provided care to four (4) other residents prior to entering Resident M2's room.	{F 880}		
{F 908} SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based review of facility's documents and staff interview, facility staff failed to maintain that all essential mechanical, electrical, and patient care	{F 908}	F 908 1. Corrective action for resident No areas within the facility are greater than 81°F. The individual heating/cooling units have been replaced in rooms #337, #336, #339, #335, and #334 and are working properly.	12/08/2021

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	095024	A. BUILDING _____ B. WING _____	R-C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(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 908}	Continued From page 48 equipment in safe operating condition evidenced by failure to ensure the air handler was working. The findings include: The facility's plan of corrective action stipulated: 1.The air handler is being addressed. Residents were checked with no concerns raised about individual room temperatures. 2. Identify other residents - An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F (degrees Fahrenheit).... There were no additional findings related to this citation. 3. Systemic changes -Staff have been educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patient care equipment are in safe working condition. 4. Monitor corrective actions - Engineering/Designee will complete weekly audits of mechanical, electrical, and patient care equipment service requests to ensure that they are in safe working condition." The facility's date of alleged compliance is November 2, 2021.	{F 908}	2. Identify other residents An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F. There were no additional findings related to this citation. 3. Systemic changes Engineering staff have been re-educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing and accurate reporting of the status of equipment operational status). The Director of Engineering, will be responsible for ensuring that mechanical, electrical, equipment is in safe working condition. Materials Management will be responsible for ensuring that patient equipment is in safe working condition. 4. Monitor corrective actions Director of Engineering/Designee will complete weekly audits of mechanical, electrical service requests to ensure that they are in safe working condition. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is December 8, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING _____ B. WING _____	R-C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(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 908}	Continued From page 49 During a face-to-face interview conducted on 11/10/2021 at approximately 9:30 AM with Employee #52 and Employee #37, they stated that the air handler has not been repaired. They further stated that the facility has stand-alone units. The individual units [in resident rooms on 3 West] had nothing to do with the air handler. The air handler is out for the kitchen. 3 West does not have an air handler. The facility staff provided the writer with an invoice form [Company Name] showing that the facility purchased Heat and Air Conditioner Units. Review of the facility's work order tickets showed that heating and air conditioning units were replaced in the following rooms: 330, 331, 332, 333, 341, 342, 343, and 344. The five (5) resident rooms cited during the recertification survey on 08/23/2021 were: 337, 336, 339, 335, and 334. During a telephone interview with the facility on 11/15/2021 at 12:35 PM, Employees' #57, #37 and #1 acknowledged the findings.	{F 908}		