STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments A Recertification Quality Indicator Survey (QIS) was conducted at your facility on September 9, 2015 through September 23, 2015. The following deficiencies are based on observations, record reviews, resident and staff interviews for 55 sampled residents. An Immediate Jeopardy (IJ) was identified at CFR 483.25 Quality of Care; F328 (Treatment/Care for Special Needs); F309 (Provide Care/ Services for Highest Well Being); and F353 (Sufficient Nurse Staffing) on September 22, 2015 at 2:20 PM. The facility's Administrator provided a letter noting a corrective action plan and the IJ was removed on September 25, 2015 at 6:00 PM. Substandard Quality of Care was identified during this survey. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AC - Assist control AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure CiPAP - Continuous positive airway pressure CTA - Clear to auscultation cm - Centimeters	L 000	Responses begin on page 9.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1	L 000		

CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - deciliter
DMH - Department of Mental Health
DBP - Diastolic blood pressure
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
FiO2 - Fraction of expired oxygen
G-tube Gastrostomy tube
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - interdisciplinary team
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligram (metric system unit of mass)
mL - milliliter (metric system measure of volume)
mg/dl - milligram per deciliter
mm/Hg - millimeter of mercury
Neuro - Neurological
NP - Nurse Practitioner
OX - oximetry
PASRR - Preadmission screen and Resident Review
PEEP - Positive Expiratory End Pressure
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POS - physician ' s order sheet
Prn - As needed
Pt - Patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 2 Q- Every QIS - Quality Indicator Survey RR - Rapid Response Rp, R/P- Responsible party SBP - systolic blood pressure S/he - She/he Sol- Solution TAR - Treatment Administration Record TV - Tidal Volume	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observations, clinical record reviews and staff interviews, it was determined that the Administration, Governing Body , and Quality Assessment and Assurance (QAA) Committee failed to develop, implement, and/or revise appropriate corrective actions: to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; to ensure that resident assessments were accurate, to initiated and revised care plans as necessary; to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care; to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 3 and plan of care; to ensure the necessary services were provided to maintain good hygiene and to carry out activities of daily living; to ensure provision of necessary care and treatment to promote healing of wound(s); to ensure that the resident environment remains as free of accident hazards as is possible; ensure that a resident maintains acceptable parameters of nutritional status, such as body weight; ensure that a resident receives proper treatment and care for respiratory care; to ensure that sufficient staff was available to provide quality care and services; to post nurse staffing information on a daily basis to include all components per the regulation; to ensure that medications were properly labeled and stored; to ensure all essential resident care equipment was in safe operating condition; to ensure that the resident call system was maintained in a safe and operating condition; to ensure that the facility maintained an effective pest control program; to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete; to comply with state and local laws and regulations; and to maintain clinical records in accordance with accepted professional standards. The findings include: During the recertification survey from September 9 - 23, 2015, the following areas of concern were identified: · Failure to ensure that facility staff notified the attending physician when there was a change in	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 4 residents' conditions. Cross reference CFR 483.10, F157 · Failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cross reference CFR 483.15, F253 · Failure to ensure that resident assessments were accurate. Cross reference 483.20, F272 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care. Cross reference 483.20 (k) (3) (ii), F282 · Failure to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Cross reference 483.25, F309 · Failure to ensure the necessary services was provided to maintain good hygiene and to carry out activities of daily living. Cross reference CFR 483.25(a) (3), F312 · Failure to ensure provision of necessary care and treatment to promote healing of wound (s). Cross reference CFR 483.25(c), F314 · Failure to ensure that the resident environment remains as free of accident hazards as is possible. Cross reference CFR 483.25, F323 · Failure to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight. Cross reference 483.25 (i), F325 · Failure to ensure that a resident receives proper treatment and care for respiratory care.	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 5 Cross reference 483.25(k) , F328 · Failure to ensure that sufficient staff was available to provide quality care and services. Cross reference 483.30 (a), F353 · Failure to ensure that medications were properly labeled and stored. Cross reference 483.60 (b), (d), (e), F431 · Failure to ensure all essential resident care equipment was in safe operating condition. Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that the facility maintained an effective pest control program. Cross reference 483.70(h)(4), F469 · Failure to comply with state and local laws and regulations. Cross reference CFR 483.75, F492 · Failure to ensure that clinical records were maintained in accordance with accepted professional standards. Cross reference CFR 483.75, F514. * Failure to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete. CFR 483.20, F272 · Failure to ensure that the Quality Assurance Committee identified and developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520. On Tuesday September 22, 2015 at approximately 2:20 PM a face-to-face interview was conducted at approximately 2:28 PM with Employee ' s #2, #3, and #4. The employees made the following responses related to the	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 6 quality concerns identified during the survey: · Employee #4 stated that during the Quality and Assessment and Assurance Review Committee conference conducted on September 18, 2015 that he/she was not aware that there was a problem regarding the residents who are vent dependent. · Employee #3 stated that he/she was aware that a potential problem could arise as a result of his/her current knowledge regarding the care and treatment of ventilator dependent residents, it seem very hard to make necessary changes. As a result of the Immediate Jeopardy (IJ) a plan of correction was developed regarding physical assessment and documentation of the respiratory system and In-services were conducted by the Respiratory therapist and the Nurse Practitioner in order to increase the knowledge base of staff and safety of the residents who are ventilator dependent. · Employee #3 and #4 acknowledged that Employee #6 did not have the required skills to identify and educate the nursing personnel needed to staff ventilator dependent residents in the facility. · Employee #3 acknowledged that the duties and responsibilities of the facility staff should be outlined more clearly to define when a Rapid Response is called for a resident in the facility and by who and what documentation should be completed. · Employee #2 and #7 acknowledged that the Resident Care Area Assessment is a computer	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 7 program problem since MDS 3.0 came into effect, and that the program no longer will allow for information to populate into the area that requires the date and location of where information could be found. · Employee #3 acknowledged that at present time there is one (1) wound doctor that covers Medicare A residents and that they are in the process of exploring hiring a another physician to join the wound team. · Employee #31 acknowledged that the external alarms for ventilator residents did not have a battery or that the battery was low, and stated that the respiratory therapists that is assigned to that particular resident will check the external ventilator alarms once a shift, and that the internal ventilator alarms are checked every four (4) hours. · Employee #2 and #3 acknowledged that the facility was under renovation in some areas. · Employee #3 acknowledged that staff did not document nor assess residents prior to and after the administration of pain medication. · Employee #3 acknowledged that the facility staff were not following the facility policy regarding weights for residents with significant unplanned weight loss. And stated that the new scales might be the reason for some of the discrepancy. At this time, it was determined that the Administrator, the Director of Nursing and	L 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 001	Continued From page 8 Educator failed to provide necessary care and services and lacked supervision for residents who required ventilator services; failed to ensure that the nursing staff accurately assessed and monitored residents who received ventilator services, failed to notify the physician when the resident experienced acute changes, failed to assess and monitor residents with pain concerns; and failed to intervene on serious conditions related to the care of residents receiving ventilator services, failed to ensure that staff who worked with resident requiring special needs and ventilator received education and training to help provide quality care and services and failed to ensure that CAAs were accurately coded. It was determined that the Quality Assessment and Assurance Committee failed to recognize and identify the necessary care concerns and services needed to provide safe and competent care to residents; and developed and implement appropriate plans of action to correct identified quality deficiencies.	L 001	Response to L001 1. See immediate corrective actions for all areas of concerns cited 2. A preliminary meeting was held with department managers responsible for areas of concern to review existing systems and processes; identify breakdown in systems and processes; determine effectiveness of current protocols and, policies and procedures. 3. The Dir. Of Quality Assurance will revise the QA program to: Identify root causes for areas of concerns cited; Determine resources needed for data collection, analyses, monitoring; Develop action plans relevant to process and systems to ensure sustainability; and Facility wide education on QAPI process. 4. All quality assessment findings and status/outcomes of action plans will be reported to Executive Team and Governing Body at scheduled intervals to ensure Nursing Center is operating and maintaining substantial compliance with all Federal regulations, DCMR chapter 32, and other related professional standards.	11.10.15
L 026	3207.1 Nursing Facilties The Medical Director shall assume full responsibility for the overall supervision of the medical care provided in the facility. If the Medical Director is absent, he or she shall delegate the continuity and supervision of resident care to a qualified physician. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 55 sampled residents, it was determined that the Medical Director failed to review the total program of care as it relates to	L 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 026	Continued From page 9 weights, labs, wound status and pain for a resident that experienced a weight loss that exceeded five (5) percent in 30 days for one (1) resident and visual function for one (1) resident. Residents #64 and #122. The findings include: 1. The Medical Director failed to review the total program of care for Resident #64 to include weights, labs, wound status and pain for a resident that experienced a weight loss that exceeded five (5) percent in 30 days. A review of the medical record revealed that Resident #64 was admitted on May 4, 2015 with diagnoses to include Sacral decubitus ulcer, Urinary Retention, Hypertension, Lymphedema Bilateral Lower Extremities, and Bilateral Lower Extremity Venous Stasis, and " Chief Complaint: Nutritional Deficient with deconditioning " as documented on the History and Physical dated May 4, 2015. Resident underwent a Percutaneous Endoscopic Gastrostomy on May 8, 2015 for Dysphagia and poor oral intake. Medical record review conducted on September 16, 2015 at 10:00 AM revealed the following documented weights: May 11, 2015- 186.8 pounds; May, 2015 (date of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. Review of the Nurse ' s Notes and Physician ' s Progress Notes from June 22, 2015 through	L 026	**Response starts on page 11** **L026, Resident 64 and 112**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 026	Continued From page 10 September 1, 2015 revealed the medical staff documented notification of significant weight loss on August 20, 2015. The medical record lacked documented evidence that the medical staff was notified of the weight loss documented between May and August 20, 2015. A face-to-face interview conducted with Employee #27 at 10:38 AM on September 16, 2015 revealed that Resident #64 was admitted as "obese". According to Employee #27, after it was determined the resident was not eating, the plan was changed to adjust tube feeding because of volume intolerance and oral intake. When queried about labs, s/he stated the labs were not available and it was assumed the albumin was low because of the sacral wound and weight loss. Juven was started for 2 weeks and then changed to Beneprotein. The resident plan of care was discussed with the nurse manager at the time. S/he was unable to provide any further insight related to physician notification. Although the dietician continued to make adjustment to the tube feeding order and the physician authenticated the order as evidence by a signature. The medical record lacked documented evidence the physician reviewed Resident #64 ' s total program of care to include weights, labs, wound status and pain prior to August 20, 2015. As of August 20, 2015, the resident had loss approximately 45.2 pounds since original weight of 186.8 pounds documented on May 11, 2015. The findings were discussed, reviewed and acknowledged by Employee # 11.	L 026	Response to L026, Resident #64 1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings. 2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician. 3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and is ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable). 4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 026	Continued From page 11 2. The Medical Director failed to review the total program of care to implement measures for one (1) resident with Visual Function Deficits. Resident #122 A review of the residents Admission ' s sheet indicated that the resident was admitted to the facility on April 16, 2015. According the History and Physical dated April 17, 2015 the resident had the following diagnoses which included: "Multiple CVA ' s (Cerebral Vascular Accidents), Chronic Respiratory Failure - Off Vent [Ventilator], Asthma ..." There was evidence of visual function status assessed on the History and Physical dated April 17, 2015. A review of the residents Admissions Minimum Data Set (MDS) dated April 23, 2015 and Significant Change MDS dated July 27, 2015 revealed in Section B1000Vision that the resident was coded " 1 " for Impaired - sees large print, but not regular print in newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. An observation and interview was conducted with Resident #122 on September 21, 2015 at approximately 11:00 AM. The resident indicated that he/she wears glasses, and that the glasses were on the dresser, however I prefer different glasses. The resident also stated that he/she could see out of the right eye and not the left eye. A review of the physician ' s progress notes	L 026	Response to L026, Resident #122 1. Physician assessed resident #122 vision and appointment scheduled for follow-up and ophthalmologist care plan updated. 2. The Resident Care Coordinators (RCC) performed an MDS audit of all residents who triggered for vision impairment in the previous quarter finding no other residents affected. 3. Standardize documentation for care planning to create an integrated interdisciplinary care plan that will identify the problem, measureable goals and interventions/approaches. The DON/Administrator will in-service the Interdisciplinary Team on the care planning process. The MDS Coordinator will re-educate the department managers on the process to electronically view MDS care area triggers for all residents. 4. MDS Coordinators will perform weekly audits to ensure discussions related to trigger CAAs are reviewed and addressed by the IDT during care planning meetings. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months.	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 026	Continued From page 12 lacked evidence of any further review related to the residents visual function deficits. A face-to-face interview was conducted on September 21, 2015 with Employee #10 at approximately 11:30 AM. After review of the above he/she acknowledged the findings, and indicated that an eye appointment would be arranged. The Medical Director to review the total program of care to implement measures for one (1) resident with Visual Function Deficits.	L 026		
L 043	3208.5 Nursing Facilities The Director of Nursing shall provide for, at a minimum, the following: (a)Delivery of nursing care services in accordance with these rules; (b)Developing and maintaining nursing service objectives, standards of practice, policy and procedure manuals, and written job descriptions for each level of nursing personnel; (c)Planning for and recommendation to the Administrator the number and levels of nursing personnel to be employed; (d)Coordinating nursing personnel, which include the following: (1)Recruitment; (2)Selection; (3)Position assignment;	L 043	Refer to page 15 for response to L043	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 13 (4)Orientation; (5)In-service education; (6)Supervision; and (7)Termination (e)Developing a staffing plan that considers residents' needs for various types of nursing care; (f)Working with the medical staff and the interdisciplinary team in developing and implementing policies for resident care; (g)Working with other employees to ensure that the interdisciplinary care plan (ICP) is coordinated and maintained; and (h)Working with the Administrator and the Medical staff or Medical Director in the allocation of funds for facility programs. This Statute is not met as evidenced by: Based on record review and staff interviews, it was determined that the Director of Nursing failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent. Additionally, the facility failed to ensure that the licensed practical nurse performed duties consistent with his/her scope of practice; and to ensure a comprehensive assessment was performed by a registered nurse as evidenced by the licensed practical nurse ' s documentation of an assessment when a change of condition was observed.	L 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 14 The findings include: A. Facility staff failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent. During the survey period interviews conducted with licensed nursing staff assigned to provide ventilator services to residents revealed a lack of knowledge in the mechanics of ventilation, ventilator function and its correlation to the resident ' s respiratory status. An example to reflect this determination is delineated in the deficient practice statement for Resident #98 documented below. A review of personnel records of licensed nursing staff assigned to provide ventilator services lacked evidence that the staff were adequately trained and/or had documented demonstration of competency in vent management and airway maintenance. On September 22, 2015 at approximately 1:00 PM, a review of 20 personnel records of staff, confirmed by Employee #10, who have taken care of residents requiring ventilator services lacked evidence that they were trained and/or had documented demonstration of competency in ventilator management. The following list of employee personnel records was reviewed: Registered Nurses Employee #9 Employee #35 Employee #10	L 043	**Response to L043** 1. 2. Immediately upon notification of this deficiency a review of the competencies confirmed findings, however no adverse event occurred to resident #98. On 9/22-9/26, 10/7, all Registered and Licensed Practical Nurses assigned to the 6th floor ventilator unit by Respiratory Department were in-serviced on ventilator mechanics, to include ventilator settings function and their correlation to respiratory function was performed for all. The scope of practice for RN and LPNs were reviewed with nursing staff, as well as the implications for daily practice. 3. A review of the retrospective review of the medical records for all residents on vent weaning protocol was performed by the Resident Care Coordinator. Results of the audit found all residents were in compliance. Continual skills and competency assessment related to vent management and airway maintenance, as well as the mechanics of the ventilator has been included in the annual requirements for all nursing staff and new hires. Residents on weaning protocol will be entered on 24-hour report to ensure communication of residents' status and order changes. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. The Nursing Ventilator Flowsheet was revised and nursing instructed on the new format. 4. The RCCs will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed. Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months.	**11.10.15 & ongoing**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 15 Employee #36 Employee #13 Employee #37 Employee #17 Employee #38 Employee #18 Employee #39 Employee #32 Employee #40 Employee #33 Employee #41 Employee #34 Licensed Practical Nurses Employee #24 Employee #44 Employee #42 Employee #45 Employee #43 On September 22, 2015 at approximately 9:30 AM a face-to-face interview was conducted with Employee #6 [staff development personnel], regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " I have no knowledge of ventilators and I made administration aware of that when I took the job. I know the staff spends one day with a Respiratory Therapist. " On September 22, 2015 at approximately 10:00 AM a face-to-face interview was conducted with Employee #9, regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " The nursing staff " shadow " a Respiratory Therapist for one (1) day. I do not have a checklist or competencies for their training. That is the responsibility of the nursing department. "	L 043	**Refer to page 15 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 16 Example of licensed nurse interviews cross referenced from 483.25 F328: Facility staff failed to ensure that licensed nursing staff assigned to provide ventilator services for Resident #98 were qualified. On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015 to the facility with a diagnosis that included Respiratory Failure. The resident was ventilator dependent. Further review of the physician ' s orders signed and dated August 26, 2015 revealed an order dated July 8, 2015 for the following ventilator settings: AC [ventilator mode], Rate 10, VT [tidal volume] 500, FIO2 [fraction of inspired oxygen] 30%, PEEP [Positive End Expiratory Pressure] 5. A subsequent order dated August 13, 2015 directed the following, " Initiate ventilator weaning protocol. " On September 21, 2015 at approximately 9:42 AM a review of the ' Ventilator Flow Sheet ' completed by Respiratory Therapy revealed that ventilator weaning was in progress, but when the resident was not weaning, the ventilator settings were as follows from September 1, 2015 to September 21, 2015: AC/ Rate 12, VT500 FI02 40% PEEP 5. An observation of the ventilator settings made on September 21, 2015 at approximately 9:40 AM confirmed that the resident was on the settings that were documented on the Respiratory Therapy ventilator flow sheets.	L 043	**Refer to page 15 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 17 Review of the Nursing Respiratory Flow sheet revealed different ventilator settings: AC, Rate 10, VT 500, FI02 30%, and PEEP 5 for the month of September, 2015. On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, who was assigned to care for the resident. Employee #16 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #16 stated the set rate was 12 and could not explain her documentation of a rate of 10 or other requested information. On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #22, who was assigned to care for residents requiring ventilator services. Employee #22 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #22 explained the set rate of 12; however, could not further explain the requested information. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with Employee #10, regarding the aforementioned findings. He/she acknowledged the findings, stating that the Respiratory Therapy staff would hold an in-service.	L 043	**Refer to page 15 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 18 On September 22, 2015 at approximately 2:00 PM, a face-to-face was conducted with Employees #2 and 3, regarding the aforementioned findings. Both Employees acknowledged the findings. Facility staff failed to ensure the staff was qualified to provide care for residents requiring ventilator services. B. Facility failed to ensure that the licensed practice nurse performed duties in accordance with his/her scope of practice as evidenced by a failure to notify the registered nurse when Resident #132 sustained a change in condition that warranted a comprehensive nursing assessment. According to District of Columbia Municipal Regulations for Practical Nursing 5514.3 " The practice of practical nursing shall include the following: (a) Participating in the performance of the ongoing comprehensive nursing assessment process of the client ' s biological, physiological, and behavioral health, including the client ' s reaction to an illness, injury, and treatment regimens by collecting data and performing focused nursing assessments; (b) Recording and reporting the findings and results of the ongoing nursing assessment process ... " Resident #132 was admitted on May 20, 2015 with diagnoses to include Anoxic Brain Injury, Coronary Artery Disease Status post Acute Myocardial Infarction (AMI), Diabetes Mellitus, Sacral Decubitus Ulcer, and Sepsis; and subsequently expired on July 17, 2015 with cause of death documented as Atherosclerotic Cardiovascular Disease and Diabetes Mellitus.	L 043	Response to L043, #B, Resident #132 1. Immediately upon notification of this deficiency, a review of the events to verify findings. 2. A retrospective review of all Rapid Response and Code Blue events in the previous 30 days were review and found no other events similar to this deficiency. 3. All nursing RN managers and supervisors were reeducated on the scope of practice for Licensed Practical Nurses. The nursing staff was in-serviced on the Rapid Response policy and algorithm, highlighting the role of members during a Rapid Response event and new documentation forms. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed. Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months..	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 19 Medical record review revealed Admission Minimum Data Set Assessment dated May 28, 2015 documented Resident #132 ' s Cognition Pattern under section C0100- "No Resident is rarely/never understood". According to the Physician ' s Order Form for June, 2015, Resident #132 was a Full Code with original dated May 20, 2015 as " Yes-CPR [Cardiopulmonary Resuscitation) " . According to the medical record, on June 17, 2015 at approximately 5:15 AM Resident #132 was found unresponsive by the nursing staff, a licensed practical nurse. According to the nurse ' s note documented at 7:35 AM, the licensed practical nurse went to hang tube feeding and found resident unresponsive as a result " the supervisor was notified right away, CPR initiated, in-house doctor notified and he was at the scene, 911 call and they arrived on time along with the police officers. The documentation also revealed Resident #132 had vital signs during CPR as follows: blood pressure 73/49 millimeter of Mercury, and [heart rate]- 144 and 66/42 millimeters of Mercury and [heart rate] 133, no respirations observed. There was no time documented to indicate the specifics of when the vital were obtained. The medical record any further physical assessment by the nursing staff after the resident was found unresponsive. The nursing supervisor documented arriving to the 6th floor at 5:15 AM " due resident being unresponsive. " Upon arrival to the unit, The nursing supervisor met CPR in progress by nursing staff. A call was placed to the " 911 crew " at 5:20 AM and the House officer was also called to the unit for further evaluation. The Emergency Medical Services team arrived at 5:30 AM and took over CPR. Resident #132 was not transported by Emergency Medical Services due	L 043	**Refer to page 19 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 20 to " asystole (indicates the heart has stopped beat and there is no electrical activity in the heart) status " . On June 17, 2015 at 6:30 AM the respiratory therapy staff documented an SBAR (Situation, Background, Assessment, and Response) note which stated a " Rapid Response " (emergency plan to initiate additional resources for a change in condition) was called at 5:15 AM for " trach [tracheostomy] pt. (patient) " that was found unresponsive by nurse with no pulse and CPR was " activated " and patient was subsequently " pronounced dead " at 5:35 AM. On June 17, 2015 at 5:40 PM, the Employee #23 documented the details of the incident at follows: " Code blue was called after patient was found unresponsive and pulseless. The patient has tracheostomy, chest compressions, was started and Ambu (manual resuscitator device used to provide ventilation to patient who are not breathing adequately) bagged the patient. The patient did not gain pulse the pulse, the pupils were fixed dilated. The 911 was called. Tried to secure the IV (intravenous) line; however, Rigor Mortis (is a sign of death when the muscles become stiff after death usually occurring two (2) to six (6) hours following death); the compression stopped. " The patient was noted to be asystole once AED (Automatic External Defibrillator device that diagnoses life-threatening cardiac arrhythmias) pads were placed. A face to face conversation was held with the Employees #2 and 3 relative to the findings on September 17, 2015 at approximately 2:20 PM regarding the findings relative to incident preceding the death of Resident #132. Consequently, the administrator arranged for the	L 043	**Refer to page 19 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 21 Employee #23 to speak with the surveyor on September 18, 2015. September 18, 2015 at approximately 8:45 AM a face to face interview was conducted with Employee #23. The physician was queried about the events on June 17, 2015 for Resident #132. According to Employee #23, Cardiopulmonary resuscitation (CPR) was in progress when s/he arrived on the unit. The nursing staff was actively doing chest compressions and bagging resident via tracheostomy. According to the Employee #23, the resident was unresponsive and pulseless. After about 20 minutes of resuscitation efforts, 911 Emergency Medical Services arrived on the scene and took over. Shortly after their initiation of CPR, the EMS staff informed the physician that "Rigor Mortis" had set in and the effort for resuscitation should be suspended and the CPR stopped. When queried about the Automatic External Defibrillator and rapid response responsibilities, S/he stated the medical team is unable to provide medication interventions secondary medications are not provided in the SNF (Skilled Nursing Facility). When necessary, the Rapid Response team with initiate intravenous line and establish airway, ambu bag, and chest compression. The resident had an established airway via tracheostomy at the time of the incident. The intravenous line was not established as a result of "EMS reported rigor mortis". The physician did not perform a physical assessment. He was unable to recall if an AED was brought to scene or utilized to determine electrical cardiac activity. September 18, 2015 at approximately 10:05 AM, a face to face interview was conducted with	L 043	**Refer to page 19 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 043	Continued From page 22 Employee # 24. S/he stated that on the night in question the resident exhibited no signs of distress to indicate a change in condition. At 5:15 AM when returning to Resident #132 ' s room, s/he observed the resident to be unresponsive. At that time a Rapid Response was called. According to the licensed practical nurse, the team that arrives from the hospital for the Rapid Response took over care. S/he was unable to state whom if anyone performed a comprehensive assessment of Resident #132. However, s/he stated that an automated blood pressure machine was utilized to take vital signs during CPR. When queried about why CPR would have continued if the resident in fact had a blood pressure and pulse the licensed practical nurse was unable to provide further insight. When queried about the last time s/he saw the resident alive, s/he state " I had just been in there to do [his/her] fingerstick and the aide gave [him/her] a bath " . In addition, when queried about the Rigor Mortis and inability to secure an intravenous access s/he could not recall. The medical record lacked documented evidence that facility staff performed a comprehensive assessment relative to the documented change in condition. The facility failed to ensure that a comprehensive assessment was performed by a registered nurse when a change in condition was identified by the licensed practical nurse.	L 043	**Refer to page 19 for response**	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 23 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: A. Based on record review and staff interview for four (4) of 55 sampled residents it was determined that the charge nurse failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) resident experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #64 and #6, #5. The findings include: The facility ' s policy entitled, " Ventilator Weaning Protocol, " dated revised: June 17, 2015, stipulated; " 1. Purpose: To provide	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 24 protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician ' s written order of " Wean per protocol. " Page 8 ... In the event of acute exacerbation of the patient ' s pulmonary condition during vent management or weaning the therapist will immediately notify the pulmonary physician and take appropriate steps to treat the symptoms. " 1.The charge nurse failed to notify the physician when Resident #145 as ventilator dependent resident demonstrated a compromise in respiratory function. Resident #145 was admitted on August 25, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. Res #145 complained of shortness of breath (SOB), refused C-PAP treatments secondary to SOB and exhibited signs of a change in mental status. The clinical record lacked evidence that nursing staff identified, acted on, comprehensively assessed and intensively monitored the resident when he/she demonstrated a change in status as evidenced by the following: Resident #145 complained of SOB and refused C-PAP treatments as follows:	L 051	Response to L051, #1, Resident #145, #5 1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders and enhance accountability. 2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross-referencing the medical record to ensure the physician was notified of any change in the resident's condition. The audit results found all medical records in compliance. Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician. 3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and is ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) The Respiratory staff were re-educated on 9/25/2015 related to the timeliness of completing physician orders, notification to physician, and the use of the communication binder..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 25 Ø August 29, 2015- 7PM-7AM- Shift Report ---- " Patient refused CPAP trails last night ...back on AC (assist control) due to patient complaining of SOB (shortness of breath) Ø August 30, 2015 - 7AM-7PM- S- Shift Report Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Resident #145 demonstrated change in mental status as follows: Ø Psychiatric consultation August 31, 2015 (hour not indicated) " ...unable to assess [secondary to] pt [patient] not responding ... responding to painful stimuli but not easily arousable ...Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain medications ... " Ø Respiratory therapy entry [shift report] dated August 31, 2015 7AM-7PM read: " ...patient remains on A/C mode, no active weaning due to patient being less arousable in PM. " There was no evidence that nursing staff conducted comprehensive assessments when Resident #145 exhibited a change in the level of arousal, complained of shortness of breath and refused treatments. The record revealed that nursing staff communicated to the mental health practitioner [psychiatric consult] that the resident was not responsive due to " pain medication. " However, a review of the Medication Administration Record [MAR] revealed Tylenol 500mg 2 caplets were administered during the 7AM - 3PM shift on August 31, 2015. A review of	L 051	**Response to L051, #1, Resident #145, #5 (cont'd)** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4.The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 26 previous administrations of Tylenol lacked evidence that the resident sustained an alteration in mental status [lack of arousal]. An in-depth review of the clinical record is as follows: A review of Physician ' s Orders dated August 25, 2015 included, but was not limited to the following: Ventilator (Ventilator Settings: AC (Assist/Control, Rate- 15, TV (Tidal Volume)- 500, PEEP (Positive End Expiratory Pressure), FIO2 - 45% (Fraction of Inspired Oxygen) Duoneb (bronchodilators) 2.5mg/3ml (millimeter)- 1 vial neb (nebulization treatment) [every] 6 hours PRN (as needed) for bronchospasms, Note: The Duo Neb order was modified on August 25, 2015 for administration " every 4 hours " [instead of every 6 hours as needed] Tylenol 500mg 2 caplets via peg 30 minutes prior to wound care for pain Seroquel (antidepressant) 25 mg (milligram) - 1 tablet via GT (Gastrostomy tube) BID (twice a day) for depression; Prozac 20 mg 1 capsule daily for Depression Midodrine (Vasopressor/Antihypotensive medication) 10mg via GT (Gastrostomy Tube) TID (three times a day) for hypotension. Hold for SBP (Systolic blood pressure) > (greater) 120, DBP (diastolic blood pressure) > 80.... Pulmonary Consult and Psychiatry consult	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 27 An Interim physician ' s order dated August 31, 2015 read: August 31, 2015- 2059 (8:59PM) - Please transfer patient to nearest ER via 911 re: Acute AMS (Altered Mental Status), tachycardia and hypotension. " Physician ' s Notes: " August 25, 2015- 3:17 PM- Pulmonary Consult: ... Awake, alert, appears anxious. Vitals: Chest-crackles [positive] bilaterally, vent settings: VT-500, AC-15, P [Peep] - 5, FIO2-45%, Impression: Chronic Respiratory Failure. PT (Patient) on vent-tolerates CPAP (Continuous Positive Airway Pressure) trials intermittently. Continue trials as tolerated. [He/she] remains very anxious ... Titrate O2 (oxygen) to sats (saturations) > (greater than or equal to) 92%. August 25, 2015- 1545 (3:45PM) - Attending/Admission Note: cc: (chief complaint) - Chronic Respiratory Failure .... Assessment/Plan: - Chronic Respiratory Failure- continue on vent at current settings, continue vent weaning trials, Pulmonary input appreciated ... Depression- Continue Prozac (Anti-depressant). August 28, 2015 - 1520 (3:20 PM) - Attending Note; cc: chronic respiratory failure. Voiced [no] complaints this afternoon. [Vital Signs Stable]- T-98, Pulse-74, Respirations-18, B/P (Blood Pressure) - 132/82. Assessment/Plan: Chronic Respiratory Failure- Continue on vent, wean as possible, suction PRN (as needed), Depression- Continue on Prozac. August 31, 2015- 2103 (9:03 PM) - Hospitalist	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 28 Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded [and] unresponsive with agonal breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension-unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " Psychiatric Diagnostic Consultation: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... " Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient not arousable and does not answer questions at this time. Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess mood/and anxiety. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]:	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 29 [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... " August 29, 2015 3:00 AM - " ...[b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [no respirations documented, two (2) different heart rates]... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: 8/31/15, Time: 9:39 PM ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " A review of the facility ' s Ventilator Policy/Protocol The facility ' s Ventilator Management and Nursing Care Respiratory Protocol [no date indicated] stipulates: " Modes of Ventilation- Assist-Control Ventilation (A/C): A/C delivers the preset volume or pressure in response to the patient ' s own inspiratory effort, but will initiate the breath if the patient does not do within the set amount of time. This means that any inspiratory attempt by the patient triggers a ventilator breath. The patient may need to be sedated to limit the	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 30 number of spontaneous breaths since hyperventilation can occur. This mode is used for patients who can initiate a breath but who have weakened respiratory muscles. " Respiratory Notes/Ventilator Flow Sheets [documented in S-BAR format]: " August 29, 2015- 7PM-7AM- Shift Report- S- Patient refused CPAP trails last night, B- Respiratory Failure, Status Post Trach. Obese. A: Sat = 99%, [Heart Rate -79, Respiratory Rate-24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Stable and alert. R- Continue to encourage patient to get weaned. Ventilator Flow Sheet- Special Procedures Done [and] Time Performed: CPAP 5/10 x10[minutes], back on AC due to patient complaining of SOB (shortness of breath) August 29, 2015- 7A-7PM- S- Shift Report, B-Respiratory Failure, A- Received on AC mode, neb tx (treatment) given as ordered. [Patient tolerated Duoneb, Pulse ox- 98%, HR-72, R- Will continue to monitor patient and wean as tolerated. August 30, 2015 - 7PM- 7AM - Shift Report- - S- [Patient] is on AC 15, 500, 45%, +5, B-Respiratory Failure, A- [Patient] is on AC. Stable O2 Sat 98%, HR-78%, RR-20. No sign of distress, R- We will continue monitoring [patient] and [symptoms] as needed. There was no evidence that Duoneb treatments (prescribed every 4 hours) were administered between 4:48 PM (last noted dose administered during the 7AM-7PM shift) and 11:59 PM on August 30th. The record revealed that the next dose was given at 12 Midnight on 8/31/15 [nearly 7 hours after the preceding dosage].	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 31 August 30, 2015 - 7AM-7PM- S- Shift Report, B-Respiratory Failure, A- Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient] ... (Illegible writing). [Pulse Ox-99%, HR (illegible writing), R- Will continue to monitor patient. Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Physician Order: Albuterol 2.5mg and Atrovent .5mg - q 4 (every 4 hours). Treatments were documented as being administered at 0020 (12:20 AM), 0410 (4:10 AM), 0800 (8:50 AM), 1310 (1:10 PM), and 16:48 (4:48PM). " The next Duoneb treatment was recorded as being administered on 8/31/15 (12MN), approximately 7 hours later. August 31, 2015- 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of " being unable to breathe " but in no apparent distress. Continue to monitor for changes. August 31, 2015- 7AM-7PM- S- Pt remains on AC mode. [No] active weaning [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) cleared, R- Will continue to monitor. Ventilator Flow Sheet revealed the following " Rate Set/Total " on the A/C mode: 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation- 97%, Heart Rate- 87 0425 (4:30 AM) - 15/33 - [Oxygen] Saturation-	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 32 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation and Heart Rate documented in the allotted space. 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " [defined: 15/34 - " 15 " reflects ventilator preset respiratory rate and " 34 " reflects - resident breaths] A review of the nebulization treatment administration record for August 30th revealed the 6th dosage [prescribed every 4 hours] of Duoneb [scheduled for administration at approximately 8:45 PM on August 30th] was omitted without explanation. However, the respiratory therapy " shift notes " [7AM-7PM] notes reveal the resident complained of shortness of breath. The clinical record lacked evidence that the physician was notified regarding the resident ' s complaint of having shortness of breath, refusing CPAP trials and the missed Duoneb treatment from August 29, 2015 at (7PM-7AM) to August 31, 2015 (7AM-7PM). Interviews: A face-to-face interview was conducted with Employee #14 (on-coming team member) September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she stated that the off-going team member, who stated that the resident was calling all night and that [he/she]. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night; and the	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 33 resident had the call bell you blow into. Employee #14 acknowledged the physician should have been informed of the resident ' s missed duoneb treatment, restlessness and the complaint of having shortness of breath and refusing to use the CPAP on August 29, 2015. A follow-up interview was conducted with Employee#14 on September 18, 2015 at approximately 3:00 PM regarding the missed Duoneb treatment on August 30, 2015. He/she stated there was only one (1) respiratory therapist on 8/30/15 (7PM-7AM) shift. There were 12 residents on ventilators, 15 residents who had tracheostomies, four (4) residents requiring BIPAP (Bi-level Positive Airway Pressure), 2 (two) residents requiring Hi-Flow, 55 [nebulization] treatments and four (4) residents weaning from ventilators. A review of the respiratory therapist assignment sheet dated August 30, 2015 revealed one respiratory therapist on for the 7PM-7AM shift. Also, the Respiratory Therapist was assigned a Registered Nurse orientee (for orientation to ventilator). The clinical record lacked evidence that facility staff consistently assessed and monitored Resident #145 when the resident ' s mental status changed, complained of having shortness of breath, and difficulty breathing. Nursing assessments failed to depict the resident being anxious, restless and having difficulty breathing. The physician was not notified when the resident complained of shortness of breath, which was first documented on August 29, 2015. The	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 34 resident ' s condition declined as evidenced by a change in mental status, heart rate elevated to 150 ' s and blood pressure as low as 77/53 as depicted in the hospitalist note on the evening of August 31, 2015. The resident was subsequently transferred to the nearest ER via 911 and hospitalized. The clinical record was reviewed on September 18, 2015. A review of records obtained from the acute care facility that the resident was transferred to revealed the resident was admitted and a physician ' s entry on 8/31/15 included: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Systolic B/P- 87, diastolic B/P (Blood Pressure)-48; [Oxygen] Saturation -100; FIO2 [Fraction of Inspired Oxygen] Ventilator- 100 [percent]. 2. The charge nurse failed to notify the attending physician in regards to a weight loss that exceeded five (5) percent in 30 days. Resident #64. According to the facility's policy; "Weight Assessment and Intervention" stipulates:, " Weight Assessment 1. The nursing staff will resident weights on admission, the next day, and weekly for one week thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter ...3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for	L 051	**Response to L051, #1, Resident #64, #6** 1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings. 2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician. 3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) 4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 35 confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing ...Analysis 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions ...2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight... " Resident #64 was admitted on May 4, 2015 with diagnoses to include Sacral decubitus ulcer, Urinary Retention, Hypertension, Lymphedema Bilateral Lower Extremities, and Bilateral Lower Extremity Venous Stasis, and " Chief Complaint: Nutritional Deficient with deconditioning " as documented on the History and Physical dated May 4, 2015. Resident underwent a Percutaneous Endoscopic Gastrostomy on May 8, 2015 for Dysphagia and poor oral intake. Medical record review conducted on September 16, 2015 at 10:00 AM revealed the following documented weights: May 11, 2015- 186.8 pounds; May, 2015 (date of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. Review of the Nurse ' s Notes and Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented notification of significant weight loss on August 20, 2015. The medical record lacked documented evidence that the medical staff was notified of the weight loss documented between May and August 20, 2015.	L 051	**Refer to page 35 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 36 A face-to-face interview conducted with Employee #27 at 10:38 AM on September 16, 2015 revealed that Resident #64 was admitted as "obese". According to Employee #27, after it was determined the resident was not eating; the plan was changed to adjust the tube feeding because of volume intolerance and oral intake. When queried about labs, he/she stated the labs were not available and it was assumed the albumin was low because of the sacral wound and weight loss. Juven was started for 2 weeks and then changed to Beneprotein. The resident plan of care was discussed with the nurse manager at the time. S/he was unable to provide any further insight related to physician notification. Although the dietician continued to make adjustment to the tube feeding order and the physician authenticated the order as evidence by a signature. The medical record lacked documented the physician was notified of the weight loss until August 20, 2015 when at the time the resident had loss approximately 45.2 pounds since original weight of 186.8 pounds on May 11, 2015. The findings were discussed, reviewed and acknowledged by Employee # 11. The clinical record was reviewed on September 16, 2015. 3. The charge nurse failed to notify the attending physician in regards to a weight loss as evidence by more than a 25% [percent] weight loss in 30 days for Resident #6.	L 051	**Refer to page 35 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 37 A review of the residents History and Physical conducted on February 13, 2015 revealed the resident has the following active diagnoses which included: Senile Dementia, Arthritis, Elephantiasis Varicosa legs, Cataract. A review of the resident's " Monthly Weights" sheet revealed the following: January 2015 - 112 pounds February 2015 -116 pounds March 2015 - 116 pounds April 2015 - 88 pounds ?? - the two (2) hand written question marks [??] were written in the corresponding space for " re-weight. " May 2015 - 88 pounds June 2015 - 89.4 pounds July 2015 - 91.2 pounds August 2015- 90.8 pounds A review of the clinical record (nursing, dietitian, physician notes and consults) lacked documented evidence that when the resident sustained a 28 pound weight loss for March 2015 to April 2015 neither the dietitian nor the physician were notified of the weight loss. In addition, there was no evidence in the clinical record that the facility staff obtained a reweight or weekly weights for confirmation or that the dietitian was notified of the weight change in April when first identified. Quarterly Nutrition Notes: A Quarterly Nutrition Review conducted dated May 19, 2015 revealed, "Swallowing /chewing difficulty; (etiology) dysphagia and missing teeth; (signs/symptoms) SLP [Speech Language	L 051	**Refer to page 35 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 38 Pathology] ordered ... mechanical soft diet; Boost Plus [nutritional supplement] BID [twice-a-day], needs assistance with eating, no teeth/dysphagia, [%] percent of meal intake (average) is 75% per RN [Registered Nurse], % Supplement ...50% per RN. Current weight 89 pounds/40.4 kg [kilograms] ... " A further review of the clinical record revealed more than 30 days had lapsed before the Quarterly Nutrition Review was conducted in May 2015. In addition, there was no evidence in the clinical record that a SLP consult was ordered. Quarterly Nutrition Review dated August 11, 2015 revealed, " Remeron [used to stimulate appetite] was added to the medications ... " which was more than 60 days since the resident ' s weight was identified at 88 pounds. Physician Notes: A review of a Physician ' s Progress Note " Attending " dated 3/20/15 [March 20, 2015] 7:45 PM revealed " pt. seen, s [none]; " O " [observation] small built, [no] distress, wt [weight] 112 pounds; A/P [Assessment/Plan] Senile Dementia, Elephentiasis, Cataract, P: Supp [supportive care] A review of a Physician ' s Progress Notes " Attending " dated 5/29/15, 7:50 PM revealed " pt. seen, reviewed labs and meds. " S " [none] " O " observation: [unclear writing] alert, disoriented, built small and frail, wt 88 pounds, A/P severe Dementia ...Plan: ADL [Activities of	L 051	**Refer to page 35 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 39 Daily Living], pt. will lose wt 20, Dementia (expected), pt. should be DNR [do Not Resuscitate], do Not Send to Hospital. " There was no evidence that the charge nurse notified the physician of the 28 pound weight loss between March and April when it was first identified. A review of the NP [Nurse Practitioner] noted dated 6/17/15 [June 17, 2015] 2:40 PM revealed " asked to evaluate resident secondary progressive weight loss. She has severe dementia with increased risk for dysphagia and weight loss ...Resident has poor appetite and eats only some foods offered to [him/her.] Resident is alert, verbally responsive, but oriented to person only ...P:start Remeron 7.5 mg [milligrams] po [by mouth] QHS [at bed time] for appetite stimulant ... " There was no evidence that the charge nurse notified of the Nurse Practitioner of the 28 pound weight loss when it first identified in April 2015 which was indicative of a 25% or more weight loss. Interviews: A face-to-face interview was conducted with Employees' #26 and #27 on September 17, 2015 at approximately 9:50 AM regarding how is the dietician notified of weight changes. Employee #26 stated that after nursing takes the weight we [dietary] review the weights and then we will request a reweight. Employee #26 acknowledged	L 051	**Refer to page 35 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 40 that a reweight should have been conducted and the resident should have been placed on weekly weights. Employee #26 also acknowledged that the facility obtained new scales in April 2015 and the weights were stable since April on and the resident ' s condition nor behavior changed. A face-to-face interview was conducted on September 17, 2015 at approximately 9:00 AM with Employee #3. He/she stated that after review of the aforementioned, he/she believed the change was due to the new scales (weighing equipment). In summary, Resident #6 sustained a 28 pound weight loss from March 2015 to April 2015. There was no evidence that the physician was notified of the weight change. The record was reviewed on September 17, 2015. 4. the charge nurse failed to notify the physician in regards to Resident #5 who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. A review of Resident #5 ' s quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. According to physician ' s orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 41 (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia with HR [140], SBP [systolic blood pressure 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O aspiration/sepsis. Will send to ER [Emergency Room] v [by] 911. "	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 42 A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. IS Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. Vs T 98.6, P 87, R 20, BP 130/77 Pulse OX 98%. Turned and repositioned, due meds give. " June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator] dependent for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3.	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 43 June 2, 2015- 8:35 AM- SBAR [Situation, Background, Assessment, Recommendation]/Acute change in condition. Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. " Respiratory Therapy Notes: A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following: "Date: June 2, 2015 Time: 0025 [12:25 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70 Date: June 2, 2015 Time: 0345 [3:45 AM] Mode: AC Fi02: 40% PEEP 5 Saturation: 98% Heart Rate: 121 Date: June 2, 2015 Time: 08:20 [8:20 AM]	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 44 Mode: AC Fi02: 40% PEEP: 5 Saturation: 99% Heart Rate: 129 There was no documented evidence that the charge nurse notified the physician in regards to Resident #5 ' s increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours. A review of the respiratory therapy shift note revealed : June 2, 2015 - 7pm-7am shift note revealed: S: Pt on A/C mode B: Respiratory resident A: Sat 98% HR 71, RR 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress. R: monitor June 2, 2015 -7AM- 7PM Shift- no documentation under shift report; indicated on flow sheet- " PT [Patient] transferred to area Hospital. " The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased. The physician was not notified when the resident ' s became tachycardia (increased heart rate), which was first documented on June 2, 2015 at 3:45 AM to be 121. The resident ' s condition declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response was called and resident	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 45 was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the resident's heart rate was 140. A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 state that his/her shift is 7:00AM to 7:00PM. Employee #18 also state, when he/she first saw the resident with the heart rate 129 is when the rapid response [When a resident's condition changes (based on predetermined criteria) and requires an assessment by a physician to stablilize his/her condition and prevent further deterioration] was called at approximately 8:20AM, the resident vomited when he/she was bagged. Employee #47 stated when he/she was conducting rounds from the rooms assigned he/she was called to the rapid response by Employee #18 who stated that the rapid response took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. There was no evidence that the charge nurse notified the physician in regards to Resident #5 who was ventilator dependent and first experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. The clinical record was reviewed on September 21, 2015.	L 051	**Refer to page 25 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 46 B. Based on observation, record review, resident and staff interview for three (3) of 55 sampled residents, it was determined that the charge nurse failed to initiate a care plan with goals and approaches for visual function for two (2)) residents and one (1) resident with pressure ulcers. Residents' #21, #64 and #122 The findings include: 1. The charge nurse failed to initiate a care plan with goals and approaches to address visual function for Resident #21. A history and physical dated January 30, 2015 revealed Resident #21 diagnoses included Hypertension, [Status Post] Left Total Hip Replacement and Dementia. A review of the residents annual Minimum Data Set (MDS) with a Assessment Reference Date of September 1, 2015 revealed in Section B1000 (Vision) the resident was coded " 1 " for Impaired - sees large print, but not regular print in newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. Further review of the annual MDS identified that Visual Function care area triggered and Care planning decision was checked indicating that the care area would be addressed in the care plan. A review of the comprehensive care plans updated August 15, 2015 lacked evidence of problem identification, goals and approaches to manage the resident ' s visual function.	L 051	**Response to L051,** **Response to #1- #3** **Resident #21, 64, 122** 1. An individualized care plan, to include care interventions and goals, for visual function was implemented for resident #21 immediately upon notification of this deficiency. Physician assessed resident #122 vision and appointment scheduled for follow-up and ophthalmologist care plan updated. A comprehensive pressure ulcer care plan, to include care interventions and goals, was developed and implemented for resident #64. 2. The Resident Care Coordinators (RCC) performed an audit of all residents who triggered for impaired vision and pressure ulcers in the previous quarter. Findings were reviewed and corrected as needed. 3. Standardize documentation for care planning to create an integrated interdisciplinary care plan that will identify the problem, measureable goals and interventions/approaches. The DON/Administrator will in-service the Interdisciplinary Team on the care planning process. The MDS Coordinator will re-educate the department managers on the process to electronically view MDS care area triggers for all residents. 4. MDS Coordinators will perform weekly audits to ensure discussions related to trigger CAAs are reviewed and addressed by the IDT during care planning meetings. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 47 The charge nurse failed to initiate a care plan with goals and approaches for Resident #21 for visual function. A face-to-face interview was conducted with Employee #12 on September 14, 2015 at approximately 3:00 PM regarding the aforementioned findings. He/she acknowledged the findings. The clinical record was reviewed on September 14, 2015. 2. The charge nurse failed to develop an individualized care plan with goals and approaches for Resident #64's pressure ulcers. Resident #64 was admitted on May 4, 2015 with diagnoses which included Surgical Wound, Sacral Wound, and Nutritional Deficit with Deconditioning. Medical record review revealed physician orders on the September 2015 Physician Order Form for the following sacral wound treatments: Calmoseptine " apply to affected area sacral/ perineal area after each incontinence care with original order date May 5, 2015; and " Sacrum Wound: Cleanse with Normal Saline, pat dry, then soak Kerlix with Dankin ' s Solution [Half Strength] every shift " with original order date May 8, 2015. The medical record contains no further order changes relative to the treatment of sacral wound. Review of the care plan dated May 6, 2015 through September 6, 2015 listed Pressure Ulcer: Sacral Stage IV with potential for delay healing due to multiple contributors as a problem. An	L 051	**Refer to page 47 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 48 entry dated May 6, 2015 stated the goal as: " Ulcer will be healed without complication; Ulcer will be clean and free of odor " . Nursing interventions to this problem include " Wound status: size of wound: measurements of depth and width, skin color, surrounding skin tissue assessment weekly, complaints of pain, effectiveness of pain medication per MD order; Apply medicated ointment per MD order; Apply dressing per MD order (space for order specific is blank); keep Dietary informed of wound status: Freq: PRN; Notify physician of wound status of change in or deterioration in status of wound; and Air mattress to promote wound healing " . The sections for Dietary, Social Services, and Activities intervention were blank with no interventions indicated. Nurse ' s notes and Nutrition Risk Assessment dated May 5, 2015 documented the presence of a 16 X 18 X 3 centimeter Stage 4 pressure ulcer on sacrum. The presence ulcer was documented as present on admission May 4, 2015. The most recent wound assessment was documented as 15 X 16 X 3.5 centimeters on August 31, 2015 with the " narrative: 08/31/15 unable to assess Resident. {She} said she is sick, pain though pain med has been given & N/V (and nausea and vomiting). Nurse aware " . The care plan did not include information on individualized interventions, or changes to plan of care to promote healing of pressure, and/or measurable goals for present on admission pressure ulcer to sacrum. The charge nurse failed to develop a care plan with measureable goals and/or interventions to promote healing for Resident #64.	L 051	**Refer to page 47 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 49 A face-to-face interview with Employee #11 was conducted on September 16, 2015 at approximately 10:14 AM. S/he stated that family is very involved in the care and new orders were obtained the day prior to transfer to the hospital. He/she was unable to provide any further insight into omission to develop a care plan with measureable goals and interventions related to the pressure ulcer. The clinical record was reviewed on September 16, 2015 3. The charge nurse failed to initiate a care plan with goals and approaches for Resident #122's visual function. A review of the residents Admission ' s sheet indicated that the resident was admitted to the facility on April 16, 2015. According the History and Physical the resident has the following diagnoses which included: "Multiple CVA ' s (Cerebral Vascular Accidents), Chronic Respiratory Failure - Off Vent [Ventilator], Asthma ..." A review of the residents Admissions Minimum Data Set (MDS) dated April 23, 2015 and Significant Change MDS dated July 27, 2015 revealed in Section B1000 Vision the resident was coded " 1 " for Impaired - sees large print, but not regular print in newspapers/books; Section B1200 Corrective Lenses (contact, glasses, or magnifying glass) used in completing B1000, vision was coded " 0 " No. An observation and interview was conducted with Resident #122 on September 21, 2015 at approximately 11:00 AM. The resident indicated that he/she wears glasses, and that the glasses were on the dresser, however I prefer different	L 051	**Refer to page 47 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 50 glasses. The resident also stated that he/she could see out of the right eye and not the left eye. Further review of the admissions and significant change MDS identified that #Visual Function care area triggered and Care planning decision was checked indicating that the care area would be addressed in the care plan. There was no evidence in the clinical record that a care plan was initiated to address Resident #122's visual function. A face-to-face interview was conducted on September 21, 2015 with Employee #10 at approximately 11:30 AM. After review of the above he/she acknowledged the findings. The clinical record was reviewed on September 21, 2015. The charge nurse failed to initiate a care plan with goals and approaches for Resident #122's visual function. C. Based on observations, record review and staff interview for six (6) of 55 sampled residents, it was determined that the charge nurse failed to make daily resident visits to assess physical status and implement any required nursing intervention(s) as evidenced by: failure to consistently assess and monitor the status of one (1) who exhibited an acute change in status as manifested by low blood pressure, increased respirations and tachycardia; to perform an accurate assessment for one (1) resident who experience a documented change in condition; to consistently assess and monitor one (1) resident who was ventilator dependent and experienced tachycardia; assess and identify the need for one (1) resident who had accumulated white colored	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 51 substance on his/ her tongue; and failed to ensure that one (1) resident wore protective head gear and that the head circumference was measured in accordance to physician's orders and failed to follow physicians orders to obtain weekly weights times four (4) weeks for one (1) resident. Residents ' #145, #37, #5, #104 and #143, #6. The findings include: 1. The charge nurse failed to consistently assess and monitor the status of Resident #145 (ventilator dependent), who exhibited an acute change in status as evidence by the presence of low blood pressure, increased respirations and persistent tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized. Resident #145 was admitted on August 25, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. Res #145 complained of shortness of breath (SOB), refused C-PAP treatments secondary to SOB and exhibited signs of a change in mental status. The clinical record lacked evidence that nursing staff identified, acted on, comprehensively assessed and intensively	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 52 monitored the resident when he/she demonstrated a change in status as evidenced by the following: Resident #145 complained of SOB and refused C-PAP treatments as follows: Ø August 29, 2015- 7PM-7AM- Shift Report ---- " Patient refused CPAP trails last night ...back on AC (assist control) due to patient complaining of SOB (shortness of breath) Ø August 30, 2015 - 7AM-7PM- S- Shift Report Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Resident #145 demonstrated change in mental status as follows: Ø Psychiatric consultation August 31, 2015 (hour not indicated) " ...unable to assess [secondary to] pt [patient] not responding ... responding to painful stimuli but not easily arousable ...Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain medications ... " Ø Respiratory therapy entry [shift report] dated August 31, 2015 7AM-7PM read: " ...patient remains on A/C mode, no active weaning due to patient being less arousable in PM. " There was no evidence that the charge nurse conducted comprehensive assessments when Resident #145 exhibited a change in the level of arousal, complained of shortness of breath and refused treatments. The record revealed that	L 051	**Response to L051, Resident #145, 37, 5, 6** 1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 ws reviewed to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders. 2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross-referencing the medical record to ensure the physician is notified of any change in the resident's condition. The audit results found all medical records in compliance. Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician. 3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) The Respiratory staff were re-educated on 9/25/2015 related to the recognition of changes in resident's status, notification to physician and timeliness of completing physician orders..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 53 nursing staff communicated to the mental health practitioner [psychiatric consult] that the resident was not responsive due to " pain medication. " However, a review of the Medication Administration Record [MAR] revealed Tylenol 500mg 2 caplets were administered during the 7AM - 3PM shift on August 31, 2015. A review of previous administrations of Tylenol lacked evidence that the resident sustained an alteration in mental status [lack of arousal]. An in-depth review of the clinical record is as follows: A review of Physician ' s Orders dated August 25, 2015 included, but was not limited to the following: Ventilator (Ventilator Settings: AC (Assist/Control, Rate- 15, TV (Tidal Volume)- 500, PEEP (Positive End Expiratory Pressure), FIO2 - 45% (Fraction of Inspired Oxygen) Duoneb (bronchodilators) 2.5mg/3ml (millimeter)- 1 vial neb (nebulization treatment) [every] 6 hours PRN (as needed) for bronchospasms, Note: The Duo Neb order was modified on August 25, 2015 for administration " every 4 hours " [instead of every 6 hours as needed] Tylenol 500mg 2 caplets via peg 30 minutes prior to wound care for pain Seroquel (antidepressant) 25 mg (milligram) - 1 tablet via GT (Gastrostomy tube) BID (twice a day) for depression; Prozac 20 mg 1 capsule daily for Depression Midodrine (Vasopressor/Antihypotensive	L 051	**Response to L051, Resident #145, 37, 5, 6** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three(3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 54 medication) 10mg via GT (Gastrostomy Tube) TID (three times a day) for hypotension. Hold for SBP (Systolic blood pressure) > (greater) 120, DBP (diastolic blood pressure) > 80.... Pulmonary Consult and Psychiatry consult An Interim physician ' s order dated August 31, 2015 read: August 31, 2015- 2059 (8:59PM) - Please transfer patient to nearest ER via 911 re: Acute AMS (Altered Mental Status), tachycardia and hypotension. " Physician ' s Notes: " August 25, 2015- 3:17 PM- Pulmonary Consult: ... Awake, alert, appears anxious. Vitals: Chest-crackles [positive] bilaterally, vent settings: VT-500, AC-15, P [Peep] - 5, FIO2-45%, Impression: Chronic Respiratory Failure. PT (Patient) on vent-tolerates CPAP (Continuous Positive Airway Pressure) trials intermittently. Continue trials as tolerated. [He/she] remains very anxious ... Titrate O2 (oxygen) to sats (saturations) > (greater than or equal to) 92%. August 25, 2015- 1545 (3:45PM) - Attending/Admission Note: cc: (chief complaint) - Chronic Respiratory Failure .... Assessment/Plan: - Chronic Respiratory Failure- continue on vent at current settings, continue vent weaning trials, Pulmonary input appreciated ... Depression-Continue Prozac (Anti-depressant). August 28, 2015 - 1520 (3:20 PM) - Attending Note; cc: chronic respiratory failure. Voiced [no] complaints this afternoon. [Vital Signs Stable]- T-	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 55 98, Pulse-74, Respirations-18, B/P (Blood Pressure) - 132/82. Assessment/Plan: Chronic Respiratory Failure- Continue on vent, wean as possible, suction PRN (as needed), Depression- Continue on Prozac. August 31, 2015- 2103 (9:03 PM) - Hospitalist Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded [and] unresponsive with agonal breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension-unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " Psychiatric Diagnostic Consultation: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... " Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient not arousable and does not answer questions at this time. Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 56 precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess mood/and anxiety. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... " August 29, 2015 3:00 AM - " ...[b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [no respirations documented, two (2) different heart rates]... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: 8/31/15, Time: 9:39 PM ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " A review of the facility ' s Ventilator Policy/Protocol The facility ' s Ventilator Management and Nursing Care Respiratory Protocol [no date indicated] stipulates: " Modes of Ventilation-	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 57 Assist-Control Ventilation (A/C): A/C delivers the preset volume or pressure in response to the patient ' s own inspiratory effort, but will initiate the breath if the patient does not do within the set amount of time. This means that any inspiratory attempt by the patient triggers a ventilator breath. The patient may need to be sedated to limit the number of spontaneous breaths since hyperventilation can occur. This mode is used for patients who can initiate a breath but who have weakened respiratory muscles. " Respiratory Notes/Ventilator Flow Sheets [documented in S-BAR format]: " August 29, 2015- 7PM-7AM- Shift Report- S- Patient refused CPAP trails last night, B- Respiratory Failure, Status Post Trach. Obese. A: Sat = 99%, [Heart Rate -79, Respiratory Rate-24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Stable and alert. R- Continue to encourage patient to get weaned. Ventilator Flow Sheet- Special Procedures Done [and] Time Performed: CPAP 5/10 x10[minutes], back on AC due to patient complaining of SOB (shortness of breath) August 29, 2015- 7A-7PM- S- Shift Report, B-Respiratory Failure, A- Received on AC mode, neb tx (treatment) given as ordered. [Patient tolerated Duoneb, Pulse ox- 98%, HR-72, R- Will continue to monitor patient and wean as tolerated. August 30, 2015 - 7PM- 7AM - Shift Report- - S- [Patient] is on AC 15, 500, 45%, +5, B-Respiratory Failure, A- [Patient] is on AC. Stable O2 Sat 98%, HR-78%, RR-20. No sign of distress, R- We will continue monitoring [patient] and [symptoms] as needed. There was no	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 58 evidence that Duoneb treatments (prescribed every 4 hours) were administered between 4:48 PM (last noted dose administered during the 7AM-7PM shift) and 11:59 PM on August 30th. The record revealed that the next dose was given at 12 Midnight on 8/31/15 [nearly 7 hours after the preceding dosage]. August 30, 2015 - 7AM-7PM- S- Shift Report, B-Respiratory Failure, A- Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient] ... (Illegible writing). [Pulse Ox-99%, HR (illegible writing), R- Will continue to monitor patient. Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Physician Order: Albuterol 2.5mg and Atrovent .5mg - q 4 (every 4 hours). Treatments were documented as being administered at 0020 (12:20 AM), 0410 (4:10 AM), 0800 (8:50 AM), 1310 (1:10 PM), and 16:48 (4:48PM). " The next Duoneb treatment was recorded as being administered on 8/31/15 (12MN), approximately 7 hours later. August 31, 2015- 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of " being unable to breathe " but in no apparent distress. Continue to monitor for changes. August 31, 2015- 7AM-7PM- S- Pt remains on AC mode. [No] active weaning [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) cleared, R- Will continue to monitor.	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 59 Ventilator Flow Sheet revealed the following " Rate Set/Total " on the A/C mode: 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation- 97%, Heart Rate- 87 0425 (4:30 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation and Heart Rate documented in the allotted space. 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " [defined: 15/34 - " 15 " reflects ventilator preset respiratory rate and " 34 " reflects - resident breaths] A review of the nebulization treatment administration record for August 30th revealed the 6th dosage [prescribed every 4 hours] of Duoneb [scheduled for administration at approximately 8:45 PM on August 30th] was omitted without explanation. However, the respiratory therapy " shift notes " [7AM-7PM] notes reveal the resident complained of shortness of breath. The clinical record lacked evidence that the physician was notified regarding the resident ' s complaint of having shortness of breath, refusing CPAP trials and the missed Duoneb treatment from August 29, 2015 at (7PM-7AM) to August 31, 2015 (7AM-7PM). A face-to-face interview was conducted with Employee #14 (on-coming team member) September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns.	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 60 He/she stated that the off-going team member, who stated that the resident was calling all night and that [he/she]. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night; and the resident had the call bell you blow into. Employee #14 acknowledged the physician should have been informed of the resident ' s missed duoneb treatment, restlessness and the complaint of having shortness of breath and refusing to use the CPAP on August 29, 2015. A follow-up interview was conducted with Employee#14 on September 18, 2015 at approximately 3:00 PM regarding the missed Duoneb treatment on August 30, 2015. He/she stated there was only one (1) respiratory therapist on 8/30/15 (7PM-7AM) shift. There were 12 residents on ventilators, 15 residents who had tracheostomies, four (4) residents requiring BIPAP (Bi-level Positive Airway Pressure), 2 (two) residents requiring Hi-Flow, 55 [nebulization] treatments and four (4) residents weaning from ventilators. A review of the respiratory therapist assignment sheet dated August 30, 2015 revealed one respiratory therapist on for the 7PM-7AM shift. Also, the Respiratory Therapist was assigned a Registered Nurse orientee (for orientation to ventilator). A review of the nursing assignment for August 30, 2015 revealed four (4) Licensed Practical Nurses (LPNs) were on duty for the 6th floor from 7:00 AM-3:30PM shift to manage residents receiving ventilator services.	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 61 The clinical record lacked evidence that facility staff consistently assessed and monitored Resident #145 when the resident ' s mental status changed, complained of having shortness of breath, and difficulty breathing. Nursing assessments failed to depict the resident being anxious, restless and having difficulty breathing. The physician was not notified when the resident complained of shortness of breath, which was first documented on August 29, 2015. The resident ' s condition declined as evidenced by a change in mental status, heart rate elevated to 150 ' s and blood pressure as low as 77/53 as depicted in the hospitalist note on the evening of August 31, 2015. The resident was subsequently transferred to the nearest ER via 911 and hospitalized. The clinical record was reviewed on September 18, 2015. A review of records obtained from the acute care facility that the resident was transferred to revealed the resident was admitted and a physician ' s entry on 8/31/15 included: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Systolic B/P- 87, diastolic B/P (Blood Pressure)-48; [Oxygen] Saturation -100; FIO2 [Fraction of Inspired Oxygen] Ventilator- 100 [percent]. 2. The charge nurse failed to perform an accurate assessment for Resident #37 that experience a	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 62 documented change in condition. Resident #37 was admitted on July 22, 2015 with diagnoses to include Chronic Respiratory Failure, Coronary Artery Disease, and Sacral Decubitus. Medical record review was conducted on September 21, 2015 at 9:40 AM. The review of clinical notes revealed inconsistencies in the assessment of Resident #37 status on September 18, 2015 at 5:00 PM as it relates to entries documented by medical staff, nursing staff, and respiratory staff. The inconsistencies are as follows: · Physician Progress note from September 18, 2015 at 5:30 PM revealed the Attending Physician was requested by the nursing staff to evaluate the resident with changes in mental status, tachycardia, and hypoxia. According to the medical staff assessment, the resident was noted to have a heart rate of 166 beats per minute, blood pressure of 125/56 millimeter of Mercury. · The nursing staff documented an ' Acute Change in Condition Report ' dated September 18, 2015 at 5:00 PM secondary to resident with elevated irregular heart rate of 166 beats per minute and oxygen saturation of 81% while on the ventilator with FiO2 of 40%. · Review of the Ventilator Flow Sheet dated September 18, 2015 revealed the respiratory therapy staff documented pre- treatment assessment at 5:00 PM which indicated the heart rate- 89 beats per minute, respiratory rate- 19 breaths per minute, and	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 63 oxygen saturation- 98 percent; and post-treatment assessment at 5:15 PM indicating heart rate was 90 beats per minute, respiratory rate 16 breaths per minute and oxygen saturation of 98%. Although the medical and nursing staff assessed Resident #37 to have experienced a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation, the respiratory therapy staff documented an assessment with the heart rate, respiratory, and oxygen saturation consistent with Resident #37 ' s baseline physical assessments. Resident #37 was subsequently transferred via Emergency Medical Services to a local emergency department. A face to face interview was conducted with Employee #31 on September 21, 2015 at approximately3:30 PM. S/he confirmed that the respiratory assessment was inconsistent with the change of condition at the time of assessment. The findings were reviewed, discussed, and acknowledged. 3. The charge nurse failed to consistently assess and monitor Resident #5 who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. A review of Resident #5 ' s quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 64 diagnoses in Section I (Active Diagnoses) included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. According to physician ' s orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia with HR [140], SBP [systolic blood pressure 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS: tachycardia ...ABD: distended...hypo	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 65 [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O aspiration/sepsis. Will send to ER [Emergency Room] v [by] 911. " A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. IS Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. Vs T 98.6, P 87, R 20, BP 130/77 Pulse OX 98%. Turned and repositioned, due meds give. " June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator] dependent for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 66 well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3. June 2, 2015- 8:35 AM- SBAR [Situation, Background, Assessment, Recommendation]/Acute change in condition. Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. " Respiratory Therapy Notes: A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following: "Date: June 2, 2015 Time: 0025 [12:25 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70 Date: June 2, 2015 Time: 0345 [3:45 AM] Mode: AC Fi02: 40% PEEP 5 Saturation: 98% Heart Rate: 121	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 67 Date: June 2, 2015 Time: 08:20 [8:20 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 99% Heart Rate: 129 There was no documented evidence that the charge nurse notified the physician in regards to Resident #5 ' s increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours. A review of the respiratory therapy shift note revealed : June 2, 2015 - 7pm-7am shift note revealed: S: Pt on A/C mode B: Respiratory resident A: Sat 98% HR 71, RR 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress. R: monitor June 2, 2015 -7AM- 7PM Shift- no documentation under shift report; indicated on flow sheet- " PT [Patient] transferred to area Hospital. " The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased. The physician was not notified when the resident ' s became tachycardia (increased heart rate) , which was first documented on June 2, 2015 at 3:45 AM to be 121. The resident ' s condition	L 051	**Refer to page 53 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 68 declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response was called and resident was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the residents heart rate of 140. A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 state that his/her shift is 7:00AM to 7:00PM. Employee #18 also state, when he/she first saw the resident with the heart rate 129 is when the rapid response [When a resident's condition changes (based on predetermined criteria) and requires an assessment by a physician to stabilize his/her condition and prevent further deterioration] was called at approximately 8:20AM, the resident vomited when he/she was bagged. Employee #47 stated when he/she was conducting rounds from the rooms assigned he/she was called to the rapid response by Employee #18 who stated that the rapid response took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. The clinical record was reviewed on September 21, 2015. 4. The charge nurse failed to assess and identify the need for medical intervention for Resident #104, who had accumulated white colored lesions on his/her tongue. The resident was subsequently diagnosed with oral Candidiasis and prescribed antifungal treatment.	L 051	**Refer to page 70 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 69 According to, " The Lippincott Manual of Nursing Practice, " Ninth Edition-2010, pp 613, revealed: " Conditions of the Mouth and Jaw .... Candidiasis-Candidiasis is a fungal infection commonly caused by Candida albicans. It usually occurs in the mouth ... Candidiasis can become a source of systemic dissemination, particularly in high-risk persons, Clinical Manifestations: (1.) Oral discomfort, burning, altered taste, erythema, (2) White, raised, painless plaques, loosely adherent, (3) Possible spread to the esophagus with pain on swallowing and chest pain Management: Topical antifungal agents in oral rinses, troches, or creams, such as Mycelex or Nystatin ... Analgesics for pain ..., Nursing Assessment: Assess extent of lesions and inflammation in mouth ... 2. Assess level of pain ... Patient Education and Health Maintenance: (2) Instruct high-risk patients about daily oral examination and signs and symptoms to observe (3). Encourage good oral hygiene .... " An observation of the Resident #104 during the survey period revealed the following: On September 10, 2015 at approximately 4:28 PM-Resident #104 ' s tongue was observed completely coated with a white substance. A second attempt was made on September 14, 2014 at approximately 12Noon to visualize Resident #104 ' s oral cavity with Employee #15. A visualization of the resident ' s oral cavity was unsuccessful because the resident rejected the employee ' s attempt to open his/her mouth. This surveyor conveyed to Employee #15 the concern related to the observation of the white substance on the resident ' s tongue. Employee #15 informed the Nurse Practitioner who evaluated	L 051	**Response to L051, Resident #104** 1. On 9/15/15 interventions were put in place by nursing for resident #104 per NP assessment. 2. All residents dependent in activities of daily living (ADL) were reassessed and an appropriate care plan updated. . 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. The RCCs or designee will perform daily clinical rounds with nursing staff to review resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline on mouth care/oral hygiene and the current products used in the facility. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits of the CNA flowsheet to ensure ADLs are performed per care plan for dependent residents. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 70 the resident and diagnosed him/her with Oral Candidiasis as follows: Nurse Practitioner note dated September 14, 2015 at 4:10 PM read: " Asked to evaluate resident with c/o [complaint of] whitish coating on tongue. Resident is bedbound and clamps mouth close [with] difficulty to adequately view oral cavity. Assessment done [with] aid of primary nurse, " = " whitish coating on tongue. Attempted to clear tongue with mouth care kit [without] any effect on mouth/tongue coating. [No] distress. A [Assessment]:- Oral Candidiasis (Thrush). Plan: Nystatin solution 100,000 units/ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days. Reassess for any adverse changes. " The charge nurse failed to assess and identify the need for intervention for Resident #104 whose tongue was observed coated with a white substance. According to the annual Minimum Data Set (MDS0 with a Assessment Reference Date (ARD) of August 14, 2015 revealed Resident #104 ' s diagnoses in Section I (Active Diagnoses) included: Seizure Disorder, Traumatic Brain Injury, Tracheostomy, Craniotomy, Dysphagia. Section G (Functional Status) resident was coded as being total dependent with one person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth ....). Physician ' s order dated August 25, 2015 directed: " Mouth care every shift. " An interim physician ' s order [subsequent to the surveyor ' s observation] dated September 14,	L 051	**Refer to page 70 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 71 2015 at 4:00 PM directed; " Nystatin (Anti-fungal medication) Oral Suspension 100,000 units per ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days for thrush. " A review of the resident ' s " CNA Charting " flow sheets from September 7, 2015 through September 15, 2015 revealed, " Personal Hygiene: Resident required one person physical assist to provide all hygiene tasks [oral care included], with no self-performance. " The comprehensive care plan updated August 11, 2015 included the following problem: " Alteration in ADL (Activities of Daily Living) function [secondary] to diagnosis of Anoxic Brain Injury, Approaches included, ... Staff to provide oral, hair and nail care qd (every day) and prn (as needed) ... " The charge nurse failed to assess and identify the need for medical intervention for Resident #104, who had an accumulation of a white colored coating on his/her tongue that was diagnosed as Candidiasis (thrush) after the surveyor ' s request for intervention. A face-to-face interview was conducted with Employees #15 and #17 on September 14th at approximately 1:00 PM. When queried about how the resident ' s mouth care is performed and the frequency, he/she stated; " It is done every day, and an oral swab is used and s/he stated there was no white coating on the resident ' s tongue. He/she further stated sometimes white secretions are in his/her mouth but they are suctioned out, and the mouth and tongue is cleaned. The clinical record was reviewed on September 15, 2015.	L 051	**Refer to page 70 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 72 5. The charge nurse failed to ensure that Resident #143 wore protective head gear and head circumference was measured weekly in accordance to physician ' s orders. On September 16, 2015 at approximately 11:45 AM and 2:00 PM. Staff was observed sitting in chair, near the window at the foot of Resident # 143 ' s bed. The resident was observed asleep, lying in bed on his/her back. A white mitten was observed on the right hand. He/she was covered with a white sheet. A helmet was positioned on the foot board. A face to face interview was conducted with Employee #48 at the time of the observation. Employee #48 was queried about the scheduled times the resident was supposed to wear the helmet. He/she stated; " He/she is supposed to wear the helmet when he/she is out of bed. Employee #48 further stated that the resident was on one to one (1:1) observation. A physician order dated August 27, 2015 directed; " Helmet to be worn Q [every] shift for safety to protect craniotomy site. Remove every 2 (two) hours to check skin integrity. Document in chart. Measure head circumference weekly. Report increase in size to MD (Medical Doctor). " The clinical record lacked evidenced that Resident #143 ' s head circumference was measured weekly in accordance to physician ' s orders. There was no evidence that the charge nurse ensured the resident wore his/her helmet in accordance to physician ' s order. A face-to-face interview was conducted with Employee #18 on September 16, 2015 at approximately 2:31 PM. He/she acknowledged the aforementioned findings. The observation and	L 051	**Response to L051, Resident #143** 1. Resident #143 suffered no adverse event. The head circumference was re-measured and found consistent with previous measurements. The attending was contacted and care plan updated to include interventions related to managing resident with a craniotomy 2. There were no other residents with an order for a helmet; therefore, no other resident was affected. 3. Staff re-educated of the standards of practice related to execution of physician orders. 4. RCC or designee will perform random audits of the medical record to ensure physician orders are followed per policy. Results of the audits will be reported the Quality Council until 100% compliance is consistently maintained for six (6) months.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 73 clinical record was conducted on September 16, 2015. 5. The charge nurse failed to conduct weekly weights times four [4] weeks according to the physician ' s orders for Resident #6. A review of the residents History and Physical conducted on February 13, 2015 revealed the resident has the following active diagnoses which included: Senile Dementia, Arthritis, Elephantiasis Varicosa legs, Cataract. A review of the resident's " Monthly Weights" sheet revealed the following: January 2015 - 112 pounds February 2015 -116 pounds March 2015 - 116 pounds April 2015 - 88 pounds ?? - the two (2) hand written question marks [??] were written in the corresponding space for " re-weight. " May 2015 - 88 pounds June 2015 - 89.4 pounds July 2015 - 91.2 pounds August 2015- 90.8 pounds A Quarterly Nutrition Review conducted dated May 19, 2015 revealed, "Swallowing /chewing difficulty; (etiology) dysphagia and missing teeth; (signs/symptoms) SLP [Speech Language Pathology] ordered ... mechanical soft diet ...(other comments) PO [by mouth] intake 75%, Boost Plus [nutritional supplement] intake 50%..(Progression on Interventions: ...(3) wwx4 [weekly weights times four] ... "	L 051	**Refer to page 73 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 74 A review of the physician ' s orders dated May 19, 2015 ... " (3) Weekly weights x 4 weeks. " A further review of the clinical record revealed more than 30 days had lapsed before the Quarterly Nutrition Review was conducted in May 2015. In addition, there was no evidence in the clinical record that weekly weights times 4 weeks were conducted as ordered per the physician orders. A face-to-face interview was conducted with Employees' #26 and #27 on September 17, 2015 at approximately 9:50 AM regarding interventions once the weight loss was identified. Employee #26 acknowledged that a reweight should have been conducted and placed on weekly weights. In summary, Resident #6 sustained a 28 pound weight loss from March 2015 to April 2015. There was no evidence that a reweight or weekly weights times 4 were conducted to confirm the weight loss. D. Based on record review and staff interview for seven (7) of 55 sampled residents, it was determined the charge nurse failed to: conduct comprehensive pain assessments to include characteristics such as intensity, type, pattern of pain, location, frequency and duration of pain for seven (7) residents; consistently assess two (2) residents response to pain intervention. Residents ' #64, #108, #107, #142, #80, #43 and #49.	L 051	**Refer to page 73 for response** **Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 75 The findings include: Facility ' s Policy -Pain Assessment and Management policy Copyright 2001 MED_PASS, INC (Revised October 2010) stipulates " Steps in the Procedure Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain ...Assessing Pain: 1. During Comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): a. History of pain and its treatment ...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; (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 that reduce pain; and f. Symptoms that accompany pain (e.g. nausea, anxiety) ...Identifying the Causes of Pain ...Define Goals and Appropriate Interventions ...Implement Pain Management Strategies1. Non-pharmacological interventions ...; 2. Pharmacological interventions ...; 4. The physician and staff will establish a treatment regimen based on consideration of the following a. The resident ' s medical condition; b. Current medication regimen; c. Nature, severity and cause of the pain; d. Course of the illness; and e. Treatment goals ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions ...Monitoring and Modifying Approaches ...Documentation 1. Document the resident ' s reported level of pain with adequate details (i.e. enough information to gauge the status of pain and the effectiveness of	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 76 interventions for pain) as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident ' s medical record. " 1. The charge nurse staff failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for resident #64 A review of the medical record revealed Resident #64 was admitted on May 4, 2015 with diagnoses which included Surgical Wound, Sacral Wound, and Nutritional Deficit with Reconditioning. Resident #64 was transferred out to a local emergency department on September 1, 2015 to manage " change in mental status " . Review of medical record conducted on September 14, 2015 revealed Resident #64 has a documented community-acquired Stage IV sacral pressure ulcer present on admission which last measured 15 X 16.5 X 3.5 centimeters according to the Wound and Skin Care Progress Note dated August 31, 2015. According to the Physician ' s Orders, the medical staff documented the following medication orders relative to pain: · July 15, 2015- Tramadol 50 milligrams via G-tube (gastrostomy tube) three times a day prior to wound care · August 24, 2015 at 2:10 PM- Discontinue Tramadol 50 milligrams; Start Tramadol 100 milligram by mouth 30 minutes prior to wound	L 051	**Response to L051,** **Resident #64, #108, #107, #142, #80, #43 and #49** 1. Immediately upon notification of this deficiency, a comprehensive pain assessment for residents #64, #107, #142, #80, #43 and #49 was completed. Resident #108 was discharged, therefore no further actions could be taken. 2. A chart audit was conducted on all residents on pain management program. Audit findings determined no other resident potentially affected by the same deficient practice. 3. All clinical staff were reeducated on 10/15, 10/25 and ongoing by the Interim Administrator/DON on the revised Pain Assessment and Management policy and the Omnicare Pharmacy Pain Flowsheet. The Omnicare Pharmacy Pain Flowsheet will be implemented 11/1/15 for pain monitoring and documentation of assessment, intensity and effectiveness. The RCCs will perform a random sample audit of the pain flowsheet weekly to ensure compliance. 4. Results of the audit findings will be reported weekly to the Risk Management Subcommittee three (3) months. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a three (3) months.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 77 treatment three times per day then one (1) by mouth every eight (8) hours as needed pain · August 31, 2015 at 1:00 PM- Discontinue Tramadol order; Start Oxy IR (Immediate Release) 5 milligram by mouth one tab 30 minutes prior to wound treatment every shift and every eight (8) hours as needed for pain · September 1, 2015 at 3:15 PM- Discontinue Oxy IR (Immediate Release)order; start Neurontin 100 milligram three times daily by mouth for neuropathic pain; Tylenol ES [Extra Strength] 500 milligrams by mouth three times daily 30 minutes prior to wound treatment every shift for pain Review of the Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented assessment of Resident #64 on June 22, 2015, July 28, 2015; August 20, 2015 and September 1, 2015. On August 20, 2015, Resident #64 was seen for significant weight loss. The medical record lacked documentation relative to pain during this visit. On September 1, 2015 at 3:20 PM, the medical staff had a discussion with Resident #64 ' s family member about " ...many questions related to issues of pain, wound care and weight loss and recurrent UTI (Urinary Tract Infections) ...We discussed pain medications being used Oxy IR which was started yesterday ' p ' (symbol for after) discontinuing Tramadol but resident is more drowsy today. Will discontinue all narcotics ... " The medical record lacked documented evidence to provide insight into the reason for adjusting the pain medication regimen prior to wound care from August 24, 2015 through September 1,	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 78 2015.Nurse ' s Notes from August 22, 2015 through September 1, 2015 revealed Resident #64 was medicated prior to wound care; however, the medical record lacked documented evidence the facility staff performed comprehensive pain assessments before and after the administration of pain medication. In addition, the medical record lacked documented evidence of unresolved or worsening pain to warrant an adjustment in the resident ' s pain medication regimen. On September 1, 2015 at 11:30 PM, the facility staff documented a " SBAR [Situation Background, Assessment and Response]/ Acute Change In Condition Report " which " detailed reason for evaluation ...change in mental status, lethargic " . The sections reserved for the documentation of " Things that make the problem worse; Pertinent recent medical history; Mental status; Change in intake/hydration; and Labs in the past 30 days " were left blank. According to the narrative contained in the SBAR: Resident #64 was " noted very sleepy but arouse to touch and verbal commands " at around 9:00 PM. The resident ' s family was in the room at the time of the observation. S/he informed the facility staff " that resident sleep deeply and not communicating with her " . SicThe attempt to start an intravenous line was unsuccessful secondary to poor vein. Resident #64 ' s respirations were also " noted " to be shallow with a change in vital signs. The vital signs were documented as follows: temperature- 97.3 degrees Fahrenheit, blood pressure- 125/55 millimeters of Mercury; respirations- 28 breaths per minute, and heart rate 120 beats per minute. The resident was subsequently transferred to the hospital via Emergency Medical Services. Subsequent review of the August 2014	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 79 Medication Administration Record (MAR) revealed the facility staff documented the administration of Tramadol 50 milligrams prior to wound care from August 1-24, 2015 and on August 25- 31, 2015 Tramadol 100 milligram, was administered three times a day. The Medication Administration Record did not contain specific time of each dose of pain medication administered and/or the time wound treatment was completed. Medication administration times were documented according to the shift, i.e. " 7-3; 3-11; 11-7 " . Furthermore, the MAR lacked documentation of comprehensive pain assessment before and after medication administration to determine the presence of pain and/or effective of the pain medication. Review of Nurse ' s Notes from August 19, 2015 through September 1, 2015 revealed the facility staff documented the pain medication administration prior to wound care. According to the note documented on August 20, 2015 at 11:00 PM, the Resident #64 was " medicated x1 with Tramadol as ordered prior to wound care for breakthrough pain with positive outcomes " , there was no documentation to provide enough description of pain to include intensity, descriptors, pattern, location and radiation, and a frequency. In addition, there were additional nurse ' s notes on August 22, 23, 24, 26, and 28, 2015 that indicated that pain medication was administered prior to wound care with " good " or " + " (positive) effects. However, the aforementioned nurse ' s notes lacked documented evidence of a pain assessment before and after the administration of the pain medication to include location, intensity, and descriptors. On August 24, 2015 at 11:00 [no indication of am	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 80 or pm documented], the facility staff documented the " resident was asked if the pain medicine ... gets is effective enough for [his/her] with [him/her] wound care, resident said yes but if [s/he] can get more, it will make [his/her] more comfortable " . The medical staff was notified and pain medication was increased. Review of the subsequent nursing notes failed to reveal the facility staff performed monitoring for effectiveness and/or adverse consequences relative to pain. On September 1, 2015 at 1:00 PM the facility staff was called to the resident ' s room because the resident was observed " drowsy " and had been unable to " be taken to therapeutic recreation this morning. " According to the September 1, 2015 at 1:00 PM note, " Resident was given Oxycodone 5mg IR and the nurse getting ready to do ... wound care. " The family at bedside and responsible party via telephone was notified Resident #64 " has a new order for Oxy IR but will have the NP (Nurse Practitioner) review this med [medication] since resident is drowsy " . Oxy IR was last administered on September 1, 2015 during the " 7-3 " shift; the specific time was not documented. It is unclear if the responsible party had been notified of the medication change at the time of the order. The medical record lacked documented evidence the nursing staff performed a comprehensive assessment when a change in condition was identified at 1:00 PM. It was at 9:00 PM on September 1, 2015 that the family " complained that resident sleep deeply and not communicating with her, resident opened her eyes then close it still responds to touch " . A call was placed to the house officer at 9:30 PM.	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 81 The medical record lacked documented evidence the facility staff continued to assess and monitor Resident #64 ' s condition with ensure s/he received necessary care and treatment to prevent and/or readily identify acute changes in status at the earliest time possible. The " Pain " care plan initiated for the period of May 6, 2015 through September 6, 2015 revealed the facility staff documented the " Problem/Need Related To " as: " Other, specify generalized " ... " Resulting In: Complaints of pain less than daily " ... " Strengths To Draw On: Able to communicate needs, Able to express level of pain " with Goal(s) identified as: " will be free of pain complaints; Will display signs of comfort, no grimacing; Will report pain resolved with pain medication and other interventions " . The " Target Review date: 5/6/15-9/6/15 " . The " Interventions " for " Nursing " include " Assess symptoms of pain on occurrence and document location and pain scale as reported by the resident; Provide quiet environment; Offer calming music, TV per resident request; Offer back rub, warm blanket; Provide pain medications as prescribed; Check vital signs: Freq. Per order and Notify Physician if: Pain persists despite intervention; vital signs are out of normal range along with pain persistence. " The sections reserved for intervention to be documented by dietary, social services, and activities were left blank. On the reverse side of the care plan for " pain " , there were three (3) entries as follows: · " 5/11/15- Cont. c [line noted above the letter ' c '] (with) POC (Plan of Care) x 90 days " · " 8/24/15- Pain reevaluated, need for increase in pain med noted CRNP (Certified Registered Nurse Practitioner) notified, Tramadol increased to 100 mg. Will cont. to monitor	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 82 resident. " · " 8/31/15- Resident is started on Oxy IR 5 mg to be given prior to wound care. Will monitor resident. Tramadol dc ' d [discontinued]. " The medical record lacked documented evidence the facility staff consistently followed the plan of care to demonstrate assessment, monitoring, and provision of necessary care and treatment in accordance with standards of practice relative to the treatment of resident with complaints of pain. Review of Significant Change in Status Assessment Minimum Data Set (MDS) dated August 9, 2015 revealed the following coding for Section J Health Conditions: J0100 Pain Management A. Been on a scheduled pain medication regimen?- " 1. Yes " ; B. Received PRN pain medications OR was offered and declined? - " 0. No " ; C. Received non-medication intervention for pain?- " 1. Yes " ; Section J0300- " Have you had pain or hurting at any time in the last 5 days? " - " 1.- Yes " ; 0J0400. Pain Frequency: " How much of the time you experience pain or hurting over the last 5 days?- " 3- Occasionally " ; and J0600 Pain Intensity A. Numeric Rating Scale (00-10)- Please rate your worst pain over last 5 days on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine- " 05 " . Further review of the medical record revealed Resident #64 experienced a significant weight loss since admission to the facility from May, 2015 through August, 2015. The weights were documented as: May 11, 2015- 186.8 pounds; May, 2015 (day of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. As a result of the documented weights the resident triggered for a significant weight loss for 30 days according to	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 83 the Nutritional Care Progress notes on June 17, 2015, July 20, 2015, and August 19, 2015. The medical record lack documented evidence that the interdisciplinary team evaluated the potential impact the resident ' s complaints of pain may have on his/her nutritional status. Although the facility staff continued to administer pain medication routinely prior to wound care, the facility staff failed to assess and reassess Resident #64 in enough details and frequency to ensure management and prevention of pain consistent with the comprehensive assessment, plan of care, and accordance with current clinical standards of practice, resident ' s goals and preferences. A face-to-face interview was conducted with Employee #11 on September 21, 2015 at approximately 9:40 AM regarding the management of pain for Resident #64. When queried about the facility ' s policy relative to pain management and assessments, s/he stated that it is expected that the nursing staff assess the pain when the medication is given and afterwards. S/he further provided a Medication Administration Record and pointed out where the documentation would be located. The reverse of the Medication Administration record for Resident #64 was reviewed, discussed, and acknowledged. The charge nurse neglected to conduct comprehensive pain assessments and reassessment before and after the administration of pain medication as is consistent with current clinical standards of practice. There was no evidence the resident was consistently monitored when pain medications were adjusted and when the resident demonstrated a change in clinical	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 84 status [e.g. lethargy], there was no comprehensive nursing assessment. On September 1, 2015, the resident demonstrated " drowsiness, " at 1:00 PM however; facility staff did not intervene for several hours [approximately 9:30 PM] until the resident ' s symptoms worsened and required emergency transport out of the facility. 2. The charge nurse failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80. A review of the medical record revealed Resident #108 was admitted on December 19, 2014 with diagnoses which include Congestive Heart Failure with EF (Ejection Fraction) 20%, Cerebrovascular Accident Status post Craniotomy, Hypertension, and Diabetes Mellitus. Medical record review conducted on September 13, 2015 revealed a Physician Order dated August 17, 2015 for Acetaminophen with Codeine 300 mg/30 mg one tab via g-tube (gastrostomy tube) every 6 (six) hours as needed for pain and on August 28, 2015 at 12:00 PM- " ...Roxanol 20 mg/ml 0.25 ml [milliliter] (5mg) SL [sublingual] q3º [every three hours] PRN [as needed] severe pain/ SOB [shortness of breath] " . A review of the September 2015 Medication Administration Record (MAR) revealed Acetaminophen with Codeine was administered for pain on the following occasions: September 3,	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 85 2015 at 11:00 AM; September 8, 2015 at 8:00 AM, September 9, 2015 at 8:00 PM, September 10, 2015 at 9:30 AM, September 11, 2015 at 11:30 AM, September 12, 2015, September 13, 2015 at 9:00 AM, and September 14, 2015 at 9:00 AM. The reverse side of the September 2015 MAR revealed the details of the Acetaminophen with Codeine administered for pain as follows: · September 3, 2015 at 11:00 AM- No documented evidence of the date/hour, medication, reason or result · September 8, 2015 at 8:00 AM- No documented evidence of the date/hour, medication, reason or result · September 9, 2015 at 8:00 PM- No documented evidence of intensity relative to reason and result was documented as " effective " no intensity documented or time of reassessment · September 12, 2015 at 9:00 PM- Reason documented as " c/o pain " (no location documented); Result documented as " effective " - no intensity or time of reassessment documented · September 13, 2015 at 9:00 AM- Result documented as " effective " - no intensity or time of reassessment documented · September 14, 2014 at 9:00 AM- Reason documented as " c/o pain " - no location documented; Result was left blank- no reassessment documented In addition, Roxanol 0.25 milliliter administration was documented on the September 2015 MAR on September 1, 2015 at 11:00 AM; September 5, 2015 at 12:30 PM; and September 6, 2015 at	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 86 7:00 PM. The three (3) occasions lacked documentation of the descriptors relative to pain to include intensity before and after the administration of the Roxanol 0.25 milliliter. In each instance, the facility staff documented " effective " in the section reserved for the result. In addition, the result did not contain the time of the reassessment. There was no evidence that the charge nurse consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen with Codeine and Roxanol. 3. The charge nurse failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #170 A review of the medical record revealed that Resident #107 was admitted on December 5, 2014 with diagnoses to include Sacral Osteomyelitis, Arrhythmia, Debility, and Status post Right Above Knee Amputation. Medical record review conducted on September 18, 2015 at 2:35 PM revealed Physician Orders date and signed by the physician on September 4, 2015 with the original order date of June 16, 2015 for Acetaminophen 325 milligrams two (2) tabs by mouth every six (6) hours as needed for pain or temperature greater than 101; and Acetaminophen 500 milligrams two (2) caplets by mouth every day 30 minutes prior to wound care for pain management.	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 87 Review of the Medication Administration Record (MAR) for August and September 2015 revealed the following: Acetaminophen 325 milligram two tablets were administered as follows: August 6, 2015 at 2:10 (no indication of AM or PM); August 10, 2015 at 1:30 PM; August 14, 2015 at 11:30 (no indication of AM or PM); August 18, 2015 at 7:00 PM; August 20, 2015 at 7:00 PM; and August 25, 2015 at 9:00 AM; and Acetaminophen 500 milligram two caplets every day prior to wound care was administered daily during the month of August and September 1 through 18, 2015. Subsequent review of the reverse side of the MAR revealed the following documentation relative to administration of Acetaminophen 325 milligrams and Acetaminophen 500 milligrams: · August 6, 2015 at 2:10 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result · August 10, 2015 at 1:30 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 14, 2015 at 11:30 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result · August 18, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 20, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 25, 2015 at 9:00 AM- No documented	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 88 evidence of the date/hour, medication, reason or result In addition, the medical record lacked a documented pain assessment relative to the administration of Acetaminophen prior to wound care in accordance with the facility ' s pain policy of at least weekly for chronic pain. There was no evidence that the charge nurse consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen. 4. The charge nurse failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #142. A review of the medical record revealed that Resident #142 was admitted on September 4, 2015 with diagnoses to include dysphagia, respiratory failure, and Guilliare-Barre Syndrome. Review of the medical record on September 16, 2015 at approximately 12:45 PM revealed Physician Orders for Tylenol 650 milligram via PEG (Percutaneous Endoscopic Gastrostomy) tube every six (6) hours as needed for pain dated September 4, 2015; and Tylenol 650 milligrams via PEG 30 minutes prior to wound care. Review of the September 2015 Medication Administration Record (MAR) revealed the facility staff documented the administration of the daily Tylenol 650 milligrams prior to wound care. In	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 89 addition on September 15, 2015 at 6:00 PM, Resident #142 received Tylenol 650 milligrams for " pain- 4/10 " no location and/or other descriptors were documented and " 1/10- effective " upon reassessment (no time of reassessment documented). The medical record lacked documented evidence the facility staff consistently conducted pain assessment for a newly admitted resident to assess the effective of the pain management regimen relative to pre-medication for pain prior to wound care and/or weekly for according to the facility ' s policy for residents with chronic pain. The charge nurse failed to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of pain. 5. The charge nurse failed to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80. A review of the medical record revealed that Resident #80 was admitted with diagnoses to include Amyotrophic Lateral Sclerosis, Anemia, Stage IV Sacral Ulcer, and Respiratory Failure. Medical record review conducted on September 16, 2015 at approximately 3:20 PM revealed Physician Order for Acetaminophen 650 milligram via G-tube (Gastrostomy tube) 30 minutes prior to wound care for pain management signed and date September 4, 2015. Review of the Medication Administration Record	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 90 for September 2015 revealed Acetaminophen 650 milligrams were administered once a day from September 1- 16, 2015. The medical record lacked documented evidence of a pain assessment before and after the administration of Tylenol for pain prior to wound care. Furthermore, the medical record lacked documented evidence of a weekly pain assessment for a resident with chronic pain. The charge nurse failed to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of chronic pain in accordance with the facility ' s policy. 6. The charge nurse failed to consistently assess Resident #43 ' s response to pain interventions. a. On September 18, 2015 at approximately 12:15 PM, a review of the admission note revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed a daily order for Percocet [narcotic analgesic] 30 minutes prior to wound care treatment for pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-17, 2015 between the 3-11PM-work shifts.	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 91 Further review of the nursing notes and clinical record revealed that the staff failed to assess the resident ' s response to pain 7 (seven) of 17 days that the pain medication was administered. On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #21 regarding the aforementioned findings. He/she reviewed the record and acknowledged the findings. The record was reviewed on September 18, 2015. b. the charge nurse failed to re-assess the effectiveness of wound care interventions for Resident #43. On September 18, 2015 at approximately 12:15 PM, a review of the admission record revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed an order that directed the following: " Cleanse sacral ulcer wound with normal saline, pat dry with gauze. Apply Maxorb [wound care dressing] Ag [silver] and cover with dry dressing daily. " Further review of the weekly wound documentation from April 2015 to September 10, 2015 revealed the following monthly wound	L 051	**Response to L051, #6b, Resident #43** 1. There was no adverse affect to the wound healing process because the 'actual' treatment being done was saline. The error was in the report submitted by the wound consultant physician. 2. A review of wound care orders were audited finding all orders in compliance. 3. Careful review of treatment orders during end of month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to ensure all orders are documented and implemented. The audit findings will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 92 information relative to the resident ' s sacral wound: April 30, 2015 Stage 4 2.8 [length] x 2.5 [width] x1.8 [depth] May 21, 2015 Stage 4 2.2 x 1.7 x1 June 25, 2015 Stage 4 1.7 x 1.5 x 2 July 23, 2015 Stage 3 2.0 x 2.5 x 1.0 August 28, 2015 Stage 3 2.9 x 2.0x 1.5 September 10, 2015 Stage 3 2.0 x 1.5 x 0.8 The resident ' s wound advanced to a Stage 4 ulcer and the record lacked documented evidence that the staff re-assessed the effectiveness of the wound care interventions. On September 18, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employee #12 regarding the wound care interventions and how the staff re-assessed the effectiveness of the treatment plan. He/she provided no answer. The record was reviewed on September 18, 2015. 7. The charge nurse failed to assess the effectiveness of pain medication that was	L 051	**Refer to page 92 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 93 administered to Resident #49. On September 18, 2015 at approximately 1:45 PM, a review of the admission note revealed that Resident #49 was initially admitted to the facility on January 26, 2011 with diagnoses that included Traumatic quadriparesis with thoracic, lumbar, and left acetabulum fractures, Diabetes Mellitus, and Hypertension. Review of the physician ' s orders signed and dated September 2015 revealed a daily order for Percocet [narcotic analgesic] for chronic pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-18, 2015 at 08:00 AM. Further review of the clinical record lacked documented evidence that the facility staff assessed the resident ' s response to the administered pain medication on September 3, 5, 6, 7, 8, 10, 11, 12, and 15, 2015. On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #20 regarding the aforementioned finding. He/she was asked to provide the documentation that the resident was assessed for the effectiveness of the daily pain medicine on the aforementioned dates. He/she reviewed the clinical record, could not provide the requested documentation, and acknowledged the findings. The record was reviewed on September 18, 2015.	L 051	**Refer to page 77 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 94	L 052		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 95 him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: A. Based on observations, record review and staff interview for six (6) of 55 sampled residents, it was determined that sufficient nursing time was not given to: provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being as evidenced by failure to: consistently assess and monitor the status of one (1) who exhibited an acute change in status as manifested by low blood pressure, increased respirations and tachycardia; to perform an accurate assessment for one (1) resident who experience a documented change in condition; to consistently assess and monitor one (1) resident who was ventilator dependent and experienced tachycardia; assess and identify the need for one (1) resident who had accumulated white colored substance on his/ her tongue; and failed to ensure that one (1) resident wore protective head gear and that the head circumference was measured in accordance to physician's orders and failed to follow physicians orders to obtain weekly weights times four (4) weeks for one (1) resident. Residents ' #145, #37, #5, #104 and #143, #6. The findings include: 1. Sufficient nursing time was not given to	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 96 consistently assess and monitor the status of Resident #145 (ventilator dependent), who exhibited an acute change in status as evidence by the presence of low blood pressure, increased respirations and persistent tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized. Resident #145 was admitted on August 25, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. Res #145 complained of shortness of breath (SOB), refused C-PAP treatments secondary to SOB and exhibited signs of a change in mental status. The clinical record lacked evidence that nursing staff identified, acted on, comprehensively assessed and intensively monitored the resident when he/she demonstrated a change in status as evidenced by the following: Resident #145 complained of SOB and refused C-PAP treatments as follows: Ø August 29, 2015- 7PM-7AM- Shift Report ---- " Patient refused CPAP trails last night ...back on AC (assist control) due to patient complaining of SOB (shortness of breath)	L 052	**Response to L051, Resident #145, 37, 5, 6** 1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 ws reviewed to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders. 2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross-referencing the medical record to ensure the physician is notified of any change in the resident's condition. The audit results found all medical records in compliance. Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician. 3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) The Respiratory staff were re-educated on 9/25/2015 related to the recognition of changes in resident's status, notification to physician and timeliness of completing physician orders..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 97 Ø August 30, 2015 - 7AM-7PM- S- Shift Report Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Resident #145 demonstrated change in mental status as follows: Ø Psychiatric consultation August 31, 2015 (hour not indicated) " ...unable to assess [secondary to] pt [patient] not responding ... responding to painful stimuli but not easily arousable ...Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain medications ... " Ø Respiratory therapy entry [shift report] dated August 31, 2015 7AM-7PM read: " ...patient remains on A/C mode, no active weaning due to patient being less arousable in PM. " There was no evidence that sufficient nursing time was given to conduct comprehensive assessments when Resident #145 exhibited a change in the level of arousal, complained of shortness of breath and refused treatments. The record revealed that nursing staff communicated to the mental health practitioner [psychiatric consult] that the resident was not responsive due to " pain medication. " However, a review of the Medication Administration Record [MAR] revealed Tylenol 500mg 2 caplets were administered during the 7AM - 3PM shift on August 31, 2015. A review of previous administrations of Tylenol lacked evidence that the resident sustained an alteration in mental status [lack of arousal].	L 052	**Response to L051, Resident #145, 37, 5, 6** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three(3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 98 An in-depth review of the clinical record is as follows: A review of Physician ' s Orders dated August 25, 2015 included, but was not limited to the following: Ventilator (Ventilator Settings: AC (Assist/Control, Rate- 15, TV (Tidal Volume)- 500, PEEP (Positive End Expiratory Pressure), FIO2 - 45% (Fraction of Inspired Oxygen) Duoneb (bronchodilators) 2.5mg/3ml (millimeter)- 1 vial neb (nebulization treatment) [every] 6 hours PRN (as needed) for bronchospasms, Note: The Duo Neb order was modified on August 25, 2015 for administration " every 4 hours " [instead of every 6 hours as needed] Tylenol 500mg 2 caplets via peg 30 minutes prior to wound care for pain Seroquel (antidepressant) 25 mg (milligram) - 1 tablet via GT (Gastrostomy tube) BID (twice a day) for depression; Prozac 20 mg 1 capsule daily for Depression Midodrine (Vasopressor/Antihypotensive medication) 10mg via GT (Gastrostomy Tube) TID (three times a day) for hypotension. Hold for SBP (Systolic blood pressure) > (greater) 120, DBP (diastolic blood pressure) > 80.... Pulmonary Consult and Psychiatry consult An Interim physician ' s order dated August 31, 2015 read: August 31, 2015- 2059 (8:59PM) - Please	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 99 transfer patient to nearest ER via 911 re: Acute AMS (Altered Mental Status), tachycardia and hypotension. " Physician ' s Notes: " August 25, 2015- 3:17 PM- Pulmonary Consult: ... Awake, alert, appears anxious. Vitals: Chest-crackles [positive] bilaterally, vent settings: VT-500, AC-15, P [Peep] - 5, FIO2-45%, Impression: Chronic Respiratory Failure. PT (Patient) on vent-tolerates CPAP (Continuous Positive Airway Pressure) trials intermittently. Continue trials as tolerated. [He/she] remains very anxious ... Titrate O2 (oxygen) to sats (saturations) > (greater than or equal to) 92%. August 25, 2015- 1545 (3:45PM) - Attending/Admission Note: cc: (chief complaint) - Chronic Respiratory Failure .... Assessment/Plan: - Chronic Respiratory Failure- continue on vent at current settings, continue vent weaning trials, Pulmonary input appreciated ... Depression- Continue Prozac (Anti-depressant). August 28, 2015 - 1520 (3:20 PM) - Attending Note; cc: chronic respiratory failure. Voiced [no] complaints this afternoon. [Vital Signs Stable]- T-98, Pulse-74, Respirations-18, B/P (Blood Pressure) - 132/82. Assessment/Plan: Chronic Respiratory Failure- Continue on vent, wean as possible, suction PRN (as needed), Depression- Continue on Prozac. August 31, 2015- 2103 (9:03 PM) - Hospitalist Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 100 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded [and] unresponsive with agonal breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension- unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " Psychiatric Diagnostic Consultation: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... " Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient not arousable and does not answer questions at this time. Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess mood/and anxiety. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... " August 29, 2015 3:00 AM - " ...[b/p] 116/62; [P]	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 101 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [no respirations documented, two (2) different heart rates]... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: 8/31/15, Time: 9:39 PM ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " A review of the facility ' s Ventilator Policy/Protocol The facility ' s Ventilator Management and Nursing Care Respiratory Protocol [no date indicated] stipulates: " Modes of Ventilation- Assist-Control Ventilation (A/C): A/C delivers the preset volume or pressure in response to the patient ' s own inspiratory effort, but will initiate the breath if the patient does not do within the set amount of time. This means that any inspiratory attempt by the patient triggers a ventilator breath. The patient may need to be sedated to limit the number of spontaneous breaths since hyperventilation can occur. This mode is used for patients who can initiate a breath but who have weakened respiratory muscles. "	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 102 Respiratory Notes/Ventilator Flow Sheets [documented in S-BAR format]: " August 29, 2015- 7PM-7AM- Shift Report- S- Patient refused CPAP trails last night, B- Respiratory Failure, Status Post Trach. Obese. A: Sat = 99%, [Heart Rate -79, Respiratory Rate-24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Stable and alert. R- Continue to encourage patient to get weaned. Ventilator Flow Sheet- Special Procedures Done [and] Time Performed: CPAP 5/10 x10[minutes], back on AC due to patient complaining of SOB (shortness of breath) August 29, 2015- 7A-7PM- S- Shift Report, B-Respiratory Failure, A- Received on AC mode, neb tx (treatment) given as ordered. [Patient tolerated Duoneb, Pulse ox- 98%, HR-72, R- Will continue to monitor patient and wean as tolerated. August 30, 2015 - 7PM- 7AM - Shift Report- - S- [Patient] is on AC 15, 500, 45%, +5, B-Respiratory Failure, A- [Patient] is on AC. Stable O2 Sat 98%, HR-78%, RR-20. No sign of distress, R- We will continue monitoring [patient] and [symptoms] as needed. There was no evidence that Duoneb treatments (prescribed every 4 hours) were administered between 4:48 PM (last noted dose administered during the 7AM-7PM shift) and 11:59 PM on August 30th. The record revealed that the next dose was given at 12 Midnight on 8/31/15 [nearly 7 hours after the preceding dosage]. August 30, 2015 - 7AM-7PM- S- Shift Report, B-Respiratory Failure, A- Received [patient] on AC mode, [nebulization treatment] given as	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 103 ordered. [Patient] ... (Illegible writing). [Pulse Ox-99%, HR (illegible writing), R- Will continue to monitor patient. Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Physician Order: Albuterol 2.5mg and Atrovent .5mg - q 4 (every 4 hours). Treatments were documented as being administered at 0020 (12:20 AM), 0410 (4:10 AM), 0800 (8:50 AM), 1310 (1:10 PM), and 16:48 (4:48PM). " The next Duoneb treatment was recorded as being administered on 8/31/15 (12MN), approximately 7 hours later. August 31, 2015- 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of " being unable to breathe " but in no apparent distress. Continue to monitor for changes. August 31, 2015- 7AM-7PM- S- Pt remains on AC mode. [No] active weaning [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) cleared, R- Will continue to monitor. Ventilator Flow Sheet revealed the following " Rate Set/Total " on the A/C mode: 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation- 97%, Heart Rate- 87 0425 (4:30 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 104 and Heart Rate documented in the allotted space. 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " [defined: 15/34 - " 15 " reflects ventilator preset respiratory rate and " 34 " reflects - resident breaths] A review of the nebulization treatment administration record for August 30th revealed the 6th dosage [prescribed every 4 hours] of Duoneb [scheduled for administration at approximately 8:45 PM on August 30th] was omitted without explanation. However, the respiratory therapy " shift notes " [7AM-7PM] notes reveal the resident complained of shortness of breath. The clinical record lacked evidence that the physician was notified regarding the resident ' s complaint of having shortness of breath, refusing CPAP trials and the missed Duoneb treatment from August 29, 2015 at (7PM-7AM) to August 31, 2015 (7AM-7PM). A face-to-face interview was conducted with Employee #14 (on-coming team member) September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she stated that the off-going team member, who stated that the resident was calling all night and that [he/she]. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night; and the resident had the call bell you blow into. Employee #14 acknowledged the physician should have been informed of the resident ' s missed duoneb treatment, restlessness and the complaint of having shortness of breath and refusing to use	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 105 the CPAP on August 29, 2015. A follow-up interview was conducted with Employee#14 on September 18, 2015 at approximately 3:00 PM regarding the missed Duoneb treatment on August 30, 2015. He/she stated there was only one (1) respiratory therapist on 8/30/15 (7PM-7AM) shift. There were 12 residents on ventilators, 15 residents who had tracheostomies, four (4) residents requiring BIPAP (Bi-level Positive Airway Pressure), 2 (two) residents requiring Hi-Flow, 55 [nebulization] treatments and four (4) residents weaning from ventilators. A review of the respiratory therapist assignment sheet dated August 30, 2015 revealed one respiratory therapist on for the 7PM-7AM shift. Also, the Respiratory Therapist was assigned a Registered Nurse orientee (for orientation to ventilator). A review of the nursing assignment for August 30, 2015 revealed four (4) Licensed Practical Nurses (LPNs) were on duty for the 6th floor from 7:00 AM-3:30PM shift to manage residents receiving ventilator services. The clinical record lacked evidence that facility staff consistently assessed and monitored Resident #145 when the resident ' s mental status changed, complained of having shortness of breath, and difficulty breathing. Nursing assessments failed to depict the resident being anxious, restless and having difficulty breathing. The physician was not notified when the resident	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 106 complained of shortness of breath, which was first documented on August 29, 2015. The resident ' s condition declined as evidenced by a change in mental status, heart rate elevated to 150 ' s and blood pressure as low as 77/53 as depicted in the hospitalist note on the evening of August 31, 2015. The resident was subsequently transferred to the nearest ER via 911 and hospitalized. The clinical record was reviewed on September 18, 2015. A review of records obtained from the acute care facility that the resident was transferred to revealed the resident was admitted and a physician ' s entry on 8/31/15 included: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Systolic B/P- 87, diastolic B/P (Blood Pressure)-48; [Oxygen] Saturation -100; FIO2 [Fraction of Inspired Oxygen] Ventilator- 100 [percent]. 2. Sufficient nursing time was not given to perform an accurate assessment for Resident #37 who experienced a documented change in condition. Resident #37 was admitted on July 22, 2015 with diagnoses to include Chronic Respiratory Failure, Coronary Artery Disease, and Sacral Decubitus. Medical record review was conducted on	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 107 September 21, 2015 at 9:40 AM. The review of clinical notes revealed inconsistencies in the assessment of Resident #37 status on September 18, 2015 at 5:00 PM as it relates to entries documented by medical staff, nursing staff, and respiratory staff. The inconsistencies are as follows: · Physician Progress note from September 18, 2015 at 5:30 PM revealed the Attending Physician was requested by the nursing staff to evaluate the resident with changes in mental status, tachycardia, and hypoxia. According to the medical staff assessment, the resident was noted to have a heart rate of 166 beats per minute, blood pressure of 125/56 millimeter of Mercury. · The nursing staff documented an ' Acute Change in Condition Report ' dated September 18, 2015 at 5:00 PM secondary to resident with elevated irregular heart rate of 166 beats per minute and oxygen saturation of 81% while on the ventilator with FiO2 of 40%. · Review of the Ventilator Flow Sheet dated September 18, 2015 revealed the respiratory therapy staff documented pre- treatment assessment at 5:00 PM which indicated the heart rate- 89 beats per minute, respiratory rate- 19 breaths per minute, and oxygen saturation- 98 percent; and post-treatment assessment at 5:15 PM indicating heart rate was 90 beats per minute, respiratory rate 16 breaths per minute and oxygen saturation of 98%.	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 108 Although the medical and nursing staff assessed Resident #37 to have experienced a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation, the respiratory therapy staff documented an assessment with the heart rate, respiratory, and oxygen saturation consistent with Resident #37 ' s baseline physical assessments. Resident #37 was subsequently transferred via Emergency Medical Services to a local emergency department. A face to face interview was conducted with Employee #31 on September 21, 2015 at approximately3:30 PM. S/he confirmed that the respiratory assessment was inconsistent with the change of condition at the time of assessment. The findings were reviewed, discussed, and acknowledged. 3. Sufficient nursing time was not given to consistently assess and monitor Resident #5 who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]. A review of Resident #5 ' s quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. According to physician ' s orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 109 Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia with HR [140], SBP [systolic blood pressure 110, RR [respiratory rate] 20s-30s; SAT [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O aspiration/sepsis. Will send to ER [Emergency Room] v [by] 911. "	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 110 A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. IS Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. Vs T 98.6, P 87, R 20, BP 130/77 Pulse OX 98%. Turned and repositioned, due meds give. " June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator] dependent for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3. June 2, 2015- 8:35 AM- SBAR [Situation, Background, Assessment, Recommendation]/Acute change in condition. Resident was noted with respiratory distress and	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 111 an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. " Respiratory Therapy Notes: A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following: "Date: June 2, 2015 Time: 0025 [12:25 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70 Date: June 2, 2015 Time: 0345 [3:45 AM] Mode: AC Fi02: 40% PEEP 5 Saturation: 98% Heart Rate: 121 Date: June 2, 2015 Time: 08:20 [8:20 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 99% Heart Rate: 129	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 112 There was no documented evidence that sufficient nursing time was given to notify the physician in regards to Resident #5 ' s increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours. A review of the respiratory therapy shift note revealed : June 2, 2015 - 7pm-7am shift note revealed: S: Pt on A/C mode B: Respiratory resident A: Sat 98% HR 71, RR 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress. R: monitor June 2, 2015 -7AM- 7PM Shift- no documentation under shift report; indicated on flow sheet- " PT [Patient] transferred to area Hospital. " The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased. The physician was not notified when the resident ' s became tachycardia (increased heart rate) , which was first documented on June 2, 2015 at 3:45 AM to be 121. The resident ' s condition declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response was called and resident was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the residents heart rate of 140.	L 052	**Refer to page 97 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 113 A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 state that his/her shift is 7:00AM to 7:00PM. Employee #18 also state, when he/she first saw the resident with the heart rate 129 is when the rapid response [When a resident's condition changes (based on predetermined criteria) and requires an assessment by a physician to stabilize his/her condition and prevent further deterioration] was called at approximately 8:20AM, the resident vomited when he/she was bagged. Employee #47 stated when he/she was conducting rounds from the rooms assigned he/she was called to the rapid response by Employee #18 who stated that the rapid response took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. The clinical record was reviewed on September 21, 2015. 4. Sufficient nursing time was not given to assess and identify the need for medical intervention for Resident #104, who had accumulated white colored lesions on his/her tongue. The resident was subsequently diagnosed with oral Candidiasis and prescribed antifungal treatment. According to, " The Lippincott Manual of Nursing Practice, " Ninth Edition-2010, pp 613, revealed: " Conditions of the Mouth and Jaw .... Candidiasis-Candidiasis is a fungal infection commonly caused by Candida albicans. It usually	L 052	**Refer to page 115 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 114 occurs in the mouth ... Candidiasis can become a source of systemic dissemination, particularly in high-risk persons, Clinical Manifestations: (1.) Oral discomfort, burning, altered taste, erythema, (2) White, raised, painless plaques, loosely adherent, (3) Possible spread to the esophagus with pain on swallowing and chest pain Management: Topical antifungal agents in oral rinses, troches, or creams, such as Mycelex or Nystatin ... Analgesics for pain ..., Nursing Assessment: Assess extent of lesions and inflammation in mouth ... 2. Assess level of pain ... Patient Education and Health Maintenance: (2) Instruct high-risk patients about daily oral examination and signs and symptoms to observe (3). Encourage good oral hygiene .... " An observation of the Resident #104 during the survey period revealed the following: On September 10, 2015 at approximately 4:28 PM-Resident #104 ' s tongue was observed completely coated with a white substance. A second attempt was made on September 14, 2014 at approximately 12Noon to visualize Resident #104 ' s oral cavity with Employee #15. A visualization of the resident ' s oral cavity was unsuccessful because the resident rejected the employee ' s attempt to open his/her mouth. This surveyor conveyed to Employee #15 the concern related to the observation of the white substance on the resident ' s tongue. Employee #15 informed the Nurse Practitioner who evaluated the resident and diagnosed him/her with Oral Candidiasis as follows: Nurse Practitioner note dated September 14, 2015 at 4:10 PM read: " Asked to evaluate resident with c/o [complaint of] whitish coating on	L 052	**Response to L051, Resident #145, 37, 5, 6** 1. On 9/15/15 interventions were put in place by nursing for resident #104 per NP assessment. 2. All residents dependent in activities of daily living (ADL) were reassessed and an appropriate care plan updated. . 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. The RCCs or designee will perform daily clinical rounds with nursing staff to review resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline on mouth care/oral hygiene and the current products used in the facility. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits of the CNA flowsheet to ensure ADLs are performed per care plan for dependent residents. A quarterly summary of the audits will be reported to the Quality Assurance Committee until..	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 115 tongue. Resident is bedbound and clamps mouth close [with] difficulty to adequately view oral cavity. Assessment done [with] aid of primary nurse, " = " whitish coating on tongue. Attempted to clear tongue with mouth care kit [without] any effect on mouth/tongue coating. [No] distress. A [Assessment]:- Oral Candidiasis (Thrush). Plan: Nystatin solution 100,000 units/ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days. Reassess for any adverse changes. " Sufficient nursing time was not given to assess and identify the need for intervention for Resident #104 whose tongue was observed coated with a white substance. According to the annual Minimum Data Set (MDS0 with a Assessment Reference Date (ARD) of August 14, 2015 revealed Resident #104 ' s diagnoses in Section I (Active Diagnoses) included: Seizure Disorder, Traumatic Brain Injury, Tracheostomy, Craniotomy, Dysphagia. Section G (Functional Status) resident was coded as being total dependent with one person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth ....). Physician ' s order dated August 25, 2015 directed: " Mouth care every shift. " An interim physician ' s order [subsequent to the surveyor ' s observation] dated September 14, 2015 at 4:00 PM directed; " Nystatin (Anti-fungal medication) Oral Suspension 100,000 units per ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days for thrush. "	L 052	**Refer to page 115 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 116 A review of the resident ' s " CNA Charting " flow sheets from September 7, 2015 through September 15, 2015 revealed, " Personal Hygiene: Resident required one person physical assist to provide all hygiene tasks [oral care included], with no self-performance. " The comprehensive care plan updated August 11, 2015 included the following problem: " Alteration in ADL (Activities of Daily Living) function [secondary] to diagnosis of Anoxic Brain Injury, Approaches included, ... Staff to provide oral, hair and nail care qd (every day) and prn (as needed) ... " Sufficient nursing time was not given to assess and identify the need for medical intervention for Resident #104, who had an accumulation of a white colored coating on his/her tongue that was diagnosed as Candidiasis (thrush) after the surveyor ' s request for intervention. A face-to-face interview was conducted with Employees #15 and #17 on September 14th at approximately 1:00 PM. When queried about how the resident ' s mouth care is performed and the frequency, he/she stated; " It is done every day, and an oral swab is used and s/he stated there was no white coating on the resident ' s tongue. He/she further stated sometimes white secretions are in his/her mouth but they are suctioned out, and the mouth and tongue is cleaned. The clinical record was reviewed on September 15, 2015. 5. Sufficient nursing time was not given to ensure that Resident #143 wore protective head gear and head circumference was measured weekly in accordance to physician ' s orders.	L 052	**Response to L052, Resident #104** 1. On 9/15/15 interventions were put in place by nursing for resident #104 per NP assessment. 2. All residents dependent in activities of daily living (ADL) were reassessed and an appropriate care plan updated. . 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. The RCCs or designee will perform daily clinical rounds with nursing staff to review resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline on mouth care/oral hygiene and the current products used in the facility. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits of the CNA flowsheet to ensure ADLs are performed per care plan for dependent residents. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months.. **Refer to page 118 for response**	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 117 On September 16, 2015 at approximately 11:45 AM and 2:00 PM. Staff was observed sitting in chair, near the window at the foot of Resident # 143 ' s bed. The resident was observed asleep, lying in bed on his/her back. A white mitten was observed on the right hand. He/she was covered with a white sheet. A helmet was positioned on the foot board. A face to face interview was conducted with Employee #48 at the time of the observation. Employee #48 was queried about the scheduled times the resident was supposed to wear the helmet. He/she stated; " He/she is supposed to wear the helmet when he/she is out of bed. Employee #48 further stated that the resident was on one to one (1:1) observation. A physician order dated August 27, 2015 directed; " Helmet to be worn Q [every] shift for safety to protect craniotomy site. Remove every 2 (two) hours to check skin integrity. Document in chart. Measure head circumference weekly. Report increase in size to MD (Medical Doctor). " The clinical record lacked evidenced that Resident #143 ' s head circumference was measured weekly in accordance to physician ' s orders. There was no evidence that sufficient nursing time was given to ensured the resident wore his/her helmet in accordance to physician ' s order. A face-to-face interview was conducted with Employee #18 on September 16, 2015 at approximately 2:31 PM. He/she acknowledged the aforementioned findings. The observation and clinical record was conducted on September 16, 2015. 5. Sufficient nursing time was not given to conduct weekly weights times four [4] weeks	L 052	**Response to L052, Resident #143** 1. Resident #143 suffered no adverse event. The head circumference was re-measured and found consistent with previous measurements. The attending was contacted and care plan updated to include interventions related to managing resident with a craniotomy 2. There were no other residents with an order for a helmet; therefore, no other resident was affected. 3. Staff re-educated of the standards of practice related to execution of physician orders. 4. RCC or designee will perform random audits of the medical record to ensure physician orders are followed per policy. Results of the audits will be reported the Quality Council until 100% compliance is consistently maintained for six (6) months **Refer to page 119 for response**	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 118 according to the physician ' s orders for Resident #6. A review of the residents History and Physical conducted on February 13, 2015 revealed the resident has the following active diagnoses which included: Senile Dementia, Arthritis, Elephantiasis Varicosa legs, Cataract. A review of the resident's " Monthly Weights" sheet revealed the following: January 2015 - 112 pounds February 2015 -116 pounds March 2015 - 116 pounds April 2015 - 88 pounds ?? - the two (2) hand written question marks [??] were written in the corresponding space for " re-weight. " May 2015 - 88 pounds June 2015 - 89.4 pounds July 2015 - 91.2 pounds August 2015- 90.8 pounds A Quarterly Nutrition Review conducted dated May 19, 2015 revealed, "Swallowing /chewing difficulty; (etiology) dysphagia and missing teeth; (signs/symptoms) SLP [Speech Language Pathology] ordered ... mechanical soft diet ...(other comments) PO [by mouth] intake 75%, Boost Plus [nutritional supplement] intake 50%..(Progression on Interventions: ...(3) wwx4 [weekly weights times four] ... " A review of the physician ' s orders dated May 19, 2015 ... " (3) Weekly weights x 4 weeks. "	L 052	**Response to L052, Resident #6** 1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings. 2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician. 3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) 4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 119 A further review of the clinical record revealed more than 30 days had lapsed before the Quarterly Nutrition Review was conducted in May 2015. In addition, there was no evidence in the clinical record that weekly weights times 4 weeks were conducted as ordered per the physician orders. A face-to-face interview was conducted with Employees' #26 and #27 on September 17, 2015 at approximately 9:50 AM regarding interventions once the weight loss was identified. Employee #26 acknowledged that a reweight should have been conducted and placed on weekly weights. In summary, Resident #6 sustained a 28 pound weight loss from March 2015 to April 2015. There was no evidence that a reweight or weekly weights times 4 were conducted to confirm the weight loss. B. Based on record review and staff interview for seven (7) of 55 sampled residents, it was determined the sufficient nursing time was not given to: conduct comprehensive pain assessments to include characteristics such as intensity, type, pattern of pain, location, frequency and duration of pain for seven (7) residents; consistently assess two (2) residents response to pain intervention. Residents ' #64, #108, #107, #142, #80, #43 and #49. The findings include:	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 120 Facility ' s Policy -Pain Assessment and Management policy Copyright 2001 MED_PASS, INC (Revised October 2010) stipulates " Steps in the Procedure Recognizing Pain: 1. Observe the resident (during rest and movement) for physiologic and behavioral (non-verbal) signs of pain ...Assessing Pain: 1. During Comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): a. History of pain and its treatment ...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; (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 that reduce pain; and f. Symptoms that accompany pain (e.g. nausea, anxiety) ...Identifying the Causes of Pain ...Define Goals and Appropriate Interventions ...Implement Pain Management Strategies1. Non-pharmacological interventions ...; 2. Pharmacological interventions ...; 4. The physician and staff will establish a treatment regimen based on consideration of the following a. The resident ' s medical condition; b. Current medication regimen; c. Nature, severity and cause of the pain; d. Course of the illness; and e. Treatment goals ...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions ...Monitoring and Modifying Approaches ...Documentation 1. Document the resident ' s reported level of pain with adequate details (i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the	L 052	**Response to L052, Resident #64, #108, #107, #142, #80, #43 and #49** 1. Immediately upon notification of this deficiency, a comprehensive pain assessment for residents #64, #107, #142, #80, #43 and #49 was completed. 2. Resident #108 was discharged, therefore no further actions could be taken. 3. A chart audit was conducted on all residents on pain management program. Audit findings determined no other resident potentially affected by the same deficient practice. All clinical staff were reeducated on 10/15, 10/25 and ongoing by the Interim Administrator/DON on the revised Pain Assessment and Management policy and the Omnicare Pharmacy Pain Flowsheet. . The Omnicare Pharmacy Pain Flowsheet will be implemented 11/1/15 for pain monitoring and documentation of assessment, intensity and effectiveness. The RCCs will perform a random sample audit of the pain flowsheet weekly to ensure compliance. 4. Results of the audit findings will be reported weekly to the Risk Management Subcommittee three (3) months. A monthly summary of the audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 121 person conducting the assessment shall record the information obtained from the assessment in the resident ' s medical record. " 1. Sufficient nursing time was not given to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for resident #64 A review of the medical record revealed Resident #64 was admitted on May 4, 2015 with diagnoses which included Surgical Wound, Sacral Wound, and Nutritional Deficit with Reconditioning. Resident #64 was transferred out to a local emergency department on September 1, 2015 to manage " change in mental status " . Review of medical record conducted on September 14, 2015 revealed Resident #64 has a documented community-acquired Stage IV sacral pressure ulcer present on admission which last measured 15 X 16.5 X 3.5 centimeters according to the Wound and Skin Care Progress Note dated August 31, 2015. According to the Physician ' s Orders, the medical staff documented the following medication orders relative to pain: · July 15, 2015- Tramadol 50 milligrams via G-tube (gastrostomy tube) three times a day prior to wound care · August 24, 2015 at 2:10 PM- Discontinue Tramadol 50 milligrams; Start Tramadol 100 milligram by mouth 30 minutes prior to wound treatment three times per day then one (1) by mouth every eight (8) hours as needed pain	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 122 · August 31, 2015 at 1:00 PM- Discontinue Tramadol order; Start Oxy IR (Immediate Release) 5 milligram by mouth one tab 30 minutes prior to wound treatment every shift and every eight (8) hours as needed for pain · September 1, 2015 at 3:15 PM- Discontinue Oxy IR (Immediate Release)order; start Neurontin 100 milligram three times daily by mouth for neuropathic pain; Tylenol ES [Extra Strength] 500 milligrams by mouth three times daily 30 minutes prior to wound treatment every shift for pain Review of the Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented assessment of Resident #64 on June 22, 2015, July 28, 2015; August 20, 2015 and September 1, 2015. On August 20, 2015, Resident #64 was seen for significant weight loss. The medical record lacked documentation relative to pain during this visit. On September 1, 2015 at 3:20 PM, the medical staff had a discussion with Resident #64 ' s family member about " ...many questions related to issues of pain, wound care and weight loss and recurrent UTI (Urinary Tract Infections) ...We discussed pain medications being used Oxy IR which was started yesterday ' p ' (symbol for after) discontinuing Tramadol but resident is more drowsy today. Will discontinue all narcotics ... " The medical record lacked documented evidence to provide insight into the reason for adjusting the pain medication regimen prior to wound care from August 24, 2015 through September 1, 2015.Nurse ' s Notes from August 22, 2015 through September 1, 2015 revealed Resident #64 was medicated prior to wound care; however,	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 123 the medical record lacked documented evidence the facility staff performed comprehensive pain assessments before and after the administration of pain medication. In addition, the medical record lacked documented evidence of unresolved or worsening pain to warrant an adjustment in the resident ' s pain medication regimen. On September 1, 2015 at 11:30 PM, the facility staff documented a " SBAR [Situation Background, Assessment and Response]/ Acute Change In Condition Report " which " detailed reason for evaluation ...change in mental status, lethargic " . The sections reserved for the documentation of " Things that make the problem worse; Pertinent recent medical history; Mental status; Change in intake/hydration; and Labs in the past 30 days " were left blank. According to the narrative contained in the SBAR: Resident #64 was " noted very sleepy but arouse to touch and verbal commands " at around 9:00 PM. The resident ' s family was in the room at the time of the observation. S/he informed the facility staff " that resident sleep deeply and not communicating with her " . SicThe attempt to start an intravenous line was unsuccessful secondary to poor vein. Resident #64 ' s respirations were also " noted " to be shallow with a change in vital signs. The vital signs were documented as follows: temperature- 97.3 degrees Fahrenheit, blood pressure- 125/55 millimeters of Mercury; respirations- 28 breaths per minute, and heart rate 120 beats per minute. The resident was subsequently transferred to the hospital via Emergency Medical Services. Subsequent review of the August 2014 Medication Administration Record (MAR) revealed the facility staff documented the administration of Tramadol 50 milligrams prior to	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 124 wound care from August 1-24, 2015 and on August 25- 31, 2015 Tramadol 100 milligram, was administered three times a day. The Medication Administration Record did not contain specific time of each dose of pain medication administered and/or the time wound treatment was completed. Medication administration times were documented according to the shift, i.e. " 7-3; 3-11; 11-7 " . Furthermore, the MAR lacked documentation of comprehensive pain assessment before and after medication administration to determine the presence of pain and/or effective of the pain medication. Review of Nurse ' s Notes from August 19, 2015 through September 1, 2015 revealed the facility staff documented the pain medication administration prior to wound care. According to the note documented on August 20, 2015 at 11:00 PM, the Resident #64 was " medicated x1 with Tramadol as ordered prior to wound care for breakthrough pain with positive outcomes " , there was no documentation to provide enough description of pain to include intensity, descriptors, pattern, location and radiation, and a frequency. In addition, there were additional nurse ' s notes on August 22, 23, 24, 26, and 28, 2015 that indicated that pain medication was administered prior to wound care with " good " or " + " (positive) effects. However, the aforementioned nurse ' s notes lacked documented evidence of a pain assessment before and after the administration of the pain medication to include location, intensity, and descriptors. On August 24, 2015 at 11:00 [no indication of am or pm documented], the facility staff documented the " resident was asked if the pain medicine ... gets is effective enough for [his/her] with [him/her]	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 125 wound care, resident said yes but if [s/he] can get more, it will make [his/her] more comfortable " . The medical staff was notified and pain medication was increased. Review of the subsequent nursing notes failed to reveal the facility staff performed monitoring for effectiveness and/or adverse consequences relative to pain. On September 1, 2015 at 1:00 PM the facility staff was called to the resident ' s room because the resident was observed " drowsy " and had been unable to " be taken to therapeutic recreation this morning. " According to the September 1, 2015 at 1:00 PM note, " Resident was given Oxycodone 5mg IR and the nurse getting ready to do ... wound care. " The family at bedside and responsible party via telephone was notified Resident #64 " has a new order for Oxy IR but will have the NP (Nurse Practitioner) review this med [medication] since resident is drowsy " . Oxy IR was last administered on September 1, 2015 during the " 7-3 " shift; the specific time was not documented. It is unclear if the responsible party had been notified of the medication change at the time of the order. The medical record lacked documented evidence the nursing staff performed a comprehensive assessment when a change in condition was identified at 1:00 PM. It was at 9:00 PM on September 1, 2015 that the family " complained that resident sleep deeply and not communicating with her, resident opened her eyes then close it still responds to touch " . A call was placed to the house officer at 9:30 PM. The medical record lacked documented evidence the facility staff continued to assess and monitor Resident #64 ' s condition with ensure s/he	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 126 received necessary care and treatment to prevent and/or readily identify acute changes in status at the earliest time possible. The " Pain " care plan initiated for the period of May 6, 2015 through September 6, 2015 revealed the facility staff documented the " Problem/Need Related To " as: " Other, specify generalized " ... " Resulting In: Complaints of pain less than daily " ... " Strengths To Draw On: Able to communicate needs, Able to express level of pain " with Goal(s) identified as: " will be free of pain complaints; Will display signs of comfort, no grimacing; Will report pain resolved with pain medication and other interventions " . The " Target Review date: 5/6/15-9/6/15 " . The " Interventions " for " Nursing " include " Assess symptoms of pain on occurrence and document location and pain scale as reported by the resident; Provide quiet environment; Offer calming music, TV per resident request; Offer back rub, warm blanket; Provide pain medications as prescribed; Check vital signs: Freq. Per order and Notify Physician if: Pain persists despite intervention; vital signs are out of normal range along with pain persistence. " The sections reserved for intervention to be documented by dietary, social services, and activities were left blank. On the reverse side of the care plan for " pain " , there were three (3) entries as follows: · " 5/11/15- Cont. c [line noted above the letter ' c '] (with) POC (Plan of Care) x 90 days " · " 8/24/15- Pain reevaluated, need for increase in pain med noted CRNP (Certified Registered Nurse Practitioner) notified, Tramadol increased to 100 mg. Will cont. to monitor resident. " · " 8/31/15- Resident is started on Oxy IR 5 mg to be given prior to wound care. Will monitor	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 127 resident. Tramadol dc ' d [discontinued]. " The medical record lacked documented evidence the facility staff consistently followed the plan of care to demonstrate assessment, monitoring, and provision of necessary care and treatment in accordance with standards of practice relative to the treatment of resident with complaints of pain. Review of Significant Change in Status Assessment Minimum Data Set (MDS) dated August 9, 2015 revealed the following coding for Section J Health Conditions: J0100 Pain Management A. Been on a scheduled pain medication regimen?- " 1. Yes " ; B. Received PRN pain medications OR was offered and declined? - " 0. No " ; C. Received non-medication intervention for pain?- " 1. Yes " ; Section J0300- " Have you had pain or hurting at any time in the last 5 days? " - " 1.- Yes " ; 0J0400. Pain Frequency: " How much of the time you experience pain or hurting over the last 5 days?- " 3- Occasionally " ; and J0600 Pain Intensity A. Numeric Rating Scale (00-10)- Please rate your worst pain over last 5 days on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine- " 05 " . Further review of the medical record revealed Resident #64 experienced a significant weight loss since admission to the facility from May, 2015 through August, 2015. The weights were documented as: May 11, 2015- 186.8 pounds; May, 2015 (day of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. As a result of the documented weights the resident triggered for a significant weight loss for 30 days according to the Nutritional Care Progress notes on June 17, 2015, July 20, 2015, and August 19, 2015.	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 128 The medical record lack documented evidence that the interdisciplinary team evaluated the potential impact the resident ' s complaints of pain may have on his/her nutritional status. Although the facility staff continued to administer pain medication routinely prior to wound care, the facility staff failed to assess and reassess Resident #64 in enough details and frequency to ensure management and prevention of pain consistent with the comprehensive assessment, plan of care, and accordance with current clinical standards of practice, resident ' s goals and preferences. A face-to-face interview was conducted with Employee #11 on September 21, 2015 at approximately 9:40 AM regarding the management of pain for Resident #64. When queried about the facility ' s policy relative to pain management and assessments, s/he stated that it is expected that the nursing staff assess the pain when the medication is given and afterwards. S/he further provided a Medication Administration Record and pointed out where the documentation would be located. The reverse of the Medication Administration record for Resident #64 was reviewed, discussed, and acknowledged. Sufficient nursing time was not given to conduct comprehensive pain assessments and reassessment before and after the administration of pain medication as is consistent with current clinical standards of practice. There was no evidence the resident was consistently monitored when pain medications were adjusted and when the resident demonstrated a change in clinical status [e.g. lethargy], there was no comprehensive nursing assessment. On	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 129 September 1, 2015, the resident demonstrated " drowsiness, " at 1:00 PM however; facility staff did not intervene for several hours [approximately 9:30 PM] until the resident ' s symptoms worsened and required emergency transport out of the facility. 2. Sufficient nursing time was not given to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80. A review of the medical record revealed Resident #108 was admitted on December 19, 2014 with diagnoses which include Congestive Heart Failure with EF (Ejection Fraction) 20%, Cerebrovascular Accident Status post Craniotomy, Hypertension, and Diabetes Mellitus. Medical record review conducted on September 13, 2015 revealed a Physician Order dated August 17, 2015 for Acetaminophen with Codeine 300 mg/30 mg one tab via g-tube (gastrostomy tube) every 6 (six) hours as needed for pain and on August 28, 2015 at 12:00 PM- " ...Roxanol 20 mg/ml 0.25 ml [milliliter] (5mg) SL [sublingual] q3º [every three hours] PRN [as needed] severe pain/ SOB [shortness of breath] " . A review of the September 2015 Medication Administration Record (MAR) revealed Acetaminophen with Codeine was administered for pain on the following occasions: September 3, 2015 at 11:00 AM; September 8, 2015 at 8:00 AM, September 9, 2015 at 8:00 PM, September	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 130 10, 2015 at 9:30 AM, September 11, 2015 at 11:30 AM, September 12, 2015, September 13, 2015 at 9:00 AM, and September 14, 2015 at 9:00 AM. The reverse side of the September 2015 MAR revealed the details of the Acetaminophen with Codeine administered for pain as follows: · September 3, 2015 at 11:00 AM- No documented evidence of the date/hour, medication, reason or result · September 8, 2015 at 8:00 AM- No documented evidence of the date/hour, medication, reason or result · September 9, 2015 at 8:00 PM- No documented evidence of intensity relative to reason and result was documented as " effective " no intensity documented or time of reassessment · September 12, 2015 at 9:00 PM- Reason documented as " c/o pain " (no location documented); Result documented as " effective " - no intensity or time of reassessment documented · September 13, 2015 at 9:00 AM- Result documented as " effective " - no intensity or time of reassessment documented · September 14, 2014 at 9:00 AM- Reason documented as " c/o pain " - no location documented; Result was left blank- no reassessment documented In addition, Roxanol 0.25 milliliter administration was documented on the September 2015 MAR on September 1, 2015 at 11:00 AM; September 5, 2015 at 12:30 PM; and September 6, 2015 at 7:00 PM. The three (3) occasions lacked documentation of the descriptors relative to pain	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 131 to include intensity before and after the administration of the Roxanol 0.25 milliliter. In each instance, the facility staff documented " effective " in the section reserved for the result. In addition, the result did not contain the time of the reassessment. There was no evidence that sufficient nursing time was given to consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen with Codeine and Roxanol. 3. Sufficient nursing time was not given to conduct comprehensive pain assessments and/or reassessments to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #107 A review of the medical record revealed that Resident #107 was admitted on December 5, 2014 with diagnoses to include Sacral Osteomyelitis, Arrhythmia, Debility, and Status post Right Above Knee Amputation. Medical record review conducted on September 18, 2015 at 2:35 PM revealed Physician Orders date and signed by the physician on September 4, 2015 with the original order date of June 16, 2015 for Acetaminophen 325 milligrams two (2) tabs by mouth every six (6) hours as needed for pain or temperature greater than 101; and Acetaminophen 500 milligrams two (2) caplets by mouth every day 30 minutes prior to wound care for pain management.	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 132 Review of the Medication Administration Record (MAR) for August and September 2015 revealed the following: Acetaminophen 325 milligram two tablets were administered as follows: August 6, 2015 at 2:10 (no indication of AM or PM); August 10, 2015 at 1:30 PM; August 14, 2015 at 11:30 (no indication of AM or PM); August 18, 2015 at 7:00 PM; August 20, 2015 at 7:00 PM; and August 25, 2015 at 9:00 AM; and Acetaminophen 500 milligram two caplets every day prior to wound care was administered daily during the month of August and September 1 through 18, 2015. Subsequent review of the reverse side of the MAR revealed the following documentation relative to administration of Acetaminophen 325 milligrams and Acetaminophen 500 milligrams: · August 6, 2015 at 2:10 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result · August 10, 2015 at 1:30 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 14, 2015 at 11:30 (no indication of AM or PM)- No documented evidence of the date/hour, medication, reason or result · August 18, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 20, 2015 at 7:00 PM- Reason- " general pain " no documentation of intensity; Result- " effective " no documentation of intensity or time of reassessment · August 25, 2015 at 9:00 AM- No documented evidence of the date/hour, medication, reason or	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 133 result In addition, the medical record lacked a documented pain assessment relative to the administration of Acetaminophen prior to wound care in accordance with the facility ' s pain policy of at least weekly for chronic pain. There was no evidence that sufficient nursing time was given to consistently conducted pain assessments that included the intensity of the pain (e.g. numeric scale) before and after the administration of Acetaminophen. 4. Sufficient nursing time was not given to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #142. A review of the medical record revealed that Resident #142 was admitted on September 4, 2015 with diagnoses to include dysphagia, respiratory failure, and Guilliare-Barre Syndrome. Review of the medical record on September 16, 2015 at approximately 12:45 PM revealed Physician Orders for Tylenol 650 milligram via PEG (Percutaneous Endoscopic Gastrostomy) tube every six (6) hours as needed for pain dated September 4, 2015; and Tylenol 650 milligrams via PEG 30 minutes prior to wound care. Review of the September 2015 Medication Administration Record (MAR) revealed the facility staff documented the administration of the daily Tylenol 650 milligrams prior to wound care. In addition on September 15, 2015 at 6:00 PM,	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 134 Resident #142 received Tylenol 650 milligrams for " pain- 4/10 " no location and/or other descriptors were documented and " 1/10- effective " upon reassessment (no time of reassessment documented). The medical record lacked documented evidence the facility staff consistently conducted pain assessment for a newly admitted resident to assess the effective of the pain management regimen relative to pre-medication for pain prior to wound care and/or weekly for according to the facility ' s policy for residents with chronic pain. Sufficient nursing time was not given to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of pain. 5. Sufficient nursing time was not given to conduct comprehensive pain assessment and/or reassessment to include characteristics such as intensity, type, pattern of pattern, location, frequency and duration of pain for Resident #80. A review of the medical record revealed that Resident #80 was admitted with diagnoses to include Amyotrophic Lateral Sclerosis, Anemia, Stage IV Sacral Ulcer, and Respiratory Failure. Medical record review conducted on September 16, 2015 at approximately 3:20 PM revealed Physician Order for Acetaminophen 650 milligram via G-tube (Gastrostomy tube) 30 minutes prior to wound care for pain management signed and date September 4, 2015. Review of the Medication Administration Record	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 135 for September 2015 revealed Acetaminophen 650 milligrams were administered once a day from September 1- 16, 2015. The medical record lacked documented evidence of a pain assessment before and after the administration of Tylenol for pain prior to wound care. Furthermore, the medical record lacked documented evidence of a weekly pain assessment for a resident with chronic pain. Sufficient nursing time was not given to consistently conduct comprehensive pain assessments that include the intensity for resident with complaints of chronic pain in accordance with the facility ' s policy. 6. Sufficient nursing time was not given to consistently assess Resident #43 ' s response to pain interventions. a. On September 18, 2015 at approximately 12:15 PM, a review of the admission note revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed a daily order for Percocet [narcotic analgesic] 30 minutes prior to wound care treatment for pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-17, 2015 between the 3-11PM-work shifts.	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 136 Further review of the nursing notes and clinical record revealed that the staff failed to assess the resident ' s response to pain 7 (seven) of 17 days that the pain medication was administered. On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #21 regarding the aforementioned findings. He/she reviewed the record and acknowledged the findings. The record was reviewed on September 18, 2015. b. Sufficient nursing time was not given to re-assess the effectiveness of wound care interventions for Resident #43. On September 18, 2015 at approximately 12:15 PM, a review of the admission record revealed that Resident #43 was initially admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnoses included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed an order that directed the following: " Cleanse sacral ulcer wound with normal saline, pat dry with gauze. Apply Maxorb [wound care dressing] Ag [silver] and cover with dry dressing daily. " Further review of the weekly wound documentation from April 2015 to September 10,	L 052	**Response to L052, #6b, Resident #43** 1. There was no adverse affect to the wound healing process because the 'actual' treatment being done was saline. The error was in the report submitted by the wound consultant physician. 2. A review of wound care orders were audited finding all orders in compliance. 3. Careful review of treatment orders during end of month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to ensure all orders are documented and implemented. The audit findings will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 137 2015 revealed the following monthly wound information relative to the resident ' s sacral wound: April 30, 2015 Stage 4 2.8 [length] x 2.5 [width] x1.8 [depth] May 21, 2015 Stage 4 2.2 x 1.7 x1 June 25, 2015 Stage 4 1.7 x 1.5 x 2 July 23, 2015 Stage 3 2.0 x 2.5 x 1.0 August 28, 2015 Stage 3 2.9 x 2.0x 1.5 September 10, 2015 Stage 3 2.0 x 1.5 x 0.8 The resident ' s wound advanced to a Stage 4 ulcer and the record lacked documented evidence that the staff re-assessed the effectiveness of the wound care interventions. On September 18, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employee #12 regarding the wound care interventions and how the staff re-assessed the effectiveness of the treatment plan. He/she provided no answer. The record was reviewed on September 18, 2015. 7. Sufficient nursing time was not given to assess	L 052	Refer to page 137 for response Refer to page 121 for response	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 138 the effectiveness of pain medication that was administered to Resident #49. On September 18, 2015 at approximately 1:45 PM, a review of the admission note revealed that Resident #49 was initially admitted to the facility on January 26, 2011 with diagnoses that included Traumatic quadriparesis with thoracic, lumbar, and left acetabulum fractures, Diabetes Mellitus, and Hypertension. Review of the physician ' s orders signed and dated September 2015 revealed a daily order for Percocet [narcotic analgesic] for chronic pain. Review of the Medication Administration Record [MAR] dated September 2015 revealed that the staff administered Percocet daily from September 1-18, 2015 at 08:00 AM. Further review of the clinical record lacked documented evidence that the facility staff assessed the resident ' s response to the administered pain medication on September 3, 5, 6, 7, 8, 10, 11, 12, and 15, 2015. On September 18, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #20 regarding the aforementioned finding. He/she was asked to provide the documentation that the resident was assessed for the effectiveness of the daily pain medicine on the aforementioned dates. He/she reviewed the clinical record, could not provide the requested documentation, and acknowledged the findings. The record was reviewed on September 18, 2015.	L 052	**Refer to page 121 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 139 C. Based on observations, record review and staff interview for two (2) of 55 sampled residents, it was determined that sufficient nursing time was not given to ensure residents received the necessary services to carry out activities of daily living, maintain good personal and oral hygiene as evidenced by: one (1) resident unable to carry out activities of daily living and one (1) resident who had an accumulation of white colored substance on his/her tongue. Residents' #80 and #104. The findings include: 1. Resident #80 was admitted with diagnoses to include Amyotrophic Lateral Sclerosis, Anemia, Stage IV Sacral Ulcer, and Respiratory Failure. During observations September 10, 2015 at approximately 8:00 AM and September 14, 2015 at approximately 2:00 PM, Resident #80 was observed in bed wearing a dress and multipodus boots bilaterally. Medical record review conducted on September 16, 2015 at approximately 3:20 PM revealed Resident #80 ' s Annual Minimum Data Set (MDS) dated April 2, 2015 revealed s/he is dependent for Activities of Daily Living (ADL ' s) to include bed mobility, transfers, dressing, eating. Review of the care plans revealed the facility staff failed to initiate a care plan relative to Activities of Daily Living for a resident who is dependent on	L 052	**Response to L052, C, Resident #80** 1. The care needs for resident #80 were assessed and an appropriate care plan was developed immediately upon notification of this deficiency. A schedule for resident #80 to be out of bed was also created. 2. ADL needs for dependent residents on each unit were reassessed and an appropriate care plan with specific interventions was developed. 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. Create quarterly care plan review of all ADL dependent residents. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits ensure ADLs are performed per care plan for dependent residents. Audit findings will be reported weekly to the Risk Management Subcommittee for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 140 thestaff to meet those needs. On September 16, 2015 at 3:20 PM a face to face interview was conducted with Employee #10. When queried about Resident #80 ' s out of bed schedules and showers Employee #80 stated that the resident is unable to get showers and does not get out of bed. According to employee #10, his/her isolation and ventilator status prevent the resident from leaving the room to shower. The resident is provided complete bed baths in the room. Employee #10 was unable to provide further explanation relative to the resident not being able to get out of bed. On September 16, 2015 the facility staff subsequently provided documentation of a physician order and care plan with date of initiation of September 16, 2015. Sufficient nursing time was not given to provide necessary care and services for a resident who is unable to do their own ADL care. 2. Sufficient nursing time was not given to assess and identify the need for medical intervention for Resident #104, who had accumulated white colored lesions on his/her tongue. The resident was subsequently diagnosed with oral Candidiasis and prescribed antifungal treatment. According to, " The Lippincott Manual of Nursing Practice, " Ninth Edition-2010, pp 613, revealed: " Conditions of the Mouth and Jaw .... Candidiasis-Candidiasis is a fungal infection commonly caused by Candida albicans. It usually	L 052	**Refer to page 142 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 141 occurs in the mouth ... Candidiasis can become a source of systemic dissemination, particularly in high-risk persons, Clinical Manifestations: (1.) Oral discomfort, burning, altered taste, erythema, (2) White, raised, painless plaques, loosely adherent, (3) Possible spread to the esophagus with pain on swallowing and chest pain Management: Topical antifungal agents in oral rinses, troches, or creams, such as Mycelex or Nystatin ... Analgesics for pain ..., Nursing Assessment: Assess extent of lesions and inflammation in mouth ... 2. Assess level of pain ... Patient Education and Health Maintenance: (2) Instruct high-risk patients about daily oral examination and signs and symptoms to observe (3). Encourage good oral hygiene .... " An observation of the Resident #104 during the survey period revealed the following: On September 10, 2015 at approximately 4:28 PM-Resident #104 ' s tongue was observed completely coated with a white substance. A second attempt was made on September 14, 2014 at approximately 12Noon to visualize Resident #104 ' s oral cavity with Employee #15. A visualization of the resident ' s oral cavity was unsuccessful because the resident rejected the employee ' s attempt to open his/her mouth. This surveyor conveyed to Employee #15 the concern related to the observation of the white substance on the resident ' s tongue. Employee #15 informed the Nurse Practitioner who evaluated the resident and diagnosed him/her with Oral Candidiasis as follows: Nurse Practitioner note dated September 14,	L 052	**Response to L052, Resident #104** 1. On 9/15/15 interventions were put in place by nursing for resident #104 per NP assessment. 2. All residents dependent in activities of daily living (ADL) were reassessed and an appropriate care plan updated. . 3. All clinical staff were reeducated regarding assessment, and documentation of ADLs emphasizing the mouth care policy and the importance of oral health care. The RCCs or designee will perform daily clinical rounds with nursing staff to review resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline on mouth care/oral hygiene and the current products used in the facility. 4. The Resident Care Coordinators (RCC) or designee will perform weekly rounds on each unit and documentation audits of the CNA flowsheet to ensure ADLs are performed per care plan for dependent residents. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 142 2015 at 4:10 PM read: " Asked to evaluate resident with c/o [complaint of] whitish coating on tongue. Resident is bedbound and clamps mouth close [with] difficulty to adequately view oral cavity. Assessment done [with] aid of primary nurse, " = " whitish coating on tongue. Attempted to clear tongue with mouth care kit [without] any effect on mouth/tongue coating. [No] distress. A [Assessment]:- Oral Candidiasis (Thrush). Plan: Nystatin solution 100,000 units/ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days. Reassess for any adverse changes. " Sufficient nursing time was not given to assess and identify the need for intervention for Resident #104 whose tongue was observed coated with a white substance. According to the annual Minimum Data Set (MDS) with a Assessment Reference Date (ARD) of August 14, 2015 revealed Resident #104 ' s diagnoses in Section I (Active Diagnoses) included: Seizure Disorder, Traumatic Brain Injury, Tracheostomy, Craniotomy, Dysphagia. Section G (Functional Status) resident was coded as being total dependent with one person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth ...). Physician ' s order dated August 25, 2015 directed: " Mouth care every shift. "	L 052	**Refer to page 142 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 143 An interim physician ' s order [subsequent to the surveyor ' s observation] dated September 14, 2015 at 4:00 PM directed; " Nystatin (Anti-fungal medication) Oral Suspension 100,000 units per ml. Apply 5 ml (millimeters) to tongue and clean tongue QID (four times a day) [times] 14 days for thrush. " A review of the resident ' s " CNA Charting " flow sheets from September 7, 2015 through September 15, 2015 revealed, " Personal Hygiene: Resident required one person physical assist to provide all hygiene tasks [oral care included], with no self-performance. " The comprehensive care plan updated August 11, 2015 included the following problem: " Alteration in ADL (Activities of Daily Living) function [secondary] to diagnosis of Anoxic Brain Injury, Approaches included, ... Staff to provide oral, hair and nail care qd (every day) and prn (as needed) ... " There was no evidence that sufficient nursing time was given to provided oral care consistent with the resident's need. A face-to-face interview was conducted with Employees #15 and #17 on September 14th at approximately 1:00 PM. When queried about how the resident ' s mouth care is performed and the frequency, he/she stated; " It is done every day,	L 052	**Refer to page 142 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 144 and an oral swab is used and s/he stated there was no white coating on the resident ' s tongue. He/she further stated sometimes white secretions are in his/her mouth but they are suctioned out, and the mouth and tongue is cleaned. The clinical record was reviewed on September 15, 2015. D. Based on observation, record review and staff interviews for two (2) of 55 sampled residents, it was determined that the sufficient nursing time was not given to promote the healing of pressure ulcers that were present as evidenced by staff failure to: perform an accurate assessment to identify the appropriate stage of a sacral ulcer for one (1) resident; and revise the plan of care related to bed surfaces, nutritional status, pain and preventative measures for one (1) resident. Residents #64 and #91 . The findings include: Sufficient nursing time was not given to provide treatment and services to promote healing of the Stage IV pressure ulcer on Resident #64 ' s sacrum. 1. Resident #64 was admitted on May 4, 2015. According to the History and Physical examination documented by the physician May 4, 2015, Resident #64 ' s diagnoses included Surgical Wound, Stage IV Sacral Wound, and Protein Malnutrition and Deconditioning. According to Section M, Skin Conditions, of the	L 052	**Response to L052, D1 & 2, Resident #64 and 91** 1. Immediately upon notification of this deficiency, the most recent comprehensive assessment was reviewed to determine triggers and care-planning needs for residents #64 and #91. A focus interdisciplinary care plan meeting was held, to include wound care team, to determine the appropriate plan of care. Resident #91 medical record was reviewed to address staging and concluded as indicated. 2. The Interdisciplinary Team reassessed residents with community acquired wounds and appropriate plan of care implemented. An audit of residents identified with a pressure ulcer were reviewed to ensure accuracy in staging. 3. The DON and Wound Care Nurse re-educated the Interdisciplinary Care Planning Team on 11/3/2015 regarding avoidable/unavoidable pressure ulcer assessment and reassessment of treatment and criteria for staging. 4. The Resident Care Coordinators (RCC) or designee will audit the MDS, wound reports and TAR to ensure MDS triggers are treatments are followed and documented per order. The audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently obtained for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 145 Admission Minimum Data Set (MDS) dated May 11, 2015, Resident #64 was coded as having two (2) Stage IV sacral ulcers, one (1) Stage 3 pressure ulcer and Moisture Associated Skin Damage (MASD). Section K, Nutritional status, revealed Resident #64 received 51% or more of his/her nutrition and hydration via feeding tube and orally via mechanically altered diet. A Significant Change MDS dated August 9, 2015 under Section M; Skin Conditions revealed Resident #64 was assessed with one (1) Stage IV and two (2) Stage 2 pressure ulcers. Medical record review revealed physician orders on the September 2015 Physician Order Form for the following sacral wound treatments: Calmoseptine " apply to affected area sacral/ perineal area after each incontinence care with original order date May 5, 2015; and " Sacrum Wound: Cleanse with Normal Saline, pat dry, then soak Kerlix with Dakin ' s Solution [Half Strength] every shift " with original order date May 8, 2015. The medical record contains no further order changes relative to the treatment of sacral wound. Review of the care plan dated May 6, 2015 through September 6, 2015 listed Pressure Ulcer: Sacral Stage IV with potential for delay healing due to multiple contributors as a problem. An entry dated May 6, 2015 stated the goal as: " Ulcer will be healed without complication; Ulcer will be clean and free of odor " . Nursing interventions to this problem include " Wound status: size of wound: measurements of depth and width, skin color, surrounding skin tissue assessment weekly, complaints of pain, effectiveness of pain medication per MD order;	L 052	**Refer to page 145 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 146 Apply medicated ointment per MD order; Apply dressing per MD order (space for order specific is blank); keep Dietary informed of wound status: Freq: PRN; Notify physician of wound status of change in or deterioration in status of wound; and Air mattress to promote wound healing " . The sections for Dietary, Social Services, and Activities intervention were blank with no interventions indicated. Nurse ' s notes and Nutrition Risk Assessment dated May 5, 2015 documented the presence of a 16 X 18 X 3 centimeter Stage 4 pressure ulcer on sacrum. The presence ulcer was documented as present on admission May 4, 2015. The most recent wound assessment was documented as 15 X 16 X 3.5 centimeters on August 31, 2015 with the " narrative: 08/31/15 unable to assess Resident. {She} said she is sick, pain though pain med has been given & N/V (and nausea and vomiting). Nurse aware " . A face to face interview was conducted with Employee #25 on September 18, 2015 at approximately 11:45 AM; s/he stated that there were occasions when weekly wound assessments could not be performed secondary to complaint of pain and not feeling well. S/he recalled that recently on August 31, 2015 Resident #64 had complaints of not feeling well and was sent out to the hospital. The medical record lacked documented evidence of pain assessment and/or physician notification relative to complaint of pain with attempt to perform wound assessment. According to Employee #25, each time the resident declines a wound assessment, the primary nurse is made aware. The employee acknowledged that the measurement (size of the wound) recorded on the August 31, 2015 ' Wound and Skin Care	L 052	**Refer to page 145 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 147 Progress Note ' was actually assessed on August 24, 2015 and not characteristic of the status of the wound on August 31, 2015. Additional documentation reviewed included nurse ' s notes for notification of change in condition, comprehensive assessment performance, weight, and nutritional status from May 4, 2015 through September 1, 2015. Resident #64 was noted to have significant weight loss, poor nutritional intake, and a persistent Stage IV sacral decubitus ulcer. The medical record lacked documented evidence to support the notification of the physician and/or revision of interventions until August 20, 2015. On August 20, 2015, the medical staff documented that they were asked to evaluate resident for significant weight loss Admission weight in May, 2015 was documented as 177 pounds and August, 2015 weight was documented as 141 pounds. The assessment documents the following relative to skin- " sacral decub [decubitus] Stage IV " . The plan on August 20, 2015 was to follow recommendations from dietician to increase tube feeding and encourage oral intake until goal is met for ideal weight and start Vitamin C and Zinc supplements for wound healing. On September 1, 2015 at 3:20 PM, the medical staff discussed the plan of care with the resident ' s responsible party according to the documentation had " many questions related to issues of pain wound care and weight loss and recurrent UTI (urinary tract infection). The plan on September 1, 2015 was to discontinue all	L 052	**Refer to page 145 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 148 narcotics due to increase drowsiness, start Neurontin and Tylenol for pain, Marinol for appetite stimulation, and schedule an appointment with Wound Care Surgeon. The facility staff was unable to fully implement the plan secondary to " change in mental status " noted at 11:30 PM on September 1, 2015. Resident #132 was transferred out to acute care facility for evaluation and treatment. Review of the Significant Change in Status Assessment Minimum Data Set dated August 9, 2015 revealed Section K0200B- Weight: 150 pounds; K0300 Weight Loss- " Loss of 5% or more in the last month or loss 10% or more in the last 6 moth " : 2.- Yes, not on physician-prescribed weight-loss regimen. Although the facility was aware of the resident ' s weight loss, persistent Stage IV sacral pressure ulcer, and continued to routinely administer pain medication prior to wound care, they failed to consistently reassess and/or modify wound treatment regimen; and/or document rationale for continuing the present treatment despite little healing as the resident was continued on Dakin ' s without change. In addition, there was no evidence the facility staff explored whether or not the resident was could benefit from specialty consultation (e.g. wound consult) and/or a variation in support surface. September 17, 2015 at approximately 11:55 AM a face to face interview was conducted with Employee #4. The findings were reviewed, discussed, and acknowledged.	L 052	**Refer to page 145 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 149 2. Sufficient nursing time was not given to identify the appropriate stage of a sacral ulcer for Resident # 91. According to the MDS [Minimum Data Set] 3.0, pressure ulcer stages and characteristics are noted as follows: " Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence ... " " Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister serum-filled blister. " A review of the clinical record for Resident #91 revealed an 'Acute Change in Condition Report' dated September 3, 2015 and timed at 0:200 AM that indicated the resident was discovered to have a " new sacral open area " that measured 0.5 cm [length] x 0.5 cm [width]. The ' Weekly Wound Documentation ' sheet revealed the following: September 3, 2015 that the resident had a Stage 1 ulcer to the sacrum that measured 0.5 cm x 0.5 cm with scant serous drainage; and on September 9, 2015 the ulcer was staged as a " 1, " measuring 0.2 cm x 0.5 cm, with scant serous drainage. A review of the physician ' s interim order form revealed an order dated September 3, 2015 that directed the following, " ...Cleanse sacral opening with NSS [Normal Saline Solution], pat dry, apply calmoseptine each shift and prn [as	L 052	**Refer to page 145 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 150 necessary]. " On September 17, 2015 at approximately 10:00 AM, a wound care observation was conducted with Employee # 17 for resident #91. Resident #91 was observed, in the presence of Employee #10 to have a Stage 2 (open) wound on his/her sacrum. Employee #10 acknowledged and confirmed the finding. Sufficient nursing time was not given to identify the appropriate stage of the sacral ulcer; according to the pressure ulcer staging described in MDS. The record was reviewed on September 14, 2015. E. Based on record review and staff interview for two (2) of 55 sampled residents, it was determined that sufficient nursing time was not given to maintained acceptable parameters of nutritional status as evidenced by two (2) residents, who sustained significant unplanned weight loss. Residents' #64 and #6. The findings include: 1.Sufficient nursing time was not given to maintain acceptable parameters of nutritional status and verify a significant weight loss for Resident #64. According to the facility's policy; "Weight Assessment and Intervention" stipulates:, " Weight Assessment 1. The nursing staff will resident weights on admission, the next day, and	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 151 weekly for one week thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter ...3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing ...Analysis 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions ...2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight... " Review of the medical record on September 14, 2015 at approximately 11: 20 AM revealed Resident #64 ' s History and Physical dated May 4, 2015 included the " Working Diagnosis " : Protein Malnutrition, PEG (Percutaneous Endoscopic Gastrostomy) tube to be placed; Rehab Potential: limited until improved nutritional status " . Medical record review conducted on September 16, 2015 at 10:00 AM revealed the following documented weights: May 11, 2015- 186.8 pounds; May, 2015 (date of month unknown) - 177 pounds; June, 2015- 163 pounds; July, 2015- 150 pounds; and August, 2015- 141 pounds. The Nutrition Care Progress Notes revealed the dietician documented monthly relative to nutritional plan of care to include adjustments to the enteral feeding products administered via Percutaneous Endoscopic Gastrostomy and nutritional status as follows:	L 052	**Response to L052, E1 & 2, Resident #64 and #6** 1. Immediately upon notification of this deficiency a review of the medical record for resident #6 to verify findings. 2. The Assistant Director of Clinical Nutrition performed a retrospective audit of the monthly weights on 10/1/2015 to ensure that all residents with significant weight changes were addressed and communicated to the attending physician. 3. Assessment and Intervention policy will be revised to reflect the Registered Dietitian (RD) as responsible for notifying the attending physician or NP of a confirmed significant weight change within 48 hours. The RD will call the attending physician or NP to inform about the significant weight change via phone and email. The RD will keep a record of physician/NP significant weight notification including date, time, and mode of communication. The RD will continue to communicate weekly to the Interdisciplinary Risk Management Subcommittee of interventions related to significant weight changes based on clinical collaborations. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) 4. The Assistant Director of Clinical Nutrition will perform monthly audits of the physician significant weight change notification record. The audit results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 152 "June 17, 2015 at 10:00 AM- Resident triggered for significant weight loss for 30 days (-7.9%); Resident on mechanical soft diet with thin liquids; Resident also receives tube feeding of Isosource 1.5 at 65 milliliter per hour for 10 hours for weight maintenance, since diet was upgraded from puree to mechanical soft. June 24, 2015 at 9:00 AM- " Resident currently presents with Stage IV sacral ulcer measuring 15X17X3 cm [centimeter] wound is showing evidence of healing, mechanical soft diet with nocturnal TF [tubefeeding] of Isosource 1.5 at 70 milliliter per hour. June 29, 2015 at 10:00 AM- Isosource 1.5 at 65 milliliter per hour for 10 hours (6 PM - 4 AM); mechanical soft diet by mouth with thin liquids; Beneprotein four (4) times per day; " no new labs, no new weight. " July 20, 2015 at 12:30 PM- " Resident triggered for significant weight change for (-7.9%), Will increase nocturnal tubefeeding at this time prevent further weight loss; Nutren 2.0 at 60 milliliter per hour for 10 hours. July 27, 2015 at 10:30 AM- " Resident on a calorie/protein dense formula overnight. Resident also receiving Beneprotein four (4) times per day for healing; Diet order mechanical soft thin liquids, p.o. (oral) intake less than 50. August 19, 2015 at 1:40 PM- " Resident triggered	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 153 for significant weight change for 30 days (-6%) and for 90 days (-20%); Current weight- 141 pounds; initial weight loss secondary to poor p.o. (oral) intake; TF [tube feeding] was increased upon initial loss; Currently on Nutren 2.0 at 60 milliliter per hour for 10 hours; will increase TF [Tube feeding] at this time to prevent further weight loss; Met with resident, would like extra gravy for meats, p.o. [oral] intake steady, made aware of weight loss, verbally understood " ; Recommendation was to increase tubefeeding to Nutren at 75 milliliter per hour for 10 hours September 1, 2015 at 12:00 PM- " ...Resident currently on Nutren 7.0 at 75 milliliter per hour for 10 hours which provides 60 grams of protein; Resident also receives zinc, vit. C (Vitamin C) and Beneprotein four times a day for wound healing upon interview resident unable to wake up and answer questions secondary to oxycodone, no current s/s (signs/ symptoms intolerance or discomfort note. Will continue POC (Plan of Care) to encourage wt.[weight] stability and wound healing. Will continue to follow. " Review of the Physician ' s Progress Notes from June 22, 2015 through September 1, 2015 revealed the medical staff documented notification of significant weight loss on August 20, 2015. The medical record lacked documented evidence that the medical staff assessed the resident to identify the nature of the problem, possible causes, and/or tailored interventions to Resident #64 ' s specific situation i.e. monitoring of labs, specialty consults, frequent monitoring of weights.	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 154 Although the dietician continued to adjust the tubefeeding orders and assessed the resident monthly, the facility staff failed to identify the nature of the problem, possible causes, and/or tailored interventions to Resident #64 ' s specific situation from May 11, 2015 through August 20, 2015. A face to face interview conducted with Employee #27 at 10:38 AM on September 16, 2015 revealed that Resident #64 was admitted as "obese". According to Employee #27, after it was determined the resident was not eating, the plan was changed to adjust tubefeeding because of volume intolerance and oral intake. When queried about labs, s/he stated the labs were not available and it was assumed the albumin was low because of the sacral wound and weight loss. Juven was started for 2 weeks and then changed to Beneprotein. The resident plan of care was discussed with the nurse manager at the time. S/he was unable to provide any further insight related to physician notification. Sufficient nursing time was not given to maintain acceptable parameters of nutritional status and verify a significant weight loss The findings were discussed, reviewed and acknowledged by Employee # 11 The clinical record was reviewed on September 16, 2015. 2. Sufficient nursing time was not given to implement measures to ensure that Resident #6 maintained acceptable parameters of nutritional	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 155 status as evidence by more than a 25% [percent] weight loss in 30 days. A review of the residents History and Physical conducted on February 13, 2015 revealed the resident has the following active diagnoses which included: Senile Dementia, Arthritis, Elephantiasis Varicosa legs, Cataract. A review of the resident's " Monthly Weights" revealed the following: January 2015 - 112 pounds February 2015 -116 pounds March 2015 - 116 pounds April 2015 - 88 pounds ?? - the two (2) hand written question marks [??] were written in the corresponding space for " re-weight. " May 2015 - 88 pounds June 2015 - 89.4 pounds July 2015 - 91.2 pounds August 2015- 90.8 pounds September 2015 - 91 pounds (27.5% weight loss over 180 days.) During the period of March through April 2015, Resident #6 sustained a significant unplanned weight loss of 28 pounds over 30 days. The clinical record lacked evidenced of a verification of the significant weight variance. Quarterly Nutrition Notes: A Quarterly Nutrition Review conducted dated May 19, 2015 (preceded Nutrition Note was dated February 13, 2015) revealed, "Swallowing	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 156 /chewing difficulty; (etiology) dysphagia and missing teeth; (signs/symptoms) SLP [Speech Language Pathology] ordered ... mechanical soft diet; Boost Plus [nutritional supplement] BID [twice-a-day], needs assistance with eating, no teeth/dysphagia, [%] percent of meal intake (average) is 75% per RN [Registered Nurse], % Supplement ...50% per RN. Current weight 89 pounds/40.4 kg [kilograms] ... " A further review of the clinical record revealed more than 30 days had lapsed before the Quarterly Nutrition Review was conducted in May 2015. However, the resident sustained the unplanned weight loss between March and April 2015. In addition, there was no evidence in the clinical record that a SLP consult was ordered. Quarterly Nutrition Review dated August 11, 2015 revealed, " Remeron [used to stimulate appetite] was added to the medications ... " which was more than 60 days since the resident ' s weight was identified at 88 pounds. Physician Notes: A review of a Physician ' s Progress Note " Attending " dated 3/20/15 [March 20, 2015] 7:45 PM revealed " pt. seen, s [none]; " O " [observation] small built, [no] distress, wt [weight] 112 pounds; A/P [Assessment/Plan] Senile Dementia, Elephentiasis, Cataract, P: Supp [supportive care]	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 157 A review of a Physician ' s Progress Notes " Attending " dated 5/29/15, 7:50 PM revealed " pt. seen, reviewed labs and meds. " S " [none] " O " observation: [unclear writing] alert, disoriented, built small and frail, wt 88 pounds, A/P severe Dementia ...Plan: ADL [Activities of Daily Living], pt. will lose wt 20, Dementia (expected), pt. should be DNR [do Not Resuscitate], do Not Send to Hospital. " There was no evidence that sufficient nursing time was given to notify the physician to address the 28 pound weight loss between March and April when it was first identified. A review of the NP [Nurse Practitioner] noted dated 6/17/15 [June 17, 2015] 2:40 PM revealed " asked to evaluate resident secondary progressive weight loss. [He/she] has severe dementia with increased risk for dysphagia and weight loss ...Resident has poor appetite and eats only some foods offered to [him/her.] Resident is alert, verbally responsive, but oriented to person only ...P:start Remeron 7.5 mg [milligrams] po [by mouth] QHS [at bed time] for appetite stimulant ... " There was no evidence that sufficient nursing time was given to notify the NP to address the 28 pound weight loss when it first identified in April 2015 which was indicative of a 25% or more weight loss. Interviews: A face-to-face interview was conducted with	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 158 Employees' #26 and #27 on September 17, 2015 at approximately 9:50 AM regarding interventions once the weight loss was identified. Employee #26 acknowledged that a reweight should have been conducted and placed on weekly weights. Employee #26 also acknowledged that the facility obtained new scales in April 2015 and the weights were stable since April on and the resident ' s condition nor behavior changed. A face-to-face interview was conducted on September 17, 2015 at approximately 9:00 AM with Employee #3. He/she stated that after review of the aforementioned, he/she believed the change was due to the new scales (weighing equipment). A face-to-face interview was conducted on September 17, 2015 at approximately 12:40 PM with Employee #28 [Attending Physician]. After review of the aforementioned, he/she stated I should have placed in the medical record that the resident has multiple medical factors for weight loss and that weight loss was expected due to the diagnosis of Dementia. In summary, Resident #6 sustained a significant unplanned weight loss of 28 pounds over 30 days between April and March 2015. There was no evidence in the clinical record (nursing, dietitian, physician notes and consults) of documented evidence that when the resident sustained a 28 pound weight loss from March 2015 to April 2015 neither the dietitian nor the physician were notified of the weight loss.	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 159 There was no evidence that a reweight was performed to confirm the weight variation and no evidence that facility staff followed through on the dietitians recommendation for a Speech consult to assist with determining the etiology of the weight loss. The record lacked evidenced of interventions to manage the significant weight loss sustained by Resident #6 (e.g. increasing the frequency of weight monitoring, labs ...) until May 19, 2015 which was 42 days later. Sufficient nursing time was not given to implement measures to ensure that Resident #6 maintained acceptable parameters of nutritional status. The record was reviewed on September 17, 2015. F. Based on record review and staff interviews for four (4) of 55 sampled residents, it was determined that sufficient nursing time was not given to ensure that residents received the necessary care and treatment relative to ventilator services as evidenced by staff failure to: consistently assess and monitor one (1) ventilator dependent resident who demonstrated symptoms of respiratory dysfunction for greater than 24 hours in the absence of close monitoring, supervision and/or physician notification, subsequently was transferred to ER via 911; consistently assess and monitor one (1) resident who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services]; accurately assess the respiratory status of one (1) resident	L 052	**Refer to page 152 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 160 requiring ventilator services; perform an accurate assessment of one (1) resident with a known change in condition; and ensure the proper execution of a consent form for insertion of a Peripheral Inserted Central Catheter for one (1) resident. Residents' #145, #37 #5, and # 98. The findings include: 1. Sufficient nursing time was not given to consistently assess and monitor the status of Resident #145 (ventilator dependent), who exhibited an acute change in status as evidence by the presence of low blood pressure, increased respirations and persistent tachycardia. Subsequently, the resident was transferred to the nearest emergency room (ER) and was hospitalized. Resident #145 was admitted on August 25, 2015. According to the admitting history and physical examination signed by the physician August 25, 2015, Resident #145 ' s diagnoses included Chronic Respiratory Failure, Status Post Tracheotomy-Continue on [Ventilator], Quadriplegia [secondary] to cervical spine injury, Non-Ischemic Cardiomyopathy, Congestive Heart Failure, Major Depression with Anxiety and Diabetes Mellitus Type II. Res #145 complained of shortness of breath (SOB), refused C-PAP treatments secondary to SOB and exhibited signs of a change in mental status. The clinical record lacked evidence that nursing staff identified, acted on, comprehensively assessed and intensively monitored the resident when he/she demonstrated a change in status as evidenced by the following:	L 052	**Response to L052, F1-3, Resident 145, 37, 5, 98** 1. Immediately upon notification of this deficiency, the medical records for resident #145 and #5 to verify findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders and enhance accountability. 2. Nursing conducted a retrospective review of the 24-hr report for indications of status change, cross-referencing the medical record to ensure the physician is notified of any change in the resident's condition. The audit results found all medical records in compliance. Respiratory Therapist conducted medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed with the attending physician. 3. The clinical nursing staff were educated 9/22-9/26, 10/7 and ongoing by the Respiratory Department on the weaning protocol and related comprehensive assessment and interventions. The Director of Nursing (DON) re-educated the nursing staff on 10/7/2015 and ongoing regarding the change in resident condition process related to assessment and interventions, highlighting the importance of physician notification. The communication binder will be created to maintain a record of notification, to include date/time/interventions (if applicable) The Respiratory staff were re-educated on 9/25/2015 related to the timeliness of completing physician orders, notification to physician, and the use of the communication binder	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 161 Resident #145 complained of SOB and refused C-PAP treatments as follows: Ø August 29, 2015- 7PM-7AM- Shift Report ---- " Patient refused CPAP trails last night ...back on AC (assist control) due to patient complaining of SOB (shortness of breath) Ø August 30, 2015 - 7AM-7PM- S- Shift Report Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Resident #145 demonstrated change in mental status as follows: Ø Psychiatric consultation August 31, 2015 (hour not indicated) " ...unable to assess [secondary to] pt [patient] not responding ... responding to painful stimuli but not easily arousable ...Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain medications ... " Ø Respiratory therapy entry [shift report] dated August 31, 2015 7AM-7PM read: " ...patient remains on A/C mode, no active weaning due to patient being less arousable in PM. " There was no evidence that sufficient nursing time was given to conducted comprehensive assessments when Resident #145 exhibited a change in the level of arousal, complained of shortness of breath and refused treatments. The record revealed that nursing staff communicated to the mental health practitioner [psychiatric consult] that the resident was not responsive due	L 052	**Response to L052, F1-3, Resident 145, 37, 5, 98** 3. Residents on weaning protocol will be entered on the 24 hour report to ensure notification of residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the 24 hour report to ensure appropriate protocol related to residents' change in condition are followed per policy. Results of the audits will be reported weekly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months. The Respiratory Department will conduct monthly audits to respiratory orders. A monthly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 162 to " pain medication. " However, a review of the Medication Administration Record [MAR] revealed Tylenol 500mg 2 caplets were administered during the 7AM - 3PM shift on August 31, 2015. A review of previous administrations of Tylenol lacked evidence that the resident sustained an alteration in mental status [lack of arousal]. An in-depth review of the clinical record is as follows: A review of Physician ' s Orders dated August 25, 2015 included, but was not limited to the following: Ventilator (Ventilator Settings: AC (Assist/Control, Rate- 15, TV (Tidal Volume)- 500, PEEP (Positive End Expiratory Pressure), FIO2 - 45% (Fraction of Inspired Oxygen) Duoneb (bronchodilators) 2.5mg/3ml (millimeter)- 1 vial neb (nebulization treatment) [every] 6 hours PRN (as needed) for bronchospasms, Note: The Duo Neb order was modified on August 25, 2015 for administration " every 4 hours " [instead of every 6 hours as needed] Tylenol 500mg 2 caplets via peg 30 minutes prior to wound care for pain Seroquel (antidepressant) 25 mg (milligram) - 1 tablet via GT (Gastrostomy tube) BID (twice a day) for depression; Prozac 20 mg 1 capsule daily for Depression Midodrine (Vasopressor/Antihypotensive medication) 10mg via GT (Gastrostomy Tube) TID (three times a day) for hypotension. Hold for	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 163 SBP (Systolic blood pressure) > (greater) 120, DBP (diastolic blood pressure) > 80.... Pulmonary Consult and Psychiatry consult An Interim physician ' s order dated August 31, 2015 read: August 31, 2015- 2059 (8:59PM) - Please transfer patient to nearest ER via 911 re: AcuteAMS (Altered Mental Status), tachycardia and hypotension. " Physician ' s Notes: " August 25, 2015- 3:17 PM- Pulmonary Consult: ... Awake, alert, appears anxious. Vitals: Chest-crackles [positive] bilaterally, vent settings: VT-500, AC-15, P [Peep] - 5, FIO2-45%, Impression: Chronic Respiratory Failure. PT (Patient) on vent-tolerates CPAP (Continuous Positive Airway Pressure) trials intermittently. Continue trials as tolerated. [He/she] remains very anxious ... Titrate O2 (oxygen) to sats (saturations) > (greater than or equal to) 92%. August 25, 2015- 1545 (3:45PM) - Attending/Admission Note: cc: (chief complaint) - Chronic Respiratory Failure .... Assessment/Plan: - Chronic Respiratory Failure- continue on vent at current settings, continue vent weaning trials, Pulmonary input appreciated ... Depression-Continue Prozac (Anti-depressant). August 28, 2015 - 1520 (3:20 PM) - Attending Note; cc: chronic respiratory failure. Voiced [no] complaints this afternoon. [Vital Signs Stable]- T-98, Pulse-74, Respirations-18, B/P (Blood Pressure) - 132/82. Assessment/Plan: Chronic	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 164 Respiratory Failure- Continue on vent, wean as possible, suction PRN (as needed), Depression- Continue on Prozac. August 31, 2015- 2103 (9:03 PM) - Hospitalist Note: I was called to evaluate [Resident #145] b/c (because) of hypotension, tachycardia, [and] acute AMS gradually since few hours ago. [His/her] HR (heart rate) has been elevated to 150 ' s [and] B/ P as low as 77/53. As per nurse even to earlier today [he/she] was A&O (alert and oriented), but currently [he/she] is obtunded [and] unresponsive with agonal breathing. [He/she] is quadriplegic. Assessment/Plan: Acute AMS [and] hypotension- unknown cause ([he/she] finished [his/her] IV (Intravenous) Cipro (antibiotic) yesterday [and] Diflucan (anti-fungal medication) was discontinued). Transfer to nearest ER (Emergency Room). " Psychiatric Diagnostic Consultation: August 31, 2015 [no time indicated] - Certified Registered Nurse Practitioner ... " Mental Status Exam: Information obtained from staff/chart/resident [not] easily arousable ... [Patient not arousable and does not answer questions at this time. Staff reports resident [Alert and Oriented x3- (time, person and place), but just received pain meds. Concerns/Findings: Per staff resident normally [Alert and oriented x3], responds to questions asked. On exam, resident responding to painful stimuli but not easily arousable and [he/she] opens eyes to name but does not answer question, (-) Insomnia, " + " [Positive] Anxiety, " + " mood and affect [secondary to medical complications/conditions per staff. Plans: Monitor for safety and fall precautions, monitor for worsening anxiety, [Follow-up] in one (1) week to reassess	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 165 mood/and anxiety. " Nursing Notes: August 28, 2015 3:13 PM - " ...V/S [vital signs]: [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 ... " August 29, 2015 3:00 AM - " ...[b/p] 116/62; [P] 78, [R] 20 ... " August 31, 2015- 12:35 PM - Resident remain alert and responsive. Vent dependent AC mode for respiratory support. Suction PRN (as needed) ...V/S- [Blood Pressure] - 134/74, 98.9 [Temperature]-, 74, 100 [no respirations documented, two (2) different heart rates]... S-BAR (Situation-Background-Assessment-Recommendation) /Acute Change in Condition Report: Situation- Date: 8/31/15, Time: 9:39 PM ... low B/P- 77/53, P-153, R-24, lethargy [and] gasping for breath, although on vent. Background: Respiratory Failure, Temp: 98.6, B/P- 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator ... Resident was noted [with] [decreased] B/P 77/53, elevated pulse rate. House officer notified who ordered to transport resident to [hospital] for further evaluation and treatment. " A review of the facility ' s Ventilator Policy/Protocol The facility ' s Ventilator Management and Nursing Care Respiratory Protocol [no date indicated] stipulates: " Modes of Ventilation- Assist-Control Ventilation (A/C): A/C delivers the preset volume or pressure in response to the	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 166 patient ' s own inspiratory effort, but will initiate the breath if the patient does not do within the set amount of time. This means that any inspiratory attempt by the patient triggers a ventilator breath. The patient may need to be sedated to limit the number of spontaneous breaths since hyperventilation can occur. This mode is used for patients who can initiate a breath but who have weakened respiratory muscles. " Respiratory Notes/Ventilator Flow Sheets [documented in S-BAR format]: " August 29, 2015- 7PM-7AM- Shift Report- S- Patient refused CPAP trails last night, B- Respiratory Failure, Status Post Trach. Obese. A: Sat = 99%, [Heart Rate -79, Respiratory Rate-24. Alert [and] stable. Patient has a lot of thick tan to white (oral) secretions. Stable and alert. R- Continue to encourage patient to get weaned. Ventilator Flow Sheet- Special Procedures Done [and] Time Performed: CPAP 5/10 x10[minutes], back on AC due to patient complaining of SOB (shortness of breath) August 29, 2015- 7A-7PM- S- Shift Report, B-Respiratory Failure, A- Received on AC mode, neb tx (treatment) given as ordered. [Patient tolerated Duoneb, Pulse ox- 98%, HR-72, R- Will continue to monitor patient and wean as tolerated. August 30, 2015 - 7PM- 7AM - Shift Report- - S- [Patient] is on AC 15, 500, 45%, +5, B-Respiratory Failure, A- [Patient] is on AC. Stable O2 Sat 98%, HR-78%, RR-20. No sign of distress, R- We will continue monitoring [patient] and [symptoms] as needed. There was no evidence that Duoneb treatments (prescribed every 4 hours) were administered between 4:48	L 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 167 PM (last noted dose administered during the 7AM-7PM shift) and 11:59 PM on August 30th. The record revealed that the next dose was given at 12 Midnight on 8/31/15 [nearly 7 hours after the preceding dosage]. August 30, 2015 - 7AM-7PM- S- Shift Report, B-Respiratory Failure, A- Received [patient] on AC mode, [nebulization treatment] given as ordered. [Patient] ... (Illegible writing). [Pulse Ox-99%, HR (illegible writing), R- Will continue to monitor patient. Special Procedures Done [and] Time Performed: Attempt to wean. Pt [Patient] on CPAP trial. [Patient] keep comp (complaining) of SOB (shortness of breath), anxious. Placed back on AC (Assist Control) mode to rest. Physician Order: Albuterol 2.5mg and Atrovent .5mg - q 4 (every 4 hours). Treatments were documented as being administered at 0020 (12:20 AM), 0410 (4:10 AM), 0800 (8:50 AM), 1310 (1:10 PM), and 16:48 (4:48PM). " The next Duoneb treatment was recorded as being administered on 8/31/15 (12MN), approximately 7 hours later. August 31, 2015- 7PM-7AM- S- [Patient] is on AC 15/[Tidal Volume]-500, [Fractioned of Inspired Oxygen-45%, [Peep]-5, B- Respiratory Failure, A- Pt stable throughout shift- Sat-98%. HR-79, RR (Respiratory Rate) -21. Pt complains of " being unable to breathe " but in no apparent distress. Continue to monitor for changes. August 31, 2015- 7AM-7PM- S- Pt remains on AC mode. [No] active weaning [due] to pt being less arousable in PM. B- Respiratory failure, A- Alert [male/female], HR-84- RR-25, Sat-98%, small thin pale secretions, BS (breath sounds) cleared, R- Will continue to monitor. Ventilator Flow Sheet revealed the following "	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 168 Rate Set/Total " on the A/C mode: 0130 (1:30 AM) - 15/34 - [Oxygen] Saturation- 97%, Heart Rate- 87 0425 (4:30 AM) - 15/33 - [Oxygen] Saturation- 98%, Heart Rate-93 0855 (8:55 AM) - 15/32 - [Oxygen] Saturation-98%, Heart Rate-87 1230 (12:30 PM) - 15/33 - No Oxygen Saturation and Heart Rate documented in the allotted space. 5:00 PM - 15/29 - [Oxygen] - 98%, Heart Rate-80 2045 (8:45 PM) - 15/23, Saturation 96%, Heart Rate- 158. " [defined: 15/34 - " 15 " reflects ventilator preset respiratory rate and " 34 " reflects - resident breaths] A review of the nebulization treatment administration record for August 30th revealed the 6th dosage [prescribed every 4 hours] of Duoneb [scheduled for administration at approximately 8:45 PM on August 30th] was omitted without explanation. However, the respiratory therapy " shift notes " [7AM-7PM] notes reveal the resident complained of shortness of breath. The clinical record lacked evidence that sufficient nursing time was given to notify the physician regarding the resident ' s complaint of having shortness of breath, refusing CPAP trials and the missed Duoneb treatment from August 29, 2015 at (7PM-7AM) to August 31, 2015 (7AM-7PM). Interviews: A face-to-face interview was conducted with Employee #14 (on-coming team member) September 18, 2015 at approximately 2:00 PM	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 169 regarding the above aforementioned concerns. He/she stated that the off-going team member, who stated that the resident was calling all night and that [he/she]. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident ' s room all night; and the resident had the call bell you blow into. Employee #14 acknowledged the physician should have been informed of the resident ' s missed duoneb treatment, restlessness and the complaint of having shortness of breath and refusing to use the CPAP on August 29, 2015. A follow-up interview was conducted with Employee#14 on September 18, 2015 at approximately 3:00 PM regarding the missed Duoneb treatment on August 30, 2015. He/she stated there was only one (1) respiratory therapist on 8/30/15 (7PM-7AM) shift. There were 12 residents on ventilators, 15 residents who had tracheostomies, four (4) residents requiring BIPAP (Bi-level Positive Airway Pressure), 2 (two) residents requiring Hi-Flow, 55 [nebulization] treatments and four (4) residents weaning from ventilators. A review of the respiratory therapist assignment sheet dated August 30, 2015 revealed one respiratory therapist on for the 7PM-7AM shift. Also, the Respiratory Therapist was assigned a Registered Nurse orientee (for orientation to ventilator). A review of the nursing assignment for August 30, 2015 revealed four (4) Licensed Practical Nurses (LPNs) were on duty for the 6th floor from 7:00 AM-3:30PM shift to manage residents receiving ventilator services.	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 170 The clinical record lacked evidence that facility staff consistently assessed and monitored Resident #145 when the resident ' s mental status changed, complained of having shortness of breath, and difficulty breathing. Nursing assessments failed to depict the resident being anxious, restless and having difficulty breathing. The physician was not notified when the resident complained of shortness of breath, which was first documented on August 29, 2015. The resident ' s condition declined as evidenced by a change in mental status, heart rate elevated to 150 ' s and blood pressure as low as 77/53 as depicted in the hospitalist note on the evening of August 31, 2015. The resident was subsequently transferred to the nearest ER via 911 and hospitalized. The clinical record was reviewed on September 18, 2015. A review of records obtained from the acute care facility that the resident was transferred to revealed the resident was admitted and a physician ' s entry on 8/31/15 included: " ...[Resident #145] presented to the ED (Emergency Department) from NH (Nursing Home) with acute AMS (Altered Mental Status), hypotension, tachycardia and fever of 107. In ED, [Temperature] - 41.7(Celsius- converted to Fahrenheit- 107.6 degrees); [Heart Rate-85]; Respirations-16; Systolic B/P- 87, diastolic B/P (Blood Pressure)-48; [Oxygen] Saturation -100; FIO2 [Fraction of Inspired Oxygen] Ventilator- 100 [percent].	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 171 2. Sufficient nursing time was not given to perform an accurate assessment for Resident #37 that experience a documented change in condition. Resident #37 was admitted on July 22, 2015 with diagnoses to include Chronic Respiratory Failure, Coronary Artery Disease, and Sacral Decubitus. Medical record review was conducted on September 21, 2015 at 9:40 AM. The review of clinical notes revealed inconsistencies in the assessment of Resident #37 status on September 18, 2015 at 5:00 PM as it relates to entries documented by medical staff, nursing staff, and respiratory staff. The inconsistencies are as follows: · Physician Progress note from September 18, 2015 at 5:30 PM revealed the Attending Physician was requested by the nursing staff to evaluate the resident with changes in mental status, tachycardia, and hypoxia. According to the medical staff assessment, the resident was noted to have a heart rate of 166 beats per minute, blood pressure of 125/56 millimeter of Mercury. · The nursing staff documented an ' Acute Change in Condition Report ' dated September 18, 2015 at 5:00 PM secondary to resident with elevated irregular heart rate of 166 beats per minute and oxygen saturation of 81% while on the ventilator with FiO2 of 40%. · Review of the Ventilator Flow Sheet dated September 18, 2015 revealed the	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 172 respiratory therapy staff documented pre- treatment assessment at 5:00 PM which indicated the heart rate- 89 beats per minute, respiratory rate- 19 breaths per minute, and oxygen saturation- 98 percent; and post-treatment assessment at 5:15 PM indicating heart rate was 90 beats per minute, respiratory rate 16 breaths per minute and oxygen saturation of 98%. Although the medical and nursing staff assessed Resident #37 to have experienced a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation, the respiratory therapy staff documented an assessment with the heart rate, respiratory, and oxygen saturation consistent with Resident #37 ' s baseline physical assessments. Resident #37 was subsequently transferred via Emergency Medical Services to a local emergency department. A face to face interview was conducted with Employee #31 on September 21, 2015 at approximately3:30 PM. S/he confirmed that the respiratory assessment was inconsistent with the change of condition at the time of assessment. The findings were reviewed, discussed, and acknowledged. 3. Sufficient nursing time was not given to consistently assess and monitor Resident #5 who was ventilator dependent and experienced an increase in heart rate and was subsequently sent out 911 [Emergency Services].	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 173 A review of Resident #5 ' s quarterly MDS (Minimum Data Set) with an Assessment Reference Date (ARD) of April 22, 2015 revealed diagnoses in Section I (Active Diagnoses) included: Hypertension, Tracheostomy, Respiratory Failure, and Ventilator. According to physician ' s orders dated May 9, 2015 directed; " Vent [Ventilator] Settings: AC (Assist Control) Mode- Rate-10, VT- 400 [Tidal Volume]- FIO2 [Fraction Inspired Oxygen]- 40% Physician ' s Progress Notes: Pulmonary Note - June 1, 2015 at 1:45 PM revealed " Patient [resident] remains on vent. Responds to stimuli, no purposeful movements. Vent settings AC [mode of Assist Control] 10, VT [tidal volume] 500, PEEP [positive expiratory end pressure] +5, Fi02 [room air] 40%. Exam: vitals 104/72, P 69, R 18, T 97.9; CTA-[clear to auscultation bilaterally no wheezes; CVS [cardiovascular] no murmurs; Abd [abdomen] + [positive] bs [bowel sounds]; Ext [extremities] no edema ...A/P Assessment/Plan (1) chronic Respiratory Failure; (2) Encephalopathy secondary CVA [Cerebral Vascular Accident] - Continue on vent support - no weaning - supportive care. " MD [Medical Doctor] Acute Note - June 2, 2015 at 08:50 AM revealed " Responding to " Rapid Response. " Patient [Resident] identified with tachycardia with HR [140], SBP [systolic blood pressure 110, RR [respiratory rate] 20s-30s; SAT	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 174 [Saturation] 96%, 100% Fi02 with ambu bagging. Emesis, tube feeding witnessed; lung (+) Rhonchi, R [right] CTA [clear to auscultation] left. CVS: tachycardia ...ABD: distended...hypo [hypoactive] bowel sounds; ENT [Ear, Nose, Throat] edema BUE [bilateral upper extremities], R [right] > [greater than] L [left]. Warm extremities; A/P [Assessment/Plan] : Respiratory Distress, R/O aspiration/sepsis. Will send to ER [Emergency Room] v [by] 911. " A review of the nursing notes revealed the following: " May 31, 2015 4:50 AM - " Resident is alert and responsive. AM care given, vs [vital signs] 98.4 temperature, P [pulse] 77 R[respirations] 16, BP [blood pressure]127/68, Pulse OX [oximetry] 96%. No evidence of pain noted. IS Care given will continue to monitor ... " May 31, 2015 6:30 PM - " Resident is alert and responsive due medications given as ordered. No abnormal findings noted. Vs T 98.2, P 86 R 20, BP 133/78. Pulse Ox 96%. Will continue to monitor. " June 1, 2015 4:00 PM - " Resident is alert and responsive PM care given. Vs T 98.6, P 87, R 20, BP 130/77 Pulse OX 98%. Turned and repositioned, due meds give. "	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 175 June 2, 2015 5:00 AM - " Resident is alert. On vent [ventilator] dependent for support. Trach [tracheostomy] and suction care provided. Total care with ADL [Activities of Daily Living]. Enteral Feeding in progress. Peg [percutaneous endoscopic gastrostomy] tube patent and flushed well. Will monitor. Vs [BP] 131/72, [P] 76, [R] 18, [T] 98.3. June 2, 2015- 8:35 AM- SBAR [Situation, Background, Assessment, Recommendation]/Acute change in condition. Resident was noted with respiratory distress and an elevated HR [heart rate] of 140 [bpm/beats per minute]. Resident was bagged by RT [Respiratory Therapy] while Rapid Response was called. Rapid Response team responded ....In house officer gave new order to transfer resident via [by] 911 [Emergency]. Emesis [vomiting] noted x [times] 1 [one] during bagging with seizure like activity. Resident was then transferred via 911 to [local hospital]. " Respiratory Therapy Notes: A review of the Respiratory Ventilator Flow Sheet for June 2, 2015 revealed the following: "Date: June 2, 2015 Time: 0025 [12:25 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 176 Date: June 2, 2015 Time: 0345 [3:45 AM] Mode: AC Fi02: 40% PEEP 5 Saturation: 98% Heart Rate: 121 Date: June 2, 2015 Time: 08:20 [8:20 AM] Mode: AC Fi02: 40% PEEP: 5 Saturation: 99% Heart Rate: 129 There was no documented evidence that sufficient nursing time was given to notify the physician in regards to Resident #5 ' s increased heart rate from June 2, 2015 (3:45 AM) to June 2, 2015 (08:20 AM), which is indicative of approximately 4 hours. A review of the respiratory therapy shift note revealed : June 2, 2015 - 7pm-7am shift note revealed: S: Pt on A/C mode B: Respiratory resident A: Sat 98% HR 71, RR 18 BS [breath sounds] Rhonchi/clear, sxn [suction] moderate yellow suction, no distress. R: monitor June 2, 2015 -7AM- 7PM Shift- no documentation under shift report; indicated on flow sheet- " PT [Patient] transferred to area Hospital. "	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 177 The clinical record lacked evidence that facility staff assessed and monitored Resident #5 when the resident ' s heart rate increased. The physician was not notified when the resident ' s became tachycardia (increased heart rate), which was first documented on June 2, 2015 at 3:45 AM to be 121. The resident ' s condition declined as evidenced by increased tachycardia (HR elevated to 129). A rapid response was called and resident was subsequently transferred to the Emergency room via 911 [Emergency Medical Services] according to the SBAR at the time of transport the resident's heart rate was 140. A face-to-face interview was conducted on September 21, 2015 at approximately 10:30 AM with Employees #18 and #47. Employee #18 state that his/her shift is 7:00AM to 7:00PM. Employee #18 also state, when he/she first saw the resident with the heart rate 129 is when the rapid response [When a resident's condition changes (based on predetermined criteria) and requires an assessment by a physician to stabilize his/her condition and prevent further deterioration] was called at approximately 8:20AM, the resident vomited when he/she was bagged. Employee #47 stated when he/she was conducting rounds from the rooms assigned he/she was called to the rapid response by Employee #18 who stated that the rapid response took over, and that the resident had vomited when he/she was bagged and then the resident was sent out 911 with a heart rate at 140. The night shift nurse was not available for interview. The clinical record was reviewed on September 21, 2015.	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 178 4. Sufficient nursing time was not given to accurately assess the respiratory status of Resident #98 who required ventilator services. The facility policy #CP.603, last revised June 17, 2015, titled, ' Ventilator Weaning Protocol ' stipulates, " II. Policy: Protocol will be applied per physician ' s written order of Wean per protocol. " On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015 to the facility with a diagnosis that included Respiratory Failure. Further review of the physician ' s orders signed and dated August 26, 2015 revealed an order dated July 8, 2015 for the following ventilator settings: AC [ventilator mode], Rate 10, VT [tidal volume] 500, FIO2 [fraction of inspired oxygen] 30%, PEEP [Positive End Expiratory Pressure] 5. A subsequent order dated August 13, 2015 directed the following, " Initiate ventilator weaning protocol. " On September 21, 2015 at approximately 9:42 AM a review of the ' Ventilator Flow Sheet ' completed by Respiratory Therapy revealed that ventilator weaning was in progress, but when the resident was not weaning, the ventilator settings were as follows from September 1, 2015 to September 21, 2015: AC/ Rate 12, VT500 FI02	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 179 40% PEEP 5. An observation of the ventilator settings made on September 21, 2015 at approximately 9:40 AM confirmed that the resident was on the settings that were documented on the Respiratory Therapy ventilator flow sheets. Review of the Nursing Respiratory Flow sheet revealed different ventilator settings: AC, Rate 10, VT 500, FI02 30%, and PEEP 5 for the month of September, 2015. On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, who was assigned to care for the resident. Employee #16 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #16 stated the set rate was 12 and could not explain her documentation of a rate of 10 or other requested information. On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #22, who was assigned to care for residents requiring ventilator services. Employee #22 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #22 explained the set rate of 12; however, could not further explain the requested information. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with	L 052	**Refer to page 161 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 180 Employee #10, regarding the aforementioned findings. He/she acknowledged the findings, stating that the Respiratory Therapy staff would hold an in-service. The record was reviewed on September 21, 2015. G. Based on record review and staff interview for 2 (two) of 55 sampled residents, it was determined that sufficient nursing time was not given to ensure the proper execution of a consent for a Peripherally Inserted Central Catheter in two (2) of 55 sample resident records Residents' #111 and #140. The findings include: Sufficient nursing time was not given to ensure the proper execution of consent for Peripherally Inserted Central Catheter. 1. Resident #111 was admitted on April 24, 2015 with diagnoses to include history of Respiratory Failure, Hypertension, and Cerebrovascular Accident. Medical record review conducted September 21, 2015 at 2:00 PM revealed a Peripheral Inserted Central Catheter (PICC) line was inserted on May 11, 2015 by an outside contract nurse. The Consents for Surgery, Procedures, Anesthesia, Transfusion and Other Treatments form dated May 11, 2015 at 6:05 PM revealed the signature of two nurses witnessing the telephone consent for the Peripherally Inserted Central Catheter; however, the form lacks the signature of the individual responsible for explaining the nature of	L 052	**Response to L052, G1, 2; Resident #111 and 140** 1. Immediately upon notification of this deficiency, the medical records for resident #111 and #140 to verify findings. 2. A concurrent chart audit of residents with a physician order for PICC insertion and a retrospective audit of residents who obtained a PICC in-house was reviewed by the RCCs of each unit. The audits found no other resident impacted by this deficient practice. 3. An in-serviced on 9/21 and is ongoing, for all nursing staff on standard of practice regarding obtain consent for all procedures. The contract nurse was reeducated regarding ensure all signatures are present prior to performing procedure. . The PICC Insertion Order Form will be revised to include a statement which will direct the Vascular Access Nurse to review the chart to ensure consent is present with all necessary signatures prior to insertion. The RCCs or designee will monitor all PICC orders to ensure all aspects of the consent is accuratly documented in the medical record prior to the procedure. 4. The Resident Care Coordinator (RCC) or designee will audit all PICC orders. Results of the audits will be reported monthly to the Risk Management Subcommittee for three (3) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 181 the patient condition, procedure, and risks/ benefits associated with undergoing the procedure. Review of the Physician ' s Progress Notes for May 11, 2015 at 5:00 PM failed to reveal the medical staff spoke with the resident and/or responsible party about the need for a Peripherally Inserted Central Catheter and/or its risks and benefits. A face to face interview was conducted with Employee# 10 on September 21, 2015 at approximately 12:55 PM regarding the execution of the consent for Peripherally Inserted Central Catheters. S/he stated that it was the understanding that the individual performing the procedure would obtain the consent. When queried about the omission with regards to Resident #11, s/he was unable to provide further insight. Sufficient nursing time was not given to ensure that a consent was properly executed before an invasive procedure was performed. The clinical record was reviewed on September 21, 2015. 2. Resident #140 was admitted on August 18, 2015 with diagnoses to include Osteomyletis. Medical record review conducted September 18, 2015 at 2:00 PM revealed a Peripheral Inserted Central Catheter (PICC) line was inserted on September 9, 2015 by an outside contract nurse.	L 052	**Refer to page 181 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 182 The Consents for Surgery, Procedures, Anesthesia, Transfusion and Other Treatments form dated September 9, 2015 at 3:15 PM revealed the signature of the resident and one (1) nurse witnessing the consent for the Peripherally Inserted Central Catheter; however, the form lacks the signature of the individual responsible for explaining the nature of the patient condition, procedure, and risks/ benefits associated with undergoing the procedure. Review of the Physician ' s Progress Notes failed to reveal documentation to demonstrate the medical staff spoke with the resident about the need for a Peripherally Inserted Central Catheter and/or its risks and benefits. A face-to-face interview was conducted with Employee# 12 on September 18, 2015 at approximately 2:55 PM regarding the execution of the consent for Peripherally Inserted Central Catheters. S/he stated that it was the understanding that the individual performing the procedure would obtain the consent. When queried about the omission with regards to Resident #11, s/he was unable to provide further insight. Sufficient nursing time was not given to ensure that a consent was properly executed before an invasive procedure was performed. The findings were reviewed, discussed, and acknowledged. The clinical record was reviewed on September 18, 2015. H. Based on record review and staff interview for	L 052	**Refer to page 181 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 183 one (1) of 55 sampled residents, it was determined that sufficient nursing time was not given to ensure that Resident #94 was free of unnecessary medications as evidenced by failure to ensure the resident received only those medications ordered by the physician, as clinically indicated. The findings include: On September 16, 2015 at approximately 12:30 PM, a review of the admission record revealed that Resident #94 was admitted to the facility on October 10, 2014. Review of the physician ' s history and physical dated October 10, 2014 revealed the resident ' s diagnoses included Deconditioning and Decubitus Ulcers. On September 16, 2015 at approximately 12:32 PM, a review of the July and September 2015 physician ' s order sheets lacked documented evidence of an order for Vitamin C to be administered to the resident. Review of the Medication Administration Record [MAR] dated July 2015 revealed the following: " Vitamin C 500mg [milligrams] po [by mouth] BID [twice a day] for wound healing. " The staff had signed the allotted signature boxes twice a day from July 1-31, 2015 which indicated the medication was given to the resident. Review of the Medication Administration Record [MAR] dated September 2015 revealed the	L 052	**Response to L052, H; Resident #94** 1. Immediately upon notification of this deficiency, the medical records for resident #94 was reviewed and identified no adverse effects. The attending physician was notified and confirmed the need for Vitamin C for wound healing. A complete order was obtained to include dose, frequency and route of administration and transcribed on the MAR. 2. An audit of the MAR for September was reviewed on each unit and were brought into compliance where indicated. 3. The nursing staff were re-educated on 10/16, 10/30 and ongoing regarding the standards of practice as it relates to administration of medication (the Five Rights) and the process of reconciliation of monthly orders. The Medical Director will send a memo to the medical staff on the standards of practice related to complete medication orders. 4. The RCCs or designee will continue to perform monthly audits of the MAR to ensure accuracy per physician order. Results of the audits will be reported weekly to the Risk Management Subcommittee for four (4) months. A quarterly summary of the audits will be reported to the Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 184 following: " Vitamin C. " The order was incomplete, lacking the dose, frequency, route of administration, and use. The staff had signed the allotted signature boxes twice a day from September 1-16, 2015 which indicated the medication was given to the resident. Sufficient nursing time was not given to ensure the resident was free from unnecessary medications as evidenced by the administration of Vitamin C to the resident for 16 days in September and 31 days in July, without a physician ' s order. On September 18, 2015 at approximately 12:40 PM, a face-to-face interview was conducted with Employee #4 regarding the aforementioned findings. He/she reviewed the records and acknowledged the findings. The record was reviewed on September 16, 2015.	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: A. Based on record review and staff interviews, it was determined that the facility staff failed to	L 056	**Refer to page 188 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 185 ensure sufficient nursing staff was provided to perform nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as evidenced by failure to have sufficient staff to meet the needs of residents. The findings include: During the recertification survey from September 9 - 23, 2015, the following areas of concern were identified: · Failure to ensure that facility staff notified the attending physician when there was a change in residents' conditions. Cross reference CFR 483.10, F157 · Failure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Cross reference CFR 483.15, F253 · Failure to ensure that resident assessments were accurate. Cross reference 483.20, F272 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident ' s written plan of care. Cross reference 483.20 (k) (3) (ii), F282 · Failure to ensure that each resident received and the facility provided the necessary care and services to attained/maintained the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive	L 056	**Refer to page 188 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 186 assessment and plan of care. Cross reference 483.25, F309 · Failure to ensure the necessary services was provided to maintain good hygiene and to carry out activities of daily living. Cross reference CFR 483.25(a) (3), F312 · Failure to ensure provision of necessary care and treatment to promote healing of wound (s). Cross reference CFR 483.25(c), F314 · Failure to ensure that the resident environment remains as free of accident hazards as is possible. Cross reference CFR 483.25, F323 · Failure to ensure that a resident maintains acceptable parameters of nutritional status, such as body weight. Cross reference 483.25 (i), F325 · Failure to ensure that a resident receives proper treatment and care for respiratory care. Cross reference 483.25(k) , F328 · Failure to ensure that sufficient staff was available to provide quality care and services. Cross reference 483.30 (a), F353 · Failure to post nurse staffing information on a daily basis to include all components per the regulation. 483.30 (e), F356 · Failure to ensure that medications were properly labeled and stored. Cross reference 483.60 (b), (d), (e), F431 · Failure to ensure all essential resident care equipment was in safe operating condition. Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that the facility maintained an effective pest control program. Cross reference 483.70(h)(4), F469 · Failure to comply with state and local laws and regulations. Cross reference CFR 483.75, F492	L 056	**Refer to page 188 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 187 · Failure to ensure that clinical records were maintained in accordance with accepted professional standards. Cross reference CFR 483.75, F514. * Failure to ensure that location and date of Care Area Assessment information on the Minimum Data Sets (MDS) under Section V was complete. CFR 483.20, F272 · Failure to ensure that the Quality Assurance Committee identified and developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520. B Based on observations, policy/record review, and interviews, it was determined that facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by the staff's failure to ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for two (2) of 13 days. The findings include According to 3211.5 of the District of Columbia Municipal Regulations, titled ' Nursing Personnel and Required Staffing Level, ' "Each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse ... " The facility failed to ensure that there was	L 056	**Response to L056, B, C** 1. See immediate corrective actions for all areas of concern sited. The staffing records for nursing and respiratory were reviewed to verify findings. 2. A lookback of the staffing records identified this event ass an isolated incident, therefore no other resident was found to be affected. 3. The Respiratory Department will develop a staffing plan based on patient census and care needs. Policy 112 *Respiratory Staffing* will be developed to outline minimum staffing requirements and contingency plans for staffing variances. BridgePoint Hospital Respiratory Staff will assist with providing respiratory services to Bridgepoint Subacute in the event of staffing shortages. RT staff will notify the hospital and subacute nursing supervisors, and the RT Department Director immediately with reference to staffing shortage. Nursing Supervisors and RT Department Director will assist staff with contingency strategies to meet the care needs. The staffing plan, to include the Ventilator Care Unit will be reviewed on 11/2/15 and ongoing with the Staffing Coordinator, RCCs and nursing supervisors by the Interim Administrator/DON. All registered nurses and licensed nurses were in-serviced 9/22-9/26, 10/7, 10/25-10/28 and ongoing regarding ventilator management care and weaning protocol to increase the number of qualified staff assigned to 6th floor. HR will implement plans to actively recruit respiratory therapists and qualified registered nurses to fill department vacancies and hire supplemental staff (i.e., PRN). 4. Staffing utilization will be tracked daily by the Director of Respiratory. Results are reported to the Administrator and DON daily. The nursing Staffing Coordinator will continue to provide a daily staffing report to the Administrator and/or DON. Staffing utilization, including the use of supplemental staff, per diem and PRN will be analyzed and reported to Executive Leadership monthly. Human Resources Department will report recruitment efforts daily in the Operations Meeting and monthly to the Quality Assurance Committee	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 188 sufficient registered nurse staffing for two (2) of 13 days from August 30, 2015 to September 13, 2015, as indicated below: August 30, 2015 0.2 September 13, 2015 0.5 C. Based on observations, record review, staff interviews, and resident outcomes, it was determined that facility staff failed to provide care and services by qualified staff and in sufficient numbers to ensure that residents received quality care consistent to meet their needs. For example, a review of the nursing assignment for August 30, 2015 revealed four (4) Licensed Practical Nurses (LPNs) were on duty for the 6th floor from 7:00 AM-3:30PM shift. There were no Registered Nurses on duty to manage the residents on the 6th floor. There was only one (1) respiratory therapist on August 30, 2015 (7PM-7AM) shift. There were 12 residents on ventilators, 15 residents who had tracheostomies, four (4) residents requiring BIPAP (Bi-level Positive Airway Pressure), 2 (two) residents requiring Hi-Flow, 55 [nebulization] treatments and four (4) residents weaning from ventilators. A face to face interview was conducted on September 16, 2015 at approximately 4:20 PM with Employees #3 and #10. After review of the aforementioned both acknowledged the findings.	L 056	**Refer to page 188 for response**	
L 067	3214.1 Nursing Facilities A comprehensive on-going in-service education program shall be provided by the facility and shall include training on the provision of resident care. This Statute is not met as evidenced by:	L 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 189 Based on record review and staff interviews, it was determined that the facility failed to ensure that in-service education for licensed nurses assigned to provide ventilator services were qualified and competent. Additionally, the facility failed to ensure that the licensed practical nurse performed duties consistent with his/her scope of practice; and to ensure a comprehensive assessment was performed by a registered nurse as evidenced by the licensed practical nurse ' s documentation of an assessment when a change of condition was observed. The findings include: A. Facility staff failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent. During the survey period interviews conducted with licensed nursing staff assigned to provide ventilator services to residents revealed a lack of knowledge in the mechanics of ventilation, ventilator function and its correlation to the resident ' s respiratory status. An example to reflect this determination is delineated in the deficient practice statement for Resident #98 documented below. A review of personnel records of licensed nursing staff assigned to provide ventilator services lacked evidence that the staff were adequately trained and/or had documented demonstration of competency in vent management and airway maintenance. On September 22, 2015 at approximately 1:00 PM, a review of 20 personnel records of staff,	L 067	**Response to L067, A** 1. Immediately upon notification of this deficiency a review of the competencies confirmed findings, however no adverse event occurred to resident #98. On 9/22-9/26, 10/7, all Registered and Licensed Practical Nurses assigned to the 6th floor ventilator unit by Respiratory Department were in-serviced on ventilator mechanics, to include ventilator settings function and their correlation to respiratory function was performed for all. The scope of practice for RN and LPNs were reviewed with nursing staff, as well as the implications for daily practice. 2. A review of the retrospective review of the medical records for all residents on vent weaning protocol was performed by the Resident Care Coordinator. Results of the audit found all residents were in compliance. 3. Continual skills and competency assessment related to vent management and airway maintenance, as well as the mechanics of the ventilator has been included in the annual requirements for all nursing staff and new hires. Residents on weaning protocol will be entered on 24-hour report to ensure communication of residents' status and order changes. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. The Nursing Ventilator Flowsheet was revised and nursing instructed on the new format. 4. The RCCs will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed. Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 190 confirmed by Employee #10, who have taken care of residents requiring ventilator services lacked evidence that they were trained and/or had documented demonstration of competency in ventilator management. The following list of employee personnel records was reviewed: Registered Nurses Employee #9 Employee #35 Employee #10 Employee #36 Employee #13 Employee #37 Employee #17 Employee #38 Employee #18 Employee #39 Employee #32 Employee #40 Employee #33 Employee #41 Employee #34 Licensed Practical Nurses Employee #24 Employee #44 Employee #42 Employee #45 Employee #43 On September 22, 2015 at approximately 9:30 AM a face-to-face interview was conducted with Employee #6 [staff development personnel], regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " I have no knowledge of ventilators and I made administration aware of that when I took the job. I know the staff spends one day with a Respiratory	L 067	**Refer to page 190 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 191 Therapist. " On September 22, 2015 at approximately 10:00 AM a face-to-face interview was conducted with Employee #9, regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " The nursing staff " shadow " a Respiratory Therapist for one (1) day. I do not have a checklist or competencies for their training. That is the responsibility of the nursing department. " Example of licensed nurse interviews cross referenced from 483.25 F328: Facility staff failed to ensure that licensed nursing staff assigned to provide ventilator services for Resident #98 were qualified. On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015 to the facility with a diagnosis that included Respiratory Failure. The resident was ventilator dependent. Further review of the physician ' s orders signed and dated August 26, 2015 revealed an order dated July 8, 2015 for the following ventilator settings: AC [ventilator mode], Rate 10, VT [tidal volume] 500, FIO2 [fraction of inspired oxygen] 30%, PEEP [Positive End Expiratory Pressure] 5. A subsequent order dated August 13, 2015 directed the following, " Initiate ventilator weaning protocol. " On September 21, 2015 at approximately 9:42 AM a review of the ' Ventilator Flow Sheet '	L 067	**Refer to page 190 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 192 completed by Respiratory Therapy revealed that ventilator weaning was in progress, but when the resident was not weaning, the ventilator settings were as follows from September 1, 2015 to September 21, 2015: AC/ Rate 12, VT500 FI02 40% PEEP 5. An observation of the ventilator settings made on September 21, 2015 at approximately 9:40 AM confirmed that the resident was on the settings that were documented on the Respiratory Therapy ventilator flow sheets. Review of the Nursing Respiratory Flow sheet revealed different ventilator settings: AC, Rate 10, VT 500, FI02 30%, and PEEP 5 for the month of September, 2015. On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, who was assigned to care for the resident. Employee #16 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #16 stated the set rate was 12 and could not explain her documentation of a rate of 10 or other requested information. On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #22, who was assigned to care for residents requiring ventilator services. Employee #22 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #22 explained the set rate of 12;	L 067	**Refer to page 190 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 193 however, could not further explain the requested information. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with Employee #10, regarding the aforementioned findings. He/she acknowledged the findings, stating that the Respiratory Therapy staff would hold an in-service. On September 22, 2015 at approximately 2:00 PM, a face-to-face was conducted with Employees #2 and 3, regarding the aforementioned findings. Both Employees acknowledged the findings. Facility staff failed to ensure the staff was qualified to provide care for residents requiring ventilator services. B. Facility failed to ensure that the licensed practice nurse performed duties in accordance with his/her scope of practice as evidenced by a failure to notify the registered nurse when Resident #132 sustained a change in condition that warranted a comprehensive nursing assessment. According to District of Columbia Municipal Regulations for Practical Nursing 5514.3 " The practice of practical nursing shall include the following: (a) Participating in the performance of the ongoing comprehensive nursing assessment process of the client ' s biological, physiological, and behavioral health, including the client ' s reaction to an illness, injury, and treatment regimens by collecting data and performing focused nursing assessments; (b) Recording and	L 067	**Refer to page 195 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 194 reporting the findings and results of the ongoing nursing assessment process ... " Resident #132 was admitted on May 20, 2015 with diagnoses to include Anoxic Brain Injury, Coronary Artery Disease Status post Acute Myocardial Infarction (AMI), Diabetes Mellitus, Sacral Decubitus Ulcer, and Sepsis; and subsequently expired on July 17, 2015 with cause of death documented as Atherosclerotic Cardiovascular Disease and Diabetes Mellitus. Medical record review revealed Admission Minimum Data Set Assessment dated May 28, 2015 documented Resident #132 ' s Cognition Pattern under section C0100- "No Resident is rarely/never understood". According to the Physician ' s Order Form for June, 2015, Resident #132 was a Full Code with original dated May 20, 2015 as " Yes-CPR [Cardiopulmonary Resuscitation) " . According to the medical record, on June 17, 2015 at approximately 5:15 AM Resident #132 was found unresponsive by the nursing staff, a licensed practical nurse. According to the nurse ' s note documented at 7:35 AM, the licensed practical nurse went to hang tube feeding and found resident unresponsive as a result " the supervisor was notified right away, CPR initiated, in-house doctor notified and he was at the scene, 911 call and they arrived on time along with the police officers. The documentation also revealed Resident #132 had vital signs during CPR as follows: blood pressure 73/49 millimeter of Mercury, and [heart rate]- 144 and 66/42 millimeters of Mercury and [heart rate] 133, no respirations observed. There was no time documented to indicate the specifics of when the vital were obtained. The medical record any	L 067	**Response to L067, B,#132** 1. Immediately upon notification of this deficiency, a review of the events to verify findings. 2. A retrospective review of all Rapid Response and Code Blue events in the previous 30 days were review and found no other events similar to this deficiency. 3. All nursing RN managers and supervisors were reeducated on the scope of practice for Licensed Practical Nurses. The nursing staff was in-serviced on the Rapid Response policy and algorithm, highlighting the role of members during a Rapid Response event and new documentation forms. 4. The Resident Care Coordinator (RCC) will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed. Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 195 further physical assessment by the nursing staff after the resident was found unresponsive. The nursing supervisor documented arriving to the 6th floor at 5:15 AM " due resident being unresponsive. " Upon arrival to the unit, The nursing supervisor met CPR in progress by nursing staff. A call was placed to the " 911 crew " at 5:20 AM and the House officer was also called to the unit for further evaluation. The Emergency Medical Services team arrived at 5:30 AM and took over CPR. Resident #132 was not transported by Emergency Medical Services due to " asystole (indicates the heart has stopped beat and there is no electrical activity in the heart) status " . On June 17, 2015 at 6:30 AM the respiratory therapy staff documented an SBAR (Situation, Background, Assessment, and Response) note which stated a " Rapid Response " (emergency plan to initiate additional resources for a change in condition) was called at 5:15 AM for " trach [tracheostomy] pt. (patient) " that was found unresponsive by nurse with no pulse and CPR was " activated " and patient was subsequently " pronounced dead " at 5:35 AM. On June 17, 2015 at 5:40 PM, the Employee #23 documented the details of the incident at follows: " Code blue was called after patient was found unresponsive and pulseless. The patient has tracheostomy, chest compressions, was started and Ambu (manual resuscitator device used to provide ventilation to patient who are not breathing adequately) bagged the patient. The patient did not gain pulse the pulse, the pupils were fixed dilated. The 911 was called. Tried to secure the IV (intravenous) line; however, Rigor Mortis (is a sign of death when the muscles become stiff after death usually occurring two (2)	L 067	**Refer to page 195 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 196 to six (6) hours following death); the compression stopped. " The patient was noted to be asystole once AED (Automatic External Defibrillator device that diagnoses life-threatening cardiac arrhythmias) pads were placed. A face to face conversation was held with the Employees #2 and 3 relative to the findings on September 17, 2015 at approximately 2:20 PM regarding the findings relative to incident preceding the death of Resident #132. Consequently, the administrator arranged for the Employee #23 to speak with the surveyor on September 18, 2015. September 18, 2015 at approximately 8:45 AM a face to face interview was conducted with Employee #23. The physician was queried about the events on June 17, 2015 for Resident #132. According to Employee #23, Cardiopulmonary resuscitation (CPR) was in progress when s/he arrived on the unit. The nursing staff was actively doing chest compressions and bagging resident via tracheostomy. According to the Employee #23, the resident was unresponsive and pulseless. After about 20 minutes of resuscitation efforts, 911 Emergency Medical Services arrived on the scene and took over. Shortly after their initiation of CPR, the EMS staff informed the physician that "Rigor Mortis" had set in and the effort for resuscitation should be suspended and the CPR stopped. When queried about the Automatic External Defibrillator and rapid response responsibilities, S/he stated the medical team is unable to provide medication interventions secondary medications are not provided in the SNF (Skilled Nursing Facility). When necessary, the Rapid Response	L 067	**Refer to page 195 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 197 team with initiate intravenous line and establish airway, ambu bag, and chest compression. The resident had an established airway via tracheostomy at the time of the incident. The intravenous line was not established as a result of "EMS reported rigor mortis". The physician did not perform a physical assessment. He was unable to recall if an AED was brought to scene or utilized to determine electrical cardiac activity. September 18, 2015 at approximately 10:05 AM, a face to face interview was conducted with Employee # 24. S/he stated that on the night in question the resident exhibited no signs of distress to indicate a change in condition. At 5:15 AM when returning to Resident #132 ' s room, s/he observed the resident to be unresponsive. At that time a Rapid Response was called. According to the licensed practical nurse, the team that arrives from the hospital for the Rapid Response took over care. S/he was unable to state whom if anyone performed a comprehensive assessment of Resident #132. However, s/he stated that an automated blood pressure machine was utilized to take vital signs during CPR. When queried about why CPR would have continued if the resident in fact had a blood pressure and pulse the licensed practical nurse was unable to provide further insight. When queried about the last time s/he saw the resident alive, s/he state " I had just been in there to do [his/her] fingerstick and the aide gave [him/her] a bath " . In addition, when queried about the Rigor Mortis and inability to secure an intravenous access s/he could not recall. The medical record lacked documented evidence that facility staff performed a comprehensive assessment relative to the documented change in condition.	L 067	**Refer to page 195 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 067	Continued From page 198 The facility failed to ensure that a comprehensive assessment was performed by a registered nurse when a change in condition was identified by the licensed practical nurse.	L 067		
L 075	3215.3 Nursing Facilities The facility shall ensure that ventilator care services are provided by a sufficient number of qualified staff and that personal provide ventilator care services commensurate with their documented training, experience, and competence. This Statute is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent. Additionally, the facility failed to ensure that the licensed practical nurse performed duties consistent with his/her scope of practice; and to ensure a comprehensive assessment was performed by a registered nurse as evidenced by the licensed practical nurse ' s documentation of an assessment when a change of condition was observed. The findings include: A. Facility staff failed to ensure that licensed nurses assigned to provide ventilator services were qualified and competent. During the survey period interviews conducted with licensed nursing staff assigned to provide ventilator services to residents revealed a lack of	L 075	**Refer to page 200 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 075	Continued From page 199 knowledge in the mechanics of ventilation, ventilator function and its correlation to the resident ' s respiratory status. An example to reflect this determination is delineated in the deficient practice statement for Resident #98 documented below. A review of personnel records of licensed nursing staff assigned to provide ventilator services lacked evidence that the staff were adequately trained and/or had documented demonstration of competency in vent management and airway maintenance. On September 22, 2015 at approximately 1:00 PM, a review of 20 personnel records of staff, confirmed by Employee #10, who have taken care of residents requiring ventilator services lacked evidence that they were trained and/or had documented demonstration of competency in ventilator management. The following list of employee personnel records was reviewed: Registered Nurses Employee #9 Employee #35 Employee #10 Employee #36 Employee #13 Employee #37 Employee #17 Employee #38 Employee #18 Employee #39 Employee #32 Employee #40 Employee #33 Employee #41	L 075	**Response to L075, #98** 1. Immediately upon notification of this deficiency a review of the competencies confirmed findings, however no adverse event occurred to resident #98. On 9/22-9/26, 10/7, all Registered and Licensed Practical Nurses assigned to the 6th floor ventilator unit by Respiratory Department were in-serviced on ventilator mechanics, to include ventilator settings function and their correlation to respiratory function was performed for all. The scope of practice for RN and LPNs were reviewed with nursing staff, as well as the implications for daily practice. 2. A review of the retrospective review of the medical records for all residents on vent weaning protocol was performed by the Resident Care Coordinator. Results of the audit found all residents were in compliance. 3. Continual skills and competency assessment related to vent management and airway maintenance, as well as the mechanics of the ventilator has been included in the annual requirements for all nursing staff and new hires. Residents on weaning protocol will be entered on 24-hour report to ensure communication of residents' status and order changes. Hand-off communication was established between Nursing and Respiratory during shift change to note status and progress of residents on weaning protocol. The Nursing Ventilator Flowsheet was revised and nursing instructed on the new format. 4. The RCCs will perform weekly audits of the nursing ventilator flowsheet to ensure settings reflect respiratory therapy ventilator flowsheet and audit the 24-hour report to ensure appropriate protocol related to residents' change in condition are followed. Results of the audits will be reported weekly to the Risk Management Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently maintained for three (3) months	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 075	Continued From page 200 Employee #34 Licensed Practical Nurses Employee #24 Employee #44 Employee #42 Employee #45 Employee #43 On September 22, 2015 at approximately 9:30 AM a face-to-face interview was conducted with Employee #6 [staff development personnel], regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " I have no knowledge of ventilators and I made administration aware of that when I took the job. I know the staff spends one day with a Respiratory Therapist. " On September 22, 2015 at approximately 10:00 AM a face-to-face interview was conducted with Employee #9, regarding ventilator management training provided to staff and the corresponding documented competencies. He/she stated, " The nursing staff " shadow " a Respiratory Therapist for one (1) day. I do not have a checklist or competencies for their training. That is the responsibility of the nursing department. " Example of licensed nurse interviews cross referenced from 483.25 F328: Facility staff failed to ensure that licensed nursing staff assigned to provide ventilator services for Resident #98 were qualified. On September 21, 2015 at approximately 9:30 AM, a review of the admission record revealed that Resident #98 was admitted on July 8, 2015	L 075	**Refer to page 200 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 075	Continued From page 201 to the facility with a diagnosis that included Respiratory Failure. The resident was ventilator dependent. Further review of the physician ' s orders signed and dated August 26, 2015 revealed an order dated July 8, 2015 for the following ventilator settings: AC [ventilator mode], Rate 10, VT [tidal volume] 500, FIO2 [fraction of inspired oxygen] 30%, PEEP [Positive End Expiratory Pressure] 5. A subsequent order dated August 13, 2015 directed the following, " Initiate ventilator weaning protocol. " On September 21, 2015 at approximately 9:42 AM a review of the ' Ventilator Flow Sheet ' completed by Respiratory Therapy revealed that ventilator weaning was in progress, but when the resident was not weaning, the ventilator settings were as follows from September 1, 2015 to September 21, 2015: AC/ Rate 12, VT500 FI02 40% PEEP 5. An observation of the ventilator settings made on September 21, 2015 at approximately 9:40 AM confirmed that the resident was on the settings that were documented on the Respiratory Therapy ventilator flow sheets. Review of the Nursing Respiratory Flow sheet revealed different ventilator settings: AC, Rate 10, VT 500, FI02 30%, and PEEP 5 for the month of September, 2015. On September 21, 2015 at approximately 9:45 AM, a face-to-face interview was conducted with Employee #16, who was assigned to care for the resident. Employee #16 was asked to observe Resident #98 and the ventilator, confirm ventilator	L 075	**Refer to page 200 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 075	Continued From page 202 settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #16 stated the set rate was 12 and could not explain her documentation of a rate of 10 or other requested information. On September 21, 2015 at approximately 10:30 AM a face-to-face interview was conducted with Employee #22, who was assigned to care for residents requiring ventilator services. Employee #22 was asked to observe Resident #98 and the ventilator, confirm ventilator settings and to describe the mode, the set rate, the resident ' s rate, and the resident ' s expected respiratory outcome in relation his/her ventilator status. Employee #22 explained the set rate of 12; however, could not further explain the requested information. On September 21, 2015 at approximately 10:45 AM a face-to-face interview was conducted with Employee #10, regarding the aforementioned findings. He/she acknowledged the findings, stating that the Respiratory Therapy staff would hold an in-service. On September 22, 2015 at approximately 2:00 PM, a face-to-face was conducted with Employees #2 and 3, regarding the aforementioned findings. Both Employees acknowledged the findings. Facility staff failed to ensure the staff was qualified to provide care for residents requiring ventilator services.	L 075	**Refer to page 200 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 077	Continued From page 203	L 077		
L 077	3215.5 Nursing Facilities The facility shall ensure that each ventilator is equipped with an alarm, designed to alert the nursing station, on both the pressure value and the volume value. This Statute is not met as evidenced by: Based on observation and staff interview made during tour of the sixth floor on September 9, 2015 at approximately 12:20 PM and September 16, 2015 at approximately 1:15 PM, it was determined that the facility failed to maintain essential equipment as evidence by the external ventilator alarm monitor for one (1) of eleven ventilator alarm monitors on multiple days. The findings include: 1. On September 16, 2015 at 12:15 PM during a tour of the ventilator unit revealed the external ventilator monitor for Resident #37 was observed to be turned off as evidenced by the lack of digital display on the screen. A face to face interview was conducted with Employee #30on September 16, 2015 at approximately at 12:20 PM. S/he stated rounds for the external ventilator alarm monitors are conducted once every shift to ensure proper functioning as a part of the ventilator checks. The external ventilator alarm monitors are battery-operated. The battery for the aforementioned alarm was observed to be low and continued to shut off when inspected by the respiratory therapist. There was not documented evidence to support	L 077	**Refer to page 205 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 077	Continued From page 204 that the facility staff monitored the proper functioning of the external ventilator alarm monitors as stated in the interview. 2. On September 16, 2015 at approximately 1:15 PM during a resident and unit observations on the ventilator unit, the external ventilator alarm monitor was observed to be off as evidenced by the lack of a digital display on the screen. Upon further inspection by the respiratory therapist, the battery was observed to be missing from the monitor. A face -to- face interview conducted with Employee #30 on September 16, 2015 at approximately 1:35 PM revealed the battery had been removed from the alarm at approximately 12:15 PM because of " low battery " . When queried about the battery replacement delay, he/she stated that he/she was distracted by another resident that required assistance. There was no documented evidence to support that the staff monitored the proper functioning of the external ventilator alarm monitors. A subsequent interview was conducted with Employee #31 on September 21, 2015 at approximately 3:30 PM. Employee #31 stated the external ventilator alarms only serve as a back-up to the manufacturer 's internal ventilator alarms on each ventilator. These observations were confirmed, and acknowledged by Employee #31 at the time of each incident.	L 077	**Response to L077, #1, #2** 1. The battery was immediately replaced by the respiratory therapist on 9/16. Immediate follow-up was conducted with the individual respiratory staff to enhance accountability. Respiratory therapy staff were reeducated on the process for checking ventilator external alarms. 2. External alarm check was performed on all patients that were on mechanical ventilation. Based on the review this was an isolated incident, resident #37, was not harmed by this deficiency. No other resident were found to be affected by this deficiency. 3. Daily rounding will be conducted at the beginning of each shift. Ventilator External Alarm Check List – All external alarms will be checked at the beginning of the shift. Effective 9/25/15, the Respiratory Therapist assigned to Subacute will record the following at the beginning of each shift: Alarm working properly and battery changed date. A running log will be maintained 4. The Director of Respiratory or designee will monitor the ventilator alarm log daily, providing a monthly summary to Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 205	L 099	**Response to L099, #1, #2**	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:20 AM, it was determined that the facility failed to prepare food under sanitary conditions as evidenced two (2) of two (2) soiled grease fryers and a kitchen floor that was marred in several areas. The findings include: 1. Two (2) of (2) grease fryers were soiled with leftover food residue. 2. The kitchen floor was marred in several areas. These observations were made in the presence of Employee #5 who acknowledged the findings.	L 099	1. Immediately upon notification of this deficiency, grease fryer in prep area was cleaned. The marred kitchen floors throughout the department will be replaced. 2. The Dietary Director conducted environmental rounds. Any sanitary or environmental issues were addressed immediately or submitted to maintenance through the electronic work order system. No residents were impacted by this deficiency. 3. The Dietary Director or designee will conduct monthly kitchen inspections to identify and correct sanitary or environmental issues. An equipment cleaning schedule will be developed and implemented by the Dietary Director. The Dietary staff were re-educated on the cleaning process of the grease fryers. 4. The Dietary Director or designee will report audit findings monthly to the Environment of Care Committee and quarterly to the Quality Assurance Committee	**11.10.15**
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on record review and staff interviews for three (3) of 55 sampled residents, it was determined that the facility staff failed to maintain	L 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 190	Continued From page 206 clinical records in accordance with accepted professional standards and practices as evidenced by: the physician failed to document the accurate intervention for wound care treatment for one (1) resident; and the staff failed to ensure the correct spelling of two (2) residents ' names were accurately documented in the clinical records. Residents # 43,108, and 138. The findings include: 1. The physician failed to document accurate intervention for wound care treatment for Resident #43. On September 18, 2015 at approximately 12:15 PM, a review of the admission note revealed and revealed that Resident #43 was admitted to the facility on April 22, 2011. A review of the physician ' s history and physical dated May 1, 2015 revealed the resident ' s diagnosis included a Stage 3 sacral ulcer and Immobility. Review of the physician ' s orders signed and dated August 31, 2015 revealed an order that directed the following: " Cleanse sacral ulcer wound with normal saline, pat dry with gauze. Apply Maxorb [wound care dressing] Ag [silver] and cover with dry dressing daily. " Review of the ' Wound Care Specialist Evaluation ' records revealed that the resident was not receiving dressing changes with Normal Saline as per physician ' s order; instead, the following wound care documentation observed in the ' Assessment & Plan ' section of the August 20, 2015 and September 10, 2015 notes described the following:	L 190	**Response to L190,#1, Resident #43** 1. There was no adverse affect to the wound healing process because the 'actual' treatment being done was saline. The error was in the report submitted by the wound consultant physician. 2. A review of wound care orders were audited finding all orders in compliance. 3. Careful review of treatment orders during end of month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to ensure all orders are documented and implemented. The audit findings will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 190	Continued From page 207 " Continue dry protective dressing once daily, silver absorbing agent -prn [as needed], Dakin ' s Solution- once daily cleanse. " On September 18, 2015 at approximately 4:26 PM, a telephone interview was conducted with Employee #9 regarding the aforementioned documentation and treatment. He/she explained, " The resident should be receiving dressing changes with saline, as the physician ordered. I meant to switch my notes to saline. " The record was reviewed on September 18, 2015. 2. Facility staff failed to ensure the correct spelling of two residents' names were accurately documented in the clinical records for Residents' #108 and 138. A. On September 16, 2015 at approximately 12:30 PM, a review of the admission note revealed that Resident #108 was admitted to the facility on December 19, 2014 with diagnoses that included Respiratory Failure. Review of the Admission Record and physician ' s history revealed documentation that the resident ' s name was spelled one way. A review of the ' Controlled Medication Record ' and Medication Administration Record [MAR] revealed documentation that the resident ' s name was spelled differently. The resident ' s name was spelled two different ways in the clinical record. On September 16, 2015 at approximately 1:20 PM, a face-to-face interview was conducted with Employees #4 and #50. Both reviewed the records and acknowledged the findings. The record was reviewed on September 16, 2015.	L 190	**Response to L190,#2A, B, Resident #108, #138** 1. Immediately upon notification, the names of resident #108 and #138 were corrected within the medical record. 2. An audit of the medical records were reviewed and none were found to have been affected. 3. The MDS Audit Tool was revised, to include verification of the spelling of residents' names A full review of each residents' name will be done during admission, utilizing all available information by the MDS Coordinator. 4. Results of the MDS audit will be reported to Risk Management Subcommittee for three (3) months and a quarterly summary to Quality Assurance Committee until 100% compliance is demonstrated for three (3) months	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 190	Continued From page 208 B. On September 10, 2015 at approximately 1:30 PM, a review of the admission note revealed that Resident #138 was admitted to the facility on August 14, 2015 with diagnosis that included Chronic Respiratory Failure. Review of the Admission Record and physician ' s history revealed documentation that the resident ' s name was spelled one way. A review of the ' Controlled Medication Record ' and Minimum Data Set [MDS] dated August 23, 2015 revealed the resident ' s name was spelled differently. The resident ' s name was spelled two different ways in the clinical record. On September 16, 2015 at approximately 1:40 PM, a face-to-face interview was conducted with Employees #7 regarding the aforementioned findings. He/she reviewed the records and acknowledged the findings. The record was reviewed on September 10, 2015.	L 190	**Refer to page 208 for response**	
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to maintain the area free of accident hazards as evidenced by two (2) of two (2) surge protectors observed on the floor of one (1) of 42 resident's rooms surveyed and one (1) of one (1) surge	L 214	**Refer to page 210 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 209 protector observed on top of the dresser in one (1) of 42 resident's rooms surveyed, nails that were sticking out of the top of the closet door in one (1) of 42 resident's rooms surveyed, an unlocked and accessible utility closet with cleaning chemicals on one (1) of three (3) resident's care unit and an unlocked and accessible oxygen storage room on one (1) of three (3) resident care units. The findings include: 1. Two (2) of two (2) surge protectors were not mounted and were observed on the floor of room #6138, and a surge protector was observed on top of a dresser in room #6104, two (2) of 42 resident's rooms surveyed. 2. Four nails were observed protruding from the top of a broken closet door in room #4132, one (1) of 42 resident's rooms surveyed. 3. The utility closet on the fifth floor where housekeeping cleaning chemicals are stored, was unlocked and accessible to residents and visitors. 4. The oxygen storage room located on the sixth floor was unlocked and accessible to residents and visitors.	L 214	**Response to L214, 1-4** 1. Immediately upon notification, the surge protectors were secured, the nails sticking out of the top of the closet door were removed and closet door repaired in the identified areas. The utility closet on 5th floor and oxygen storage room on 6th floor was securely locked. 2. Facilities Supervisor and Interim Administrator performed Environment of Care (EOC) rounds on each unit focusing on surge protector location, resident closet doors and utility closet on each unit. Those found out of compliance were repaired and/or placed on a maintenance repair schedule. 3. Environmental Surveillance Rounds will continue to include Facilities Director, Maintenance Supervisor and EVS Supervisor. An electronic work order system was established to submit and track completion. An Environment of Care Committee (EOC) was formed to monitor maintenance/repair activities based on findings from the surveillance rounds and electronic work order system 4. The Facilities Director or designee will audit the work order system and surveillance round findings to ensure EOC activities are addressed. A monthly compliance summary will be reported to the EOC Committee and Quality Assurance Committee	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 214	Continued From page 210 These observations were made in the presence of Employee #8 who acknowledged the findings.	L 214		
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to maintain resident's call system in good working condition as evidenced by a call bell in the bathroom of room #6146 that missing the pull cord. The findings include:	L 306	**Response to L306, #1** 1. Immediately upon notification, the call bell light was repaired and the call bell cord of room 6146 bathroom was replaced. 2. Maintenance Supervisor and 6th Fl RCC conducted environmental rounds to ensure the call bells in resident rooms and bathrooms were functioning. All rooms were in compliance. 3. Environmental rounds will be conducted bi-weekly on a rotational schedule by a work group to include Maintenance Supervisor or designee, Housekeeping Supervisor or designee, Clinical Care Coordinator or designee, and Administrator or designee. The work group will utilize the electronic work order system to ensure tracking and just-in-time status report of any outstanding environmental concerns identified. The staff was in-serviced on 9/27, 9/30 and is ongoing regarding the work order process by the Maintenance Supervisor. 4. Results of ongoing quality monitoring, findings, and actions taken during inspections will be reported to EOC Committee monthly and Quality Assurance Committee at least quarterly	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 306	Continued From page 211 1. The call bell in the bathroom of room #6146 was missing a pull cord, one (1) of 41 resident's rooms surveyed. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 306		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made during an environmental tour of the facility on September 14, 2015 at approximately 2:30 PM and on September 16, 2015 at approximately 10:00 AM, it was determined that facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by marred walls in 23 of 42 resident's rooms, stained ceiling tiles in two (2) of 42 rooms, non-functioning sink hoopers on the fourth, fifth and sixth floor, marred entrance doors in 30 of 87 resident's rooms in the facility, wall lights that were out of order in two (2) of 42 resident's rooms surveyed, and broken ceiling lights in one of 42 resident's rooms surveyed, one (1) of one (1) expired eyewash solution in the utility room on the fifth floor and one (1) of one (1) eyewash solution with a missing cap in the utility room on the sixth floor.	L 410	**Refer to page 213 for response**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 212 The findings include: 1. Walls in resident's rooms were marred including rooms # 4111, # 4112, # 4115, # 4118, # 4119, # 4123, # 4132, # 4144, # 4153, # 4157, # 5102, # 5119, # 5133, # 5142, # 5143, # 5149, # 5156, # 5157, # 6119, # 6129, # 6138, # 6146, # 6156, a total of 23 of 42 rooms surveyed. 2. Ceiling tiles were stained in resident room # 5156, # 5149, two (2) of 42 resident's rooms surveyed. 3. Three (3) of three (3) clinical sinks hoppers located in soiled utility rooms on the fourth, fifth and sixth floor (One per floor) failed to flush and were not functioning as intended. 4. Entrance doors to resident's rooms were marred including rooms # 4104, # 4123, # 4130, # 4132, # 4139, # 4144, # 4155, # 4156, # 4157, # 5102, # 5104, # 5106, # 5110, # 5111, # 5113, # 5116, # 5127, # 5130, # 5131, # 5132, # 5135, # 5142, # 5143, # 5146, # 5149, # 6113, # 6116, # 6145, # 6150 and # 6155, a total of 30 of 87 rooms in the facility. 5. Over the bed wall lights were not functioning when tested in resident's room # 5133 and # 6156, two (2) of 42 resident's rooms surveyed. 6. Three (3) of three (3) ceiling lights were out in room # 6146.	L 410	**Response to L410, #1-7** 1. Immediately upon notification of these deficiencies the marred walls; marred entrance doors; stained ceiling tiles; non-functional bed wall lights; and ceiling lights were painted, repaired and/or replaced in the identified areas. The clinical sink hoppers located in the soiled utility rooms of each floor were repaired and functional, allowing complete water exchange when flushed. The expired eyewash on the 5th floor and the eyewash solution with a missing cap on the 6th floor were immediately replaced. 2. Environmental rounds were performed by the Interim Administrator and Maintenance Supervisor to identify additional areas out of compliance. Those rooms identify will be placed on a maintenance/repair schedule. An audit of all eyewash solutions was throughout the facility was completed, replacing any found expired. 3. Environmental Surveillance Rounds will continue to include Facilities Director, Maintenance Supervisor and EVS Supervisor. An electronic work order system was established to submit and track completion. An Environment of Care Committee (EOC) was formed to monitor maintenance/repair activities based on findings from the surveillance rounds and electronic work order system 4. The Facilities Director or designee will audit the work order system and surveillance round findings to ensure EOC activities are addressed. A compliance summary will be reported to the EOC Committee and Quality Assurance Committee monthly.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 213 7. One (1) of one (1) eyewash solution located in the utility room on the fifth floor was expired as of February 2015 and one (1) of one (1) eyewash solution located in the utility room on the sixth floor was missing a missing a cap and could not be used as intended. These observations were made in the presence of Employee #8 who acknowledged the findings.	L 410	**Response to L426, 1-2** 1. Immediately upon notification, pest control measures have been implemented to control flying insects on the fourth, fifth, and sixth floor.	
L 426	3257.3 Nursing Facilities Each facility shall be constructed and maintained so that the premises are free from insects and rodents, and shall be kept clean and free from debris that might provide harborage for insects and rodents. This Statute is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:30 AM, it was determined that the facility failed to maintain an effective pest control program as evidenced by a crawling insect seen in the garbage disposal located in the prep area and flying insects seen throughout the facility during the survey. The findings include: 1. A crawling insect was observed in one (1) of three (3) the garbage disposal located in the prep area 2. Flying pest were observed throughout the	L 426	2. Environmental rounds were conducted on 9/23 by Environmental Services Supervisor and Administrator to ensure pest control issue related to flying insects has been resolved. 3. Environmental rounds will be conducted bi-weekly on a rotational schedule by a work group to include Maintenance Supervisor or designee, Environmental Services Supervisor or designee, Clinical Care Coordinator or designee, and Administrator or designee. Environmental Services Supervisor will implement routine cleaning schedule for trash and deep cleaning schedule for residents' rooms as part of the pest control program. Pest Control Company will be required to communicate with the EVS Supervisor and nursing staff prior to doing rounds to ensure all locations are addressed. A logbook of Pest Control visit will be maintained and monitored by EVS Supervisor. 4. Results of ongoing quality monitoring, findings, and actions taken during inspections will be reported to EOC Committee monthly and Quality Assurance Committee quarterly.	11.10.15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 426	Continued From page 214 facility on the fourth, fifth and sixth on numerous occasions during the survey. The first observation was made in the presence of Employee #5 who acknowledged the finding.	L 426		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations made on September 9, 2015 at approximately 9:20 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by one (1) of three (3) garbage disposals with a torn gasket and missing slats from air curtains located in one (1) of one (1) walk-in refrigerator and one (1) of one (1) walk-in refrigerator/freezer. The findings include: 1. One (1) of three (3) garbage disposals located in the prep area had a torn splash guard. 2. Air curtains from one (1) of one (1) walk-in refrigerator and one (1) of one (1) walk-in refrigerator/freezer were missing slats. These observations were made in the presence of Employee #5 who acknowledged the findings.	L 442	**Response to L442, 1, 3** 1. Immediately upon notification, the splashguard in the prep area was replaced. A work order was submitted to repair the air curtain and slats in the walk-in refrigerator. 2. The Dietary Director conducted environmental rounds. Any sanitary or environmental issues were addressed immediately or submitted to maintenance through the electronic work order system. No residents were impacted by this deficiency. 3. The Dietary Director or designee will conduct monthly kitchen inspections to identify and correct sanitary or environmental issues. 4. The Dietary Director or designee will report audit findings monthly to the Environment of Care Committee and quarterly to the Quality Assurance Committee.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 442	Continued From page 215 B. Based on observation and staff interview made during tour of the sixth floor on September 9, 2015 at approximately 12:20 PM and September 16, 2015 at approximately 1:15 PM, it was determined that the facility failed to maintain essential equipment as evidence by the external ventilator alarm monitor for one (1) of eleven ventilator alarm monitors on multiple days. The findings include: 1. On September 16, 2015 at 12:15 PM during a tour of the ventilator unit revealed the external ventilator monitor for Resident #37 was observed to be turned off as evidenced by the lack of digital display on the screen. A face to face interview was conducted with Employee #30on September 16, 2015 at approximately at 12:20 PM. S/he stated rounds for the external ventilator alarm monitors are conducted once every shift to ensure proper functioning as a part of the ventilator checks. The external ventilator alarm monitors are battery-operated. The battery for the aforementioned alarm was observed to be low and continued to shut off when inspected by the respiratory therapist. There was not documented evidence to support that the facility staff monitored the proper functioning of the external ventilator alarm monitors as stated in the interview.	L 442	**Response to L442, #B1** 1. The battery was immediately replaced by the respiratory therapist on 9/16. Immediate follow-up was conducted with the individual respiratory staff to enhance accountability. Respiratory therapy staff were reeducated on the process for checking ventilator external alarms. 2. External alarm check was performed on all patients that were on mechanical ventilation. Based on the review this was an isolated incident, resident #37, was not harmed by this deficiency. No other resident were found to be affected by this deficiency. 3. Daily rounding will be conducted at the beginning of each shift. Ventilator External Alarm Check List – All external alarms will be checked at the beginning of the shift. Effective 9/25/15, the Respiratory Therapist assigned to Subacute will record the following at the beginning of each shift: Alarm working properly and battery changed date. A running log will be maintained 4. The Director of Respiratory or designee will monitor the ventilator alarm log daily, providing a monthly summary to Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months.	**11.10.15**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0024	A. BUILDING: _____ B. WING _____	09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUB-ACUTE AND REHAB	700 CONSTITUTION AVE. NE WASHINGTON, DC 20002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 442	Continued From page 216 2. On September 16, 2015 at approximately 1:15 PM during a resident and unit observations on the ventilator unit, the external ventilator alarm monitor was observed to be off as evidenced by the lack of a digital display on the screen. Upon further inspection by the respiratory therapist, the battery was observed to be missing from the monitor. A face -to- face interview conducted with Employee #30 on September 16, 2015 at approximately 1:35 PM revealed the battery had been removed from the alarm at approximately 12:15 PM because of " low battery " . When queried about the battery replacement delay, he/she stated that he/she was distracted by another resident that required assistance. There was no documented evidence to support that the staff monitored the proper functioning of the external ventilator alarm monitors. A subsequent interview was conducted with Employee #31 on September 21, 2015 at approximately 3:30 PM. Employee #31 stated the external ventilator alarms only serve as a back-up to the manufacturer 's internal ventilator alarms on each ventilator. These observations were confirmed, and acknowledged by Employee #31 at the time of each incident.	L 442	**Refer to page 216 for response**	