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 _____	12/08/2022

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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL HARBOR	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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F 000	INITIAL COMMENTS An unannounced Focused Infection Control Survey was conducted at this facility on December 8, 2022. Survey activities consisted of observations, record reviews, and staff interviews. The facility's census during the survey was 115 and the survey sample included 10 residents. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue DI - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing	F 000	**This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute and admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors" findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keysha Dale	NHA	1-9-23

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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ED - Emergency Department
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
ER - Emergency Room
F - Fahrenheit
FR. - French
FRI - Facility reported incident
G-tube - Gastrostomy tube
HR - Human Resources
Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO - by mouth

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F 000	Continued From page 2 POA - Power of Attorney POS - physician's order sheet Prn - As needed Pt - Patient Q - Every RD - Registered Dietitian RN - Registered Nurse ROM - Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable 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	F 656	1. Residents #3 & #4's care plans will be reviewed and updated. There were no negative outcomes for resident's # 3 and #4. 1-4-23 2. An audit of residents on isolation for COVID-19 will be conducted to ensure all active COVID-19 residents have updated care plans related to COVID-19. 1-4-23 3. The Interdisciplinary Team (IDT) will be educated by the DON and/or designee on the importance of having care plans related to COVID-19 for each resident that is COVID-19 positive. The MDS team will make certain care plans related to COVID-19 are updated with new goals, interventions, or treatments for new diagnosis of COVID-19. 1-9-23 4. A monthly audit of care plans related to COVID-19 will be conducted by the MDS team to ensure all residents have updated comprehensive care plans. All findings will be reported to the QAPI Committee for (3) consecutive months for review and recommendations or until 100% compliance Any care plans that are out of compliance will be corrected as appropriate. 5. Date of compliance: 1-9-23	

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F 656	Continued From page 3 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 10 sampled residents, facility staff failed to develop or implement care plan goals, interventions or treatments to address their new COVID-19 diagnosis. (Residents' #3 and #4). The findings included: Review of the policy "Care Planning - Interdisciplinary Team" revised on 11/02/22 showed, "Our facility's Care Planning/Interdisciplinary Team is responsible for	F 656		

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F 656	Continued From page 4	F 656		

the development of an individualized comprehensive care plan for each resident ..."

Review of the policy "Care Plans, Comprehensive Person-Centered" revised on 11/02/22 showed, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ..."

1. Resident #3 was admitted to the facility on 02/04/22 with multiple diagnoses that included Rhabdomyolysis, Type 2 Diabetes Mellitus and Heart Failure.

Review of Resident #3's medical record revealed:

12/07/22 [physician's order] "Maintain isolation for resident ...due to new diagnose (sp) of COVID-19, as evidenced by a positive test to the SAR-CoV-2 virus; specimen collected on 12/6/22 ..."

12/07/22 at 8:03 AM [General Progress Note] "continue on droplet Isolation for positive [COVID-19] ..."

Review of the care plan section of the electronic clinical record on 12/08/22 lacked documented evidence that facility staff developed or implemented new care plan goals, interventions or treatments for Resident #3's new diagnosis of COVID-19.

2. Resident #4 was admitted to the facility on 08/12/22 with diagnoses that included Acute Respiratory Failure with Hypoxia, Pulmonary Hypertension, and Atrial Fibrillation.

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F 656	Continued From page 5 Review of Resident #4's medical record revealed: 12/07/22 [physician's order] "Maintain isolation for resident ...due to new diagnose (sp) of COVID-19, as evidenced by a positive test to the SAR-CoV-2 virus; specimen collected on 12/6/22 ..." 12/07/22 at 7:59 AM [General Progress Note] "Resident on quarantine for COVID-19. Contact/Droplet Isolation maintained ..." Review of the care plan section of the electronic clinical record on 12/08/22 lacked documented evidence that facility staff developed or implemented care plan goals, interventions or treatments for Resident #4's new diagnosis of COVID-19. During a face-to-face interview conducted on 12/08/22 at 2:42 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comments. DCMR 3210.4	F 656		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	1.Identified employee #4 was re-educated on facility's Infection Control Policy & Procedure COVID-19; proper PPE practices during patient care interactions. 2.A random audit of infection control practices was conducted on 12/9/22 by Infection Preventionist. There were no residents found to have the potential to be affected by this finding. 3.Staff will be re-educated on Infection Control Policy & Procedures for COVID-19, proper PPE practices during patient care interactions by Infection Preventionist.	12-9-22 12-9-22 1-9-23

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F 880	Continued From page 6 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 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	4.IP or Designee will conduct (10) weekly random observations of employees to ensure Infection Control Policies are being followed by clinical and non-clinical employees. All findings will be reported to the QAPI Committee for (3) consecutive months for review, recommendations, and on-going compliance. Any observed failures to follow Infection Control Policies will be addressed immediately to include additional training. 5.Date of compliance: 1-9-23 F 880 1.There were no residents impacted by this alleged deficient practice. 2.All residents have the potential to be affected by the alleged deficient practice. Employees #2 & #3 began the process of moving COVID-19 positive residents to dedicated space within the facility for cohorting and managing care of residents. An in-house audit was conducted on 12/8/22 to ensure all identified COVID-19 positive residents were cohorted to dedicated space. 3.Staff will be re-educated on the importance of identifying and providing a dedicated space for cohorting and managing care of residents who are COVID-19 positive by the DON and/or Educator. 4.The IP or Designee will conduct weekly audits to ensure that all COVID-19 positive residents are cohorting appropriately to dedicated unit. All findings will be reported to the QAPI Committee for (3) consecutive months for review, recommendations, and on-going compliance. If any residents are not cohorted appropriately, immediate action will be taken to move the resident as appropriate and additional actions will be taken as directed by the infection preventionist .	1-9-23 12-8-22 1-9-23 1-9-23

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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 observations, record reviews and staff interviews, for one (1) of 10 sampled residents, facility staff failed to prevent potential spread of infection as evidenced by: not wearing the required Personal Protective Equipment (PPE) while interacting with a confirmed positive COVID-19 resident; and not having a dedicated space in the facility for cohorting and managing care of residents with COVID-19. (Resident #2)

The findings included:

Review of facility's policy entitled "Infection Control Policy & Procedure-COVID 19", revised in April 2020, showed, "For resident that may be a suspected COVID that may not require a higher level of care ...that resident will be placed on contact isolation precaution for 14 days ... Full PPE per CDC (Center for Disease Control) guidelines will be worm by staff for known or suspected cases of COVID-19 to avoid

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F 880	Continued From page 8 transmission within the facility." Review of the facility's policy entitled, "COVID-19 Guidelines For Quarantine And Testing Of Patients & Healthcare Providers" under the section "Isolation Precautions" reviewed on 02/08/21 showed, "PPE Requirements ... Exam Mask: At all times within the facility ... Eye Shield: At all times when working with patients/residents." 1. Facility staff failed to minimize the potential spread of COVID-19 by not wearing a face shield while interacting with Resident #2. Resident #2 was admitted to the facility on 03/11/22 with multiple diagnoses, including Infection and Inflammatory Reaction due to Internal Fixation Device of Left Humerus, Paroxysmal Atrial Fibrillation, Dysphagia and Dementia. Review of Resident #2's medical record and the facility's COVID-19 line listing showed that Resident #2 tested positive for COVID-19 on 12/07/22. During face-to-face interview on 12/08/22 at approximately 9:56 AM, Employee #2 [Director of Nursing; DON] stated, "PPE Policy for COVID positive patients is all staff providing direct patient care is to wear full PPE, gown, gloves, face shield, N95." During observation of Unit 2 East on 12/08/22 at approximately 11:20 AM, Employee #4 (Unit Manager) was observed coming out of Resident #2's room, wearing an N95 mask, but not a face shield. During a face-to-face interview conducted at the time of the observation, Employee #4 was	F 880		

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asked where his face shield was, and he stated, "It's over there," pointing in the direction of the nurse's station. When asked if he knew that Resident #2 tested positive for COVID-19, he stated "Yes, I know. I was only helping him with the phone to talk with his family, just in there for a few minutes." When Employee #4 was asked if he knew the facility's PPE policy, he stated, "We must wear a face shield and N95 at all times." He was then observed walking to the nurse's station, picked up a face shield that was still wrapped in its packaging, began opening the new face shield package then proceeded to put on the face shield.

It should be noted that Employee #4 signed his name to attest that he received the staff education entitled, "2022 Skills Fair Competency Review ... Infection Control and Prevention - Transmission-based precautions, hand hygiene, COVID update, PPE ..." on 11/29/22.

DCMR 3217.6

2. Facility staff failed to have a dedicated space in the facility for cohorting and managing care of residents who are COVID-19 positive.

During a review of the facility's line listing for COVID-19 on 12/08/22, it was noted that their current outbreak started on 11/23/22 when one (1) employee tested positive followed by one resident on 11/25/22.

During a conference with Employees #1 (Administrator), #2 (DON), and #3 (Infection Preventionist) conducted on 12/08/22 at 2:42 PM, they were asked, where is the designated location for residents who test positive for COVID-19.

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F 880	Continued From page 10 Employee #2 stated, "There is no dedicated space as of now. We are converting 3 west to the COVID-19 unit and it was agreed upon yesterday. We are in the process of moving [COVID-19 positive] residents there now." DCMR 3217.3	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883	1.All residents have the potential to be impacted by the deficient practice. Resident #2's RP was contacted on 12/9/22 to offer and obtain consent of pneumococcal immunization; Resident#2 was given immunization on 1/3/23. The Clinical Management team completed CDC training on 12/11/22 and took immediate action to obtain consents and administer resident vaccinations on 12/11/22 and 12/22/22. Employee #3 will be re-educated on the facility's Vaccination of Residents policy by 1-4-23. 2.The MDS Coordinators or Designee will conduct a full in-house audit by 1-9-23. All residents who have consented to receiving vaccinations will receive them in accordance with facility policy. 3. Unit Managers will receive education regarding facility vaccination policy and procedure of residents on pneumococcal vaccination and consents as well as CDC recommendations by the DON. 4.IP or Designee will conduct monthly audit to ensure vaccination and consent form have been offered and/or completed. All findings will be reported to the QAPI Committee for (3) consecutive months for review, recommendations, and on-going compliance. Any missing consents will be obtained and addressed according to the resident and/or responsible party's wishes. 5.Date of Compliance: 1-9-23	1-3-23 1-4-23 1-9-23 1-9-23 1-9-23

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F 883	Continued From page 11 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 10 sampled residents, facility staff failed to offer one (1) resident the pneumococcal immunization. Resident #2. The findings included: Review of the facility's policy entitled, "Vaccination of Residents" dated 12/17/18 showed, "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated ...if vaccines are refused, the refusal shall be documented in the	F 883		

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 _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 12 resident's medical record ..." Review of the facility's policy entitled, "Pneumococcal Vaccine" dated 12/17/18 showed, "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections ..." Resident #2 was admitted to the facility on 03/11/22 with multiple diagnoses, including Infection and Inflammatory Reaction due to Internal Fixation Device of Left Humerus, Paroxysmal Atrial Fibrillation, Dysphagia and Dementia. Also, based on the residents age, he is eligible to receive the pneumococcal vaccine. Review of Resident #2's medical record revealed the following: -Face sheet that documented the resident as his own "responsible party" and his wife listed at "responsible party care conference person emergency contact #1," and -Quarterly Minimum Data Set (MDS) dated 10/05/22 that showed the facility coded the resident as having severe cognitive impairment and that the pneumococcal vaccine was "Not offered". There was no documented evidence that Resident #2 had prior pneumococcal immunization, that he did not receive the pneumococcal immunization due to medical contraindication or refusal or that facility staff provided education regarding the benefits and potential side effects of pneumococcal immunization to Resident #2 or his responsible party.	F 883		

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F 883	Continued From page 13 During a face-to-face interview conducted on 12/08/22 at 2:42 PM, Employee #3 (Infection Preventionist) was asked why Resident #2 was consented and offered the flu vaccine and not the pneumococcal vaccine. Employee #3 stated, "That is a lapse on my end." DCMR 3231.12	F 883		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced	F 885	1. There were no residents impacted by this alleged deficient practice. Employee #1 took immediate corrective action on modifying notification letter by adding the cumulative updates for both residents and staff on 12/13/22. 2. An audit of notification letters was conducted and there were no additional findings related to this citation. 3. Employee #1 and Director of Social Services will be educated on COVID-19 reporting requirements specifically for cumulative updates for both residents and families by the Regional Director of Operations. 4. Administrator or Designee will conduct a monthly audit of COVID-19 notification letters. All findings will be reported to the QAPI Committee for (3) consecutive months for review and recommendations or until 100% compliance. Any letters that do not meet the requirements will be corrected and re-sent. 5. Date of Completion 1/4/22	12-13-22 1-3-23 1-4-23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 885	Continued From page 14 by: Based on record review and staff interview, facility staff failed to include cumulative updates for residents, their representatives, and families each time a confirmed infection of COVID-19 was identified. The findings included: Review of the facility's notification letter sent out to residents, their representatives, and families dated 12/07/22 documented, " ...We are writing to share the news that we have three (3) residents who tested positive for COVID-19 and our COVID screening was performed on 12/7/22. The staff will remain off work until the CDC (Centers for Disease Control) criteria for return-to-work are satisfied." On the day of the survey on 12/08/22, the facility provided documented evidence that from 11/23/22 (date of first positive case in the facility) to 12/07/22 (14 days later), 13 residents had tested positive for COVID-19 as well as seven (7) staff members (totaling 20 cases). The evidence showed that the facility failed to provide cumulative updates when a new confirmed infection of COVID-19 was identified in residents and or staff. During a face-to-face interview conducted on 12/08/22 at 2:42 PM, Employee #1 (Administrator) acknowledged the findings and stated that she would make sure the notification letters are cumulative moving forward.	F 885		