

December 30, 2015

Cassandra Kingsberry, RN Supervisory Nurse Consultant Health Care Facilities Division DC Department of Health 899 North Capitol Street, NE 2nd Floor Washington, DC 20002

Dear Ms. Kingsberry:

Attached is the modified 2567 for BridgePoint Sub-Acute and Rehabilitation Capitol Hill for your review and approval.

Please don't hesitate to contact me at (202) 629-5471, should you have questions.

Sincerely,

James W. Linhares

Chief Executive Officer

Cc Keysha Dale, SNF Administrator

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002	031	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	was conducted at ye 2015 through Septe deficiencies are bas reviews, resident ar sampled residents. An Immediate Jeop scope and severity 483.25 Quality of Ceach resident attain practicable physical well-being, in accordance assessment and pla #145 and 11 additionesidents that have this deficient practic residents receive the relative to ventilator #145 and 11 additionesidents that have this deficient practic in the areas of F-35 in both numbers and needs of residents; related to the provisidentified in the regulation and quality of I Assessment; F-282 nurses assigned to qualified and compet #98, 145, and 11 acceptance.	uality Indicator Survey (QIS) our facility on September 9, amber 23, 2015. The following sed on observations, record and staff interviews for 55 ardy (IJ) was identified at a of "J" in the areas of CFR are, F-309 Failure to ensure that ed/maintained the highest and care - specifically, Resident and ventilator dependent the potential to be affected by se; F-328 Failure to ensure that enecessary care and treatment services - specifically, Resident and ventilator dependent the potential to be affected by se; scope and severity of "K" 3 Failure to have sufficient staff d/or qualifications to meet the specifically, deficient practices ion of needed care for residents ulatory groupings of quality of ife and 483.20 Resident Failure to ensure that licensed provide ventilator services were stent - specifically, Residents Iditional ventilator dependent the potential to be affected by	F	000	Please begin typing here:		
ABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
1	. 1.) 0.1			_	C >=		11/02/2015

opy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afectuards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of trivey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these locuments are made available to the facility. If deficiencles are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
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F 000	corrective action pla IJ was removed on S Subsequently, the In lowered to a scope a F-309 and F-328, F- Substandard Quality this survey. The following is a dir acronyms that may b Abbreviations AC - Assist con AMS - Altered Me ARD - assessme BID - Twice-a-c B/P - Blood Pre CiPAP - Continuou CTA - Clear to au cm - Centimeters CMS - Centers for Services CNA- Certified N CRF - Communi D.C District of DCMR- District of DCMR- District of D/C Discontinue DI - deciliter DMH - Departme DBP - Diastolic EKG - 12 lead El	strator provided a letter noting a in [see letter attached] and the September 25, 2015 at 6:00 PM. Inmediate Jeopardy was and severity of "E" for tags, 282 and F-353. If of Care was identified during rectory of abbreviations and/or be utilized in the report: Introlemental Status interference date lay is sure is positive airway pressure is cultation in Medicare and Medicaid iturse Aide ity Residential Facility	F	000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	_			<u>)MB NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
	_	095027	B. WING			09/2	23/2015
NAME OF P	ROVIDER OR SUPPLIER	···	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	00 CONSTITUTION AVE. NE		
BRIDGEP	OINT SUB-ACUTE AN	D REHAB CAPITOL HILL		V	VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	G-tube Gastrosti HVAC - Heating vi ID - Intellectual IDT - interdiscip L - Liter Lbs - Pounds (IMAR - Medication MD- Medical Di MDS - Minimum Mg - milligram pount nound milligram pound milligram pound nound pox oximetry PASRR - Preadmis Review PEEP - Positive Deg tube - Percutan po- by mouth POS - physician pound p	of expired oxygen comy tube entilation/Air conditioning al disability dinary team unit of mass) n Administration Record Doctor Data Set (metric system unit of mass) metric system measure of oer deciliter of mercury ical actitioner sion screen and Resident Expiratory End Pressure eous Endoscopic Gastrostomy of 's order sheet ed dicator Survey sponse ole party ood pressure Administration Record me	F	000			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP COD 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	E		
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F 000		ge 3 sment/recommendation - method cation used in healthcare	F 0	00			
F 154 SS=D	STATUS, CARE, & The resident has the language that he or	e right to be fully informed in she can understand of his or	F 1	54			
	The resident has the advance about care	e right to be fully informed in and treatment and of any e or treatment that may affect					
	This REQUIREMEN	IT is not met as evidenced by:		190			
	(two) of 55 sampled the facility staff faile fully informed as evi execute a consent	view and staff interview for 2 residents, it was determined d to ensure patient's right to be idenced by the failure to properly for a Peripherally Inserted two (2) of 55 sample resident #111 and #140.					
	The findings include	x:					
		rure the proper execution of rally Inserted Central Catheter.					
	1. Resident #111 wa	as admitted on April 24, 2015					

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OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 095027 **B. WING** 09/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 483.100(b)(3), 483.10(d)(2) INFORMED OF HEALTH Continued From page 4 F 154 STATUS, CARE, & TREATMENTS with diagnoses to include history of Respiratory Response to #1-2, Resident #111 and #140 Failure, Hypertension, and Cerebrovascular Accident. Immediately upon notification of this deficiency, the medical records for resident #111 and #140 to verify findings. Medical record review conducted September 21, 2015 at 2:00 PM revealed a Peripheral Inserted A concurrent chart audit of residents with a Central Catheter (PICC) line was inserted on May physician order for PICC insertion and a 11, 2015 by an outside contract nurse. The retrospective audit of residents who Consents for Surgery, Procedures, Anesthesia, obtained a PICC in-house was reviewed Transfusion and Other Treatments form dated May by the RCCs of each unit. The audits found no other resident impacted by this 11, 2015 at 6:05 PM revealed the signature of two deficient practice. nurses witnessing the telephone consent for the Peripherally Inserted Central Catheter; however, the An in-serviced on 9/21 and is ongoing, 11.10.2015 form lacks the signature of the individual for all nursing staff on standard of responsible for explaining the nature of the patient practice regarding obtain consent for all procedures. The contract nurse condition, procedure, and risks/ benefits associated was reeducated regarding ensure all with undergoing the procedure. signatures are present prior to performing procedure... Review of the Physician 's Progress Notes for May The PICC insertion Order Form will be 11, 2015 at 5:00 PM failed to reveal the medical revised to include a statement which will direct the Vascular Access Nurse to staff spoke with the resident and/or responsible review the chart to ensure consent is party about the need for a Peripherally Inserted present with all necessary signatures Central Catheter and/or its risks and benefits. prior to insertion. The RCCs or designee will monitor all PICC orders to ensure all aspects of the consent A face to face interview was conducted with is accurately documented in the medical Employee# 10 on September 21, 2015 at record prior to the procedure. approximately 12:55 PM regarding the execution of the consent for Peripherally Inserted Central The Resident Care Coordinator (RCC) or Catheters. S/he stated that it was the understanding designee will audit all PICC orders. Results of the audits will be reported monthly to the that the individual performing the procedure would Risk Management Subcommittee for three obtain the consent. When queried about the (3) months. A quarterly summary of the omission with regards to Resident #111, s/he was audits will be reported to the Quality unable to provide further insight. Assurance Committee until 100% compliance is demonstrated consistently for three (3) months.

	CORRECTION	IDENTIFICATION NUMBER:	' '		CONSTRUCTION	COMP	LETED
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F 154	properly executed b was performed. The	ed to ensure that consent was efore an invasive procedure clinical record was reviewed on	F	154	483.100(b)(3), 483.10(d)(2) INFORMED OF HE STATUS, CARE, & TREATMENTS Response to #1-2, Resident #111 and #140 Refer to page 5 for response.	ALTH	
	Medical record revies 2015 at 2:00 PM review Central Catheter (Pl September 9, 2015 The Consents for Stransfusion and Ott September 9, 2015 signature of the resi witnessing the consentral Catheter; he signature of the indicate the nature of the particular signature signature of the particular signature signature signature signature signature signature signature si	as admitted on August 18, 2015					
	reveal documentation staff spoke with the	cian 's Progress Notes failed to on to demonstrate the medical resident about the need for a d Central Catheter and/or its					
	Employee# 12 on Sapproximately 2:55	riew was conducted with eptember 18, 2015 at PM regarding the execution of pherally Inserted Central				i	

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F 154	that the individual perobation the consent. You omission with regard unable to provide further facility staff failed properly executed be was performed. The	ed that it was the understanding erforming the procedure would When queried about the disto Resident #11, s/he was erther insight. ed to ensure that consent was efore an invasive procedure findings were reviewed, nowledged. The clinical record	F	154	483.100(b)(3), 483.10(d)(2) INFORMED OF HE STATUS, CARE, & TREATMENTS Response to #1-2, Resident #111 and #140 Refer to page 5 for response.	ALTH	25
F 157 SS=E	consult with the resinotify the resident's interested family me involving the resider the potential for requisignificant change in or psychosocial statemental, or psychosocharatening condition need to alter treatmed discontinue an existic adverse consequent form of treatment); of discharge the reside in §483.12(a). The facility must also and, if known, the resident in the second of the seco	diately inform the resident; dent's physician; and if known, legal representative or an imber when there is an accident at which results in injury and has ulring physician intervention; a in the resident's physical, mental, us (i.e., a deterioration in health, cial status in either life as or clinical complications); a cent significantly (i.e., a need to ing form of treatment due to ces, or to commence a new or a decision to transfer or ent from the facility as specified to promptly notify the resident esident's legal representative or mber when there is a change in	F	157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #1 & #4, Resident #145, #5 Refer to page 8 for response.		

F 157 Continued From page 7 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 55 sampled residents it was determined that facility staff failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents that experienced a weight loss that expected five (5) percent in 30 days. Residents' #145 and #84 and #6, #5. The facility's policy entitled, "Ventilator Weaning Protocol," dated revised: June 17, 2015, stipulated; "1. Purpose: To provide protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician' is written order of "Wean per protocol." Page 8 … In the event of acute exacerbation of the patient's pulmonary physician and take appropriate steps to morning the therapist will immediately to the pulmonary physician and take appropriate steps to morning promonary physician and take appropriate promonary physician a		CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (A) 10 PREFIX TAG F 157 Continued From page 7 Sepecified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: The facility that falled to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents that experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #84 and #8, #5. The findings include: The facility 's policy entitled, "Ventilator Weaning Protocol," dated revised: June 17, 2015, stipulated; "1. Purpose: To provide protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician or weaning the therapist will immediately notify the pulmonary physician and take appropriate steps to weaning the therapist will immediately notify the completing residual to the control of acute exacerbation of the patient 's pulmonary or ordition during vent tempagement or weaning the therapist will immediately notify the completing physician order, notification to physician and take appropriate steps to constitute AS IND PROFICE ACM PROFICE AND PROFICE			095027	B. WING			09/	/23/2015
F 157 Continued From page 7 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 55 sampled residents it was determined that facility staff failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents that experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #64 and #6, #5. The facility 's policy entitled, "Ventilator Weaning Protocol," dated revised: June 17, 2015, stipulated; "1. Purpose: To provide protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician's was notice and interestions, highlighting the importance of physician and take appropriates tesps to memoral raise and provided and provided physician and the vent of acute exacerbation of the patient 's pulmonary physician and take appropriate steps to memoral raise and provided and provided physician ordes, notice on the members of completing physician ordes, notice on the members of completing physician ordes, notice of the patient 's pulmonary physician and take appropriate steps to order, and interestions, bysician and take appropriate steps to medical eroors in completing physician ordes, notice of the patient 's pulmonary physician and take appropriate steps to order, and interesticant part of the pulmonary physician and take appropriate steps to order, and interesticant part of the pulmonary physician and take appropriate steps to order, and interesticant part of the patient or the pulmonary physician and take appropriate steps to order, and interesticant part or the pulmonary phy			ND REHAB CAPITOL HILL		70	00 CONSTITUTION AVE. NE		
specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for four (4) of 55 sampled residents it was determined that facility staff failed to notify the physician when two (2) ventilator dependent residents who demonstrated a compromise in respiratory function and two (2) residents that experienced a weight loss that exceeded five (5) percent in 30 days. Residents' #145 and #64 and #6, #5. The facility 's policy entitled, "Ventilator Weaning Protocol," dated revised: June 17, 2015, stipulated; "1. Purpose: To provide protocols for the management and weaning of ventilator support. Policy: Protocol will be applied per physician is 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	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
1. Facility staff failed to notify the physician when	F 157	specified in §483.1 rights under Federa specified in paragra. The facility must readdress and phone representative or in This REQUIREMENT. Based on record read (4) of 55 sampled refacility staff failed to (2) ventilator dependemonstrated a corand two (2) reside loss that exceeded Residents' #145 and The findings included The facility 's policy Protocol, " dated restipulated; "1. Purp the management and Policy: Protocol will written order of " We the event of acute of pulmonary condition weaning the therap pulmonary physicial treat the symptoms."	5(e)(2); or a change in resident all or State law or regulations as aph (b)(1) of this section. Cord and periodically update the number of the resident's legal terested family member. AT is not met as evidenced by: Eview and staff interview for four esidents it was determined that to notify the physician when two dent residents who in member in respiratory function into that experienced a weight five (5) percent in 30 days. In evised: June 17, 2015, pose: To provide protocols for and weaning of ventilator support. The protocol. "Page 8 In exacerbation of the patient's in during vent management or ist will immediately notify the in and take appropriate steps to"	F	157	(INJURY/DECLINE/ROOM, ETC) Response to #1, Resident #145, #5 1. Immediately upon notification of this deficien medical records for resident #145 and #5 to findings. On 9/16/15, 1:1 education of the Respiratory staff involved was held on the tin of completing respiratory orders and enhance accountability. 2. Nursing conducted a retrospective review of hir report for indications of status change, conceferencing the medical record to ensure the physician was notified of any change in the resident's condition. The audit results found medical records in compliance. Respiratory Therapist conducted medical reaudits to identify new/changed orders and in of missed orders. Those found out of compliance addressed with the attending physician. 3. The clinical nursing staff were educated 9/22 10/7 and ongoing by the Respiratory Depart the weaning protocol and related compreher assessment and interventions. The Director of Nursing (DON) re-educated nursing staff on 10/7/2015 and is ongoing rethe change in resident condition process reliassessment and interventions, highlighting timportance of physician notification. The communication binder will be created to mai record of notification, to include date/time/interventions (if applicable) The Respiratory staff were re-educated on 9 related to the timeliness of completing physiorders, notification to physician, and the use	verify meliness the 24- pss- all cord dications ance the garding ated to the intain a	

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	SUMMARY STA	TO REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 157	Resident #145, a verdemonstrated a com Resident #145 begatherath on August 29 treatments beginning demonstrated an alta August 31, 2015. Or 9:03 PM, Resident #145 was a According to the adrexamination signed 2015, Resident #145 Respiratory Failure, Continue on [Ventila to cervical spine injuto Cardiomyopathy, Continue on incomplete to continue on incomplete to continue on incomplete in incomplete incomplete in incomplete incomplete in incomplete i	ntilator dependent resident apromise in respiratory function. In complaining of shortness of 2, 2015, refused CPAP 2, 2015, refused CPAP 3, 2015 and 3 and 3 aration in the level of arousal on a August 31st at approximately 3 and 4 achycardia. Sident was transferred to the 4 admitted on August 24, 2015. Sident was transferred to the 4 admitted on August 24, 2015. Sident was included Chronic 3 and 3	F 15	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) [Cont' Response to #1, Resident #145, #5 (Cont' of the 24 hour report to ensure notificat residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during change to note status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) we perform weekly audits of the 24 hour reposition to ensure appropriate protocol related to residents' change in condition are follower per policy. Results of the audits will be reported we to the Risk Management Subcommittee three (3) months. A quarterly summary the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated consistently three (3) months. The Respiratory Department will conduct audits to respiratory orders. A monthly sthe audits will be reported to the Quality Committee until 100% compliance is demonstrated consistently for three (3) months.	d d d d d d d d d d d d d d d d d d d	11.10.2015

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F 157	of SOB [shortness of August 30, 2015 - 'Received [patient] of treatment] given as writing). [oxygen sawriting), Will continuprocedures done CPAP trial. [Patient] SOB [shortness of the on AC [Assist Control [August 30, 2015 to S- [Patient] is on AC [Fractioned of Inspiractioned (Inspiractioned Inspiractioned Inspiraction Inspiractio	"7AM-7PM- Shift Report - " on AC mode, [nebulization ordered. [Patient] (Illegible turation] -99%, HR (illegible use to monitor patient. Special Attempt to wean. Pt [Patient] on] keep comp [complaining] of oreath], anxious. Placed back rol] mode to rest. " of August 31, 2015- "7PM-7AM-C 15/[Tidal Volume]-500, ired Oxygen-45%, [Peep]-5, B-A-Pt stable throughout shift-R (Respiratory Rate) -21. Pt gunable to breathe but in no Continue to monitor for changes. 7AM-7PM- S- Pt remains on AC a weaning do [due] to pt being M. B- Respiratory failure, A- Alert B4- RR-25, Sat-98%, small thin (breath sounds) clear, R- Will" Ventilator Flow Sheet " atory therapist] revealed the et/Total " on the A/C mode: ned: 15/34 - "15" reflects spiratory rate and "34" reflects - ove the set rate]		157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #1 & #4, Resident #145, # Refer to page 8 for response.	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ND REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Heart Rate-93 0855 (8:55 AM) - 15 Heart Rate-87 1230 (12:30 PM) - 15 and Heart Rate doc [1700] 5:00 PM - 15 Rate-80 2045 (8:45 PM) - 15 Rate-158. " The nurse practition Resident #145 as for August 31, 2015 [not Registered Nurse P [psychiatric] and Mo obtained from staff/ arousable [Patier answer questions a Alert and Oriented or just received pain in staff resident normal responds to question responding to painfrarousable and [he/stage) does not answer que [Positive] Anxiety, " [secondary to medic staff. Plans: Monitor monitor for worsenif week to reassess in The record revealed communicated to the resident was " not a received pain medic	5/33 - [Oxygen] Saturation- 98%, 5/32 - [Oxygen] Saturation-98%, 5/33 - No Oxygen Saturation cumented in the allotted space. 6/29 - [Oxygen] - 98%, Heart 6/23, Saturation 96%, Heart 6/23, Saturation 96%, Heart 6/23, Saturation 96%, Heart 6/23, Saturation 96%, Heart 6/24, Saturation 96%, Heart 6/25, Saturation 96%, Heart 6/26, Saturation 96%, Heart 6/27, Saturation 96%, Heart 6/28, Saturation 96%, Heart 6/29 - [Oxygen] - 096%, Heart 6/20 - [Oxygen] - 09	F [*]	157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #1 & #4, Resident #145, #5 Refer to page 8 for response.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COMP	SURVEY LETED
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	9072	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	were administered 3 treatment during the 2015. The specific tireview of the MAR received Tylenol 500 to wound treatment through August 30, 2 documented evidence "lack of arousal" a dosages of Tylenol a pain medication. " Nursing Notes: August 28, 2015 3:1 [b/p-blood pressure] [R-respirations] 18 August 29, 2015 3:0 [R] 20 " August 31, 2015- 12 and responsive. Ver mode for respiratory needed) V/S- [Bloof [Temperature]-, 74, rates] no respirations. S-BAR (Situation-Background on) /Acute Change in Date: August 31, 20 is the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35 PM entry] Icelethargy [and] gaspin preserview of the successive nut 12:35	alled Tylenol 500mg 2 caplets in minutes prior to wound 7AM - 3PM shift on August 31, me was not noted. Further evealed that Resident #145 along 2 caplets 30 minutes prior during the period of August 25th 2015. There was no be that Resident #145 sustained associated with any preceding administration or "just received administration or "just received " 3 PM - " V/S [vital signs]: 108/58; [P-pulse] 99; no acute distress noted " 0 AM - " [b/p] 116/62; [P] 78,:35 PM - Resident remain alert at [ventilator] dependent AC support. Suction PRN (as and Pressure] - 134/74, 98.9 100 [two (2) different heart	F	157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #1 & #4, Resident #145, #5 Refer to page 8 for response.		

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED
		095027	B. WING		09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 157	ventilator Resider B/P 77/53, elevated notified who ordered [hospital] for further There was no evider respiratory staff ider exhibited progressiv and mental) that wai intervention before tunresponsive with a transfer to higher levalust 31, 2015-21 [physician] Note: I w #145] b/c (because) [and] acute AMS gra [His/her] HR (heart resides [and] B/P as low a earlier today [he/she but currently [he/she arousal and awarend agonal (gasping) bre Assessment/Plan: A unknown cause ([he (Intravenous) Cipro Diflucan (anti-fungal Transfer to nearest I The clinical record la notified the physicial progressive complai breath, refusing CPA	unds: Crackles, Pulse ox: 93% at was noted [with] [decreased] pulse rate. House officer I to transport resident to evaluation and treatment. " Ince that licensed nursing and attified that Resident #145 e change in status (respiratory tranted monitoring and/or the resident became obtunded, gonal breathing requiring	F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #1 & #4, Resident #145, #5 Refer to page 8 for response.	

PRINTED: 12/29/2015 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 095027 **B. WING** 09/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 483.10(b)(11) NOTIFY OF CHANGES F 157 Continued From page 13 F 157 (INJURY/DECLINE/ROOM, ETC) 2015 until 9:03PM when the resident was obtunded Response to #1 & #4, Resident #145, #5 and with agonal breathing. Refer to page 8 for response. Interviews A face-to-face interview was conducted with Employee #14 [on-coming day-shift team member, August 31, 2015 7AM - 7PM] September 18, 2015 at approximately 2:00 PM regarding the above aforementioned concerns. He/she said that the off-going team member [night shift August 30th 7PM through August 31, 2015 7AM] stated that the resident was calling all night, using the type of call bell one blows into. Employee #14 further stated the off-going therapist and the nurse was in and out of the resident 's room all night. Employee #14 acknowledged the physician should have been informed of the resident's restlessness, complaint of having shortness of breath and refusal of CPAP treatments. The clinical record was reviewed September 18, 2015. Cross referenced 483.20(k)(3)(ii) F282: 483.25 F309; 483.30(a) F353; 483.25(k) F328 2. Facility staff failed to notify the attending physician in regards to a weight loss that exceeded 483.10(b)(11) NOTIFY OF CHANGES five (5) percent in 30 days. Resident #64. (INJURY/DECLINE/ROOM, ETC) Response to #2 & #3, Resident #64, #6 According to the facility's policy; "Weight Refer to page 16 for response. 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

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	concerns are noted measured monthly to change of 5% or monthly to assessment will be confirmation. If the trimmediately notify the immediately notified and medianorexia, weight loss weight " Resident #64 was a diagnoses to include Retention, Hyperter Lower Extremities, a Venous Stasis, and Deficient with decort the History and Phy Resident underwent Gastrostomy on Ma poor oral intake. Medical record reviet 2015 at 10:00 AM redocumented weight May, 2015 (date of	at this point, weights will be thereafter3. Any weight presented the last weight retaken the next day for weight is verified, nursing will the Dietician in writingAnalysis mation shall be analyzed by the m and conclusions2. The multidisciplinary team will identify ications that may be causing as or increasing the risk of a sor increasing the risk of	F	157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #2 & #3, Resident #64, #6 Refer to page 16 for response.		
	Progress Notes from September 1, 2015 documented notification	e's Notes and Physician's n June 22, 2015 through revealed the medical staff ation of significant weight loss on ne medical record lacked					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONST		(X3) DATE	PLETED
		095027	B. WING _			09/	23/2015
BRIDGEF	SUMMARY S	ND REHAB CAPITOL HILL TATEMENT OF DEFICIENCIES	ID	700 CON WASHII	ADDRESS, CITY, STATE, ZIP CODE ISTITUTION AVE. NE NGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	.	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)		COMPLETION DATE
F 157	notified of the weight May and August 20 A face-to-face inter #27 at 10:38 AM or that Resident #64 v. According to Employ the resident was not to adjust the tube for intolerance and orallabs, he/she stated it was assumed the sacral wound and v. 2 weeks and then or resident plan of car manager at the time any further insight r. Although the dietici adjustment to the tophysician authentic signature. The meditable the physician was r. August 20, 2015 while loss approximately weight of 186.8 pour The findings were cacknowledged by E.	nce that the medical staff was ht loss documented between	F1		483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #2 and #3 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 montweights 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 ((as responsible for notifying the attending physician or NP of a confirmed significant change within 48 hours. The RD will call thattending physician or NP to inform about significant weight change via phone and e. The RD will keep a record of physician/NP significant weight notification including date 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 clinic collaborations. The Director of Nursing (DON) re-educated 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 notification, to include date/time/interventicapplicable) 4. The Assistant Director of Clinical Nutrition perform monthly audits of the physician significant weight change notification record the audit results will be reported to Qualit Assurance Committee. Auditing will continuntil 100% compliance is demonstrated to minimum of three (3) months.	RD) weight e the mail. the of ons (if will rd. y nue	11.10.2015

	LAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MOLTIPLE CONSTRUCTION A. BUILDING		COMPLETED				
		095027	B. WING _			09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE D CONSTITUTION AVE. NE ASHINGTON, DC 20002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	physician in regard	age 16 ed to notify the attending ls to a weight loss as evidence by percent] weight loss in 30 days	F 1	57	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Response to #2 & #3, Resident #64, #6 Refer to page 16 for response.		
s	conducted on Febr resident has the fo	idents History and Physical ruary 13, 2015 revealed the llowing active diagnoses which rementia, Arthritis, Elephantiasis aract.					
	revealed the follow January 2015 - 11 February 2015 - 11 March 2015 - 110 April 2015 - 88 written question mass space for "re-weig May 2015 - 88 June 2015 - 88 July 2015 - 91	2 pounds 6 pounds 6 pounds 7 pounds 9 pounds ?? - the two (2) hand arks [??] were written in the corresponding 9.4t. " pounds 9.4 pounds	÷				
	physician notes an evidence that wher pound weight loss neither the dietitian of the weight loss. evidence in the clir obtained a reweigh confirmation or tha	cical record (nursing, dietitian, d consults) lacked documented in the resident sustained a 28 for March 2015 to April 2015 in nor the physician were notified In addition, there was no nical record that the facility staff into the dietitian was notified of the april when first identified.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		7(TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	00/2	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From pa	ge 17	F	157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)		
	Quarterly Nutrition	Notes:		±.	Response to #2 & #3, Resident #64, #6		
	19, 2015 revealed, (etiology) dysphagia (signs/symptoms) S Pathology] ordered Plus [nutritional supneeds assistance w [%] percent of meal [Registered Nurse], Current weight 89 p A further review of than 30 days had la	n Review conducted dated May "Swallowing /chewing difficulty; a and missing teeth; SLP [Speech Language mechanical soft diet; Boost oplement] BID [twice-a-day], with eating, no teeth/dysphagia, intake (average) is 75% per RN % Supplement50% per RN oounds/40.4 kg [kilograms] "			Refer to page 16 for response.		
	addition, there was record that a SLP of Quarterly Nutrition revealed, "Remero	as conducted in May 2015. In no evidence in the clinical onsult was ordered. Review dated August 11, 2015 n [used to stimulate appetite]	85				
	than 60 days since identified at 88 pour Physician Notes:	nedications " which was more the resident 's weight was nds.					·
	Attending dated 3 PM revealed pt. s [observation] small 112 pounds; A/P [A	can s Progress Note 3/20/15 [March 20, 2015] 7:45 seen, s [none]; " O " built, [no] distress, wt [weight] ssessment/Plan] Senile tiasis, Cataract, P: Supp					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	F 157 Continued From page 18		F 1	57	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)		
					Response to #2 & #3, Resident #64		
	Attending dated seen, reviewed lab observation: [uncle small and frail, wt 8Plan: ADL [Activi wt 20, Dementia (e Not Resuscitate], do	ician 's Progress Notes " 5/29/15, 7:50 PM revealed "pt. s and meds. "S" [none] "O" ar writing] alert, disoriented, built 88 pounds, A/P severe Dementia ties of Daily Living], pt. will lose xpected), pt. should be DNR [do to Not Send to Hospital. " ence that the physician was ound weight loss between March as first identified.			Refer to page 16 for response.		
	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 lossResident has poor appetite and eats only some foods offered to [him/her.] Resident is alert, verbally responsive, but oriented to person onlyP:start Remeron 7.5 mg [milligrams] po [by mouth] QHS [at bed time] for appetite stimulant " There was no evidence that the NP was notified of the 28 pound weight loss when it first identified in April 2015 which was indicative of a 25% or more weight loss.						
	Interviews:						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095027	B. WING	·	09/23/2015			
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 157	A face-to-face interved Employees' #26 and approximately 9:50 of dietician notified of versided that after nurse [dietary] review the versident should have resident should have weights. Employee facility obtained new weights were stable secondition nor behave a face-to-face interved September 17, 2015 Employee #3. He/sl aforementioned, he/due to the new scale weight loss from Mawas no evidence that the weight change. September 17, 2015 5. Facility staff failed Resident #5, a yentidemonstrated an ele subsequent comprosed.	riew was conducted with 1 #27 on September 17, 2015 at AM regarding how is the weight changes. Employee #26 sing takes the weight we weights and then we will request ee #26 acknowledged that a re been conducted and the e been placed on weekly #26 also acknowledged that the resident in a scales in April 2015 and the since April on and the resident invior changed. The was conducted on a state of the stated that after review of the she believed the change was es (weighing equipment). The sustained a 28 pound rich 2015 to April 2015. There at the physician was notified of The record was reviewed on it. If to notify the physician when lator dependent resident evated heart rate and mise in respiratory function. If #5's quarterly MDS (Minimum assessment Reference Date 2015 revealed diagnoses in	F 15	483.10(b)(11) NOTIFY OF CHAN (INJURY/DECLINE/ROOM, ET Response to #5, Resident # Refer to page 8 for response	TC) 5			

	CORRECTION	IDENTIFICATION NUMBER:	` '	NG		COMPLETED
		095027	B. WING_			09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	AND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STAT 700 CONSTITUTION AVE. N WASHINGTON, DC 200	NE	V3.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)	
F 157	Physician's orders Vent [Ventilator] S Mode- Rate-10, V [Fraction Inspired Physician 's Program Pulmonary Note - " Patient [resident] stimuli, no purpose AC [mode of Assis 500, PEEP [positiv Fi02 [room air] 400 18, T 97.9; CTA-[a wheezes; CVS [ca [abdomen] + [positiv Fi02 [room air] 400 18, T 97.9; CTA-[a wheezes; CVS [ca [abdomen] + [positiv [extremities] no ed chronic Respirator secondary CVA [C Continue on vent s care. " MD [Medical Docto 08:50 AM revealed Response. " Pat tachycardia [rapid 140, SBP [systolic [respiratory rate] 2 100% Fi02 with an feeding witnessed [clear to auscultati system]: tachycar [hypoactive] bowel	nsion, Tracheostomy, Respiratory ator. dated May 9, 2015 directed; "ettings: AC (Assist Control) I- 400 [Tidal Volume]- FIO2 Oxygen]- 40%		157		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 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)			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	[rule out] aspiration/ [Emergency Room] A review of the nurs " May 31, 2015 4:50 responsive. AM cartemperature, P [puls [blood pressure]127 No evidence of pain to monitor " May 31, 2015 6:30 Fresponsive, due meabnormal findings not 133/78. Pulse Ox 96 June 1, 2015 4:00 Presponsive PM care [temperature] 98.6, I BP [blood pressure] 98%. Turned and responsive to the pressure of the pressure	extremities; A/P : Respiratory Distress, R/O sepsis. Will send to ER	F	157			
11	well. Will monitor. \[T] 98.3.	omy] tube patent and flushed /s [BP] 131/72, [P] 76, [R] 18, AM- SBAR [standardized					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FOR PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Background, A = As Recommendation]/A read: "Resident wardistress and an elev [bpm/beats per minured RT [Respiratory The was called. Rapid Rhouse officer gave in [by] 911 [Emergency [times] 1 [one] during activity. Resident was [local hospital]."	ealthcare - S = Situation, B = sessment, R = Acute change in condition note as noted with respiratory rated HR [heart rate] of 140 ute]. Resident was bagged by grapy] while Rapid Response Response team respondedIn new order to transfer resident via y]. Emesis [vomiting] noted x g bagging with seizure like as then transferred via 911 to y Notes: Privatory Ventilator Flow Sheet realed the following: AM]	F	157			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IG	_	COMPLETED		
		095027	B. WING _		-	09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STA 700 CONSTITUTION AVE. WASHINGTON, DC 20	. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		
F 157	PEEP: 5 Saturation: 99% Heart Rate [HR]: 1 There was no docuphysician was notificated heart rated June 2, 2015 (08:2) approximately 4 how approximately 5 how approximately 6 how approxim	imented evidence that the fied in regards to Resident #5's e from June 2, 2015 (3:45 AM) to 0 AM), which is indicative of ours. piratory therapy shift notes s beginning June 1, 2015 7PM - e 2, 2015 12 Midnight - 7AM] - e revealed: ident RR [respiratory rate] 18 BS inonchi/clear, sxn [suction] uction, no distress.	F1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING _	E CONSTRUCTION	(X3) DATE SURV COMPLETED	
		095027	B. WING		09/23/20	015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL	7	TREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) MPLETION DATE
F 157	via 911 [Emergency the SBAR at the tim heart rate was 140. A face-to-face interview in the september 21, 2015 with Employees #18 that his/her shift was #18 also stated, who with the heart rate 1 was called at approxyomited when he/sh resuscitated using a #47 stated when he from the rooms assist the rapid response to that the rapid response to that the rapid response to the resident had vor and then the resident rate at 140. The night for interview. There was no evide physician in regards ventilator dependent increase in heart rate out 911 [Emergency	erred to the Emergency room Medical Services] according to e of transport the resident's view was conducted on at approximately 10:30 AM and #47. Employee #18 stated s 7:00AM to 7:00PM. Employee en he/she first saw the resident 29 is when the rapid response ximately 8:20AM, the resident he was bagged [manually he bag valve mask]. Employee /she was conducting rounds gned when he/she was called to by Employee #18 who stated hase [team] took over, and that mited when he/she was bagged hat was sent out 911 with a heart which shift nurse was not available make that facility staff notified the at to Resident #5 who was at and first experienced an an and was subsequently sent	F 157			
F 246 SS=D	OF NEEDS/PREFE		F 246			
	services in the facilit	ght to reside and receive by with reasonable individual needs and				

	CORRECTION	IDENTIFICATION NUMBER:	' '				COMP	PLETED
		095027	B. WING_			<u> </u>	09/	23/2015
	SUMMARY ST. (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	700 WA	CONSTITASHINGTO	ESS, CITY, STATE, ZIP CODE UTION AVE. NE ON, DC 20002 PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 246	preferences, except individual or other residual	when the health or safety of the esidents would be endangered. T is not met as evidenced by: ons, record review and staff of 55 sampled residents, it was lity staff failed to ensure able accommodation relative to so get out of bed for a resident d is was unable to do so on their .	F 2	46	NEED	Fig. (1) REASONABLE ACCOMMODATION SIPREFERENCES Inse to #1 Resident #80 The care needs for resident #80 was assessed and an appropriate care plan of developed immediately upon notification this deficiency. A schedule for resident to be out of bed was also created. ADL needs for dependent residents on equit were reassessed and an appropriate care plan with specific interventions was developed. All clinical staff were re-educated 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. The Resident Care Coordinators (RCC) designee will perform weekly rounds on each unit and documentation audits ensure ADLs are performed per care plated for dependent residents. Audit findings will be reported weekly to Management Subcommittee for three (3 months. The Respiratory Department we conduct monthly audits to respiratory of monthly summary of the audits will be not to the Quality Assurance Committee un compliance is demonstrated consistent three (3) months.	was of #80 each e iii Inders. A eported til 100%	11.10.2015

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION IG	C	(X3) DATE SURVEY COMPLETED		
		095027	B. WING _			09/23/2015		
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL) i	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 246	is it to you to go out weather is good? - During a follow-up of September 16, 2015 nodded in the affirm informed him/her the bed and asked if the Review of the care failed to initiate a care failed to get shown as unable to greative to the reside bed. On September 16, 2015 and of September 16, 2015 The facility failed to accommodation to residence and shown as unable to get shown as unable to	Preference: "G. how important side to get fresh air when the 1= Very Important " Prisit with Resident #80 on 5 at 3:30 PM, Resident #80 native when Employee #10 at s/he would be getting out of at was okay with him/her. Polans revealed the facility staff are plan relative to Activities of sident who is dependent on the needs. 2015 at 3:20 PM a face to face acted with Employee #10. When then the face with Employee #10. When then the face with the resident were and does not get out of mployee #10, his/her isolation is prevent the resident from shower. The resident is seed baths in the room. Employee provide further explanation ent not being able to get out of 2015 the facility staff led documentation of a care plan with date of initiation 2015. Provide reasonable meet the need for transfer at of bed for a resident who is	F 2	46				

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		TRUCTION		PLETED
		095027	B. WING _			09	/23/2015
RAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	700 CO WASH	ADDRESS, CITY, STATE, ZIP CODE NSTITUTION AVE. NE INGTON, DC 20002 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 253 SS=E	The facility must promaintenance service sanitary, orderly, and This REQUIREMEN Based on observati environmental tour of 2015 at approximate 16, 2015 at approximate 16, 2015 at approximate the termined that faci housekeeping and not omaintain a sanitary interior as evidence resident's rooms, standard to maintain a sanitary interior as evidence resident's rooms, standard to maintain a sanitary interior as evidence resident's rooms, standard to maintain a sanitary interior as evidence resident's rooms, and 42 rooms, non-funct fourth, fifth and sixth 30 of 87 resident's rooms surveyed, and 42 resident's rooms expired eyewash so fifth floor and one (1 with a missing cap in floor. The findings include 1. Walls in resident's rooms # 4111, # 4123, # 4119, # 4123, # 5102, # 5119, # 55	s rooms were marred including 12, # 4115, # 4118, 4132, # 4144, # 4153, # 4157,	F 2	SEF	Immediately upon notification of these de the marred walls; marred entrance doors ceiling tiles; non-functional bed wall lights lights were painted, repaired and/or replaidentified areas. The clinical sink hoppers located in the s rooms of each floor were repaired and fur allowing complete water exchange when the expired eyewash on the 5th floor and eyewash solution with a missing cap on the was immediately replaced. Environmental rounds were performed by Administrator and Maintenance Supervisia additional areas out of compliance. Thos identify will be placed on a maintenance/schedule. An audit of all eyewash solution throughout the facility was completed, refound expired. Environmental Surveillance Rounds will dinclude Facilities Director, Maintenance sand EVS Supervisor. An electronic work order system was est submit and track completion. An Environment of Care Committee (EO formed to monitor maintenance/repair acon findings from the surveillance rounds electronic work order system The Facilities Director or designee will an order system and surveillance round findensure EOC activities are addressed. A summary will be reported to the EOC Co Quality Assurance Committee monthly.	ficiencies stained; and ceiling ced in the celling c	11.10.2015 & ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	-	095027	B. WING			09/23/2015	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL				7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	5156, # 5149, two (2 surveyed. 3. Three (3) of three located in soiled utilififth and sixth floor and were not function. 4. Entrance doors to including rooms # 4" # 4130, # 4132, # 4157, # 5102, # 5" # 5110, # 5111, # 5131, # 5132, # 5" # 5143, # 5146, # 6150 and # 6155, of 87 rooms in the survey of the ested in reside # 6156, two (2) of 6. Three (3) of three room # 6146. 7. One (1) of one (1) the utility room on the expired as of Feb (1) eyewash solution.	stained in resident room # 2) of 42 resident's rooms (3) clinical sinks hoppers ity rooms on the fourth, or (One per floor) failed to flush oning as intended. resident's rooms were marred 104, # 4123, 4139, # 4144, # 4155, # 4156, 104, # 5106, 5113, # 5116, # 5127, # 5130, 135, # 542, 5149, # 6113, # 6116, # 6145, a total of 30 e facility. lights were not functioning ent's room # 5133 and 42 resident's rooms surveyed. (3) ceiling lights were out in e eiffth floor was oruary 2015 and one (1) of one on located in the utility of floor was missing a missing a	F	253			

PRINTED: 12/29/2015 FORM APPROVED

<u>CENTER</u>	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		30.2010
					00 CONSTITUTION AVE. NE		
BRIDGEF	POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL			VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From pag	ge 29	F	253			
		were made in the presence of cknowledged the findings.					
F 272 SS=E	483.20(b)(1) COMP	REHENSIVE ASSESSMENTS	F	272			
30 2	comprehensive, acc reproducible assess functional capacity. A facility must make of a resident's need assessment instrum The assessment mu	ment of each resident's a comprehensive assessment s, using the resident ent (RAI) specified by the State. est include at least the following:				×	
	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-be						
	Disease diagnosis at Dental and nutritions Skin conditions; Activity pursuit; Medications; Special treatments at Discharge potential; Documentation of stitle additional assess areas triggered by the Dental and Discharge potential; Documentation of stitle additional assess areas triggered by the Dental and Discharge potential; Documentation of stitle additional assess areas triggered by the Dental and Den	and procedures; ummary information regarding sment performed on the care ne completion of the Minimum					
	Data Set (MDS); and Documentation of page 1	articipation in assessment.					:

	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		095027	B. WING			09	/23/2015
		D REHAB CAPITOL HILL		700 CO	ADDRESS, CITY, STATE, ZIP CODE INSTITUTION AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 272	This REQUIREMEN Based on record revolution of 55 sampled reside facility staff failed to Care Area (CAA)informanual or significant (MDS) under Section #6, #9, #27, #41, #4, #86, #122, #129, #1. The findings include According to Chapte Manual, "for each to date and location of documentation shou complicating factors resident for this care 1. Facility staff failed of Care Area Assess Section V [V0200]. Summary "of the si set for Resident #5. A review of Resident dated July 21, 2015 addressed 'in Care Loss, #3 Visual Fund Urinary Incontinence	T is not met as evidenced by: view and staff interview for 17 ents, it was determined that identify the location and date of ormation on the admission, change Minimum Data Sets n V [V0200A]. Residents' #5, 3, #46, #49, #51, #63 #79, #80, 32 and #141. er 4 of the MDS 3.0 Users ' niggered care area, indicate the the CAA documentationCAA ld include information on the nisks and any referrals for the	F 27	Re:	sponse to #1 - #17 sidents' #5, #6, #9, #27, #41, #43, #46, #49 9, #80, #86, #122, #129, #132 and #141. MDSs for residents #5, #6, #27, #43, #45, #80, #86, and #141 were reviewed and c 10.28.2015. Residents' #9 and #122 no is resides in the facility, therefore no further could be taken. Residents #41, #46, #51, #129, and #132 prior to identification of this deficiency the further measures could be taken. MDS Coordinators performed an audit of record for any residents impacted by this correcting those found out of compliance. The MDS Coordinator revised the curren Tool for retrospective reviews of the med include monitoring of CAAs completion. The CAA worksheet, provided through the Charting System (ECS), will be used by the Coordinators during Interdisciplinary Tea. MDS Coordinators will perform weekly at reviewing findings during the IDT meeting summary of the audit results will be repoind Quality Assurance Committee. Auditing wuntil 100% compliance is demonstrated finding minimum of three (3) months.	#51, #63 #63, #79, orrected on onger measures expired refore no the medical deficiency, at MDS Audit ical record to the MDS m meetings. It is a monthly ted to vill continue	11.10.2015
		, 					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027 B. WING		09/23/2015			
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL				70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Nutrition, #13 Fee Maintenance, #16 The record reveal including informat risks, and any refeareas #2, #3, #4, #16] was not including corresponding. There was no evid documented the loregarding informat A face-to-face intended from the end of the maintenance of the maintenance of Location the program detended from the program of the progr	ding Tube, #14 Dehydration/fluid Pressure Ulcers. ed that the location and date ion on the complicating factors, errals for this resident [for care #6, #7, #10, #11, #12, #13 #14, uded in the documentation line for a triggered care area. Idence that the facility staff ocation in the clinical record tion related the CAA 's. erview was conducted with September 17, 2015 at 30 AM regarding the CAA IDS. He/she acknowledged the andings and stated "No matter ation I [Employee #7] write in the and Data of CAA documentation faults to only stating "CAA 3.0 today 's date.) to provide date and location of sment [CAA] information on the on V [V0200]. ed to provide the location and Assessment [CAA] information would be a defined as a session of the content of the care Area Assessment and the care Areas and 's revealed the Care Areas and 's re Plan triggered for #2 Cognitive	F	272	483.20(b)(1) COMPREHENSIVE ASSESSME Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #14' Refer to page 31 for response.	#51, #63	
			1				1

NAME OF PROMDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES PRETEX PROMDER OR ALL PARKS STATEMENT OF DEFICIENCIES CONTINUITON AVE. NE WASHINGTON, DC 20002 FRETZ Continued From page 32 Communication, #5 ADLs [Activity of Daily Living/functional Status, #6 Uninary Incontinence/Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident (for care areas #2, #3, #4, #5, #6, #11, #12, #16) was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA's. A face-to-face interview was conducted with Employse #7 on September 17, 2015 at approximately 11-30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information in [Employee #7] write in the area of "Location and Data of CAA documentation", the program defaults to only stating "CAA 3.0 9/18/15 (which is today"s date.) Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary" of the admissions minimum data set for Resident #9. A review of Resident #9"s admission's MDS dated May 21, 2015 revealed the Care Area Area Sandission and Carea Area Area Area Area Area Area Area	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
REIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID (X4) ID (PAPER) TAG REACH DEPICIENCY MUST BE PRECEDED BY PULL REQULATORY TAG FOR USE STREET ADDRESS, CITY, STATE, JP CODE TOP CONSTITUTION AVE. NE WASHINGTON, DC 20002 PREVIOUS PLAN OF CORRECTION CRACH DEPICIENCY MUST BE PRECEDED BY PULL REQULATORY TAG FOR USE STREET ADDRESS, CITY, STATE, JP CODE TOP CONSTITUTION AVE. NE WASHINGTON, DC 20002 PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE COMMETTION CHIEF TAG CONTINUED From page 32 Communication, #5 ADLs (Activity of Daily Living)/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #2, #3, #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA 's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated 'No matter how much information I [Employee #7] write in the area of "Location and Data of CAA documentation ', the program defaults to only stating "CAA 3.0 9/16/15 (which is today 's date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information under Section V [V0200]. 'Care Area Assessment Summary of the Morition Under Section V [V0200]. 'Care Area Assessment Summary of the dimissions minimum data set for Resident #9", A review of Resident #9" 's admission's MDS dated			095027	B. WING	B. WING			23/2015
FREETY TAG FOR LSC IDENTIFYING INFORMATION F 272 Continued From page 32 Communication, #5 ADLs [Activity of Daily Living/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #2, #3, #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA 's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at a approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information [Employee #7] write in the area of "Location and Data of CAA documentation ', the program defaults to only stating "CAA 3.0 9/16/15 (which is today 's date.) Facility staff failed to provide date and location and date of Care Area Assessment [CAA] information under Section V [V0200]. 3. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary" of the admissions minimum data set for Resident #9' s admissions minimum data set for Resident #9' s admissions is MDS dated			ID REHAB CAPITOL HILL		70	00 CONSTITUTION AVE. NE		
Communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident (for care areas #2, #3, #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA 's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information I [Employee #7] write in the area of "Location and Data of CAA documentation", the program defaults to only stating "CAA 3.0 9/16/15 (which is today 's date.) Facility staff failed to provide date and location of Care Area Assessment [CAA] information on the MDS under Section V [V0200]. "Care Area Assessment Summary" of the admissions minimum data set for Resident #9. A review of Resident #9's admission's MDS dated	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
	F 272	Communication, #5 Living]/functional Sta Incontinence/Cathet Pressure Ulcers. The record revealed including information risks, and any referr areas #2, #3, #4, #5 included in the docu corresponding trigge. There was no evided documented the locaregarding information. A face-to-face interve Employee #7 on Sea approximately 11:30 summary of the MDS aforementioned find how much information area of "Location at the program defact 9/16/15 (which is too Facility staff failed to Care Area Assessme MDS under Section V [VO Summary " of the action of the section	ADLs [Activity of Daily atus, #6 Urinary er, #11 Falls, #12 Nutrition, #16 I that the location and date on on the complicating factors, als for this resident [for care of the thin the facility staff ation in the clinical record on related the CAA's. The was conducted with prember 17, 2015 at the AM regarding the CAA of the facility staff at the facility staff at the facility staff at the care area. The was conducted with prember 17, 2015 at the facility staff at the care and the capacity of the form of the capacity of	F	272	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141	51, #63	

NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (XA) ID (EACH DEPICIONAL VIMUAT BE PROCEEDED FIRLIL REGULATORY OR LS: IDEATE PINAL BY CORRECTION OR	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 (CA) (DA) (PA) (PA) (PA) (PA) (PA) (PA) (PA) (P			095027	B. WING _			09/	23/2015
FREETY TAG (EACH DEPICIENCY MUST BE PRECEDED BY PULL REQULATORY TAG RLSC IDENTIFYING INFORMATION) F 272 Continued From page 33 'addressed' in Care Plan triggered for #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #14 Dehydration/fluid Maintenance, #16 Pressure Ulcers and #17 Psychotropic Medication Use. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident (for care areas #5, #6, #11, #12, #14, #16, #17) was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated. "No matter how much information Telmployee #7 write in the area of "Location and Data of CAA documentation", the program defaults to only stating. "CAA 3.0 9/16/15 (which is today's date.) Facility staff failed to provide date and location of Care Area Assessment (CAA) information under Section V (V02000), "Care Area Assessment Summary' of the Annual Minimum Data Set [MDS] for Resident Tag F 272 483.20(b)(1) COMPREHENSVE ASSESSMENTS Response to #1 + #17 Residents '\$5, #8, #9, #27, #41, #45, #16, #17 Residents' \$5, #8, #9, #27, #41, #45, #16, #47 Residents' \$5, #8, #9, #27, #41, #45, #16, #47 Residents' \$5, #8, #9, #27, #41, #45, #16, #47 Residents' \$5, #8, #9, #27, #41, #45, #46, #47, #47 Residents' \$5, #8, #9, #27, #41, #45, #46, #47, #47 Residents' \$5, #8, #9, #27, #41, #45, #47, #47, #47, #47, #47, #47, #47, #47					70	0 CONSTITUTION AVE. NE		
'addressed' in Care Plan triggered for #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, #14 Dehydration/fluid Maintenance, #16 Pressure Ulcers and #17 Psychotropic Medication Use. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #5, #6, #11, #12, #14, #16, #17] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information I [Employee #7] write in the area of "Location and Data of CAA documentation", the program defaults to only stating "CAA 3.0 9/16/15 (which is today's date.)) Facility staff failed to provide date and location of Care Area Assessment [CAA] information under Section V [V0200A]. Care Area Assessment Summary' of the Annual Minimum Data Set [MDS] for Resident	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
	F 272	'addressed' in Car [Activity of Daily Liv Incontinence/Cathe Dehydration/fluid Mand #17 Psychotrop The record revealed including information risks, and any referrances #5, #6, #11, #included in the docucorresponding trigge There was no evide documented the loc regarding information A face-to-face interved and the local regarding information of the MD aforementioned find how much information area of "Location at the program defail 9/16/15 (which is to Facility staff failed to Care Area Assessment [Over Incomplete	re Plan triggered for #5 ADLs ing]/functional Status, #6 Urinary ter, #11 Falls, #12 Nutrition, #14 aintenance, #16 Pressure Ulcers on the complicating factors, rals for this resident [for care £12, #14, #16, #17] was not umentation line for the ered care area. Ince that the facility staff ation in the clinical record on related the CAA 's. View was conducted with ptember 17, 2015 at DAM regarding the CAA S. He/she acknowledged the lings and stated "No matter on I [Employee #7] write in the and Data of CAA documentation ults to only stating "CAA 3.0 day 's date.) Deprovide date and location of the CAA information under Section Area Assessment Summary ' of	F 2	7.72	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141	! 51, # 63	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING	B. WING		09/:	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 272	Assessment Refered 4, 2015 lacked evidic clinical record when triggered care areas. A face-to-face intended in the Employee #7 on Seapproximately 10:50 findings. The record 2015. 5. Facility staff failed date of Care Area Aunder Section V [V0 Summary " of the afor Resident #41. A review of Resider dated November 25 and 'addressed' in Cognitive Loss, #4 Incontinence/Cathe #10 Activities, #11 Fitube(s), #14 Dehydrom Pressure Ulcers and The record revealed including information risks, and any referrareas #4, #5, #6, #1 was not included in corresponding triggor There was no evided.	nt #27's Annual MDS with an ence Date (ARD) of September ence of the location in the ethe information related to the soculd be found. Wiew was conducted with eptember 16, 2015 at DAM. He/she acknowledged the diswere reviewed September 16, dispersional to provide the location and assessment [CAA] information 2000]. "Care Area Assessment admission's minimum data set of the Hamber of the Care Areas of the Care Plan triggered for #2 Communication, #6 Urinary ter, #7 Psychosocial Well-being, Falls, #12 Nutrition, #13 Feeding ration/Fluid Maintenance, #16 did #18 Physical Restraints. If that the location and date in on the complicating factors, rals for this resident [for care 11, #12, #14, #16, #17, #18] the documentation line for the	F	272	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141 Refer to page 31 for response.	51,#63	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	A face-to-face interemployee #7 on Sapproximately 11:3 summary of the MI aforementioned fin how much informare and "Location", the program defa 9/16/15 (which is to Facility staff failed Care Area Assessim MDS under Section 6. Facility staff failed Care Area Assessment V [V0200A], 'Care the Annual Minimus #43. A review of Reside Assessment Refere 2015 lacked evider record where the irricare areas could be A face-to-face interemployee #7 on Scapproximately 10:5 findings. The record 2015. 7. Facility staff failed Area Assessment	rview was conducted with eptember 17, 2015 at 30 AM regarding the CAA DS. He/she acknowledged the dings and stated "No matter tion I [Employee #7] write in the and Data of CAA documentation aults to only stating "CAA 3.0 oday 's date.) to provide date and location of ment [CAA] information on the N [V0200]. ed to provide the location of Care [CAA] information under Section a Area Assessment Summary ' of m Data Set [MDS] for Resident ent #43's Annual MDS with an ence Date (ARD) of March 8, nce of the location in the clinical information related to the triggered	F	272	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141 Refer to page 31 for response.	51, #63	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY
		095027	B. WING			ng/	23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002	1 03/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	Continued From p	page 36	F	272	483.20(b)(1) COMPREHENSIVE ASSESSMEN	пѕ	
	Summary ' of the [MDS] for Resider	Admissions Minimum Data Set nt #46.			Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, #5 #79, #80, #86, #122, #129, #132 and #141.		
a a	revealed the Care Areas triggered for Urinary Incontiner Well-being, Activit Tube(s), Dehydra Care, and Pressu revealed the follow for the location an Psychosocial Well 3.0 04/16/15 " an Urinary Incontiner Feeding Tube(s),	um Data Set dated April 11, 2015 e Areas and the Care Planning or Cognitive Loss, Communication, nce/Catheter, Psychosocial ties, Falls, Nutrition, Feeding tion/ Fluid Maintenance, Dental re Ulcers. The medical record wing documentation in the space and date of the CAA information: Il-being and Activities as " CAA and Cognitive Loss, Communication, nce/Catheter, Falls, Nutrition, Dehydration/ Fluid Maintenance, Pressure Ulcers as " CAA 3.0			Refer to page 31 for response.		
	the facility staff re document the date aforementioned co	the CAA Worksheet provided by vealed that the facility staff did not e and location for the are areas in the medical record e Area Assessment.					
	Employee #7 on Sapproximately 10: of the Care Area A Minimum Data Se stated that the couthe documentation CAA Documentation Set. The informati Worksheet. The fi	erview was conducted with September 15, 2015 at 30 AM regarding the completion Assessment information on the et under Section V0200. S/he inputer software does not allow for in into the "Location and Date of ion " field of the Minimum Data ion is entered on the CAA indings were reviewed, discussed, d that the location					

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL Too CONSTITUTION AVE. NE WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES ID PROFILE PROFILE PROFICE OF STULL REGULATORY OR LSC IDENTIFYING INFORMATION) F272			095027	B. WING			09/:	23/2015
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 272 Continued From page 37 and/or date were not documented in the medical record. 8. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #49. A review of Resident #49's Annual MDS with an Assessment Reference Date (ARD) of March 15, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16,			ID REHAB CAPITOL HILL		70	00 CONSTITUTION AVE. NE		
and/or date were not documented in the medical record. 8. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], ' Care Area Assessment Summary ' of the Annual Minimum Data Set [MDS] for Resident #49. A review of Resident #49's Annual MDS with an Assessment Reference Date (ARD) of March 15, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at approximately 10:50 AM. He/she acknowledged the findings. The records were reviewed September 16,	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
9. Facility staff failed to provide the location of Care Area Assessment [CAA] information under Section V [V0200A], 'Care Area Assessment Summary' of the Annual Minimum Data Set [MDS] for Resident #51. A review of Resident #51's Annual MDS with an Assessment Reference Date (ARD) of April 20, 2015 lacked evidence of the location in the clinical record where the information related to the triggered care areas could be found. A face-to-face interview was conducted with Employee #7 on September 16, 2015 at	F 272	and/or date were no record. 8. Facility staff failed Area Assessment [CV [V0200A], 'Care the Annual Minimum #49. A review of Resident Assessment Refered 2015 lacked evident record where the inficare areas could be A face-to-face interved Employee #7 on Sel approximately 10:50 findings. The record 2015. 9. Facility staff failed Area Assessment [CV [V0200A], 'Care the Annual Minimum #51. A review of Resident Assessment Refered 2015 lacked evident record where the inficare areas could be A face-to-face interverse.	It to provide the location of Care CAA] information under Section Area Assessment Summary ' of a Data Set [MDS] for Resident at #49's Annual MDS with an ance Date (ARD) of March 15, ce of the location in the clinical formation related to the triggered found. The was conducted with prember 16, 2015 at a AM. He/she acknowledged the swere reviewed September 16, at to provide the location of Care CAA] information under Section Area Assessment Summary ' of a Data Set [MDS] for Resident at #51's Annual MDS with an ance Date (ARD) of April 20, ce of the location in the clinical formation related to the triggered found.	F	272	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, #5 #79, #80, #86, #122, #129, #132 and #141.	51, #63	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	:	(X3) DATE COMP	SURVEY LETED
		095027	B. WING _			09/2	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	CODE		0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE
F 272	Continued From pa	ge 38	F 2	483.20(b)(1) COMPREHENS	SIVE ASSESSMEI	NTS	
	the findings. The re 16, 2015.	ecords were reviewed September		Response to # Residents' #5, #6, #9, #27, #41 #79, #80, #86, #122, #12	, #43, #46, #49, #		
	Care Area Assessn Section V [V0200A	led to provide the location of ment [CAA] information under], 'Care Area Assessment Annual Minimum Data Set [MDS]		Refer to page 31 fo	or response.		
	Assessment Reference of	nt #79's Annual MDS with an ence Date (ARD) of July 3, 2015 the location in the clinical record ion related to the triggered care and.		2			
	Employee #7 on Se approximately 10:5	view was conducted with eptember 16, 2015 at 0 AM. He/she acknowledged the ds were reviewed September 16,					
	Area Assessment [V [V0200A], 'Care	to provide the location of Care CAA] information under Section Area Assessment Summary of m Data Set [MDS] for Resident					
	Area Assessment [V [V0200A], 'Care	ed to provide the location of Care CAA] information under Section Area Assessment Summary ' of nge in status Minimum Data Set #64					
		ļ					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	A Significant Chand dated August 9, 20 Care Planning Dec Function, ADLs/ Fulncontinence/ Cath Tube(s), Dehydratic Care, and Pressure review revealed the space for location adocumentation: Nu Dehydration/ Fluid 08/03/15 "; and Vis Status, Urinary Inco Care, and Pressure 08/11/2015. Further review of the facility staff revedocument the date aforementioned carrelated to the Care A face-to-face interemployee #7 on Seapproximately 10:3 of the Care Area As Minimum Data Set stated that the compthe documentation CAA Documentation Set. The informatio Worksheet. The fin and acknowledged	ge in Status Assessment (SCSA) 15 revealed the Care Areas and isions triggered for Visual Inctional Status, Urinary eter, Falls, Nutrition, Feeding on/ Fluid Maintenance, Dental e Ulcers. The medical record of following documentation in the and date of the CAA trition, Feeding Tube(s), and Maintenance as "CAA 3.0 sual Function, ADLs/ Functional continence/ Catheter, Falls, Dental of Ulcers as "CAA 3.0 sual Function of CAA 3.0 sual Function, ADLs/ Functional continence/ Catheter, Falls, Dental of Ulcers as "CAA 3.0 sual Function of CAA 3.0 sual Function of CAA 3.0 sual Function of CAA 3.0 sual Function, ADLs/ Functional continence/ Catheter, Falls, Dental of CAA Worksheet provided by ealed that the facility staff did not and location for the re areas in the medical record	F	272	483.20(b)(1) COMPREHENSIVE ASSESSMI Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, #79, #80, #86, #122, #129, #132 and #14 Refer to page 31 for response.	#51, #63	

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	Care Area Assess Section V [V0200/ Summary of the for Resident #80 Annual Minimum I 2015 revealed the Planning Areas tri Communication, U Activities, Falls, N Dehydration/ Fluid Pressure Ulcers. Trevealed the follow for location and data	age 40 siled to provide the location of sment [CAA] information under A], 'Care Area Assessment Annual Minimum Data Set [MDS] Data Set (MDS) dated April 2, Care Areas and the Care ggered for Cognitive Loss, Urinary Incontinence/Catheter, utrition, Feeding Tube(s), Maintenance, Dental Care, and The medical record review ving documentation in the space ate of the CAA documentation for oned Care Areas as: "CAA 3.0"	F	272	483.20(b)(1) COMPREHENSIVE ASSESSME Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141 Refer to page 31 for response.	51, #63	
	the facility staff redocument the date aforementioned carelated to the Care. A face to face intended Employee #7 on Sapproximately 10: of the Care Area A Minimum Data Se stated that the corthe documentation CAA Documentation Set. The informati Worksheet. The finand acknowledged	the CAA Worksheet provided by wealed that the facility staff did not a and location for the are areas in the medical record a Area Assessment. Tryiew was conducted with september 15, 2015 at 30 AM regarding the completion Assessment information on the tunder Section V0200. S/he inputer software does not allow for in into the "Location and Date of on " field of the Minimum Data on is entered on the CAA indings were reviewed, discussed, dithat the location and/or date inted in the medical	E E				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			E SURVEY PLETED
	095027	B. WING		09	/23/2015
ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		12012010
(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
Continued From page	ge 41	F 27	Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46,	#49, #51, #63	
date of Care Area A under Section V [V0	Assessment [CAA] information 0200]. "Care Area Assessment				
dated June 5, 2015 addressed ' in Care communication, #5 Living]/functional St Incontinence/Cathe	revealed the Care Areas and 'e Plan triggered for #4 ADLs [Activity of Daily atus, #6 Urinary ter, #11 Falls, #12 Nutrition, and				
including information risks, and any refer areas #4, #5, #6, #1 in the documentatio	n on the complicating factors, rals for this resident [for care 1, #12, #16] was not included n line for the corresponding		÷		
documented the loc	ation in the clinical record				
Employee #7 on Se approximately 11:30 summary of the MD aforementioned find how much informatiarea of "Location a", the program defa	ptember 17, 2015 at D AM regarding the CAA S. He/she acknowledged the lings and stated "No matter on I [Employee #7] write in the and Data of CAA documentation ults to only stating "CAA 3.0				
	CONT SUB-ACUTE AN SUMMARY ST (EACH DEFICIENCY MUS' OR LSC IDE Continued From parrecord. 13. Facility staff failedate of Care Area Aunder Section V [VC Summary " of the aResident #86. A review of Residerdated June 5, 2015 addressed ' in Care communication, #5 Living]/functional St Incontinence/Cathe #16 Pressure Ulcers The record revealed including information risks, and any referrances #4, #5, #6, #1 in the documentation triggered care area. There was no evided documented the location area of "Location ar	POINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 record. 13. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary" of the admissions minimum data set for	ROVIDER OR SUPPLIER POINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 41 record. 13. Facility staff failed to provide the location and date of Care Area Assessment [CAA] information under Section V [V0200]. "Care Area Assessment Summary" of the admissions minimum data set for Resident #86. A review of Resident #86 's admission's MDS dated June 5, 2015 revealed the Care Areas and 'addressed' in Care Plan triggered for #4 communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information I [Employee #7] write in the area of "Location and Data of CAA documentation ', the program defaults to only stating "CAA 3.0	ROVIDER OR SUPPLIER O95027 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 GEACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) COntinued From page 41 record. Continued From page 41 record. 13. Facility staff failed to provide the location and date of Care Area Assessment Summary of the admissions minimum data set for Resident #86'. A review of Resident #86' s admission' s MDS dated June 5, 2015 revealed the Care Areas and 'addressed' in Care Plan triggered for #4 communication, #5 ADLs [Activity of Daily Living]/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident [for care areas #4, #5, #6, #11, #12, #15] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documented the location in the clinical record regarding information related the CAA's. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information I [Employee #7 on CAA documentation ", the program defaults to only stating" "CAA 3.0	ROVIDER OR SUPPLIER O95027 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE TOO CONSTITUTION AVE. NE WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM THE CONSTITUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTINUED FROM THE CONSTITUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTINUED FROM THE CONSTITUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTINUED FROM THE CONSTITUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTINUED FROM THE CONSTITUTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE F 272 483.20(b/t) COMPREHENSIVE ASSESSMENTS Response to \$\frac{1}{2}\$ #17 Residents #5, #6, #8, #27, #41, #33.46, #46, \$51, #63 #79, #80, #86, #12, #123 and #141. Refer to page 31 for response. A review of Resident #86 's admission's MDS dated June 5, 2015 revealed the Care Areas and 'addressed' in Care Plan triggered for #4 communication, #5 ADLs (Activity of Daily Living/functional Status, #6 Urinary Incontinence/Catheter, #11 Falls, #12 Nutrition, and #16 Pressure Ulcers. The record revealed that the location and date including information on the complicating factors, risks, and any referrals for this resident (flor care areas #4, #5, #6, #11, #12, #16] was not included in the documentation line for the corresponding triggered care area. There was no evidence that the facility staff documentation fine for the corresponding triggered care area. There was no evidence that the facility staff documentation fine for the corresponding triggered care area. A face-to-face interview was conducted with Employee #7 on September 17, 2015 at approximately 11:30 AM regarding the CAA summary of the MDS. He/she acknowledged the aforementioned findings and stated "No matter how much information is lated the CAA" on the proportion of the propor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` `		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Facility staff failed Care Area Assessi MDS under Section 14. Facility staff failed atte of Care Area ander Section V [V Summary " of the set for Resident #1 A review of Reside MDS dated July 27 and 'addressed' Visual Function, #5 Living]/functional S Incontinence/Cathe #16 Pressure Ulce Medication Use. The record reveale including informationisks, and any reference areas #3, #5, #6, # included in the doccorresponding trigg. There was no evided documented the longarding information A face-to-face interection for the MI aforementioned fin how much information area of "Location"	to provide date and location of ment [CAA] information on the n V [V0200]. Iled to provide the location and Assessment [CAA] information (0200]. "Care Area Assessment significant change minimum data 22. Int #122 's significant change ', 2015 revealed the Care Areas in Care Plan triggered for #3 ADLs [Activity of Daily status, #6 Urinary eter, #11 Falls, #12 Nutrition, and rs and #17 Psychotropic Ind that the location and date on on the complicating factors, rrals for this resident [for care 11, #12, #16, #17] was not umentation line for the gered care area. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's. Indication in the clinical record on related the CAA 's.	F	272			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ECONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING		<u> </u>	09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 272	date.) Facility staff failed Care Area Assess MDS under Section 15. Facility staff fadate of Care Area under Section V [Nammary " Admission Minimu revealed the Care Areas triggered for Communication, U Psychosocial Well-Tube(s), Dehydrati Pressure Ulcers. Trevealed the follow for location and da Dehydration/ Fluid Tube(s) as " CAA Well-Being and Ac "; and Cognitive L Communication, A Incontinence/ Cathas " CAA 3.0 07/2	to provide date and location of ment [CAA] information on the n V [V0200]. alied to provide the location and Assessment [CAA] information (0200]. "Care Area Assessment sions Minimum data set for m Data Set dated July 15, 2015 Areas and the Care Planning Cognitive Loss, Visual Function, rinary Incontinence/Catheter, Being, Activities, Falls, Feeding ion/ Fluid Maintenance, and the medical record review ving documentation in the space the of the CAA documentation for Maintenance and Feeding 3.0 07/08/2015 "; Psychosocial ctivities as "CAA 3.0 07/15/2015 oss, Visual Function, DLs/Functional Status, Urinary neter, Falls, and Pressure Ulcers	F	272	483.20(b)(1) COMPREHENSIVE ASSESSMEN Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, #: #79, #80, #86, #122, #129, #132 and #141. Refer to page 31 for response.	51, #63	
	document the date aforementioned ca	and location for the areas in the medical record Area Assessment.			4		
Ī	A face to face inter	view was conducted with					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	approximately 10:30 of the Care Area As Minimum Data Set us stated that the compthe documentation in CAA Documentation in CAA Documentation Set. The information Worksheet. The find and acknowledged is were not documented were not documented. 16. Facility staff failed date of Care Area Aunder Section V [V0 Summary" Admission Resident #132. Admission Minimum revealed the Care Aneas triggered for Communication, United Pressure Ulcers revealed the following for location and date Nutrition, Feeding Time Maintenance as "Communication, Application, Application, Application, Application and Staff Care And 3.0 05/27/2015 Communication, Application in the Care And Staff Care And S	ptember 15, 2015 at DAM regarding the completion sessment information on the under Section V0200. S/he outer software does not allow for into the "Location and Date of in" field of the Minimum Data is entered on the CAA lings were reviewed, discussed, that the location and/or date ed in the medical record. The detail of the location and seessment [CAA] information 200]. "Care Area Assessment ons Minimum data set for Data Set dated May 28, 2015 reas and the Care Planning Cognitive Loss, Visual Function, nary Incontinence/Catheter, Being, Activities, Falls, Nutrition, ehydration/ Fluid Maintenance, as The medical record reviewing documentation in the space of the CAA documentation for the ube(s), and Dehydration/Fluid AA 3.0 05/22/2015"; Cognitive Well-Being, and Activities as "	F	272	483.20(b)(1) COMPREHENSIVE ASSESSME Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141 Refer to page 31 for response.	51, #63	
							·

	CORRECTION	IDENTIFICATION NUMBER:	` '			COMP	LETED
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE DO CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Further review of the the facility staff reve document the date	e CAA Worksheet provided by ealed that the facility staff did not and location for the e areas in the medical record	F	272	483.20(b)(1) COMPREHENSIVE ASSESSMEN Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, #\$ #79, #80, #86, #122, #129, #132 and #141. Refer to page 31 for response.	i1, #63	
	Employee #7 on Se approximately 10:30 of the Care Area As Minimum Data Set ustated that the compthe documentation i CAA Documentation Set. The information Worksheet. The find and acknowledged	riew was conducted with ptember 15, 2015 at 0 AM regarding the completion sessment information on the under Section V0200. S/he outer software does not allow for not the "Location and Date of n " field of the Minimum Data is entered on the CAA dings were reviewed, discussed, that the location and/or date ed in the medical record.		:			
	date of Care Area A under Section V [V0 Summary " of the a for Resident #141. A review of Resider	d to provide the location and assessment [CAA] information [200]. "Care Area Assessment dmission 's minimum data set at #141s admission 's MDS					
	addressed ' in Care Communication, #5 Living]/functional St Incontinence/Cather #14 Dehydration/Flu	revealed the Care Areas and 'e Plan triggered for #4 ADLs [Activity of Daily atus, #6 Urinary ter, #11 Falls, #12 Nutrition, and aid Maintenance, #16 Pressure chotropic Medication Use, and					
	The record revealed	I that the location and date					

	F CORRECTION	IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		SURVEY
		095027	B. WING			no	23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE OF CONSTITUTION AVE. NE ASHINGTON, DC 20002	1 00/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	including informati risks, and any refe areas #4, #5, #6, # was not included it corresponding trig. There was no evid documented the loregarding information of the Materian of the Materian of Location of Location of the program def 9/16/15 (which is the risks, and any reference of the Materian of Location of the program def 9/16/15 (which is the Facility staff failed	errals for this resident [for care #11, #12, #14, #16, #17, #18] in the documentation line for the gered care area. Hence that the facility staff focation in the clinical record ion related the CAA 's. In the documentation line for the gered care area. Hence that the facility staff focation in the clinical record ion related the CAA 's. In the conducted with the eptember 17, 2015 at 130 AM regarding the CAA DS. He/she acknowledged the addings and stated "No matter tion I [Employee #7] write in the land Data of CAA documentation focation of coday 's date.) Ito provide date and location of ment [CAA] information on the	F	272	483.20(b)(1) COMPREHENSIVE ASSESSME Response to #1 - #17 Residents' #5, #6, #9, #27, #41, #43, #46, #49, # #79, #80, #86, #122, #129, #132 and #141 Refer to page 31 for response.	51, #63	
F 279 SS=E	A facility must use develop, review ar comprehensive pla. The facility must diplan for each resid objectives and time medical, nursing, a	E CARE PLANS the results of the assessment to ad revise the resident's	F	279	483.20(d), 483.20(k)(1) DEVELOP COMPREHE CARE PLANS Residents' #21, #64 and #122. Refer to page 49 for response	NSIVE	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING	and the second s	09/2	3/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL	7	TREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE VASHINGTON, DC 20002	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 279	be furnished to attai highest practicable pysychosocial well-be and any services that under §483.25 but a resident's exercise of including the right to §483.10(b)(4). This REQUIREMEN Based on observati staff interview for the it was determined the care plan with goals function for two (2)) with pressure ulcers #122 The findings include 1. Facility staff failed goals and approach Resident #21. A history and physic revealed Resident # Hypertension, [Statu Replacement and D A review of the reside (MDS) with a Asses September 1, 2015	describe the services that are to n or maintain the resident's obysical, mental, and sing as required under §483.25; at would otherwise be required are not provided due to the of rights under §483.10, orefuse treatment under T is not met as evidenced by: on, record review, resident and ree (3) of 55 sampled residents, at facility staff failed to initiate a and approaches for visual residents and one (1) resident. Residents' #21, #64 and It to initiate a care plan with the set of address visual function for all dated January 30, 2015 and dated January 3	F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENCARE PLANS Residents' #21, #64 and #122. Refer to page 49 for response	NSIVE	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		TE SURVEY MPLETED
		095027	B. WING			09	/23/2015
	SUMMARY STA	D REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	70 W	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODE	.D BE	(X5) COMPLETION DATE
F 279	Lenses (contact, glaused in completing in No. Further review of the Visual Function care planning decision was care area would be at A review of the company August 15, 2015 lactidentification, goals a resident 's visual fur Facility staff failed to and approaches for function. A face-to-face intervising function. A face-to-face int	Section B1200 Corrective asses, or magnifying glass) B1000, vision was coded "0" annual MDS identified that area triggered and Care as checked indicating that the addressed in the care plan. The present a care plans updated ked evidence of problem and approaches to manage the action. The initiate a care plan with goals Resident #21 for visual iew was conducted with aptember 14, 2015 at PM regarding the acknowledged the record was reviewed on to develop an individualized and approaches for Resident	F	279	Ass.20(d), 483.20(k)(1) DEVELOP COMPRICARE PLANS Residents' #21, #64 and #122 1. An individualized care plan, to include care interventions and goals, for visual function implemented for resident #21 immediate notification of this deficiency. Physician assessed resident #122 vision appointment scheduled for follow-up and ophthalmologist care plan updated. A comprehensive pressure ulcer care placare interventions and goals, was develouinglemented for resident #64. 2. The Resident Care Coordinators (RCC) an audit of all residents who triggered for vision and pressure ulcers in the previous Findings were reviewed and corrected at the previous of the process of the linterdisciplinary Team on the care plann. The MDS Coordinator will re-educate the managers on the process to electronical care area triggers for all residents. 4. MDS Coordinators will perform weekly a ensure discussions related to trigger CA reviewed and addressed by the IDT durit planning meetings. A monthly summary results will be reported to Quality Assura Committee. Auditing will continue until 10 compliance is demonstrated for a minimic (3) months.	re n was y upon and and an, to include ped and berformed impaired is quarter. is needed. ning to e plan that als and e ng process. department y view MDS udits to as are ng care of the audit nce 10%	11.10.2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015	
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OF CONSTITUTION AVE. NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Calmoseptine "a perineal area afte original order dat Wound: Cleanse soak Kerlix with I every shift " with The medical recording relative Review of the car September 6, 20 Stage IV with pot multiple contribut May 6, 2015 state healed without cofree of odor " . No include " Wound measurements or surrounding skin complaints of pai per MD order; Apply dres specific is blank); status: Freq: PR of change in or do Air mattress to prosections for Dieta intervention were indicated. Nurse 's notes ar May 5, 2015 door X 3 centimeter State The presence uldo	aral wound treatments: apply to affected area sacral/ er each incontinence care with e May 5, 2015; and "Sacrum with Normal Saline, pat dry, then Dankin's Solution [Half Strength] original order date May 8, 2015. ord contains no further order to the treatment of sacral wound. The plan dated May 6, 2015 through 15 listed Pressure Ulcer: Sacral mential for delay healing due to mors as a problem. An entry dated ed the goal as: "Ulcer will be complication; Ulcer will be clean and mursing interventions to this problem status: size of wound: f depth and width, skin color, tissue assessment weekly, n, effectiveness of pain medication ply medicated ointment per MD sing per MD order (space for order keep Dietary informed of wound N; Notify physician of wound status eterioration in status of wound; and monote wound healing". The mry, Social Services, and Activities blank with no interventions and Nutrition Risk Assessment dated umented the presence of a 16 X 18 mage 4 pressure ulcer on sacrum. mer was documented as present on medicated on the presence of a 16 X 18 mage 4 pressure ulcer on sacrum. mer was documented as present on medicated on the presence of a 16 X 18 mage 4 pressure ulcer on sacrum. mer was documented as present on medicated on the presence of a 16 X 18 mage 4 pressure ulcer on sacrum.	F	279	483.20(d), 483.20(k)(1) DEVELOP COMPREHE CARE PLANS Residents' #21, #64 and #122. Refer to page 49 for response.	NSIVE		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279	the "narrative: 08/3 Resident. {She} said med has been giver vomiting). Nurse aw The care plan did no individualized intervicate to promote hea measurable goals for pressure ulcer to sa The facility staff fails measureable goals healing for Resident A face-to-face intervicent conducted on Septe 10:14 AM. S/he state the care and new or prior to transfer to the to provide any furthed develop a care plan interventions related clinical record was re 2015 3. Facility staff failed goals and approach function.	meters on August 31, 2015 with 81/15 unable to assess d she is sick, pain though pain a & N/V (and nausea and vare". In this include information on entions, or changes to plan of aling of pressure, and/or or present on admission for the entions to promote at 464. In the with Employee #11 was ember 16, 2015 at approximately the entity in the entity is very involved in reders were obtained the day the hospital. He/she was unable the insight into omission to with measureable goals and did to the pressure ulcer. The reviewed on September 16, and to initiate a care plan with the es for Resident #122's visual	F2	279	483.20(d), 483.20(k)(1) DEVELOP COMPREHEN CARE PLANS Residents' #21, #64 and #122. Refer to page 49 for response.	SIVE	
	indicated that the re facility on April 16, 2 Physical the resider which included: "Me	dents Admission 's sheet sident was admitted to the 2015. According the History and it has the following diagnoses ultiple CVA 's (Cerebral Vascular Respiratory Failure - Off Vent					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
		095027	B. WING			09/	23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 51	F	279	483.20(d), 483.20(k)(1) DEVELOP COMPREHE CARE PLANS	NSIVE		
					Residents' #21, #64 and #122.			
	Set (MDS) dated Ap Change MDS dated Section B1000 Vision for Impaired - sees in newspapers/book Lenses (contact, gl	dents Admissions Minimum Data pril 23, 2015 and Significant July 27, 2015 revealed in on the resident was coded "1" large print, but not regular print (s; Section B1200 Corrective asses, or magnifying glass) B1000, vision was coded "0"			Refer to page 49 for response.			
	Resident #122 on S approximately 11:00 that he/she wears g were on the dresser glasses. The reside	interview was conducted with deptember 21, 2015 at D AM. The resident indicated classes, and that the glasses r, however I prefer different ent also stated that he/she could eye and not the left eye.			er e			
	change MDS identifiarea triggered and (e admissions and significant ied that #Visual Function care Care planning decision was that the care area would be re plan.						
		nce in the clinical record that a ted to address Resident #122's						
	September 21, 2019 approximately 11:30 he/she acknowledge	view was conducted on 5 with Employee #10 at 5 AM. After review of the above ed the findings. The clinical d on September 21, 2015.	Ē					
		o initiate a care plan with goals Resident #122's visual						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING			09/	23/2015
		D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 279 F 282 SS=K	The services provide must be provided by accordance with eac care. This REQUIREMEN Based on observation of employee person was determined that 20 of 20 licensed nuventilator services for residents were qualifications is staff failure to identifications of the ventilator services for the ventilator services of the ventilator to the resident set the ventilator to the ventilator services for the ventilator to the ventilator services for the ventilator to the ventilator the ventilator services for the ventilator that the ventilator th	AVICES BY QUALIFIED RE PLAN ed or arranged by the facility a qualified persons in the resident's written plan of the facility failed to ensure that the facility failed to ensure that the facility failed to ensure that the resident of the provide or 12 of 12 ventilator dependent fied and competent as of documentation in personnel experience and competencies to an ventilator management, and for the way the ventilator delivers ent, if the resident initiated lator, if the ventilator delivered a and how the ventilator assisted thing (mechanics of ventilation). Requently, Residents #13, 37, 4, 135, 137, 138, and 142 also be effected by this deficient		279 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response		
	483.20 Resident Ass	: ardy (IJ) was identified at CFR sessment; F282 (Failure to nurses assigned to provide					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE D CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	ventilator services The facility's Admir corrective action pl September 25, 201	age 53 were qualified and competent). histrator provided a letter noting a an and the IJ was removed on 5 at 6:00 PM. Subsequently, the hitified at a scope and severity of	F2	282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response		
	assigned to provide qualified and compount of the survey provided in the mechanics of and its correlation of status. An example	to ensure that licensed nurses e ventilator services were etent. Deriod interviews conducted with aff assigned to provide ventilator ts revealed a lack of knowledge f ventilation, ventilator function to the resident's respiratory to reflect this determination is efficiency documented for					
	Ventilator Manager Respiratory Educatinformation: " care tubemodes of vercausesbreath sor patient suctioning.	icy dated May 15, 2015, titled 'ment and Nursing Care tion 'detailed the following of the tracheostomy ntilationalarms and common unds assessmentweaning, and "[This document was provided y on September 22, 2015 by the or [Employee #1].				100	
	Definitions ' (no init	tled, 'Ventilator Settings iated or revised date) included nation: "Mode: The way a breath Control: A/C,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FOR PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Synchronized International Continuous Positive (bpm- breath per mi breaths per minute, volume inhaled in the a pre-set volume of fraction of inspired of patient is inhaling], and Positive [PEEP]: Special setting the lungs expanded lungs into the bloods provided to the State 2015 by the Nurse E. ? The facility police 17, 2015, titled, 'Vestipulates," II. Policy physician's written of the administration of the administration of the resident #98 was a facility with a diagnor Failure. Physician's Orders: ? A physician's or for the resident to hamechanical machine spontaneous breath following settings: A 500, Fi02 30%, and	nittent Ventilation: SIMV, Airway Pressure CPAP Rate: nute), usually set at 8-12 Tidal Volume: The amount of the lungs. The ventilator delivers gas with each breath, Fi02: toxygen [percent of oxygen a ve End Expiratory Pressure ting on the ventilator that keeps to help get oxygen from the stream. " [This policy was the Agency on September 22, Educator]. by #CP.603, last revised June tentilator Weaning Protocol ty: Protocol will be applied per trider of Wean per protocol." 2015 at approximately 9:30 AM, tission record revealed that dmitted on July 8, 2015 to the tentilator weaning Protocol the sist that included Respiratory and der dated July 8, 2015 revealed that assists or replace ing] programmed at the /C, Rate 10, Tidal Volume [VT]	F	282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response		
	directed the followin	g, "Initiate ventilator weaning by the National Institutes of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY
		095027	B. WING _			09/	23/2015
		ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP OF TOO CONSTITUTION AVE. NE WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 282	support through util modes, periods of the appropriate rest periods of the appropriate rest periods. Although the support of t	ual withdrawal of ventilatory lization of a variety of ventilator total spontaneous ventilation, and riods for muscle unloading by was responsible for initiating er.nih.gov/ccmd/cctrcs/pdf_docs/agement/02-Ventilator%20Weani	F 28	483.20(k)(3)(ii) SERVICES PERSONS/PER CA Residents' #S Refer to page 59 for	RE PLAN 98.		
	VT - 500						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AI	ND REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 100 CONSTITUTION AVE. NE NASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Fi02 - 30% PEEP - 5 The documented as recorded by the nuity 2015 failed to correspond for entiled to correspond failed to correlate with documented by the documented by the linterviews: On September 21, 201 of ventilator settings failed to correlate with documented by the linterviews: On September 21, 21 a face-to-face interviews: On September 21, 22 a face-to-face interviews and the ventilator of at the bedside of Reventilator. He/she with 498 and the ventilator settings, describe the resident's rate, and ventilator. Employer could not explain hid and Fi02 30% or requested information the specialized ventilator. On September 21, 23 a face-to-face interviews.	essessment of ventilator settings resing staff on September 21, late with the actual settings that atory status of the resident, as ally, from September 1, 2015 to 5, the documented assessment is recorded by the nursing staff with the actual settings respiratory therapist. 2015 at approximately 9:45 AM, wiew was conducted with registered nurse (RN) who was resident #98. Employee #16 his/her assignment included the i37, 98, 111, 134, 137, 138, who rependent. She was interviewed resident #98, at the site of the was asked to observe Resident tor, confirm the ventilator the mode, the set rate, the the resident's response to the er #16 stated the rate was 12; but s/her documentation of a rate of redescribe the remaining on related to the nursing care for		282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING		09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	who was assigned to ventilator services. It observe Resident #8 ventilator settings, a rate, the resident's response to the venthe set rate of 12; he describe the reques nursing care for the On September 21, 2 a face-to-face interview Employee #10, the regarding the aforen acknowledged the firespiratory therapy sthe nursing staff. On September 22, 2 face-to-face interview Employee #6, the Stregarding ventilator to staff and the correct competencies. He/s of ventilators, and I that when I took the day with a Respirator On September 22, 2 a face-to-face interview Employee #31, regarding provided to documented compening staff shadow	care for residents requiring Employee #42 was asked to 98 and the ventilator, confirm and describe the mode, the set ate, and the resident 's tilator. Employee #42 explained owever, he/she could not further ted information related to the specialized ventilator services. 2015 at approximately 10:45 AM iew was conducted with nurse manager for the unit, mentioned findings. He/she andings, stating that the staff would hold an in-service for 2015 at approximately 9:30 AM a w was conducted with taff Development Coordinator, management training provided esponding documented he stated, "I have no knowledge made administration aware of job. I know the staff spends one ory Therapist." 2015 at approximately 10:00 AM jew was conducted with urding ventilator management staff and the corresponding tencies. He/she stated, "The vs a respiratory therapist for one checklist or competencies for	F 282	2. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Residents' #98. Refer to page 59 for response		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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RAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 282	Employee Record R On September 22, 2 a review of 20 perso by Employee #10, w requiring ventilator s they were trained ar demonstration of co	nursing department." Review: 2015 at approximately 1:00 PM, onnel records of staff, confirmed who had taken care of residents services lacked evidence that addor had documented mpetency in ventilator ollowing is a list of employee hat were reviewed:	F	282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PEI PLAN Response to #A 1. Immediately upon notification of this deficiency a review competencies confirmed findings, however no a event occurred to resident #98. On 9/22-9/26, 10/7, all Registered and Licensed Pra Nurses assigned to the 6th floor ventilator unit by Richard Department were in-serviced on ventilator mechanic include ventilator settings function and their correlative respiratory function was performed for all. The scope of practice for RN and LPNs were review nursing staff, as well as the implications for daily practice for all residents on vent weaning protocol was performed for all residents on vent weaning protocol was perfor the Resident Care Coordinator. Results of the audit residents were in compliance. 3. Continual skills and competency assessment relater management and airway maintenance, as well as the mechanics of the ventilator has been included in the requirements for all nursing staff and new hires. Residents on weaning protocol will be entered on 2 report to ensure communication of residents' status order changes. Hand-off communication was established between leand Respiratory during shift change to note status a progress of residents on weaning protocol. The Nur Ventilator Flowsheet was revised and nursing instruction ensure settings reflect respiratory there ventilator flowsheet and audit the 24-hour report to appropriate protocol related to residents' change in are followed. Results of the audits will be reported weekly to the finangement Subcommittee for any actions plans/recommendations if deemed necessary. A quarterly summary will be reported to the Quality Assurance Committee until 100% is consistently may for three (3) months.	view of dverse actical espiratory ss, to ion to ved with actice. records remed by found all d to vent he annual 4-hour and Nursing and sing acted on ventilator apy ensure condition	11.10.2015

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002			007	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE E APPROPRIATE	
F 282	Employee #43 A review of the per nursing staff assign lacked evidence the trained and/or had competence in ven management. Additional Interview of the per nurses in ven management. Additional Interview of the per nurses in ven management in ven management. Additional Interview of the per nurses in the afore unaware that there nurses in knowledge treatment for ventile. On Tuesday Septe 2:20 PM a face-to-fapproximately 2:28 and #4. The employee responses related the during the survey: On September PM Employee #3 so a potential problem knowledge deficit run of ventilator dependent in the per nurse in the per	sonnel records of licensed ned to provide ventilator services at the staff were adequately documented experience and tilator care services and airway	F	282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONAL Residents' #98. Refer to page 59 for response.	ONS/PER	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ND REHAB CAPITOL HILL	-	70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	nursing personnel at that required the vereducation and training care and treatment services. In Summary: Pursuant to the reviewed and signed 2015] nursing staff in proficiency in Ventil Care and Specialized tracheostomy tube, and common caused weaning, and patients? There was no easigned to care for ventilator services in on-going in-service ventilator management documented evidents specialized area of the service of t	ntilator services and ne/she failed to ensure that assigned to care for residents intilator services received the ing necessary to ensure proper related to specialized ventilator. If acility's practice and policy [last d by facility administration May is required to demonstrate ator Management, Respiratory ed services such as, care of the modes of ventilation, alarms is, breath sounds assessment,	F	282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSO CARE PLAN Residents' #98. Refer to page 59 for response.	ONS/PER	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			0	(X3) DATE SURVEY COMPLETED	
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	ND REHAB CAPITOL HILL		700 C	ONSTITUTION AVE. NE	•		
(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY		×	(EACH CORRECTIVE ACTION SHO	OULD BE		
ventilator services we the resident's special 483.25 PROVIDE CHIGHEST WELL BI Each resident must provide the necessar maintain the highes and psychosocial we comprehensive assemble. This REQUIREMENT A. Based on observinterview for five (5) determined that facinecessary care and attain or maintain the mental, and/or psychological evidenced by facility assess and monitor who exhibited a challow blood pressure, tachycardia [rapid hadminister a bronch ordered for the sam accurate assessme sustained a change heart rate, increase oxygen saturation; the monitor one (1) residependent and expendent and expendent and expendent services and monitor one (1) residependent and expendent expenden	were trained in areas to address al health care needs. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain or it practicable physical, mental, rell-being, in accordance with the ressment and plan of care. AT is not met as evidenced by: vations, record review and staff of 55 sampled residents, it was ility staff failed to provide the services to ensure residents be highest practicable physical, thosocial well-being as y staff's failure to: consistently increased respirations and reart rate and failed to perform an interest of the status of the condition to include elevated of respirations, and decreased to consistently assess and ident who was ventilator erienced tachycardia; assess						
2	SUMMARY ST (EACH DEFICIENCY MUS OR LSC IDI Continued From pa ventilator services we the resident's speci- 483.25 PROVIDE CHIGHEST WELL BI Each resident must provide the necessary and psychosocial we comprehensive ass This REQUIREMENT A. Based on observinterview for five (5) determined that fact necessary care and attain or maintain the mental, and/or psychological psychological providenced by facility assess and monitor who exhibited a challow blood pressure, tachycardia [rapid hadminister a bronch ordered for the same accurate assessme sheart rate, increase oxygen saturation; the monitor one (1) residependent and expland identify the nee an accumulated when the same accumulated wh	CORRECTION LIBER: 095027	OVIDER OR SUPPLIER DINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 ventilator services were trained in areas to address the resident's special health care needs. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and staff interview for five (5) of 55 sampled residents, it was determined that facility staff failed to provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and/or psychosocial well-being as evidenced by facility staff 's failure to: consistently assess and monitor the status of one (1) resident who exhibited a change in status as manifested by low blood pressure, increased respirations and tachycardia [rapid heart rate] and failed to administer a bronchodilator treatment [Duoneb] as ordered for the same resident; failed to perform an accurate assessment for one (1) resident who sustained a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation; to consistently assess and monitor one (1) resident who associated and experienced tachycardia; assess and monitor one (1) resident who had an accumulated white coating on his/ her tongue;	DINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY BY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 ventilator services were trained in areas to address the resident's special health care needs. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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This REQUIREMENT is not met as evidenced by: A. Based on observations, record review and staff interview for five (5) of 55 sampled residents attain or maintain the highest practicable physical, mental, and provide the necessary care and services to ensure residents attain or maintain the highest practicable physical, mental, and or psychosocial well-being as evidenced by facility staff "s failure to: consistently assess and monitor the status of one (1) resident who exhibited a change in status as manifested by low blood pressure, increased respirations and tachycardia (rapid heart rate) and failed to administer a bronchodilator treatment (Duoneb) as ordered for the same resident; failed to perform an accurate assessment for one (1) resident who sustained a change in condition to include elevated heart rate, increased respirations, and decreased oxygen saturation; to consistently assess and monitor who save venitator dependent and experienced tachycardia; assess and monitor one (1) resident who had an accumulated white costing on his/ her tongue;	DOUDER OR SUPPLIER DINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDEMTIFYING INFORMATION) COntinued From page 61 F 282 Continued From page 61 F 309 Continued From page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	SUMMARY ST (EACH DEFICIENCY MUS	ID REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	700 CONSTIT	RESS, CITY, STATE, ZIP CODE TUTION AVE. NE TON, DC 20002 PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD I OSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	that one (1) resident that the head circulaccordance to phys (is affiliated with the severity), #37, #5, # An Immediate Jeop CFR 483.25; F309 I Highest Well Being Lack of supervision special needs and for serious medical the IJ was made on at 2:20 PM. The facility's Adminicorrective action plamultiple aspects of to licensed nursing A review of the IJ ac September 25, 2019 deficiency was iden "E." The findings included 1. Facility staff failed assess and monitor demonstrated change repeated complaints of respiratory treatment of respiratory treatment of the ID action of the ID action of the ID action of the ID action of	t wore protective head gear and inference was measured in ician's orders. Residents #145 immediate jeopardy scope and i104 and #143. ardy (IJ) was identified at 42 Provide Care/ Services for for Failure to prevent neglect: for individuals with known failure to monitor and intervene conditions. The notification of September 22, 2015 (Tuesday) istrator provided a letter noting a in inclusive of staff training on the provision of respiratory care staff and respiratory therapists. In the provision of september 20 and severity of at 6:00 PM. Subsequently, the tified at a scope and severity of to identify, comprehensively Resident #145 when he/she ge in status as evidenced by sof shortness of breath, refusal tents [CPAP - Continuous sesure - breathing treatment] and	F	Response 1.	B.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING The to #A1-3, 5 Resident #145, #37, #5, #1 Immediately upon notification of this deficiency, the medical records for resider #145 and #5 were reviewed to verify findit On 9/16/15, 1:1 education of the Respiratory staff involved was held on the timeliness of completing respiratory orders. Nursing conducted a retrospective review the 24-hr report for indications of status change, cross- referencing the medical records in the resident's condition. The auresults found all medical records in compliance. Respiratory Therapist conducted medical record audits to identify new/changed orders in didications of missed orders. Those fourt of compliance were addressed with the attending physician. 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-educate the nursing staff on 10/7/2015 and ongoin regarding the change in resident condition process related to assessment and interventions, highlighting the importance physician notification. The communication binder will be created to maintain a record notification, to include date/time/interventicification, to include date/time/interventicification, to include date/time/interventicification's status, notification to physician timeliness of completing physician orders	of coord adit ers ound be of cond adit of cond adit and anges in and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	700 W/	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 309	August 31, 2015. Or 9:03 PM, Resident # pressure, increased Subsequently, the renearest emergency in intensive care. Resident #145 was According to the addrexamination signed 2015, Resident #148 Respiratory Failure, Continue on [Ventilato cervical spine injuicardiomyopathy, Continue on injuicardiomyopathy, Continue on the following was respiratory therapy; [situation/backgrounthe following was respiratory Rathas a lot of thick tan Continue to encoura CPAP 5/10 x10[micontrol] due to patie [shortness of breath August 30, 2015 - "Received [patient] otreatment] given as signed and signed substantial signed substa	record entries documented by in S-BAR format d/assessment/recommendation]	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #10 3. Residents on weaning protocol will be enter on the 24 hour report to ensure notification residents' status and order changes are communicated across shift. Hand-off communication was established between Nursing and Respiratory during st change to note status and progress of 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 maudits to respiratory orders. A monthly sum the audits will be reported to the Quality As Committee until 100% compliance is demo consistently for three (3) months.	od4 red of hift dents t	11.10.2015

STATEMENT OF DEFICIENCIES (X1 ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	procedures done/ CPAP trial. [Patient] SOB [shortness of b on AC [Assist Control [August 30, 2015 to] S- [Patient] is on AC [Fractioned of Inspi Respiratory Failure, Sat-98%. HR-79, Rf complains of being apparent distress. C " August 31, 2015- " mode, O [No] active less arousable in PN [male/female], HR-8 pale secretions, BS continue to monitor. August 31, 2015 " \ [recorded by respira following " Rate Se [Rate Set/Total defir ventilator preset resi resident breaths abo 0130 (1:30 AM) - 15 Saturation[normal ra Rate-87 0425 (4:25 AM) - 15 Heart Rate-93 0855 (8:55 AM) - 15 Heart Rate-87	Attempt to wean. Pt [Patient] on keep comp [complaining] of reath], anxious. Placed back of mode to rest. " August 31, 2015- "7PM-7AM-15/[Tidal Volume]-500, red Oxygen-45%, [Peep]-5, B-A-Pt stable throughout shift-R (Respiratory Rate) -21. Pt unable to breathe but in no continue to monitor for changes. AM-7PM- S- Pt remains on AC weaning do [due] to pt being M. B- Respiratory failure, A- Alert 4- RR-25, Sat-98%, small thin (breath sounds) clear, R- Will " Ventilator Flow Sheet " tory therapist] revealed the tt/Total " on the A/C mode: ned: 15/34 - "15" reflects piratory rate and " 34" reflects - ove the set rate]	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5 Refer to page 63 for response	#104	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			09/23/2015		
	POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	[1700] 5:00 PM - 15 Rate-80 2045 (8:45 PM) - 15 Rate-158. " The nurse practition Resident #145 as for August 31, 2015 [not Registered Nurse Pr [psychiatric] and Me obtained from staff/or arousable [Patient answer questions at Alert and Oriented x just received pain m staff resident normal responds to question responding to painfor arousable and [he/s does not answer que [Positive] Anxiety, " [secondary to medic staff. Plans: Monitor monitor for worsenin week to reassess m The record revealed communicated to the resident was "not ar pain medication ". If 2015 Medication Ad revealed Tylenol 50 administered 30 min	umented in the allotted space. /29 - [Oxygen] - 98%, Heart /23, Saturation 96%, Heart er documented a change in allows: time indicated] - Certified ractitioner Initial "Psychematal Status Exam: Information chart/resident [not] easily to arousable and does not this time. Staff reports resident 3- [time, person and place], but eds. Concerns/Findings: Per lly [Alert and oriented x3], ans asked. On exam, resident all stimuli but not easily he] opens eyes to name but estion, (-) Insomnia, " + " + " mood and affect all complications/conditions per for safety and fall precautions, and anxiety, [Follow-up] in one (1) cood/and anxiety." I that nursing staff the nurse practitioner that the ousable "due to "just received However, a review of the August ministration Record [MAR] ong 2 caplets were nutes prior to wound treatment M shift on August 31, 2015. The	F3	609	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #1 Refer to page 63 for response	04		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
095027	B. WING	<u> </u>	09/23/2015	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL] 7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)	ATORY ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 309 Continued From page 66 Further review of the MAR revealed that Res #145 received Tylenol 500mg 2 caplets 30 m prior to wound treatment during the period of 25th through August 30, 2015. There was not documented evidence that Resident #145 stored in the prior to wound treatment during the period of 25th through August 30, 2015. There was not documented evidence that Resident #145 stored in the prior to wound treatment and preceded sages of Tylenol administration or "just make pain medication." Nursing Notes: August 28, 2015 3:13 PM - "V/S [vital sign [b/p-blood pressure] 108/58; [P-pulse] 99; [R-respirations] 18 no acute distress noted August 29, 2015 3:00 AM - " [b/p] 116/62 [R] 20 " August 31, 2015- 12:35 PM - Resident remain and responsive. Vent [ventilator] dependent mode for respiratory support. Suction PRN (needed)V/S- [Blood Pressure] - 134/74, 9 [Temperature]-, 74, 100 [two (2) different herates] no respirations documented S-BAR (Situation-Background-Assessment-Recommon) /Acute Change in Condition Report: Situ Date: August 31, 2015, Time: 9:39 PM [of note is the successive nursing note to the August 12:35 PM entry] low B/P- 77/53, P-153, R lethargy [and] gasping for breath, although of Background: Respiratory Failure, Temp: 98. 77/53, RESP: 24, Pulse: 153, Lung sounds: Crackles, Pulse ox: 93% ventilator Reside noted [with] [decreased] B/P 77/53, elevated rate. House officer notified who ordered to tree.	ninutes f August D ustained eding eccived ns]: d " ; [P] 78, in alert AC as 8.9 art nendati ation- ote, this 31st -24, on vent. 6, B/P- ent was pulse	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #1 Refer to page 63 for response	04	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	POINT SUB-ACUTE	AND REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 309	treatment. " There was no evic respiratory staff id exhibited progress and mental) that wintervention before unresponsive with transfer to higher August 31, 2015-[physician] Note: I #145] b/c (becaus [and] acute AMS (His/her] HR (heats [and] B/ P as low earlier today [he/s but currently [he/s arousal and aware agonal (gasping) I Assessment/Plantunknown cause ([(Intravenous) Cipr Diflucan (anti-fung Transfer to neares The clinical record notified the physic progressive comp breath, refusing C of arousal from Au	dence that licensed nursing and entified that Resident #145 sive change in status (respiratory varranted monitoring and/or ethe resident became obtunded, agonal breathing requiring level of care. 2103 (9:03 PM) - Hospitalist was called to evaluate [Resident e) of hypotension, tachycardia, gradually since few hours ago. It rate) has been elevated to 150 vas 77/53. As per nurse even to he] was A&O (alert and oriented), he] is obtunded (diminished eness) [and] unresponsive with preathing. [He/she] is quadriplegic. Acute AMS [and] hypotension-he/she] finished [his/her] IV to (antibiotic) yesterday [and] yal medication) was discontinued). It ER (Emergency Room). " I lacked evidence that nursing that regarding the resident's laint of having shortness of PAP trials, alteration in the level ugust 28, 2015 to August 31, 2015 in the resident was obtunded and	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #1 Refer to page 63 for response	04	

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	G		COMPLETED	
		095027	B. WING			09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 309	A face-to-face inter Employee #14 [on-August 31, 2015 7/at approximately 2: aforementioned coroff-going team mer through August 31, resident was calling bell one blows into off-going therapist the resident 's roor acknowledged the informed of the reshaving shortness of treatments. A review of records facility that the resident #145] publication from MAS (Altered Ment tachycardia and feverally for the clinical record 2015. Cross referenced 4 F282; 483.30(a) F3	view was conducted with coming day-shift team member, AM - 7PM] September 18, 2015 00 PM regarding the above incerns. He/she said that the inber [night shift August 30th 7PM 2015 7AM] stated that the gall night, using the type of call Employee #14 further stated the and the nurse was in and out of mall night. Employee #14 physician should have been ident's restlessness, complaint of the breath and refusal of CPAP is obtained from the acute care dent was transferred to revealed cian 's entry dated 8/31/15: "bresented to the ED (Emergency IH (Nursing Home) with acute all Status), hypotension, wer of 107. In ED, [Temperature] werted to Fahrenheit- 107.6 ate-85]; Respirations-16; Blood	F 30	483.25 PROVIDE CARE/SERVICES HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37 Refer to page 63 for response			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREF	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 309	documented changed The respiratory them inconsistent with the the nurse's and phys September 18, 2015 respectively. Resident #37 was a diagnoses to include Coronary Artery Dis Medical record revies September 21, 2015 clinical notes reveal assessment of Resident 8, 2015 at 5:00 PM documented by medical respiratory staff. The Review of the Ventil September 18, 2015 therapy staff documented assessment at 5:00 rate-89 beats per minute, percent; and post-traindicating heart rate respiratory rate 16 big saturation of 98%. The nursing staff documents of 98%. The nursing staff documents of 98%.			309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #14 Refer to page 63 for response	04	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		095027	B. WING _			09/23/2015		
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 309	at 5:30 PM revealed requested by the nuresident with change and hypoxia. Accord assessment, the restrate of 166 beats per 125/56 millimeter of Although the medical Resident #37 to have condition to include respirations, and determinations, and determinations assessment with the oxygen saturation of baseline physical assubsequently transfers Services to a local endange of a local endange of a local endange of condition findings were review acknowledged. 3. Facility staff failed monitor Resident #5 and experienced an subsequently sent of the sident with the condition	the Attending Physician was raing staff to evaluate the es in mental status, tachycardia, ling to the medical staff ident was noted to have a heart r minute, blood pressure of Mercury. If and nursing staff assessed experienced a change in elevated heart rate, increased creased oxygen saturation, the staff documented an experienced and experienced with Resident #37 's sessments. Resident #37 was experienced experienced with experienced experienced with experienced experienced with experienced experienced with experienced experienced experienced with experienced experienced with experienced e	F3	09	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, #1 Refer to page 63 for response	D4		

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		095027	B. WING		9 448-4	09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		, = 0 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 309	diagnoses in Section	ge 71 (D) of April 22, 2015 revealed on I (Active Diagnoses) included: leostomy, Respiratory Failure,	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Response to #A1-3, 5 Resident #145, #37, #5, # Refer to page 63 for response	104	
	directed; " Vent [Ve	an 's orders dated May 9, 2015 ntilator] Settings: AC (Assist e-10, VT- 400 [Tidal Volume]- red Oxygen]- 40%					
	Physician 's Progre	ss Notes:					
i	"Patient [resident] restimuli, no purposeft AC [mode of Assist 500, PEEP [positive Fi02 [room air] 40%. 18, T 97.9; CTA-[cle wheezes; CVS [card [abdomen] + [positive [extremities] no eder chronic Respiratory secondary CVA [Cel	une 1, 2015 at 1:45 PM revealed emains on vent. Responds to all movements. Vent settings Control] 10, VT [tidal volume] expiratory end pressure] +5, Exam: vitals 104/72, P 69, R ear to auscultation bilaterally no diovascular] no murmurs; Abd e] bs [bowel sounds]; Ext ma A/P Assessment/Plan (1) Failure; (2) Encephalopathy rebral Vascular Accident] - pport - no weaning - supportive					
	08:50 AM revealed Response. "Patientachycardia with HR pressure 110, RR [re [Saturation] 96%, 10	Acute Note - June 2, 2015 at Responding to Rapid It Resident] identified with [140], SBP [systolic blood Respiratory rate] 20s-30s; SAT 10% Fi02 with ambu bagging. It g witnessed; lung (+)					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING		·	09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	00,1	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	CVS: tachycardia . [hypoactive] bowel sedema BUE [bilatera [greater than] L [left] [Assessment/Plan] aspiration/sepsis. W Room] v [by] 911. " A review of the nurse "May 31, 2015 4:50 responsive. AM cartemperature, P [pulsa [blood pressure]127. No evidence of pain continue to monitor May 31, 2015 6:30 Fresponsive due medabnormal findings not 133/78. Pulse Ox 96 June 1, 2015 4:00 Presponsive PM care BP 130/77 Pulse Ox repositioned, due med June 2, 2015 5:00 A [ventilator] depender	TA [clear to auscultation] leftABD: distendedhypo counds; ENT [Ear, Nose, Throat] al upper extremities], R [right] > . Warm extremities; A/P : Respiratory Distress, R/O fill send to ER [Emergency ing notes revealed the following: O AM - "Resident is alert and e given, vs [vital signs] 98.4 se] 77 R[respirations] 16, BP /68, Pulse OX [oximetry] 96%. noted. IS Care given will" PM - "Resident is alert and lications given as ordered. No oted. Vs T 98.2, P 86 R 20, BP 6%. Will continue to monitor. " M - "Resident is alert and given. Vs T 98.6, P 87, R 20, K 98%. Turned and	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST BEING Response to #A1-3, 5 Resident #145, #37, #5, #16 Refer to page 63 for response		

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		095027	B. WING		09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL	7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
F 309	Feeding in progress endoscopic gastrost well. Will monitor. V[T] 98.3. June 2, 2015- 8:35 / Background, Assess change in condition. respiratory distress of 140 [bpm/beats p bagged by RT [Resp. Response was calle respondedIn hou transfer resident via [vomiting] noted x [ti with seizure like acti transferred via 911 to Respiratory Therapy	rities of Daily Living]. Enteral Peg [percutaneous romy] tube patent and flushed Vs [BP] 131/72, [P] 76, [R] 18, AM-SBAR [Situation, rement, Recommendation]/Acute Resident was noted with and an elevated HR [heart rate] reminute]. Resident was rotatory Therapy] while Rapid d. Rapid Response team rese officer gave new order to response team response	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHE BEING Response to #A1-3, 5, Resident #145, #37, #5, # Refer to page 63 for response		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	OINT SUB-ACUTE AN	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	physician was notificincreased heart rate June 2, 2015 (08:20 approximately 4 hou A review of the respirevealed: June 2, 2015 - 7pm- S: Pt on A/C mode B: Respiratory resid A: Sat 98% HR 71, F Rhonchi/clear, sxn [s suction, no distress. R: monitor June 2, 2015 - 7AM-	mented evidence that the ed in regards to Resident #5 's from June 2, 2015 (3:45 AM) to AM), which is indicative of rs. iratory therapy shift note 7am shift note revealed: lent RR 18 BS [breath sounds] suction] moderate yellow 7PM Shift- no documentation dicated on flow sheet- "PT	F	309			
		ncked evidence that facility staff ored Resident #5 when					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		ATE SURVEY DMPLETED	
		095027	B. WING			09/2	23/2015	
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	was not notified whetachycardia (increase documented on Jung The resident's condincreased tachycard response was called transferred to the Er [Emergency Medica SBAR at the time of rate of 140. A face-to-face interv September 21, 2015 with Employees #18 that his/her shift is 7 #18 also state, where with the heart rate 1. [When a resident's compression to state of the prevent further determined criterity a physician to state of the prevent further determined criterity approximately 8:20.4 he/she was bagged. he/she was conduct assigned he/she was by Employee #18 will response took over, vomited when he/sh resident was sent on The night shift nurse.	arate increased. The physician on the resident's became ed heart rate), which was first e 2, 2015 at 3:45 AM to be 121. dition declined as evidenced by ia (HR elevated to 129). A rapid and resident was subsequently nergency room via 911. Services] according to the transport the residents heart iew was conducted on at approximately 10:30 AM and #47. Employee #18 state:00AM to 7:00PM. Employee he/she first saw the resident 29 is when the rapid response condition changes (based on ia) and requires an assessment abilize his/her condition and fioration] was called at the many counds from the rooms is called to the rapid response no stated that the rapid and that the resident had e was bagged and then the at 911 with a heart rate at 140. It was not available for interview.	F	309				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	SUMMARY S (EACH DEFICIENCY MUS	ND REHAB CAPITOL HILL TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY SENTIFYING INFORMATION)	ID PREFI TAG	700 CONST WASHING	RESS, CITY, STATE, ZIP CODE ITUTION AVE. NE TON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IN THE APPROPRING FOR ACTION SHOULD IN THE ACTION SHOULD SHOULD IN THE ACTION SHOULD SHOULD SHOULD SHOULD SHOULD SHOUL	BE	(X5) COMPLETION DATE
F 309	4. Facility staff failuneed for medical in who had accumula his/her tongue. A review of docume Daily Living [ADL] #104 and through sthat oral care was by facility staff. How that facility staff ide intervention to addiresident 's tongue. Following the survy examined by the midiagnosed with oral antifungal treatment. According to, "The Practice, "Ninth E Conditions of the M Candidiasis is a fur by Candidiasis is a fur by Candidiasis can dissemination, part Clinical Manifestati burning, altered tas painless plaques, lespread to the esopland chest pain Maragents in oral rinse Mycelex or Nystatir Nursing Assessme inflammation in mo Patient Education a	ed to assess and identify the attervention for Resident #104, ted white colored lesions on entation related to Activities of performed on behalf of Resident staff interview, it was determined consistently provided each shift wever, there was no evidence entified the need for medical ress the white substance on the reor's query, the resident was edical team and subsequently I Candidiasis and prescribed	F	309 483.25 1. 2. 3.	place by nursing for resident #104 per NP assessment. All residents dependent in activities of living (ADL) were reassessed and appropriate care plan updated. 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 d clinical rounds with nursing staff to rev resident care needs. An in-service will be scheduled for CNAs and licensed staff by Medline or mouth care/oral hygiene and the current products used in the facility.	daity an an aily iew or the the	11.10.2015

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AI	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP C 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 309	An observation of a survey period reveal on September 10, Resident #104 's to coated with a white. A second attempt we 2015 at approximate #104 's oral cavity visualization of the unsuccessful because employee 's attemps surveyor conveyed related to the observation of the resident 's tong Nurse Practitioner with a diagnosed him/her. Nurse Practitioner with a diagnosed him/her. Nurse Practitioner with a diagnosed him/her. Resident is bedbout [with] difficulty to a diagnosed him/her. Assessment done [whitish coating on the tongue with mouth mouth/tongue coating a diagnosed him/her.] Assessment]:- Ora Nystatin solution 10 (millimeters) to tong	gns and symptoms to observe d oral hygiene " the Resident #104 during the aled the following: 2015 at approximately 4:28 PM-ongue was observed completely substance. vas made on September 14, sely 12Noon to visualize Resident with Employee #15. A resident 's oral cavity was use the resident rejected the of to open his/her mouth. This to Employee #15 the concernivation of the white substance on pue. Employee #15 informed the who evaluated the resident and with Oral Candidiasis as follows: note dated September 14, 2015 Asked to evaluate resident with hitish coating on tongue. note dated September 14 cose lequately view oral cavity. with] aid of primary nurse, " = " ongue. Attempted to clear care kit [without] any effect on	F3	109			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015	
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From pag	ge 78	F	309				
	for medical intervent	assess and identify the need tion for Resident #104 whose d coated with a white						
	staff must anticipate evidenced by the an assessment dated A Hearing, Speech, ar Resident 104 was urarely/never underst Cognition, the reside cognitively impaired decisions, Section I Seizure Disorder, Tr Tracheostomy, Cran (Functional Status) ras being totally dependent of the physical assist and promaintains personal brushing teeth). Physician 's order da' Mouth care every so A review of clinical day and Septendent of August and Septendent of August and Septendent of August and Septendent of Septendent of August and Septendent of August and Septendent of Septendent of August and Septendent of Septendent	totally dependent and facility the resident 's needs as nual Minimum Data Set [MDS] august 14, 2015. Section B, ad Vision was coded that nable to speak and was ood. Under Section C, ent was coded as severely and never/rarely made (Active Diagnoses) included: aumatic Brain Injury, iotomy, Dysphagia. Section G revealed the resident was coded endent with one person for personal hygiene (how resident anygiene, including combing hair, ated August 25, 2015 directed: shift. " locumentation [ADL sheets and ration Records] for the months ember 2015 revealed staff al care was provided every shift. 's order [subsequent to the tion] dated September 14, 2015 " Nystatin (Anti-fungal						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Apply 5 ml (millimete	ge 79 spension 100,000 units per ml. ers) to tongue and clean tongue ey) [times] 14 days for thrush. "	F	309			
	assistant] Charting " 2015 through Septer Personal Hygiene: F physical assist to pro	lent's "CNA [nursing flow sheets from September 7, mber 15, 2015 revealed, " Resident required one person ovide all hygiene tasks [oral no self-performance."					
	2015 included the for ADL (Activities of Da to diagnosis of Anox	care plan updated August 11, ollowing problem: " Alteration in aily Living) function [secondary] tic Brain Injury, Approaches provide oral, hair and nail care orn (as needed) "			25		
		nce that facility staff provided with the resident's need.					
	Employees #15 and approximately 1:00 I the resident 's mout frequency, he/she st and an oral swab is no white coating on	iew was conducted with #17 on September 14th at PM. When queried about how th care is performed and the tated; " It is done every day, used and s/he stated there was the resident's tongue. He/she imes white secretions		•			

	CORRECTION	IDENTIFICATION NUMBER:	,,		COMPLETED
		095027	B. WING		09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL	7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 309	the mouth and tonguclinical record was no 2015. 5. Facility staff failed wore protective head circumference meas with physician 's ordor on September 16, 2 and 2:00 PM, Staff whear the window at the bed. The resident who bed on his/her back on the right hand. He sheet. A helmet was a face to face intervity Employee #48 at the Employee #48 was at times the resident whe Employee #48 further on one to one (1:1) of A physician's order of "Helmet to be worn protect craniptomy is hours to check skin Measure head circuit increase in size to Measure and to the clinic Treatment Administration.	but they are suctioned out, and are is cleaned every shift. The eviewed on September 15, It to ensure that Resident #143 digear and underwent head surements weekly in accordance ders. O15 at approximately 11:45 AM was observed sitting in chair, the foot of Resident # 143 's was observed asleep, lying in A white mitten was observed e/she was covered with a white a positioned on the foot board. Siew was conducted with the time of the observation. Queried about the scheduled as supposed to wear the ed; "He/she is supposed to en he/she is out of bed.	F 309	Response to #A5, Resident #143 1. Resident #143 suffered no adverse event. The head circumference re-measured and found consis with previous measurements. If attending was contacted and corplan updated to include interverselated to managing resident with craniotomy. 2. There were no other residents an order for a helmet; therefore other resident was affected. 3. Staff re-educated of the standal practice related to execution of physician orders. 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.	erse e was tent The are intions ith a with e, no rds of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` <i>'</i>	IPLE CONSTRUCTION NG		E SURVEY PLETED
		095027	B. WING _		09	/23/2015
		D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIF 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	through September Resident #143 's he measured weekly in orders and there wa staff consistently ap the physician. A face-to-face interved Employee #18 on Seapproximately 2:31 aforementioned find clinical record was consistently approximately 2:31 aforementioned find clinical record was considered to the facility of 55 sam determined the facility comprehensive pain characteristics such pain, location, frequence ween (7) residents; residents response the facility 's Policy -Pamagement policy INC (Revised Octob the Procedure Recoresident (during rest and behavioral (non Assessing Pain: 1 assessment gather the staff of the procedure for the staff of the staff	16, 2015 lacked evidenced that had circumference was accordance with physician's is no documented evidence that plied the helmet as directed by liew was conducted with eptember 16, 2015 at PM. He/she acknowledged the ings. The observation and conducted on September 16, review and staff interview for pled residents, it was the staff failed to: conduct assessments to include as intensity, type, pattern of ency and duration of pain for consistently assess two (2) to pain intervention. Residents '42, #80, #43 and #49. Example 19 Comprehensive pain the following information as esident (or legal representative): dits treatmentb.	F 3	Response to #B1- Residents #64, #108, #107, #14 1. Immediately upon notificat comprehensive pain assessment #107, #142, #80, #43 and #49 w #108 was discharged therefore in taken. 2. A chart audit was conduct pain management program. Aud other resident potentially affected practice. 3. All clinical staff were reeduland ongoing by the Interim Admin revised Pain Assessment and M. Omnicare Pharmacy Pain Flowsheet will be pain monitoring and documentat intensity and effectiveness. The RCCs will perform a random flowsheet weekly to ensure compute the Risk Management Subcorn A monthly summary of the audit Quality Assurance Committee. A 100% compliance is demonstrated.	ing it is a second of the pain obliance. Is a second of the care of the pain obliance. Is a second of the pain obliance. Is a second of the pain obliance. Is a second of the pain obliance. Is will be reported weekly mutter of the pain obliance. Is will be reported to auditing will continue until	11.10.2015

IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED						
		095027	B. WING			09/:	23/2015	
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 309	pain scale); (2) Des pain (e.g. constant radiation of pain; (5 of pain; c. Impact of that precipitate or e strategies that redu accompany pain (e.g. the Causes of Pain InterventionsImp Strategies1. Non-pl 2. Pharmacological physician and staff regimen based on the resident 's memedication regimen of the pain; d. Cour Treatment goals (regimen as ordered results of the interve Modifying Approach Document the resided adequate details (i.g. the status of pain and interventions for paraccordance with the Upon completion of person conducting information obtainer resident 's medical sassessment archaracteristics such	measured on a standardized criptors of pain; (3) Pattern of or intermittent); (4) Location and) Frequency, timing and duration f pain on quality of life; d. Factors xacerbate pain; e. Factors and ce pain; and f. Symptoms that g. nausea, anxiety)IdentifyingDefine Goals and Appropriate lement Pain Management narmacological interventions; interventions; 4. The will establish a treatment consideration of the following a. dical condition; b. Current consideration of the following a. dical condition; b. Current consideration of the medication carefully documenting the entionsMonitoring and the entionsMonitoring and the encough information to gauge and the effectiveness of in) as necessary and in the pain assessment, the the assessment shall record the defrom the assessment in the	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	#64 was admitted of which included Sur Nutritional Deficit was a emergency department of the manage	dical record revealed Resident on May 4, 2015 with diagnoses gical Wound, Sacral Wound, and with Reconditioning. Transferred out to a local ment on September 1, 2015 to in mental status ". Trecord conducted on September Resident #64 has a documented d Stage IV sacral pressure ulcer on which last measured 15 X ters according to the Wound and Shote dated August 31, 2015. The following medication orders are following medication orders. Tramadol 50 milligrams via by tube) three times a day prior to sacral pressure and the following medication orders. Tramadol 50 milligrams via by tube) three times a day prior to sacral prior to wound so per day then one (1) by mouth the sacral forms as needed pain. Tramadol 50 milligrams via by tube) three times a day prior to wound so per day then one (1) by mouth the sacral forms as needed pain. Tramadol 50 milligrams via by tube) three times a day prior to wound so per day then one (1) by mouth the sacral forms and the sacral forms are selected by the one tab 30 minutes prior to wery shift and every eight (8) or pain.	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING		·	09/:	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Strength] 500 millig 30 minutes prior to pain Review of the Phys June 22, 2015 throw the medical staff do Resident #64 on Ju August 20, 2015 and On August 20, 2015 had a discussion wit member about " of pain, wound care UTI (Urinary Tract I medications being uyesterday 'p' (syn Tramadol but reside discontinue all narcontinue all narcontinu	rams by mouth three times daily wound treatment every shift for ician 's Progress Notes from ugh September 1, 2015 revealed cumented assessment of ne 22, 2015, July 28, 2015; d September 1, 2015. 5, Resident #64 was seen for iss. The medical record lacked tive to pain during this visit. On at 3:20 PM, the medical staff ith Resident #64 's family many questions related to issues and weight loss and recurrent infections)We discussed pain used Oxy IR which was started inbol for after) discontinuing ent is more drowsy today. Will	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED			
		095027	B. WING _			09/23/2015		
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 309	On September 1, 20 documented a "SB Assessment and Re Condition Report "evaluationchange The sections reserv Things that make the recent medical historintake/hydration; and were left blank. Account the SBAR: Reside but arouse to touch around 9:00 PM. The room at the time of the facility staff "that communicating with an intravenous line poor vein. Resident noted "to be shallod The vital signs were temperature- 97.3 dipressure- 125/55 mid respirations- 28 breat 120 beats per minut subsequently transfer Emergency Medical Subsequent review Administration Reconstant on August Medication Administration Administration Administration Reconstant on August Medication Administration Administration Reconstant on August Medication Administration Administration Reconstant on August Medication Administration Administration Administration and Medication Administration Administration and Medication Administration Admini	AR [Situation Background, esponse]/ Acute Change In which "detailed reason for in mental status, lethargic". ed for the documentation of "e problem worse; Pertinent bry; Mental status; Change in d Labs in the past 30 days "ording to the narrative contained ent #64 was "noted very sleepy and verbal commands" at e resident 's family was in the enthe observation. S/he informed that resident sleep deeply and not her". SicThe attempt to start was unsuccessful secondary to #64 's respirations were also "with a change in vital signs. I documented as follows: egrees Fahrenheit, blood enthe resident was erred to the hospital via	F3	Response to #B1- Residents #64, #108, #107, #142, #80, # Refer to page 82 for resp	#43 and #49			

	CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED
		095027	B. WING		09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL	70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 309	3-11; 11-7". Further documentation of cobefore and after medetermine the present the pain medication. Review of Nurse's through September staff documented the prior to wound care. documented on Aug Resident #64 was ordered prior to wou with positive outcomedocumentation to propain to include interellocation and radiation there were additional 23, 24, 26, and 28, 24 medication was admithed "good" or "4 the aforementioned documented evidence and after the adminitional include location, in On August 24, 2015 pm documented], the resident was asked effective enough for care, resident said ywill make [his/her] medical staff was no increased.	ccording to the shift, i.e. "7-3; more, the MAR lacked emprehensive pain assessment dication administration to ence of pain and/or effective of the Motes from August 19, 2015 1, 2015 revealed the facility e pain medication administration According to the note just 20, 2015 at 11:00 PM, the medicated x1 with Tramadol as and care for breakthrough pain	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHE BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and # Refer to page 82 for response	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING_			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 0 CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	effectiveness and/or to pain. On September 1, 20 was called to the research was observed unable to "be taken morning." According 1:00 PM note, "Resonable to "be taken morning." According 1:00 PM note, "Resonable to "be taken morning." The family a via telephone was noted that the telephone was noted that the telephone was noted to september 1, 20 specific time was not responsible party has medical record lacken nursing staff perform assessment when a identified at 1:00 PM or family "complained to the telephone was placed to the homedical record lacken medical record lacken noted to the homedical record lacken noted noted to the homedical record lacken noted no	aff performed monitoring for adverse consequences relative of the sident's room because the red "drowsy" and had been in to therapeutic recreation this ag to the September 1, 2015 at sident was given Oxycodone se getting ready to do wound at bedside and responsible party totified Resident #64 " has a R but will have the NP (Nurse this med [medication] since . Oxy IR was last administered 15 during the "7-3" shift; the ot documented. It is unclear if the ad been notified of the at the time of the order. The end a comprehensive is change in condition was also in September 1, 2015 that the that resident sleep deeply and with her, resident opened her ill responds to touch ". A call ouse officer at 9:30 PM. The end documented evidence the	F3	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #49 Refer to page 82 for response		
	Resident #64 's cor necessary care and readily identify acute earliest time possible	ed to assess and monitor ndition with ensure s/he received treatment to prevent and/or e changes in status at the e. an initiated for the period of					

	CORRECTION	IDENTIFICATION NUMBER:	' '	S		ATE SURVEY OMPLETED
		095027	B. WING		_ _ c	9/23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	the facility staff do Related To " as: "Resulting In: Com Strengths To Draw Able to express le identified as: " wil display signs of copain resolved with interventions " . The " In include " Assess and document locaby the resident; Procalming music, To rub, warm blanket prescribed; Check Notify Physician if intervention; vital salong with pain pereserved for intervention; vital s	Igh September 6, 2015 revealed cumented the "Problem/Need of Other, specify generalized "" plaints of pain less than daily "" of On: Able to communicate needs, vel of pain " with Goal(s) I be free of pain complaints; Will omfort, no grimacing; Will report pain medication and other ne "Target Review date: 5/6/15-terventions " for "Nursing "symptoms of pain on occurrence ation and pain scale as reported rovide quiet environment; Offer per resident request; Offer back provide pain medications as a vital signs: Freq. Per order and Pain persists despite signs are out of normal range ensistence. "The sections rention to be documented by vices, and activities were left perse side of the care plan for " three (3) entries as follows: [line noted above the letter 'c'] of Care) x 90 days "evaluated, need for increase in RNP (Certified Registered Nurse and care. Will monitor resident."	F 30	A83.25 PROVIDE CARE/SERVICES FOR BEING Response to #B1- Residents #64, #108, #107, #142, #80, #4 Refer to page 82 for respo	43 and #49	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Review of Significan Minimum Data Set (revealed the followin Conditions: J0100 f scheduled pain med Received PRN pain and declined? - " 0. non-medication interested pain or heart through any time in the last through any	Indards of practice relative to the t with complaints of pain. It Change in Status Assessment (MDS) dated August 9, 2015 are coding for Section J Health (Pain Management A. Been on a dication regimen? - "1. Yes "; B. medications OR was offered (No "; C. Received (Invention for pain? - "1. Yes "; ave you had pain or hurting at (Invention for pain? - "1. Yes "; OJ0400. How much of the time you (Inutring over the last 5 days? - "Ind J0600 Pain Intensity A. (Independent of the worst pain (Independent of the worst pain (Independent of the state of the younds) of the weights were (Independent of the younds) of the state of the state of the state of the state of the gress notes on June 17, 2015, august 19, 2015.	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #4 Refer to page 82 for response		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING _			09/2	23/2015
_	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	pain medication rour facility staff failed to #64 in enough detail management and put the comprehensive accordance with curpractice, resident 's A face-to-face interved Employee #11 on Scapproximately 9:40 of pain for Resident facility 's policy rela assessments, s/he sonursing staff assess given and afterward Medication Administ where the document reverse of the Medic Resident #64 was reacknowledged. Facility staff neglect pain assessments a after the administration consistent with curred There was no evider consistently monitor adjusted and when a change in clinical stano comprehensive in September 1, 2015, drowsiness, " at 1:00 #64 #65 #65 #65 #65 #65 #65 #65 #65 #65 #65	staff continued to administer tinely prior to wound care, the assess and reassess Resident Is and frequency to ensure evention of pain consistent with assessment, plan of care, and rent clinical standards of goals and preferences. Tiew was conducted with eptember 21, 2015 at AM regarding the management #64. When queried about the tive to pain management and stated that it is expected that the the pain when the medication is s. S/he further provided a tration Record and pointed out tation would be located. The cation Administration record for eviewed, discussed, and ed to conduct comprehensive and reassessment before and ion of pain medication as is ent clinical standards of practice. Ince the resident demonstrated a latus [e.g. lethargy], there was bursing assessment. On the resident demonstrated "10 PM however; facility staff did veral hours [approximately 9:30]	F3	609	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		

	CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED
		095027	B. WING _			09/	23/2015
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 91 s symptoms worsened and required emergency transport out of the facility. 2. Facility 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 f Resident #80. A review of the medical record revealed Resident			70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002			
PRÉFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	s symptoms worse	ned and required emergency	F 3	09	483.25 PROVIDE CARE/SERVICES FOR HIGHES' BEING Response to #B1-		
	pain assessment a characteristics suc pattern, location, fr Resident #80. A review of the me #108 was admitted diagnoses which ir with EF (Ejection F	nd/or reassessment to include h as intensity, type, pattern of equency and duration of pain for dical record revealed Resident on December 19, 2014 with include Congestive Heart Failure raction) 20%, Cerebrovascular st Craniotomy, Hypertension,	5		Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		
	2015 revealed a PI 2015 for Acetamine mg one tab via g-tu (six) hours as need 2015 at 12:00 PM- [milliliter] (5mg) SL hours] PRN [as nee [shortness of breat A review of the Sep Administration Red Acetaminophen with pain on the followir	otember 2015 Medication ord (MAR) revealed th Codeine was administered for ng occasions: September 3, 2015					
	September 9, 2015 2015 at 9:30 AM, S	ember 8, 2015 at 8:00 AM, 5 at 8:00 PM, September 10, September 11, 2015 at 11:30 AM, 5, September 13, 2015 at 9:00 er 14, 2015 at					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		00 CONSTITUTION AVE. NE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	revealed the details Codeine administer September 3, 3 documented evider reason or result September 8, 3 documented evider reason or result September 9, 3 documented evider and result was documented evider and result was documented as red documented as red documented as reassessment documented as reassessment documented; Result documented as red coumented as red documented as reassessment documented; Result documented as reassessment documented; Result documented; Result documented as red documented; Result documented; Res	f the September 2015 MAR sof the Acetaminophen with red for pain as follows: 2015 at 11:00 AM- No nice of the date/hour, medication, 2015 at 8:00 AM- No nice of the date/hour, medication, 2015 at 8:00 PM- No nice of intensity relative to reason tumented as "effective" no nice of intensity relative to reason tumented as "effective" no nice of intensity relative to reason tumented as "effective" no nice of reassessment nice of pain " (no location tult documented as "effective" - no intensity or time of tumented nice of the pain " - no intensity or time of tumented nice of pain " - no location nice of the pain " - no location nice	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #44 Refer to page 82 for response		

PRINTED: 12/29/2015 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 095027 B. WING 09/23/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL** WASHINGTON, DC 20002 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) Continued From page 93 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL F 309 **BEING** on September 1, 2015 at 11:00 AM; September 5. 2015 at 12:30 PM; and September 6, 2015 at 7:00 Response to #B1-PM. The three (3) occasions lacked documentation Residents #64, #108, #107, #142, #80, #43 and #49 of the descriptors relative to pain to include intensity before and after the administration of the Roxanol Refer to page 82 for response 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 facility staff 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. Facility 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 #80 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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		00 CONSTITUTION AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 309	mouth every day 30 pain management. Review of the Medi (MAR) for August a following: Acetamin were administered 2:10 (no indication at 1:30 PM; August of AM or PM); August of AM or PM); August 20, 2015 at 7:00 PM AM; and Acetamino every day prior to w daily during the most through 18, 2015. Subsequent review revealed the following administration of Acetaminopher August 6, 2015 PM)- No document medication, reason August 10, 201 general pain " no dicessible and acetaminopher or time of reassession August 14, 201 or PM)- No document medication, reason August 18, 201 general pain " no dicessible and acetaminopher acetaminopher and acetaminopher acetaminopher and acetaminopher acetamino	cation Administration Record and September 2015 revealed the ophen 325 milligram two tablets as follows: August 6, 2015 at of AM or PM); August 10, 2015 14, 2015 at 11:30 (no indication ust 18, 2015 at 7:00 PM; August M; and August 25, 2015 at 9:00 ophen 500 milligram two caplets round care was administered with of August and September 1 of the reverse side of the MAR and documentation relative to be the aminophen 325 milligrams at 2:10 (no indication of AM or red evidence of the date/hour, or result 5 at 1:30 PM- Reason- "ocumentation of intensity;" no documentation of intensity; "no documentation of the date/hour, or the devidence of the date/hour, or the date/hour or the date/hour, or the date/hour or th	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES' BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		
		2008					

	CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	general pain " no d Result- " effective " or time of reassessi August 25, 201 evidence of the date result In addition, the med documented pain as administration of Ac care in accordance at least weekly for of There was no evide consistently conductinctuded the intensit scale) before and at Acetaminophen. 4. Facility staff failed pain assessment and characteristics such pattern, location, free Resident #142. A review of the medical Resident #142 was with diagnoses to infailure, and Guilliand Review of the medical 2015 at approximate Orders for Tylenol 6	eassessment 5 at 7:00 PM- Reason- " ocumentation of intensity; no documentation of intensity ment 5 at 9:00 AM- No documented e/hour, medication, reason or ical record lacked a ssessment relative to the etaminophen prior to wound with the facility 's pain policy of thronic pain. nce that the facility staff ted pain assessments that ty of the pain (e.g. numeric fer the administration of d to conduct comprehensive ad/or reassessment to include as intensity, type, pattern of equency and duration of pain for lical record revealed that admitted on September 4, 2015 clude dysphagia, respiratory		309	483.25 PROVIDE CARE/SERVICES FOR HIGHES' BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #49 Refer to page 82 for response		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pag	-	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST BEING	WELL	
tube every six (6) hours as needed for September 4, 2015; and Tylenol 650 PEG 30 minutes prior to wound care.		and Tylenol 650 milligrams via			Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #49 Refer to page 82 for response		
	Administration Reco staff documented th Tylenol 650 milligral addition on Septemi Resident #142 rece " pain- 4/10 " no loo were documented a	ember 2015 Medication ord (MAR) revealed the facility e administration of the daily ms prior to wound care. In ber 15, 2015 at 6:00 PM, lived Tylenol 650 milligrams for cation and/or other descriptors nd " 1/10- effective " upon ime of reassessment	¥				
W	the facility staff cons assessment for a ne the effective of the p relative to pre-medic care and/or weekly policy for residents	·					,
	comprehensive pair intensity for resident 5. Facility staff faile pain assessment an characteristics such	ed to consistently conduct a assessments that include the t with complaints of pain. d to conduct comprehensive id/or reassessment to include as intensity, type, pattern of equency and duration of pain for			,		
	Resident #80 was a	ical record revealed that dmitted with diagnoses to c Lateral Sclerosis, Anemia,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	OINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)			(X5) COMPLETION DATE
	Medical record revie 2015 at approximate Order for Acetamino (Gastrostomy tube) for pain managemen 2015. Review of the Medic September 2015 remilligrams were adm September 1- 16, 20 documented eviden and after the adminito wound care. Furtillacked documented assessment for a remilligram to resident in accordance with the facility staff failed comprehensive pain intensity for resident in accordance with the facility staff failed Resident #43 's response a. On September 1- PM, a review of the Resident #43 was in April 22, 2011. A review of physical dated in the facility staff failed Resident #43 was in April 22, 2011. A review of physical dated in the facility staff failed Resident #43 was in April 22, 2011. A review of physical dated in the facility staff failed Resident #43 was in April 22, 2011. A review of physical dated in the facility staff failed Resident #43 was in April 22, 2011. A review of the Resident #43 was in April 22, 2011. A review of the Resident #43 was in April 22, 2011.	er, and Respiratory Failure. ew conducted on September 16, ely 3:20 PM revealed Physician ophen 650 milligram via G-tube 30 minutes prior to wound care not signed and date September 4, eation Administration Record for wealed Acetaminophen 650 ministered once a day from 215. The medical record lacked ace of a pain assessment before estration of Tylenol for pain prior nermore, the medical record evidence of a weekly pain sident with chronic pain. ed to consistently conduct assessments that include the twith complaints of chronic pain the facility 's policy. d to consistently assess conse to pain interventions. 8, 2015 at approximately 12:15 admission note revealed that nitially admitted to the facility on view of the physician 's history May 1, 2015 revealed the es included a Stage 3 sacral	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- Residents #64, #108, #107, #142, #80, #43 and #45 Refer to page 82 for response		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Review of the physical August 31, 2015 rev [narcotic analgesic] treatment for pain. Review of the Medic [MAR] dated Septemadministered Percot 2015 between the 3-2015 between the 3-201	cian 's orders signed and dated ealed a daily order for Percocet 30 minutes prior to wound care sation Administration Record of the 2015 revealed that the staff set daily from September 1-17, 11PM-work shifts. In ursing notes and clinical the staff failed to assess the to pain 7 (seven) of 17 days tion was administered. O15 at approximately 12:15 PM, item was conducted with ding the aforementioned item the record and ordings. The record was other 18, 2015. It to re-assess the effectiveness the effectiveness the effectiveness that itially admitted to the facility on item of the physician 's history May 1, 2015 revealed the included a Stage 3 sacral	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGH WELL BEING Response to #B6b, Residents #43 1. There was no adverse effect to the wound h process because the 'actual' treatment being was saline. The error was in the report submit the wound consultant physician. 2. A review of wound care orders were audited all orders in compliance. 3. Careful review of treatment orders during en month review and reconciliation to ensure at Review reports submitted by consulting wou physician with signed physician order in medical record. 4. The RCCs or designee will audit the TAR to all orders are documented and implemented audit findings will be reported to Risk Manag Subcommittee for three (3) months and a qu summary to Quality Assurance Committee u 100% compliance is demonstrated for three months	ealing y done itted by finding d of curacy. nd lical ensure . The ement arterly ntil	11.10.2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP O 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
	Continued From page Review of the physic August 31, 2015 rev following: "Cleanse saline, pat dry with go care dressing] Ag [staressing daily." Further review of the from April 2015 to Stollowing monthly we resident 's sacral we April 30, 2015 Stage 2.5 [width] x1.8 [dep May 21, 2015 Stage June 25, 2015 Stage July 23, 2015 Stage August 28, 2015 Stage August 28, 2015 Stage September 10, 2015 0.8	cian's orders signed and dated realed an order that directed the sacral ulcer wound with normal gauze. Apply Maxorb [wound ilver] and cover with dry e weekly wound documentation eptember 10, 2015 revealed the bund information relative to the bund: 2.8 [length] x 4 2.2 x 1.7 x1 4 1.7 x 1.5 x 2 3 2.0 x 2.5 x 1.0 age 3 2.9 x 2.0x 1.5	TAG	CROSS-REFERENCED TO T	THE APPROPRIA		
	and the record lacke	ed documented evidence that d the effectiveness of the wound					

	CORRECTION	IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COMP	LETED
		095027	B. WING	_		09/2	23/2015
	POINT SUB-ACUTE AN	D REHAB CAPITOL HILL	_	70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From pag	ge 100	F 30		483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING	T WELL	
	a face-to-face interview Employee #12 regar interventions and ho effectiveness of the	2015 at approximately 12:40 PM, iew was conducted with rding the wound care by the staff re-assessed the treatment plan. He/she provided ord was reviewed on September			Response to #B1- 6a, 7 Residents #64, #108, #107, #142, #80, #43 and #4 Refer to page 82 for response.	9	
		I to assess the effectiveness of was administered to Resident					ď.
	a review of the admi Resident #49 was in January 26, 2011 wi Traumatic quadripar	on the control of the					
		cian's orders signed and dated realed a daily order for Percocet for chronic pain.					
×	[MAR] dated Septen	eation Administration Record ober 2015 revealed that the staff cet daily from September 1-18,	ei.				
	documented evidence the resident 's response.	e clinical record lacked be that the facility staff assessed onse to the administered pain ember 3, 5, 6, 7, 8, 10, 11, 12,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION (2)		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015	
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)				(X5) COMPLETION DATE	
F 309	Continued From pag	ge 101	F	309	483.25 PROVIDE CARE/SERVICES FOR HIGHES BEING Response to #B1- 6a, 7 Residents #64, #108, #107, #142, #80, #43 and #4			
	a face-to-face interv Employee #20 regal finding. He/she was documentation that the effectiveness of aforementioned date record, could not pro documentation, and	2015 at approximately 12:15 PM, iew was conducted with rding the aforementioned asked to provide the the resident was assessed for the daily pain medicine on the es. He/she reviewed the clinical ovide the requested acknowledged the findings. The d on September 18, 2015.		=	Refer to page 82 for response.			
F 312 SS=G	A resident who is ur daily living receives	ARE PROVIDED FOR DENTS nable to carry out activities of the necessary services to ion, grooming, and personal and	F	312				
	Based on observati interview for one (1) determined that faci resident received ne good oral hygiene a who was observed v colored substance of #104. The findings include Facility staff failed to	ons, record review and staff of 55 sampled residents, it was lity staff failed to ensure the ecessary services to maintain s evidenced by: one (1) resident with an accumulation of white on his/her tongue. Resident						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/:	23/2015
	SUMMARY ST	D REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG	70 W	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE /ASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
F 312	had accumulated what tongue. A review of docume Daily Living [ADL] put 104 and through state that oral care was considered by facility staff. How that facility staff identification intervention to addressed the survey of examined by the mediagnosed with oral antifungal treatment. According to, "The Conditions of the McConditions of the McCond	ntation related to Activities of erformed on behalf of Resident aff interview, it was determined onsistently provided each shift ever, there was no evidence atified the need for medical ess the white substance on the eor's query, the resident was adical team and subsequently Candidiasis and prescribed each and Jaw Candidiasisgal infection commonly caused to the tributh and Jaw Candidiasisgal infection commonly caused to the source of systemic cularly in high-risk persons, and (1.) Oral discomfort, e, erythema, (2) White, raised, cosely adherent, (3) Possible agus with pain on swallowing agement: Topical antifungal, troches, or creams, such as Analgesics for pain, to Assess extent of lesions and th 2. Assess level of pain and Health Maintenance: (2) itents about daily oral ans and symptoms to observe		312	483.25(a)(3) ADL CARE PROVIDED FOR DEPERESIDENTS Response to #1 Resident #104 1. The care needs for resident #104 was asses an appropriate care plan was developed imn upon notification of this deficiency. A scheduresident #80 to be out of bed was also created were reassessed and an appropriate care plaspecific interventions was developed. 3. All clinical staff were re-educated 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 dwill perform weekly rounds on each unit and documentation audits ensure ADLs are perform the performance of the perfor	NDENT sed and lediately le for led. unit lessignee lession les interes les i	11.10.2015

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY
		095027	B. WING		09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	1	20.20.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 103	F 31	483.25(a)(3) ADL CARE PROVIDED FOR RESIDENTS	DEPENDENT	
	survey period reveal On September 10,	2015 at approximately 4:28 PM- ongue was observed completely		Response to #1 Resident #104 Refer to page 103 for respons	e	
	2015 at approximat #104 's oral cavity visualization of the unsuccessful becauemployee 's attemployee 's tong Nurse Practitioner of diagnosed him/her. Nurse Practitioner of at 4:10 PM read: "c/o [complaint of] with Resident is bedbout [with] difficulty to ach assessment done [whitish coating on the tongue with mouth of mouth/tongue coati [Assessment]:- Ora Nystatin solution 10 (millimeters) to tong	I Candidiasis (Thrush). Plan: 00,000 units/ml. Apply 5 ml gue and clean tongue QID (four 14 days. Reassess for any				

	F CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	PLETED
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002		EU/EU I U
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From pa	ge 104	F	312	483.25(a)(3) ADL CARE PROVIDED FOR DEPEN RESIDENTS	IDENT	
	for medical interver	o assess and identify the need ation for Resident #104 whose ed coated with a white			Response to #1 Resident #104 Refer to page 103 for response		
	staff must anticipate evidenced by the ar assessment dated A Hearing, Speech, a Resident 104 was urarely/never unders Cognition, the reside cognitively impaired decisions, Section I Seizure Disorder, T Tracheostomy, Craf (Functional Status) as being totally dep physical assist and maintains personal brushing teeth). Physician 's order do Mouth care every A review of clinical Treatment Administ of August and Septi documented that or An interim physician surveyor 's observer at 4:00 PM directed medication) Oral Surveyor Surve	totally dependent and facility to the resident's needs as annual Minimum Data Set [MDS] August 14, 2015. Section B, and Vision was coded that unable to speak and was tood. Under Section C, ent was coded as severely and never/rarely made (Active Diagnoses) included: raumatic Brain Injury, niotomy, Dysphagia. Section G revealed the resident was coded endent with one person for personal hygiene (how resident hygiene, including combing hair, lated August 25, 2015 directed: shift. " documentation [ADL sheets and tration Records] for the months ember 2015 revealed staff al care was provided every shift. n's order [subsequent to the ation] dated September 14, 2015; "Nystatin (Anti-fungal uspension 100,000 units per ml. ers) to tongue and clean					

	CORRECTION	IDENTIFICATION NUMBER:	1 ' '			COMP	LETED
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	thrush. "	nes a day) [times] 14 days for	f:	312	483.25(a)(3) ADL CARE PROVIDED FOR DEPEN RESIDENTS Response to #1 Resident #104 Refer to page 103 for response	Ident	
	assistant] Charting ' 2015 through Septe Personal Hygiene: F physical assist to pro-	dent's "CNA [nursing flow sheets from September 7, mber 15, 2015 revealed, "Resident required one person ovide all hygiene tasks [oral no self-performance."					ű.
	2015 included the for ADL (Activities of Date to diagnosis of Anox	care plan updated August 11, ollowing problem: "Alteration in aily Living) function [secondary] cic Brain Injury, Approaches provide oral, hair and nail care orn (as needed) "					
		nce that facility staff provided with the resident's need.					
	Employees #15 and approximately 1:00 the resident 's mout frequency, he/she stand an oral swab is no white coating on further stated somethis/her mouth but the	iew was conducted with #17 on September 14th at PM. When queried about how th care is performed and the tated; "It is done every day, used and s/he stated there was the resident's tongue. He/she imes white secretions are in ey are suctioned out, and the s cleaned every shift.					

PRINTED: 12/29/2015 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, 2 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD E		(X5) COMPLETION DATE
F 314 SS=D	The clinical record v 2015. 483.25(c) TREATMI PRESSURE SORES Based on the compresident, the facility enters the facility wi develop pressure so clinical condition dec unavoidable; and a receives necessary promote healing, pre sores from developing	rehensive assessment of a must ensure that a resident who thout pressure sores does not pressure that they were resident having pressure sores treatment and services to event infection and prevent new ng.		312			
	Based on observati interviews for two (2 was determined that consistently provide treatment to manage by failure to perform identify the approprione (1) resident; and promote healing such status and pain mar Residents #64 and at The findings include			483.25(c) TREATI PREVENT/HEAL PI Response to #1, 2, Refer to page 108	RESSURE SORES Resident #64, #91		

	CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	COMF	PLETED
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 10 CONSTITUTION AVE. NE PASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 314	According to the His documented by the Resident #64 's dia Wound, Stage IV Sa Malnutrition and Decording to Section Admission Minimum 2015, Resident #64 Stage IV sacral ulcer and Moisture A (MASD). Section K, Resident #64 receiv nutrition and hydrativia mechanically altowards assessed with Stage 2 pressure ulcer and Moisture A Significant Changunder Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Stage 2 pressure ulcer Section M; Sk #64 was assessed with Sk #6	dmitted on May 4, 2015. Story and Physical examination physician May 4, 2015, gnoses included Surgical acral Wound, and Protein conditioning. In M, Skin Conditions, of the n Data Set (MDS) dated May 11, was coded as having two (2) ers, one (1) Stage 3 pressure Associated Skin Damage Nutritional status, revealed red 51% or more of his/her on via feeding tube and orally ered diet. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers. In MDS dated August 9, 2015 kin Conditions revealed Resident with one (1) Stage IV and two (2) cers.		314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, #2, Resident #64 and #91 1. Immediately upon notification of this deficiency, the most recent comprehensive assessment was reviewed to determine triggers and car planning needs for residents #64 and #91. A focus interdisciplinary care pla meeting was held, to include wound care team, to determine the appropria plan of care. Resident #91 medical record was reviewed to address stagin 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 reeducated the Interdisciplinary Care Planning Team on 11/3/2015 regardin 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 the reported to the Quality Assurance Countil 100% compliance is consistently obtained for three (3) months.	n te g g f f c)	11.10.2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FOR PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 314	through September Sacral Stage IV with to multiple contributed dated May 6, 2015 shealed without complete of odor ". Nursinclude "Wound stame as urements of desurrounding skin tisse complaints of pain, per MD order; Apply order; Apply dressin specific is blank); ke status: Freq: PRN; Nof change in or dete Air mattress to promisections for Dietary, intervention were blaindicated. Nurse's notes and Nay 5, 2015 docum X 3 centimeter Stag The presence ulcer admission May 4, 20 assessment was docentimeters on Augunarrative: 08/31/15 side said she is side been given & N/V (a aware". A face to face intervent Employee #25 on Sapproximately 11:45 were occasions where	6, 2015 listed Pressure Ulcer: In potential for delay healing due pors as a problem. An entry stated the goal as: "Ulcer will be colication; Ulcer will be clean and ing interventions to this problem atus: size of wound: epth and width, skin color, sue assessment weekly, effectiveness of pain medication or medicated ointment per MD org per MD order (space for order epe Dietary informed of wound Notify physician of wound status rioration in status of wound; and note wound healing ". The Social Services, and Activities ank with no interventions Jutition Risk Assessment dated ented the presence of a 16 X 18 e 4 pressure ulcer on sacrum. was documented as present on D15. The most recent wound cumented as 15 X 16 X 3.5 Just 31, 2015 with the " Junable to assess Resident.	F	314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, 2, Resident #64, #91 Refer to page 108 for response.		

	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095027		(X2) MULT A. BUILDIN		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			09/	23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 0 CONSTITUTION AVE. NE ASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	ť	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 314	recalled that recentil #64 had complaints out to the hospital. I documented evidency physician notification with attempt to perform According to Employ declines a wound as made aware. The ermeasurement (size August 31, 2015 'V Note' was actually and not characterist August 31, 2015. Additional document notes for notification comprehensive asseand nutritional status September 1, 2015. have significant weigand a persistent State The medical record support the notification of intervention of intervention of intervention of intervention of intervention weight loss 2015 was document 2015 weight was do assessment document according to the control of the control o	y on August 31, 2015 Resident of not feeling well and was sent The medical record lacked ce of pain assessment and/or in relative to complaint of pain orm wound assessment. It is easient, the primary nurse is imployee acknowledged that the of the wound) recorded on the Vound and Skin Care Progress assessed on August 24, 2015 it of the status of the wound on the vound and Skin Care Progress assessed on August 24, 2015 it of the status of the wound on Resident performance, weight, is from May 4, 2015 through Resident #64 was noted to got loss, poor nutritional intake, ge IV sacral decubitus ulcer. Itacked documented evidence to it on of the physician and/or ons until August 20, 2015. In the medical staff documented do to evaluate resident for its Admission weight in May, ited as 177 pounds and August, cumented as 141 pounds. The ents the following relative to its [decubitus] Stage IV ". The 2015 was to follow	F3	14	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, 2, Resident #64, #91 Refer to page 108 for response.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING		<u>.</u>	09/:	23/2015
	SUMMARY ST	ID REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	70 W	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	dietician to increase oral intake until goa Vitamin C and Zinc	tube feeding and encourage l is met for ideal weight and start supplements for wound healing.	F3	314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, 2, Resident #64, #91 Refer to page 108 for response.		
	discussed the plan of responsible party and had " many question wound care and were (urinary tract infection 2015 was to discontinuous discont	of care with the resident 's coording to the documentation in related to issues of pain ight loss and recurrent UTI on). The plan on September 1, inue all narcotics due to s, start Neurontin and Tylenol for betite stimulation, and schedule in Wound Care Surgeon. The lable to fully implement the plan ighe in mental status " noted at miber 1, 2015. Resident #132 to acute care facility for ment.					
	Assessment Minimu 2015 revealed Secti pounds; K0300 Wei in the last month or	icant Change in Status Im Data Set dated August 9, on K0200B- Weight: 150 ght Loss- "Loss of 5% or more loss 10% or more in the last 6 on physician-prescribed				.1	
	weight loss, persiste ulcer, and continued medication prior to v consistently reasses	was aware of the resident 's ent Stage IV sacral pressure I to routinely administer pain wound care, they failed to es and/or modify wound and/or document rationale for					

	PLAN OF CORRECTION IDENTIFICATION NUMBER		l ` ′	G	COMPLETED
		095027	B. WING _		09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AI	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 314	continuing the pres healing as the resid without change. In the facility staff exp was could benefit fi	ge 111 ent treatment despite little lent was continued on Dakin 's addition, there was no evidence lored whether or not the resident rom specialty consultation (e.g. l/or a variation in support	F 3	14 483,25(c) TREATMENT/SVCS 1 PREVENT/HEAL PRESSURE SO Response to #1, 2, Resident #64 Refer to page 108 for response	,#91
	face to face intervie	5 at approximately 11:55 AM a www.as conducted with Employee are reviewed, discussed, and	•		
	According to the MI pressure ulcer stag as follows: " Stage 1: Intact so of a localized area on the minimum of the minimum of the clinic revealed an 'Acute dated September 3 that indicated the results of a sacral open as a scalar open as a sca	ed to identify the appropriate cer for Resident # 91. DS [Minimum Data Set] 3.0, es and characteristics are noted kin with non-blanchable redness usually over a bony prominence nickness loss of dermis allow open ulcer with a red or thout slough. May also present a ruptured blister serum-filled cal record for Resident #91 Change in Condition Report' 2015 and timed at 0:200 AM esident was discovered to have a urea " that measured 0.5 cm idth]. The 'Weekly			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/2	23/2015
_	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 314	following: September a Stage 1 ulcer to the x 0.5 cm with scant September 9, 2015 measuring 0.2 cm x drainage. A review of the physic revealed an order dedirected the following with NSS [Normal Stage 2 (open) words a Stage 2 (open) words Employee #10 acknown finding.	ion ' sheet revealed the er 3, 2015 that the resident had be sacrum that measured 0.5 cm serous drainage; and on the ulcer was staged as a "1," 0.5 cm, with scant serous sician 's interim order form ated September 3, 2015 that g, "Cleanse sacral opening aline Solution], pat dry, apply shift and prn [as necessary]. " 2015 at approximately 10:00 AM, wation was conducted with esident #91. Resident #91 was sence of Employee #10 to have bund on his/her sacrum. owledged and confirmed the didentify the appropriate stage according to the pressure ulcer MDS. The record was reviewed	F	314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Response to #1, 2, Resident #64, #91 Refer to page 108 for response.		
F 323 SS=D	environment remain is possible; and eac		F	323			

	F CORRECTION	IDENTIFICATION NUMBER:	l ` ′		ONSTRUCTION		E SURVEY PLETED
		095027	B. WING _			09/	/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		700	EET ADDRESS, CITY, STATE, ZIP CODE CONSTITUTION AVE. NE ISHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Based on observation environmental tour of 2015 at approximate 16, 2015 at approximate 16, 2015 at approximate 16, 2015 at approximate 16, 2015 at approximate 17 of 18	ons made during an of the facility on September 14, ely 2:30 PM and on September mately 10:00 AM, it was lity staff failed to maintain the thazards as evidenced by two protectors observed on the floor dent's rooms surveyed and one protector observed on top of the f42 resident's rooms surveyed, ing out of the top of the closet 2 resident's rooms surveyed, an sible utility closet with cleaning of three (3) resident's care unit d accessible oxygen storage hree (3) resident care units.		323	 483.25(h) FREE OF ACCIDENT H AZARDS/SUPERVISION/DEVICES Response to #1-4 Immediately upon notification, the surge prote were secured, the nails sticking out of the top the closet door were removed and closet door repaired in the identified areas. The utility clos 5th floor and oxygen storage room on 6th floor securely locked. Facilities Supervisor and Interim Administrator performed Environment of Care (EOC) rounds each unit focusing on surge protector location resident closet doors and utility closet on each those found out of compliance were repaired and/or placed on a maintenance repair sched Environmental Surveillance Rounds will contit 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 formed to monitor maintenance/repair act based on findings from the surveillance round electronic work order system The Facilities Director or designee will audit the order system and surveillance round findings EOC activities are addressed. A monthly comsummary will be reported to the EOC Commit Quality Assurance Committee. 	of r set on was r s on o, h unit. I siule. Inue	11.10.2015 & ongoing

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		095027	B. WING	_		09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE CONSTITUTION AVE. NE ASHINGTON, DC 20002		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	of a broken closet d one (1) of 42 residuals. 3. The utility closet housekeeping clean unlocked and acc	bserved protruding from the top oor in room #4132, dent's rooms surveyed. on the fifth floor where hing chemicals are stored, was ressible to residents and visitors. ge room located on the sixth and accessible to	F	323			
		s were made in the presence of cknowledged the findings.					
F 328 SS=J	NEEDS The facility must ensproper treatment an services: Injections; Parenteral and ente	tomy, or ileostomy care;	F	328			
	This REQUIREMEN	T is not met as evidenced by:					
	Based on record re	view and staff interviews for					

	F CORRECTION	IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	four (4) of 55 samp that the facility staff received the necess to ventilator service recognize, assess a complications for or resident who demodysfunction for greasubsequently transfered use a complications for or ventilator depender in heart rate [tachyotransferred via 911 accurately assess tresident requiring vaccurate assessme known change in coaffiliated with the inseverity), 37, 5, and An Immediate Jeop CFR 483.25(k); F32 residents receive procare for Failure to psupervision for indicand Failure to monimedical conditions, made on September PM. The facility's Admin corrective action planultiple aspects of to licensed nursing	led residents, it was determined failed to ensure that residents sary care and treatment relative is as evidenced by failure to: and monitor potential ne (1) ventilator dependent instrated symptoms of respiratory after than 24 hours; and was ferred via 911 to an emergency spitalized in intensive care; assess and monitor potential ne (1) resident who was not and experienced an increase cardia] and was subsequently to an emergency department; the respiratory status of one (1) rentilator services and perform an ant of one (1) resident with a condition. Residents #145 (is a mediate jeopardy scope and 198. Part (IJ) was identified at 42 and the end of the	F	328	Response to #A1-3, Resident #145, #37, #5, in the 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 any change in the resident's condition. The audit results found all medical record audits to identify new/changed orders and indications of missed orders. Those found out of compliance were addressed of 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 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 comphysician orders, notification to physician, the use of the communication binder.	t pof pleting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	SUMMARY ST	ND REHAB CAPITOL HILL FATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	7 V	PROVIDERS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Subsequently, the oscope and severity The findings include Facility staff failed to that placed Resider dependent, at risk for the president is read for the resident is read and alter. The resident begand breath on August 20 treatments beginning demonstrated an all August 31, 2015. Of 9:03 PM, Resident pressure, increased Subsequently, the rearest emergency in intensive care. Resident #145 was According to the add examination signed 2015, Resident #14 Respiratory Failure. Continue on [Ventilito cervical spine inj. Cardiomyopathy, Continue on the pression with Antil. According to clinical respiratory therapy;	deficiency was identified at a of "E." e: o recognize and assess factors at #145, who was ventilator or complications as evidenced epeated complaints of shortness are respiratory treatments [CPAP - e Airway Pressure - breathing ration in level of arousal. complaining of shortness of 9, 2015, refused CPAP and August 28, 2015 and terration in the level of arousal on an August 31st at approximately #145 sustained low blood at respirations and tachycardia. The resident was transferred to the room (ER) and was hospitalized admitted on August 24, 2015. In this physician August 25, 15's diagnoses included Chronic Status Post Tracheotomyator], Quadriplegia [secondary] ury, Non-Ischemic ongestive Heart Failure, Major xiety and Diabetes Mellitus Type	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL Response to #A1-3, Resident #145, #37, #5 (Cont'd) 3. Residents on weaning protocol will be enter 24 hour report to ensure notification of resid status and order changes are communicate shift. Hand-off communication was established be Nursing and Respiratory during shift change status and progress of residents on weaning protocol. 4. The Resident Care Coordinator (RCC) will pweekly audits of the 24 hour report to ensur appropriate protocol related to residents' ch condition are followed per policy. Results of the audits will be reported weekly Risk Management Subcommittee for three months. A quarterfy summary of the audits reported to the Quality Assurance Committe 100% compliance is demonstrated consistent three (3) months. The Respiratory Department will conduct maudits to respiratory orders. A monthly sum the audits will be reported to the Quality Assurance Committee until 100% compliance is demonstrated is demonstrated consistently for three (3) months.	ed on the lents' d across etween e to note g perform e ange in v to the (3) will be se until intry for onthly many of surance	11.10.2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
BRIDGEF		ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	Shift Report - " Patinight; Sat = 99% [ox 79, [Respiratory Rathas a lot of thick tan Continue to encouraCPAP 5/10 x10[m control] due to patie [shortness of breath August 30, 2015 - " Received [patient] of treatment] given as writing). [oxygen satwriting), Will continue procedures done/CPAP trial. [Patient] SOB [shortness of bon AC [Assist Control of CPAP trial is on AC [Fractioned of Inspiratory Failure, Sat-98%. HR-79, Recomplains of being apparent distress. Complains of the complaint o	August 29, 2015 - " 7PM-7AM-ent refused CPAP trails last tygen saturation], [Heart Rate] e] 24. Alert [and] stable. Patient into white (oral) secretions. In the secretions of the secretion of the secretio	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL NI Response to #A1-4, Resident #145, #37, #5, # Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	[recorded by respiral following "Rate Set/Total definition of the following "Rate Set/Total definition of the following "Rate Set/Total definition of the following set of the fo	tory therapist] revealed the et/Total " on the A/C mode: ned: 15/34 - "15" reflects piratory rate and " 34" reflects - ove the set rate]	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		
	August 28, 2015 3:1 [b/p-blood pressure] [R-respirations] 18 August 29, 2015 3:0 [R] 20 " August 31, 2015-12 and responsive. Ver mode for respiratory needed)V/S- [Blood of the content of t	3 PM - "V/S [vital signs]: 108/58; [P-pulse] 99; no acute distress noted " 0 AM - " [b/p] 116/62; [P] 78, 2:35 PM - Resident remain alert at [ventilator] dependent AC support. Suction PRN (as and Pressure] - 134/74, 98.9 100 [two (2) different					

		IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095027	B. WING			09	/23/2015	
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002	,	20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 328	Continued From page 119 heart rates] no respirations documented		F	F 328 483.25(k) TREATMENT/CARE FOR SPECIAL				
	S-BAR (Situation-Backgron) /Acute Change Date: August 31, 2 is the successive 12:35 PM entry] lethargy [and] gas Background: Resp 77/53, RESP: 24, Crackles, Pulse of noted [with] [decre rate. House office resident to [hospit treatment. " There was no evic respiratory staff id exhibited progress	cound-Assessment-Recommendati e in Condition Report: Situation- 2015, Time: 9:39 PM [of note, this nursing note to the August 31st . low B/P- 77/53, P-153, R-24, ping for breath, although on vent. biratory Failure, Temp: 98.6, B/P- Pulse: 153, Lung sounds: x: 93% ventilator Resident was eased] B/P 77/53, elevated pulse r notified who ordered to transport al] for further evaluation and			Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.	#98	8	
	unresponsive with transfer to higher August 31, 2015- [physician] Note: I #145] b/c (becaus [and] acute AMS (His/her] HR (hear s [and] B/ P as love earlier today [he/s but currently [he/s arousal and award agonal (gasping) I	e the resident became obtunded, agonal breathing requiring level of care. 2103 (9:03 PM) - Hospitalist was called to evaluate [Resident e) of hypotension, tachycardia, gradually since few hours ago. It rate) has been elevated to 150 vas 77/53. As per nurse even to he] was A&O (alert and oriented), he] is obtunded (diminished eness) [and] unresponsive with breathing. [He/she] is quadriplegic. Acute AMS [and] hypotension-						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` <i>'</i>	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095027	B. WING _		09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	D BE	(X5) COMPLETION DATE
F 328	unknown cause ([he (Intravenous) Cipro Diflucan (anti-fungal Transfer to nearest) The clinical record la respiratory staff record the physician, the resolution of having shortness alteration in the lever 2015 to August 31, 2015 to August 31, 2015 at approximately 2:0 aforementioned con off-going team mem through August 31, 2015 at the resident was calling bell one blows into. Off-going therapist at the resident 's room acknowledged the pinformed of the residents. A review of records facility that the resid the following physici	Ashe] finished [his/her] IV (antibiotic) yesterday [and] medication) was discontinued). ER (Emergency Room). " acked evidence that nursing and ognized and communicated to sident's progressive complaint of breath, refusing CPAP trials, I of arousal from August 28, 2015 until 9:03PM, when the ed and with agonal breathing. iew was conducted with oming day-shift team member, M - 7PM] September 18, 2015 0 PM regarding the above cerns. He/she said that the ber [night shift August 30th 7PM 2015 7AM] stated that the all night, using the type of call Employee #14 further stated the nd the nurse was in and out of all night. Employee #14 hysician should have been lent's restlessness, complaint of breath and refusal of CPAP obtained from the acute care ent was transferred to revealed an 's entry dated 8/31/15: " resented to the ED (Emergency	F 3:	483.25(k) TREATMENT/CARE FOR SPECIAL Response to #A1-4, Resident #145, #37, # Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095027	B. WING _			09/	23/2015
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND R	EHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE CONSTITUTION AVE. NE ASHINGTON, DC 20002		
PREFIX (EACH DEFICIENCY MUST BE	MENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY YING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
hypotension, tachycardi [Temperature] - 41.7(Ce Fahrenheit- 107.6 degre Respirations-16; Blood 87/48. " The clinical record was 2015. Cross referenced 483.2 483.10(b)(11) F157 2. Facility staff failed to assessment for Resider documented change in the respiratory therapy inconsistent with the rest the physician and nurse September 18, 2015 at respectively. Resident #37 was admit diagnoses to include Checoronary Artery Disease Medical record review was September 21, 2015 at clinical notes revealed in assessment of Resident 18, 2015 at 5:00 PM as documented by medical respiratory staff. The incomplete in the september 21 in the incomplete in the september 21 in the incomplete in the incomplete in the september 21 in the incomplete in the	(Altered Mental Status), ia and fever of 107. In ED, elsius- converted to ees); [Heart Rate-85]; Pressure (Systolic/Diastolic) reviewed September 18, 5 F309; 483.30(a) F353; perform an accurate at #37 that experienced a condition. staff assessment was sident's status as reflected in b's assessment on 5:30 PM and 5:00 PM; tted on July 22, 2015 with aronic Respiratory Failure, e, and Sacral Decubitus. vas conducted on 9:40 AM. The review of anconsistencies in the trelates to entries a staff, nursing staff, and consistencies are as follows: e from September 18, 2015	F3	328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	ST BE PRECEDED BY FULL REGULATORY		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY)			(X5) COMPLETION DATE
F 328	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	department. A face to face interved Employee #31 on Stapproximately3:30 Frespiratory assessment change of condition findings were review acknowledged. 3. Facility staff failed factors that potential ventilator dependent evidenced by failure resident when he/sheart rate and substrespiratory function, sent out 911 [Emerging A review of Resident Data Set) with an Asta (ARD) of April 22, 20 Section I (Active Dia Hypertension, Trach and Ventilator. Physician's orders of Vent [Ventilator] Set Mode- Rate-10, VT- [Fraction Inspired O Physician's Progre Pulmonary Note - Julmonary Not	iew was conducted with eptember 21, 2015 at PM. S/he confirmed that the pent was inconsistent with the at the time of assessment. The yed, discussed, and If to recognize and assess lly placed Resident #5, who was that risk for complications as assess and monitor the pent compromise in the resident was subsequently pency Services]. If #5's quarterly MDS (Minimum assessment Reference Date D15 revealed diagnoses in agnoses) that included: Interest May 9, 2015 directed; "Interest May 9, 2015 directed; "Inte	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL Response to #A1-4, Resident #145, #37, #5 Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE	AND REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	[tidal volume] 500 pressure] +5, Fi0: 104/72, P 69, R 1 auscultation bilate [cardiovascular] r [positive] bs [bow edemaA/P Ass Respiratory Failu CVA [Cerebral Vavent support - no MD [Medical Doc 08:50 AM reveale Response. " Patachycardia [rapid 140, SBP [systoli [respiratory rate] 100% Fi02 with a feeding witnessee [clear to ausculta system]: tachyca [hypoactive] bowedema BUE [bilate [greater than] L [late [rule out] aspiratio [Emergency Room A review of the notation of the pressure] 1 pressure] 1 pressure] 1	[mode of Assist Control] 10, VT 0, PEEP [positive expiratory end 2 [room air] 40%. Exam: vitals 8, T 97.9; CTA-[clear to erally no wheezes; CVS no murmurs; Abd [abdomen] + el sounds]; Ext [extremities] no essment/Plan (1) chronic re; (2) Encephalopathy secondary ascular Accident] - Continue on weaning - supportive care. " tor] Acute Note - June 2, 2015 at ed "Responding to "Rapid tient [Resident] identified with if heart rate] with HR [heart rate] c blood pressure] 110, RR 20s-30s; SAT [Saturation] 96%, mbu bagging. Emesis, tube d; lung (+) Rhonchi, R [right] CTA tion] left. CVS[Cerebrovascular rdiaABD: distendedhypo el sounds; ENT [Ear, Nose, Throat] teral upper extremities], R [right] > eft]. Warm extremities; A/P n]: Respiratory Distress, R/O on/sepsis. Will send to ER	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL (Response to #A1-4, Resident #145, #37, #5 Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
095027 B. WING		09/23/2015	
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL STREET ADDRESS, CITY 700 CONSTITUTION A WASHINGTON, DC	AVE. NE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		
Continued From page 125 F 328 continue to monitor "	MENT/CARE FOR SPECIAL NE A1-4, Resident #145, #37, #5, # to page 116 for response.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVEY COMPLETED		
		095027	B. WING			09/	23/2015
	POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		1 00	20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 328	for June 2, 2015 rev "Date: June 2, 2015 Time: 0025 [12:25 / Mode: AC Fi02: 40% PEEP: 5 Saturation: 97% Heart Rate: 70 Date: June 2, 2015 Time: 0345 [3:45 Al Mode: AC Fi02: 40% PEEP 5 Saturation: 98% Heart Rate: 121 Date: June 2, 2015 Time: 08:20 [8:20 Al Mode: AC Fi02: 40% PEEP: 5 Saturation: 99% Heart Rate [HR]: 125 There was no docum physician was notification increased heart rate June 2, 2015 (08:20 approximately 4 hours	Motes: Diratory Ventilator Flow Sheet dealed the following: AMI MI MI Pented evidence that the end in regards to Resident #5's from June 2, 2015 (3:45 AM) to AM), which is indicative of		328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		

CEIVIE	13 FOR WEDICARE	A MEDICAID SERVICES				<u>UVI DIVIC</u>	<u>. 0936-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		(X3) DATE SURVEY COMPLETED		
		095027	B. WING_			09/	23/2015
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
221245				7	00 CONSTITUTION AVE. NE		
BRIDGE	POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL	ľ	V	VASHINGTON, DC 20002		
()(4) 15	CUMMARY ST	ATEMENT OF DEFICIENCIES	15	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	Continued From pag	ne 127	F3	328	483.25(k) TREATMENT/CARE FOR SPECIAL N	IEEDS	
	June 2, 2015 [notes	beginning June 1, 2015 7PM -		,20	Response to #A1-4, Resident #145, #37, #5,	#98	
		2, 2015 12 Midnight - 7AM] -			Refer to page 116 for response.		
	7pm-7am shift note S: Pt on A/C mode	revealed:			Neier to page 110 for response.		
	B: Respiratory resid	lent					
		RR [respiratory rate] 18 BS					
		onchi/clear, sxn [suction]					
	moderate yellow suc	ction, no distress.					
	R: monitor						
	June 2, 2015 -7AM- 7PM Shift- " PT [Patient] transferred to area Hospital. "						
	assessed and monit resident's heart rat documented on Jun-121. The resident' evidenced by increa rate - elevated to 12 response [a team of responds to interver of clinical deterioratic cardiac arrest] was subsequently transfevia 911 [Emergency	acked evidence that facility staff ored Resident #5 when the e increased which was first e 2, 2015 at 3:45 AM, heart rate s condition declined as sed tachycardia [rapid heart 9 beats per minute]. A rapid health care providers that he when a resident shows signs on to prevent respiratory of called and the resident was erred to the Emergency room Medical Services] according to e of transport the resident's		9	9		
	September 21, 2015 with Employees #18 that his/her shift was #18 also stated, who with the heart rate 1 was called at approx	riew was conducted on at approximately 10:30 AM and #47. Employee #18 stated a 7:00AM to 7:00PM. Employee en he/she first saw the resident 29 is when the rapid response kimately 8:20AM, the resident e was bagged [manually bag valve			·		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG				κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 328	conducting rounds fine/she was called to Employee #18 who a sent out 911 with a linurse was not availad. The record was revied. 4. Facility staff failed respiratory status of ventilator services. The facility policy day ventilator Managem Respiratory Education information: " care of modes of ventilation breath sounds assessuctioning." [This distance and state Agency on Seadministrator [Employed Assist Control: A/C, Ventilation: SIMV, Contilation: SIMV, Contilation: The amount The ventilator delivered.	47 stated when he/she was rom the rooms assigned when the rapid response by stated that the rapid response d that the resident had vomited agged and then the resident was heart rate at 140. The night shift able for interview. We we September 21, 2015. It to accurately assess the Resident #98 who required Atted May 15, 2015, titled 'nent and Nursing Care on' detailed the following of the tracheostomy tube, and, alarms and common causes, assment, weaning, and patient locument was provided to the ptember 22, 2015 by the Facility oyee #1]. 'Ventilator Settings Definitions sed date) included the following The way a breath is delivered, Synchronized Intermittent continuous Positive Airway e: (bpm- breath per minute), oreaths per minute, Tidal at of volume inhaled in the lungs. The appreciation of inspired oxygen	F3	328	483.25(k) TREATMENT/CARE FOR SPECIAL NI Response to #A1-4, Resident #145, #37, #5, # Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE
F 328	inhaling], and Positiv [PEEP]: Special sett the lungs expanded lungs into the bloods provided to the State 2015 by the Nurse E The facility policy #C 2015, titled, 'Ventila stipulates, " II. Policiphysician's written On September 21, 2 a review of the admit Resident #98 was a facility with a diagnor Failure. A physician's order of the resident have a mechanical machine spontaneous breath following settings: A 500, Fi02 30%, and A physician's order of the following, "Initiat [Defined by the Natingradual withdrawal of utilization of a variet total spontaneous we periods for muscle of was responsible for http://clinicalcenter-ventilator%20Managng.pdf]	ve End Expiratory Pressure ting on the ventilator that keeps to help get oxygen from the stream." [This policy was e Agency on September 22, Educator]. CP.603, last revised June 17, stor Weaning Protocol 'ey: Protocol will be applied per order of Wean per protocol." 2015 at approximately 9:30 AM, ission record revealed that dmitted on July 8, 2015 to the exist that included Respiratory dated July 8, 2015 directed that mechanical ventilator [a e that assists or replace ing] programmed at the /C, Rate 10, Tidal Volume [VT] PEEP 5. dated August 13, 2015 directed e ventilator weaning protocol." onal Institutes of Health as the of ventilatory support through y of ventilator modes, periods of entilation, and appropriate rest inloading [Respiratory therapy	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL	•	700	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	AM, an observation Patient #98 was in A/C, Rate 12 VT 500 Fi02 40% PEEP 5 On September 21 a review of the 'Ve by respiratory their settings as per we of September 1, 2 revealed the follow settings: A/C Rate - 12 VT - 500 Fi02 - 40% PEEP - 5 Review of the "Nurevealed the follow for the period of S 21, 2015: A/C Rate - 10 VT - 500 Fi02 - 30% PEEP - 5 The documented a recorded by the new 2015 failed to correflected the respinoserved. Addition September 21, 20	n of the ventilator settings for	F	328	483.25(k) TREATMENT/CARE FOR SPECIAL N Response to #A1-4, Resident #145, #37, #5, Refer to page 116 for response.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	ULTIPLE CONSTRUCTION LDING			TE SURVEY MPLETED
		095027	B. WING			0:	9/23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		700	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	Y STATEMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 328	On September 2 a face-to-face int Employee #16, the assigned to care also confirmed the care of Residents were all ventilator interviewed at the site of the ventilator set set rate, the resident response to the ventilator set set rate, the resident response to the ventilator set set rate, the remarked to nursing services. On September 2 a face-to-face into Employee #22, we residents requiring the mode, the set resident's response to the ventilator, confirm the mode, the set resident's response xplained the set not further explaint to nursing care for services. On September 2 a face-to-face into Employee #10, the mode, the set not further explaint to nursing care for services.	ettings documented by the	F	328	483.25(k) TREATMENT/CARE FOR SPERAR Response to #A1-4, Resident #145, #3 Refer to page 116 for response	37, #5, #98	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095027	B. WING		09/23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL	70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 328	Continued From pa	ge 132 indings, stating that the	F 328		
	respiratory therapy	staff would hold an in-service for ne record was reviewed on			
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	GIMEN IS FREE FROM RUGS	F 329	483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	
	unnecessary drugs. drug when used in eduplicate therapy); without adequate mindications for its use consequences which reduced or disconting reasons above. Based on a compressident, the facility have not used antipethese drugs unless necessary to treat a and documented in who use antipsychologically.	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate ee; or in the presence of adverse th indicate the dose should be nued; or any combinations of the thensive assessment of a must ensure that residents who sychotic drugs are not given antipsychotic drug therapy is specific condition as diagnosed the clinical record; and residents tic drugs receive gradual dose avioral interventions, unless eated, in an effort to discontinue		1. Immediately upon notification of this deficiency, the medical records for resid #94 was reviewed and identified no adverifieds. The attending physician was notified and confirmed the need for Vita C for wound healing. A complete order vobtained to include dose, frequency and route of administration and transcribed the MAR. 2. An audit of the MAR for September was reviewed on each unit and were brough 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 memor the medical staff on the standards of practice related to complete medication orders.	min was on 11.10.2015
	This REQUIREMEN	IT is not met as evidenced by:		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	
		view and staff interview for one esidents, it was determined that ensure that		reported to the Quality Assurance Committee until 100% compliance is consistently demonstrated for three (3) months.	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII		(X3) DATE SURVEY COMPLETED		
		095027	B. WING_			09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	as evidenced by fail	ree of unnecessary medications ure to ensure the resident medications ordered by the	F3	329	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Response to Resident #94 Refer to page 133 for response.		
	The findings include	:					
	a review of the adm Resident #94 was a 10, 2014. Review of physical dated Octo	2015 at approximately 12:30 PM, ission record revealed that dmitted to the facility on October the physician's history and ber 10, 2014 revealed the es included Deconditioning and					
	a review of the July s order sheets lacke	2015 at approximately 12:32 PM, and September 2015 physician 'ed documented evidence of an to be administered to the					
	[MAR] dated July 20 Vitamin C 500mg [m [twice a day] for woo signed the allotted s	cation Administration Record 115 revealed the following: " hilligrams] po [by mouth] BID und healing. " The staff had signature boxes twice a day from the indicated the medication was t.					
	[MAR] dated Septer	cation Administration Record nber 2015 revealed the C. " The order was incomplete, equency, route of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	allotted signature be September 1-16, 20 medication was given The staff failed to er unnecessary medical administration of Vitidays in September 2	use. The staff had signed the oxes twice a day from 15 which indicated the	F	329			
	a face-to-face interv Employee #4 regard findings. He/she rev	2015 at approximately 12:40 PM, iew was conducted with ling the aforementioned iewed the records and ndings. The record was aber 16, 2015.					
F 353 SS=K	PER CARE PLANS The facility must have provide nursing and maintain the highest and psychosocial we determined by reside plans of care. The facility must pronumbers of each of on a 24-hour basis to residents in accordance.	ve sufficient nursing staff to related services to attain or transcription of each resident, as entrassessments and individual evide services by sufficient the following types of personnel to provide nursing care to all ence with resident care plans: d under paragraph (c) of this rese and other nursing	F	353	483.30(a) SUFFICIENT 24 HR NURSING ST Refer to page 137 for response.	AFF	

	CORRECTION	IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION	(X3) DATE	PLETED
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	Except when waive section, the facility	ed under paragraph (c) of this must designate a licensed nurse	F3	353	483.30(a) SUFFICIENT 24 HR NURSING STAR	\FF	
		ge nurse on each tour of duty. NT is not met as evidenced by:					
	interviews, and residetermined that the sufficient nursing sinursing and related the highest practic psychosocial well-evidenced by failure.	ations, record review, staff sident outcomes, it was a facility failed to provide staff to ensure the delivery of d services to attain or maintain able physical, mental, and being of each resident, as a re to have sufficient staff in both ualifications to meet the needs of residents.					
	scope and severity 483.25 Quality of 0 each resident attai practicable physica well-being, in acco assessment and p #145 and 11 additi residents that have this deficient practi relative to ventilate #145 and 11 additi residents that have this deficient practi was identified at F- staff in both numbe the needs of reside	pardy (IJ) was identified at a of "J" in the areas of CFR Care, F-309 Failure to ensure that ned/maintained the highest al, mental, and psychosocial ordance with the comprehensive lan of care - specifically, Resident onal ventilator dependent ethe potential to be affected by ice; F-328 Failure to ensure that the necessary care and treatment or services - specifically, Resident onal ventilator dependent ethe potential to be affected by ice; a scope and severity of "K" -353 Failure to have sufficient ers and/or qualifications to meet ents, specifically, deficient of the provision of needed care					

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCT		COMPLETED				
		095027	B. WING		,	09	/23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE /ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	quality of care and of Resident Assessmelicensed nurses asservices were qualit Residents #98, 145 dependent resident affected by this define the facility's Adminicorrective action plands as a service as	ed in the regulatory groupings of quality of life and 483.20 ent; F-282 Failure to ensure that signed to provide ventilator fied and competent - specifically, and 11 additional ventilator is that have the potential to be cient practice. Istrator provided a letter noting a an [see letter attached] and the September 25, 2015 at 6:00 PM. Immediate Jeopardy was and severity of "E" for each of 09, F-328 and F-353.	F	353	 See immediate corrective actions for all areas of sited. The staffing records for nursing and respirar reviewed to verify findings. A lookback of the staffing records identified this elisolated incident, therefore no other resident was affected. The Respiratory Department will develop a staffin based on patient census and care needs. Policy it Respiratory Staffing will be developed to outline in staffing requirements and contingency plans for sidentified in staffing requirements and contingency plans for sidentified in staffing requirements and contingency plans for sidentified in staffing respiratory services to Bridgepoint Subsevent of staffing shortages. RT staff will notify the and subacute nursing supervisors, and the RT De Director immediately with reference to staffing shortages. RT staff with contingency strategles to meet the care. The staffing plan, to include the Ventilator Care U reviewed on 11/2/15 and ongoing with the Staffing Coordinator, RCCs and nursing supervisors by the Administrator/DON. All registered nurses and lice were in-serviced 9/22-9/26, 10/7, 10/25-10/28 and regarding ventilator management care and wean to increase the number of qualified staff assigned. HR will implement plans to actively recruit respirat therapists and qualified registered nurses to fill de vacancies and hire supplemental staff (i.e., PRN). Staffing utilization will be tracked daily by the Dire Respiratory. Results are reported to the Administrator DON daily. The nursing Staffing Coordinator will provide a daily staffing report to the Administrator DON daily. The nursing Staffing coordinator will cardership monthly. Human Resources Department will report recruit daily in the Operations Meeting and monthly to the Assurance Committee. 	concern tory were went ass an found to be g pian 12 ninimum taffing with cute in the hospital apartment ortage. will assist needs. In the will be g e interim needs on g protocol to 6th floor. It is tory apartment coro of ator and continue to and/or intal staff, to Executive ment efforts	11.10.2015 & ongoing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/:	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 10 CONSTITUTION AVE. NE L'ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	¢ 22	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	mechanical pressur- residents requiring he cannula oxygen the nebulization treatme whose plan of care is services. The staffing assignment included four (4) Licon duty during the difference of Reg [8/30/15 day shift]. The absence of Reg [8/30/15 day shift] for services to residents practice, would allow nursing unit to be sure with State requirement. The scope of practice District of Columbia Practical Nursing units to be sure with State requirement. The persons who are ill, alteration in health regressing or superinclude: (a) Participation ongoing comprehen process of the client behavioral health, in an illness, injury, at collecting data and process.	ssure - a non-invasive e support ventilation], 2 (two) di-Flow therapy [High flow nasal rapy], 55 residents who required ents and four (4) residents included ventilator weaning nent for August 30, 2015 ensed Practical Nurses (LPNs) ay shift and one (1) respiratory ring the period of 7:00 AM - 7:00 gistered Nursing staff on duty or the provision of direct care is and/or supervision of LPN is residents on the 6th floor abject to practices inconsistent	F3	353	483.30(a) SUFFICIENT 24 HR NURSING STAR Refer to page 137 for response.	FF	
		of the ongoing nursing					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		095027	B. WING		<u> </u>	09/	23/2015	
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	of Columbia Munici Nursing under Chapractice of registers performance of acts specialized knowled upon principles of the behavioral and soci The observation, concevaluation and recombehavioral signs and and injury including examinations and to the purpose of identication and family Additionally, care diquantity and/or quandelineated in this signoupings of Reside and Quality of Care follows: Cross referenced 4483.20(k)(3)(ii) F28483.25(a)(3)F312; 483.25(k) F328 Resident Rights - 4546 failed to notify the proportion of the performance in response in response in response in response in response in the process of the performance in response in response in response in response in response in response in the performance of the p	ice for RNs According to District pal Regulations for Registered pter 54, Section 5414 "The ed nursing means the sequiring substantial dge, judgment, and skill based he biological, physical, ial sciences in the following: (a) comprehensive assessment, ording of physiological and ad symptoms of health, disease the performance of esting and their evaluation for stifying the needs of the client dity of nursing staff are curvey report under the regulatory ent Rights, Resident Assessment and cross referenced as		353	DEFICIENCY) 483.30(a) SUFFICIENT 24 HR NURSING STA			
		0 days. Residents' #145 and #64						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/:	23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		STREET ADDRESS, C 700 CONSTITUTION WASHINGTON, D	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 353	failed to ensure that assigned to provide ventilator depender competent as evide in personnel record competencies to vermanagement, and state ventilator delivered the ventilator delivered the ventilator assist (mechanics of ventilator assist (mechanics of ventilator delivered by the Quality of Care - 48 provide the necessive residents attain or rephysical, mental, are evidenced by failure monitor the status acute change in state perform an accurator resident who experienced tachyoneed for one (1) resident who we experienced tachyoneed for one (1) resident who we experienced to ensure that head gear and that measured in according the provided to the status and the status assistant as the provided tachyoneed for one (1) resident who we experienced tachyoneed for one (1) resident who we are according to the provided tachyoneed for one (1) resident who we are according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who we according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who according to the provided tachyoneed for one (1) resident who accordi	ent - 483.20(k)(3)(ii) F282 Facility it 20 of 20 licensed nurses eventilator services for 12 of 12 nt residents were qualified and enced by a lack of documentation is of training, experience and entry qualifications in ventilator staff failure to identify the way ers a breath to the resident, if the eaths on the ventilator, if the eaths on the resident #98. idents #13, 37, 80, 98, 100, 111, and 142 also had the potential is deficient practice. 33.25 F309 Nursing staff failed to eary care and services to ensure maintain the highest practicable and/or psychosocial well-being as eto: consistently assess and of one (1) who exhibited an extra as manifested by low blood difference and decomposition one (1) increase and identify the easy exentilator dependent and eardia; assess and identify the sident who had accumulated ance on his/ her tongue; and tone (1) resident wore protective the head circumference was dance to physician's orders. #37, #5, #104 and #143.	F	553	er to page 137 for response.	VFF	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` `	TIPLE CONSTR		(X3) DATE SURVEY COMPLETED	
	095027	B. WING			09/:	23/2015
BRIDGEPOINT SUB-ACUTE			700 CONS	DDRESS, CITY, STATE, ZIP CODE STITUTION AVE. NE IGTON, DC 20002		
PREFIX (EACH DEFICIENCY ML	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
comprehensive pacharacteristics supain, location, free seven (7) resident residents respons #64, #108, #107, and with an accumulate his/her tongue. Residenced by one with an accumulate his/her tongue. Residenced by failed consistently and treatment to revidenced by failurassessment to ide sacral ulcer for on measures to prominutritional status are resident. Resident Quality of Care - 4 failed to ensure the necessary care are services as evider consistently assess dependent resider respiratory dysfun	sy staff failed to conduct ain assessments to include ch as intensity, type, pattern of quency and duration of pain for its and consistently assess two (2) et to pain intervention. Residents '#142, #80, #43 and #49. 183.25(a)(3)F312 Nursing staff ne resident received necessary in good oral hygiene as (1) resident who was observed tion of white colored substance on esident #104. 183.25(c), F-314 Nursing staff provide the necessary services nanage pressure ulcers as the to perform an accurate entify the appropriate stage of a e (1) resident; and implement to the healing such as bed surfaces, and pain management for one (1) its #64 and #91. 183.25(k), F-328 Nursing staff at residents received the and treatment relative to ventilator need by staff failure to: as and monitor one (1) ventilator at who demonstrated symptoms of ction for greater than 24 hours in one monitoring, supervision and/or	F	953	483.30(a) SUFFICIENT 24 HR NURSING STARREST TO page 137 for response.	FF	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ISTRUCTION	(X3) DATE COMF	SURVEY PLETED
	095027	B. WING			09/	23/2015
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AN	D REHAB CAPITOL HILL		700 C	T ADDRESS, CITY, STATE, ZIP CODE ONSTITUTION AVE. NE HINGTON, DC 20002		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
consistently assess who was ventilator of increase in heart rate out 911 [Emergency the respiratory statu ventilator services a assessment of one (change in condition. # 98.	ansferred to ER via 911; and monitor one (1) resident dependent and experienced an e and was subsequently sent Services]; accurately assess is of one (1) resident requiring and perform an accurate 1) resident with a known Residents' #145, #37 #5, and		353	483.35(I) FOOD PROCURE,		
The facility must - (1) Procure food fror considered satisfact authorities; and (2) Store, prepare, d sanitary conditions This REQUIREMEN Based on observative 2015 at approximate that the facility failed conditions as eviden	n sources approved or ory by Federal, State or local istribute and serve food under T is not met as evidenced by: ons made on September 9, ly 9:20 AM, it was determined to prepare food under sanitary ced two (2) of two (2) soiled kitchen floor that was marred in	F3		STORE/PREPARE/SERVE SANITARY Response to #1 and #2 1. Immediately upon notification of this deficiency, grease fryer in prep area cleaned. The marred kitchen floors throughout the department will be replaced. 2. The Dietary Director conducted environmental rounds. Any sanitary environmental issues were addresse immediately or submitted to mainten through the electronic work order system to residents were impacted by this deficiency. 3. The Dietary Director or designee will conduct monthly kitchen inspections identify and correct sanitary or environmental issues. An equipment cleaning schedule will be developed implemented by the Dietary Director. The Dietary staff were re-educated or cleaning process of the grease fryer. The Dietary Director or designee will audit findings monthly to the Environ Care Committee and quarterly to the Assurance Committee.	or d ance tem. to and the c report ment of	11.10.2015 & ongoing

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From pag	ge 142	F	371			
	1. Two (2) of (2) gre leftover food residue	ase fryers were soiled with					
	2. The kitchen floor	was marred in several areas.					
		were made in the presence of cknowledged the findings.					
F 386 SS=D	483.40(b) PHYSICIA CARE/NOTES/ORD	AN VISITS - REVIEW ERS	F	386			
	program of care, inc treatments, at each of this section; write at each visit; and sig exception of influent polysaccharide vaccadministered per ph	review the resident's total luding medications and visit required by paragraph (c), sign, and date progress notes in and date all orders with the ca and pneumococcal cines, which may be ysician-approved facility policy for contraindications.				,	
: : :	This REQUIREMEN	T is not met as evidenced by:	()				
	(2) of 55 sampled re the physician failed of care as it relates to pain for a resident that that exceeded five (5)	view and staff interview for two sidents, it was determined that to review the total program of weights, labs, wound status and lat experienced a weight loss 5) percent in 30 days for one (1) unction for one (1) resident.				·	
	The findings include	:					
		n n					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		095027	B. WING			09/23/2015	
	SUMMARY ST.	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COMMENCE OF	CORRECTION ON SHOULD BE HE APPROPRIA		
F 386	1. The physician fai of care for Resident wound status and particles are percent in 30 days. A review of the med Resident #64 was a diagnoses to include Retention, Hyperten Lower Extremities, a Venous Stasis, and Deficient with decont the History and Physical Resident underwent Gastrostomy on May poor oral intake. Medical record review 2015 at 10:00 AM reduced and August, 2015 (date of round June, 2015-163 pour and August, 2015-163 pour and August, 2015-163 pour and August, 2015-163 pour and August, 2015 through the medical staff does ignificant weight los medical record lacked the medical staff assist the nature of the protailored interventions.	iled to review the total program #64 to include weights, labs, ain for a resident that int loss that exceeded five (5) ical record revealed that dmitted on May 4, 2015 with a Sacral decubitus ulcer, Urinary sion, Lymphedema Bilateral and Bilateral Lower Extremity "Chief Complaint: Nutritional iditioning "as documented on sical dated May 4, 2015. If a Percutaneous Endoscopic y 8, 2015 for Dysphagia and we conducted on September 16, evealed the following si May 11, 2015- 186.8 pounds; month unknown) - 177 pounds; unds; July, 2015- 150 pounds; 41 pounds. Ician 's Progress Notes from gh September 1, 2015 revealed cumented notification of sis on August 20, 2015. The end documented evidence that sessed the resident to identify oblem, possible causes, and/or is to Resident #64 's specificing of labs, specialty consults,	F 38	483.40(b) PHYSICIAN VIS CARE/NOTES/OR Response to #1, Resident #64 1. Immediately upon notification of a review of the medical record to verify findings. 2. The Assistant Director of Clinic performed a retrospective audit weights on 10/1/2015 to ensure residents with significant weight addressed and communicated physician. 3. Assessment and Intervention prevised to reflect the Registere responsible for notifying the att NP of a confirmed significant weight change via phone and keep a record of physician/NP notification including date, time communicate weekly to the Int Management Subcommittee or related to significant weight change in reside process related to assessmen highlighting the importance of notification. The communication created to maintain a record of include date/time/interventions 4. The Assistant Director of Clinic monthly audits of the physician change notification record. The reported to Quality Assurance continue until 100% compliance minimum of three (3) months	of this deficiency for resident #6 al Nutrition to f the monthly e that all not changes were to the attending holicy will be ad Dietitian (RD) ending physician reight change all the attending ut the significant weight change all the attending to the significant weight change all the attending to the significant weight change all the attending to the significant weight, and mode of continue to the transport of the significant weight changes based on re-educated the is ongoing ent condition to the significant weight in binder will be finotification, to significant weight and intervention the significant weight end in the signific	as 11.10.2015 & ongoing will ht sk perform ht rill be liting will	
	requent monitoring	oi weignis.					

	CORRECTION	IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095027	B. WING		09/23/2015
	SUMMARY (EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 386	#27 at 10:38 AM of that Resident #64 According to Empthe resident was not adjust the tube intolerance and or labs, s/he stated the was assumed the sacral wound and 2 weeks and then Although the dietic adjustment to the physician authentisignature. The me evidence the physician for August 20, 2018 approximately 45.3 186.8 pounds doc The findings were acknowledged by 2. The physician for care to implement with Visual Function According the Hist	erview conducted with Employee on September 16, 2015 revealed was admitted as "obese". Toyee #27, after it was determined of eating, the plan was changed feeding because of volume all intake. When queried about the labs were not available and it albumin was low because of the weight loss. Juven was started for changed to Beneprotein. The changed to make tube feeding order and the cated the order as evidence by a dical record lacked documented ician reviewed Resident #64's are to include possible cause of lanned weight variance, labs, pain prior to August 20, 2015. As 5, the resident had loss 2 pounds since original weight of umented on May 11, 2015.	F 38	6 483.40(b) PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS Response to #2, 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 create an integrated interdisciplinary care plan will identify the problem, measureable goals a 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 residents. 4. MDS Coordinators will perform weekly audit ensure discussions related to trigger CAAs are reviewed and addressed by the IDT during caplanning meetings. A monthly summary of the results will be reported to Quality Assurance Committee. Auditing will continue until 100% compliance is demonstrated for a minimum of (3) months.	all ts to e are e audit

	CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	COMP	SURVEY LETED
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE VASHINGTON, DC 20002	<u> </u>	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 386	Vascular Accident Off Vent [Ventilato A review of the res Set (MDS) dated A Change MDS date Section B1000Visi 1 " for Impaired - print in newspaper Corrective Lenses glass) used in com " 0 " No. An observation an Resident #122 on approximately 11: that he/she wears were on the dress glasses. The residuals are out of the righ A review of the ph evidence an asses visual function def A face-to-face inte September 21, 20 approximately 11: he/she acknowled that an eye appoint The physician faile	Multiple CVA's (Cerebral s), Chronic Respiratory Failure - r], Asthma" Sident's Admission Minimum Data April 23, 2015 and Significant ed July 27, 2015 revealed in on that the resident was coded "sees large print, but not regular rs/books; Section B1200 (contact, glasses, or magnifying apleting B1000, vision was coded dinterview was conducted with September 21, 2015 at 200 AM. The resident indicated glasses, and that the glasses er, however I prefer different dent also stated that he/she could t eye and not the left eye. Sysician's progress notes lacked sement related to the residents icits. Tryiew was conducted on 15 with Employee #10 at 30 AM. After review of the above ged the findings, and indicated atment would be arranged.	F	386	483.40(b) PHYSICIAN VISITS REVIEW CARE/NOTES/ORDERS Response to #2, Resident #122 Refer to page 145 for response.		
F 431 SS=E		DRUG RECORDS, RUGS & BIOLOGICALS	F	431			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		095027	B. WING			09	/23/2015
	ROVIDER OR SUPPLIER	AND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE 1/ASHINGTON, DC 20002	1 00	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From p	page 146	F	431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STO DRUGS & BIOLOGICALS	RE	
	licensed pharmac records of receipt drugs in sufficient reconciliation; and in order and that a is maintained and Drugs and biologilabeled in accorda professional princ accessory and ca expiration date what In accordance wit facility must store compartments undancess to the keys The facility must permanently affixe controlled drugs li Comprehensive Dact of 1976 and o except when the fidrug distribution s stored is minimal detected.	h State and Federal laws, the all drugs and biologicals in locked der proper temperature controls, uthorized personnel to have			Response to #1-6, Resident #16, 17, 31, 91,108 140 Refer to page 148 for response.	and	
		ation and staff interviews for six residents, it was determined					

	CORRECTION	IDENTIFICATION NUMBER:	` '	G	_	COMPLETED	:
		095027	B. WING _	_	_	09/23/2015	5
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRE CROSS-REFERE	E. NE		
F 431	that the facility staff biologicals used in the accordance with curprinciples as evident medications stored is names on the vials (1) expired medication cart, accordance without notation of the state	failed to ensure drugs and the facility were labeled in trently accepted professional ced by: Five (5) vials of opened without notation of the resident 's or date they were opened; one on was stored in the refrigerator medication was stored in the essible for use. Residents 'and 140. : 4, 2015 at approximately 3:30 orage observation was the floor with Employee #49. The is were observed opened and the resident 's names on the vials were opened: asulin-aspart] unlabeled vial in a solution. (1) of one (1) vial of Tuberculin vative (lot#762019) was open ion of the date the vial was first consulting the conducted with the acknowledged the	F4	Response to #1-6, and 140 1. Immediately upor residents #16, 17 relabeled using the containers. The eremoved from suresidents were not practice. 2. All medication carchecked to ensure appropriate labels and date medication carchecks also ensuremoved if noted. affected. 3. The DON re-eduction of the second process to remove the contracting process to remove the contracting promorthly schedule carts and storage RCCs or designer medication carts: ensure proper late. 4. Pharmacy will process to remove the contracting process to remove the contracting promorthly schedule carts and storage RCCs and DON, Quality Assurance compliance is derivered (3) months. RCCs or designer nursing audit find Committee until 1	n notification, the vials for 7, 31, 108, and 140 were the information affixed to the expired medication was poly and discarded. The pot impacted by this deficient arts and storage areas were the all medications had so to include resident's name tion/vial was opened. The prediction was opened. The impacted was opened. The impacted was opened to the resident was catted licensed staff on 9/16, bing the regarding proper ling of medications and the expired medications. The impact will performed a daudits of the Medication areas. The will perform daily checks of and refrigerated vials to be ling. Devide a monthly report to the and a quarterly summary to be Committee until 100% monstrated for a minimum of	e 11.10.2	2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	AND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 10 CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441 SS=D	12:20 PM, a medic conducted on the standard following medication without notation of and were expired: Lorazepam [all (lot # 083352) for I date of August 8, 2 vitamin C (23 Resident #91, with 2015. Additionally, o Morphine Sulfate f without notification date the vial was fill On September 16, a face-to-face intelemployee #4. He/staforementioned fin	cation storage observation was 5th floor with Employee #49. The ons were observed opened and if the date the vials were opened inti- anxiety medication], 1ml vial - Resident #17, with an expiration 2015. tablets-Lot# 0105326) for an expiration date of July 31, me (1) of one (1) bottle of for Resident #108 was open, of the resident 's name and the irst opened. 2015 at approximately 12:30 PM, rview was conducted with she acknowledged the adings. N CONTROL, PREVENT		131	483.65 INFECTION CONTROL, PREVENT SPRI	EAD,	
	Control Program d sanitary and comfo	stablish and maintain an Infection esigned to provide a safe, ortable environment and to help opment and transmission of ion.			Response to #1-2, Refer to page 150 for response.		
	Program under wh (1) Investigates, co the facility; (2) Decides what p	stablish an Infection Control					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION		B) DATE SURVEY COMPLETED	
		095027	B. WING			ا ا	9/23/2015	
	SUMMARY ST.	D REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	70 W	PROVIDER'S PLAN OF CO (EACH CORSECTIVE ACTION PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	(3) Maintains a reco actions related to infections related to infections related to infection when the Infection that a resident need of infection, the facility must communicable diseadirect contact will transmit (3) The facility must hands after each dirhand washing is indepractice. (c) Linens Personnel must han transport linens so a infection. This REQUIREMEN Based on observatifuely staff failed to and transmission of evidenced by: staff vadministering care to failed to maintain an practices, as eviden on the resident's be	rd of incidents and corrective fections. ad of Infection on Control Program determines is isolation to prevent the spreadity must isolate the resident. prohibit employees with a lase or infected skin lesions from esidents or their food, if direct	F	441	483.65 INFECTION CONTROL, PREVILINENS Response to #1-2 1. Immediately upon of the direct caregiver was educated of the infection control praction. It re-education of En #51 was held on 9/16 respectively, by the DC standards of infection including use of PPE, equipment and hand including use of PPE, equipment and hand in the education was compliant practices where the staff on is ongoing regarding to infection control practiceleaning of medical ecof floor mats during be prevention of cross-compliant prevention of cross-compliance is demonst of three (3) months.	notification, r involved violation in ce. nployee #48 and and 9/23 DN on the control practice, cleaning hygiene. staff during care ed by RCCs. Justice performed if non-iere observed. ator/DON re-10/27, 10/28 and the standards of ce, to include quipment, removal diside care and ontamination. Il perform random urveillance weekly, ummary to the until 100%	11.10.2015 & ongoing	

PRINTED: 12/29/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 095027 B. WING 09/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE **BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL** WASHINGTON, DC 20002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 441 Continued From page 150 483.65 INFECTION CONTROL, PREVENT SPREAD, F 441 LINENS The findings include: Response to #1-2, Refer to page 150 for response. 1. Facility staff failed to maintain and perform good hygienic practices. On September 16, 2014 at approximately 11:45 AM and 2:00 PM, Employee #48 was observed walking

2. Facility staff failed to staff failed to maintain and perform good hygienic practices.

on the floor mat, while administering care to a

The observation was made in the presence of Employee #18 who acknowledged the finding.

resident in room #6122.

On September 21, 2015 at approximately 12:36 PM, a medication observation was conducted on the 5th floor, with Employee #51. During the observation, Employee #51 performed a finger stick on Resident #77, who was in room 5131, to check the blood glucose. After the test was completed, Employee #51 placed the glucometer on the resident 's bed, left the room using one gloved hand to open the door, and went into room 5138 to use the hand sanitizer. He/she returned, retrieved the glucometer, and returned it to storage in the medication cart, without first cleaning the glucometer.

On September 21, 2015 at approximately 12:45 PM, a face-to-face interview was conducted with Employee #51 who acknowledged the aforementioned findings.

F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

F 456

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095027	B. WING			09/:	23/2015
	POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	307.	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE
F 456	electrical, and patier operating condition. This REQUIREMEN Based on observati 2015 at approximate that the facility failed equipment in good wby one (1) of three (2) gasket and missing one (1) of one (1) wo one (1) walk-in refrigione (1) walk-in refrigione (1) of three (2) the prep area had a 2. Air curtains from a refrigerator/freezer with the prep area had a 2. Air curtains from a refrigerator/freezer with the prep area had a 3. B. Based on observating tour of the six during tour of the six duri	intain all essential mechanical, at care equipment in safe T is not met as evidenced by: ons made on September 9, ely 9:20 AM, it was determined It to maintain essential vorking condition as evidenced 3) garbage disposals with a torn slats from air curtains located in alk-in refrigerator and one (1) of gerator/freezer. : 3) garbage disposals located in torn splash guard. one (1) of one (1) walk-in (1) of one (1) walk-in vere missing slats. were made in the presence of cknowledged the findings.	F	456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Response to #A1-2 1. Immediately upon notification, the splash gual the prep area was replaced. A work order was submitted to repair the air curtain and slats in 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 orde 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 a findings monthly to the Environment of Care Committee and quarterly to the Quality Assur Committee.	s the i	

NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCES TO CONSTITUTION AVE. NE WASHINGTON, DC 20002 F 456 Continued From page 152 was determined that the facility failed to maintain essential equipment as evidence by the external 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 877 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 #30 on September 16, 2015 at approximately at 12:20 PM. She stated rounds for the external ventilator checks. 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 conducted once every shift to ensure proper functioning of the aforementioned alarm was observed to be low and continued to shut off when inspected by the respiratory therapist of Should with employee #30 on September 16, 2015 at 12:15 PM during a tour of the ventilator checks. The external ventilator alarm monitors are conducted once every shift to ensure proper functioning of 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 are stated in the interview.		OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCES TAG SUMMARY STATEMENT OF DEFICIENCES CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCES CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCES CAPITOL HILL F 456 Continued From page 152 was determined that the facility failed to maintain essential equipment as evidence by the external ventilator alarm monitor for net (1) of eleven ventilator alarm monitor or one (1) of eleven ventilator remotion for one (1) of eleven ventilator alarm monitor or one (1) of eleven ventilator alarm solution to the ventilator to remotion of the ventilator alarm solution to the ventilator or one ventilator alarm solution to the external ventilator unit revealed the external ventilator in one ventilator alarm solutions as a part of the ventilator checks. 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.			095027	B. WING			09/	23/2015
F 456 Continued From page 152 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 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. F 456 A83,70(e)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Response to #81-2 1. The battery was immediately replaced by the respiratory the heavy staff were reducted follow-up was conducted with the individual respiratory therapist on the external alarm. Check was performed on all patents that were on mechanical ventilator. Based on the revised alarms. 2. External alarm check was performed on all patents that were on mechanical ventilator. Based on the revised alarms. 2. External alarm check was performed on all patents that were on mechanical ventilator. Based on the revised alarms. 2. External alarm check was performed on all patents that were on mechanical ventilator. Based on the revised alarms will be deficiency. No treatient were found to be affected by this deficiency. 3. Daily rounting till be conducted at the beginning of each shift. Effective 9/25/15, the Respiratory Therapist assigned to Subacute will record the following a the beginning of the shift. Barm working properly and battery changed date. A running log will be maintained 4. Th	BRIDGEP (X4) ID PREFIX	POINT SUB-ACUTE A SUMMARY S (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES	PREF	70 W	OO CONSTITUTION AVE. NE /ASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
was observed to be off as evidenced by		Continued From payas determined the essential equipmer ventilator alarm moventilator monitor for the turned off as evidisplay on the screen and continued to sapproximately at 12 the external ventilator alarm monitors are the aforementioned and continued to sapproximately at 12 the external ventilator alarm monitors are the aforementioned and continued to sapproximately staff moven the facility staff moven the external ventilator the interview.	at the facility failed to maintain at as evidence by the external nitor for one (1) of eleven nitors on multiple days. e: 6, 2015 at 12:15 PM during a r unit revealed the external or Resident #37 was observed to denced by the lack of digital en. view was conducted with eptember 16, 2015 at 2:20 PM. S/he stated rounds for tor alarm monitors are conducted ensure proper functioning as a r checks. The external ventilator battery-operated. The battery for I alarm was observed to be low nut off when inspected by the st. umented evidence to support that nitored the proper functioning of tor alarm monitors as stated in 6, 2015 at approximately 1:15 and unit observations on the external ventilator alarm monitor			483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Response to #B1-2 1. The battery was immediately replaced by the respiratory therapist on 9/16. Immediate follow up was conducted with the individual respirate staff to enhance accountability. Respiratory therapy staff were reeducated on the process 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 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 in the ventilator alarm log daily, providing a mor summary to Quality Assurance Committee us 100% compliance is consistently demonstrati	v- ory s for	

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONS	TRUCTION		E SURVEY PLETED
		095027	B. WING			09	/23/2015
	POINT SUB-ACUTE	AND REHAB CAPITOL HILL		700 CO	ADDRESS, CITY, STATE, ZIP CODE NSTITUTION AVE. NE INGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 456	Continued From p	page 153	F4	156			
	further inspection	al display on the screen. Upon by the respiratory therapist, the ved to be missing from the		2			
	#30 on Septembe PM revealed the the the alarm at appro- low battery ". What replacement delay	terview conducted with Employee or 16, 2015 at approximately 1:35 coattery had been removed from eximately 12:15 PM because of "nen queried about the battery y, he/she stated that he/she was ther resident that required					
		sumented evidence to support that d the proper functioning of the alarm monitors.					2
	Employee #31 on approximately 3:3 external ventilator	September 21, 2015 at 0 PM. Employee #31 stated the alarms only serve as a back-up to so internal ventilator alarms on					
:		ns were confirmed, and Employee #31 at the time of each		:			
F 463 SS=D	483.70(f) RESIDE ROOMS/TOILET/	NT CALL SYSTEM - BATH	F4	163			
	resident calls thro	n must be equipped to receive ugh a communication system from nd toilet and bathing facilities.					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095027	B. WING		09/23/2015
	SUMMARY S'	ND REHAB CAPITOL HILL TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	7	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	(X5) BE COMPLETION
F 46	This REQUIREMENT Based on observation environmental tour 2015 at approximat 16, 2015 at approximate determined that factoresident's call systems.	NT is not met as evidenced by: tions made during an of the facility on September 14, tely 2:30 PM and on September mately 10:00 AM, it was ility staff failed to maintain am in good working condition as bell in the bathroom of room	F 463	483.70(f) RESIDENT CALL SYSTEM ROOMS/TOILET/BATH 1. Immediately upon notification, the call bell lig was repaired and the call bell cord of room 6146 bathroom was replaced. 2. Maintenance Supervisor and 6th FIRCC conducted environmental rounds to ensure call bells in resident rooms and bathrooms were functioning. All rooms were in compliance. 3. Environmental rounds will be conducted biweekly on a rotational schedule by a work g to include Maintenance Supervisor or design	roup
F 46 SS=	missing a pull cord, surveyed. These observations Employee #8 who a	te bathroom of room #6146 was one (1) of 41 resident's rooms is were made in the presence of acknowledged the findings.	F 469	Housekeeping Supervisor or designee, Clin Care Coordinator or designee, and Administrator or designee. The work group will utilize the electronic work order system to ensure tracking and just-intime 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, finding actions taken during inspections will be reported.	gs, and
55=	The facility must ma program so that the rodents. This REQUIREMEN	aintain an effective pest control facility is free of pests and NT is not met as evidenced by: ions made on September 9,			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	SUMMARY ST (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	700 CONSTITUTION, WASHINGTON, PRO (EACH			(X5) COMPLETION DATE
F 490 SS=E	determined that the effective pest controcrawling insect seer in the prep area and the facility during the The findings included. 1. A crawling insect three (3) the garbage prep area. 2. Flying pest were on the fourth, fifth an occasions during. The first observation Employee #5 who at 483.75 EFFECTIVE WELL-BEING. A facility must be adenables it to use its efficiently to attain of practicable physical well-being of each results aff interviews, it was administration failed revise appropriate cophysician when ther condition; to provide maintenance serviced.	facility failed to maintain an oll program as evidenced by a in the garbage disposal located of flying insects seen throughout electric survey. Was observed in one (1) of electric disposal located in the cobserved throughout the facility and sixth on numerous the survey. Was made in the presence of cknowledged the finding. ADMINISTRATION/RESIDENT consistence of cknowledged the finding. ADMINISTRATION/RESIDENT consistence of cknowledged the finding. The interest in a manner that resources effectively and remaintain the highest consistence. The interest is not met as evidenced by: Ons, clinical record reviews and as determined that the let to develop, implement, and/or corrective actions: to notify the electric was a change in the resident's	F	PROGRAM Response 1. Immedia measum flying in the second	te to #1, 2 sately upon notification, pest control res have been implemented to control research on the fourth, fifth, and sixth fix amental rounds were conducted on 9/ irronmental Services Supervisor and strator to ensure pest control issue to flying insects has been resolved. Amental rounds will be conducted bion a rotational schedule by a work god Maintenance Supervisor or designental Services Supervisor or designental Services Supervisor or designental Services Supervisor or designental Services Supervisor will ent routine cleaning schedule for trace p cleaning schedule for residents' as part of the pest control program. Control Company will be required to enicate with the EVS Supervisor and a staff prior to doing rounds to ensure as are addressed. A logbook of Pest visit will be maintained and monitore is Supervisor. To forgoing quality monitoring, finding taken during inspections will be reported to committee monthly and Quality Assure the equarterly.	ol oor. /23 froup nee, nee, nee, gs, and orted to	11.10.2015

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/2	23/2015
	ROVIDER OR SUPPLIER	D REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	initiate and revise caensure that services facility must be provaccordance with each care; to ensure that facility provided the attained/maintained physical, mental, an accordance with the and plan of care; to were provided to macarry out activities of necessary care and for wound(s); to ensure that sufficient staff we care and services; to a daily basis to in regulation; to ensure that the residing a safe and operating facility maintained and to ensure that location (MDS) under Section with state and local	assessments were accurate, to are plans as necessary; to provided or arranged by the ided by qualified persons in the resident 's written plan of each resident received and the necessary care and services to the highest practicable dipsychosocial well-being, in comprehensive assessment ensure the necessary services aintain good hygiene and to fidaily living; to ensure provision and treatment to promote healing the that the resident is as free of accident hazards as that a resident receives proper for respiratory care; to ensure as available to provide quality to post nurse staffing information include all components per the enthal that medications were properly to ensure all essential resident in safe operating condition; to dent call system was maintained ing condition; to ensure that the in effective pest control program; on and date of Care Area attion on the Minimum Data Sets in V was complete; to comply laws and regulations; and to ords in accordance with all standards.	F	490	483.75 EFFECTIVE ADMINISTRATION/RESII WELL BEING Refer to page 158 for response.	DENT	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/23/2015	
	SUMMARY STA	D REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 490	21, 2015, the following identified: Failure to ensurattending physician a vaccine as ordered 483.10, F157 Failure to provide maintenance services anitary, orderly, and reference CFR 483. Failure to ensurate accurate. Crossing Failure to ensurate accurate. Crossing Failure to ensurate plans with appreto address care new reference CFR 483. Failure to ensurating by the facing qualified persons in swritten plan of care (3) (ii), F282 Failure to ensurand the facility proviservices to attained/practicable physical, well-being, in accordassessment and pla 483.25, F309 Failure to ensurating provided to maintain activities of daily livit 483.25(a) (3), F312 Failure to ensurating the facility of the same provided to maintain activities of daily livit 483.25(a) (3), F312	e that facility staff notified the when a resident did not receive d. Cross reference CFR le housekeeping and es necessary to maintain a d comfortable interior. Cross 15, F253 e that resident assessments as reference 483.20, F272 e that facility staff developed opnate goals and approaches do fresidents. Cross 20, F279 e that services provided or lity must be provided by accordance with each resident 'e. Cross reference 483.20 (k) e that each resident received ded the necessary care and maintained the highest mental, and psychosocial lance with the comprehensive in of care. Cross reference e the necessary services was good hygiene and to carry out ing. Cross reference CFR	F	490	1. The facility administrative staff addressed all of immediate concern related to care of all re (equipment safety, staff qualification, and competencies with special focus on compete and skills required to care for residents with SC Care Needs. Environmental hazards were immediately abate 2. Any resident impacted by these deficiencies addressed immediately 3. The Nursing Leadership Team assessed sysprocess and outcomes to determine effective in meeting daily management and operation facility. The Interim Administrator/DON in collaborating the Interim Administrator will work on selection of personnel with required qualificate skills and competencies to ensure the highest practicable well-being of each resident. The Director of QA in partnership with the DC continue ongoing assessment of education attaining of staff. The Director of QA, Interim Administrator/DO revise the Quality Assurance program that we identify opportunities for improvement; addresses in systems or processes; develop and implement an improvement or corrective plate continuously monitor effectiveness of interversing and Managers Operations Review at executive level.	areas sidents encies Special were stems eness s of on with the ation st DN will will ess and entions.	11.10.2015 & ongoing

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		095027	B. WING_			09	/23/2015
	ROVIDER OR SUPPLIER	ND REHAB CAPITOL HILL		STREET ADDRESS, 700 CONSTITUTION, WASHINGTON,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		BE	(X5) COMPLETION DATE
F 490	remains as free of Cross reference CI Failure to ensuroper treatment at Cross reference 48 Failure to ensuroper treatment at Cross reference 48 Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.60 (b), (d), (e), Failure to ensuroperly labeled and 483.70 (h), (4), F469 Failure to ensuroperly labeled and 483.70 (h), F514. Failure to ensuroperly labeled and 483.75, F514. Failure to ensuroperly labeled and 483.75, F514. Failure to ensuroperly labeled and 483.20, F272	ire that the resident environment accident hazards as is possible. FR 483.25, F323 are that a resident receives and care for respiratory care. 63.25(k), F328 are that sufficient staff was equality care and services. 63.30 (a), F353 are that medications were ad stored. Cross reference F431 are all essential resident care afe operating condition. Cross 6.70, F456 are that the call bell system was a working condition. Cross 6.70, F463 are that the facility maintained an rol program. Cross reference are that clinical records were redance with accepted ards. Cross reference CFR are that location and date of Care information on the Minimum Data Section V was complete. CFR are that the Quality Assurance and developed corrective as the concerns identified during are Cross reference CFR 483.75,	F4	483.75 EFF WELL BEI	FECTIVE ADMINISTRATION/RESING Refer to page 158 for response		

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		095027	B. WING		09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION	
F 490	approximately 2:20 conducted at appro's #2, #3, and #4. following response identified during the . Employee #4 s Assessment and A conference conduction he/she was not awaregarding the resident of the services were conference to make necessary Immediate Jeopard developed regarding documentation of the services were conference to make necessary Immediate Jeopard developed regarding documentation of the services were conference to the services w	PM a face-to-face interview was eximately 2:28 PM with Employee The employees made the stream of the employees made the stream of the quality concerns a survey: Stated that during the Quality and ssurance Review Committee sted on September 18, 2015 that are that there was a problem ents who are vent dependent. Stated that he/she was aware that a could arise as a result of his/her regarding the care and treatment dent residents, it seem very hard changes. As a result of the ly (IJ) a plan of correction was an an apply sical assessment and the respiratory system and and the respiratory system and an action of the later of later	F 49	483.75 EFFECTIVE ADMINISTRATION/R WELL BEING Refer to page 158 for respon		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	completed. Employee #2 ar Resident Care Area program problem sin and that the program information to popul the date and location found. Employee #3 actime there is one (1) Medicare A resident process of exploring join the wound team. Employee #31 a alarms for ventilator or that the battery w respiratory therapist particular resident walarms once a shift, alarms are checked. Employee #2 ar facility was under received. Employee #3 action of pair action of pair action of pair action.	at documentation should be and #7 acknowledged that the Assessment is a computer ace MDS 3.0 came into effect, an no longer will allow for ate into the area that requires an of where information could be acknowledged that at present awound doctor that covers as and that they are in the a hiring a another physician to acknowledged that the external aresidents did not have a battery as low, and stated that the as that is assigned to that and that the internal ventilator and that the internal ventilator every four (4) hours. The draw are and after the anovation in some areas. Cocknowledged that staff did not as residents prior to and after the an medication. The draw are an area and after the and that the anovation in some areas. The draw are an area and after the anovation in some areas. The draw are an area and after the anovation in some areas. The draw are an area and after the anovation in some areas. The draw are an area and after the anovation in some areas. The draw are an area and after the anovation in some areas. The draw area and a after the anovation in some areas. The draw area and a after the anovation and after the an	F	490	483.75 EFFECTIVE ADMINISTRATION/RESIDI WELL BEING Refer to page 158 for response.	ENT	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095027	B. WING	6	0	9/23/2015	
	SUMMARY ST (EACH DEFICIENCY MUS	ID REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE	
F 490	services and lacked required ventilators nursing staff accura residents who receive notify the physician acute changes, failed residents with pain on serious condition residents receiving ensure that staff where special needs and with training to help prover and failed to ensure coded. It was determined the recognize and identified and services needed care to residents; and appropriate plans of quality deficiencies. 483.75(d)(1)-(2) GOPOLICIES/APPOINT The facility must have designated persons body, that is legally implementing policies and operation of the appoints the administrate where licensing for the management	supervision for residents who ervices; failed to ensure that the tely assessed and monitored wed ventilator services, failed to when the resident experienced to assess and monitor concerns; and failed to intervene is related to the care of wentilator services, failed to o worked with resident requiring rentilator received education and ide quality care and services that CAAs were accurately at the Administration failed to ify the necessary care concerns do to provide safe and competent addeveloped and implement action to correct identified EVERNING BODY-FACILITY TADMN To a governing body, or functioning as a governing responsible for establishing and the seregarding the management of facility; and the governing body strator who is licensed by the ag is required; and responsible		483.75(d)(1) (2) GOVERNING BODY FACE POLICIES/APPOINT ADMIN 1. See immediate corrective actions for concerns cited. The governing body that there is an administrator who is licensed in the District of Columbia. governing body holds (held) the admaccountable for the proper manager facility in accordance with federal reand DC licensure requirements. 2. The governing body convened all deheads, managers, and committee of directed each person to implement in corrective action to abate any immer and/or hazard to residents' well-bein safety. These corrective actions including and docume skills and competencies specific to the residents with special needs. Hired to provide all office related services. 3. Under the direction of the Interim Administrator/DON and Dir. QA: • Undertake a review of resident policies and procedures by deheads including the medical of heads including the heads	rail areas of ensure(d) duly The inhistrator ment of the gulations partment lairs and mmediate fiate threat g and laded staff intation of the care of contractors at care apartment lirector. Program and sees that cessary care of to provide esidents. status/outcomes recutive Team intervals to and maintaining aral regulations,	11.10.2015 & ongoing	

		IDENTIFICATION NUMBER:	l ` '	G	COMPLETED
134		095027	B. WING		09/23/2015
	095027 ME OF PROVIDER OR SUPPLIER RIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTION
F 493	Based on observa staff interviews, it is Governing Body fa and/or revise appronotify the physiciar resident's condition maintenance service sanitary, orderly, a that resident assess initiated and revise ensure that service facility must be proaccordance with eactordance with eactordance with eattained/maintained physical, mental, a accordance with thand plan of care; to were provided to mearry out activities of necessary care of wound(s); to enenvironment remai is possible; ensure treatment and care that sufficient staff care and services; on a daily basis to regulation; to ensulabeled and stored care equipment was ensure that the resin a safe and operafacility maintained to ensure that local	tions, clinical record reviews and was determined that the illed to develop, implement, opriate corrective actions: to a when there was a change in the it, to provide housekeeping and ces necessary to maintain a and comfortable interior; to ensure isments were accurate, to do care plans as necessary; to it is provided or arranged by the evided by qualified persons in each resident 's written plan of at each resident received and the enecessary care and services to do the highest practicable and psychosocial well-being, in the comprehensive assessment of ensure the necessary services an aintain good hygiene and to of daily living; to ensure provision and treatment to promote healing sure that the resident receives proper for respiratory care; to ensure was available to provide quality to post nurse staffing information include all components per the re that medications were properly; to ensure all essential resident is in safe operating condition; to ident call system was maintained ating condition; to ensure that the an effective pest control program; tion and date of Care Area	F 49	483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN Refer to page 162 for response.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING _			09/:	23/2015
	POINT SUB-ACUTE AN	ND REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE 10 CONSTITUTION AVE. NE 14 ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 493	comply with state a	Section V was complete; to nd local laws and regulations; ical records in accordance with	F4	193	483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN Refer to page 162 for response.		
		e: eation survey from September 9 - ring areas of concern were					
	attending physician a vaccine as ordered 483.10, F157 Failure to proving maintenance service sanitary, orderly, and reference CFR 483. Failure to ensure were accurate. Crown Failure to ensure accurate. Crown Failure to ensure accurate care plans with appeto address care new reference CFR 483. Failure to ensure arranged by the faccuration plan of care (3) (ii), F282. Failure to ensure and the facility proving services to attained practicable physical well-being, in according to proving the services of the services and the facility proving the services to attained practicable physical well-being, in according the services of the services and the facility proving the services to attained practicable physical well-being, in according the services of the services and the services to attained practicable physical well-being, in according the services are services as the services are services to attained practicable physical well-being, in according to the services are services as the servi	re that resident assessments is reference 483.20, F272 re that facility staff developed ropriate goals and approaches eds of residents. Cross					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095027	B. WING_		<u> </u>	09/:	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI; TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 493	provided to maintair activities of daily livi 483.25(a) (3), F312 Failure to ensur and treatment to proceed the consurremains as free of a Cross reference CF Failure to ensurremains as free of a Cross reference CF Failure to ensurremains as reference 483 Failure to ensurremailable to provide Cross reference 483 Failure to ensurremailable to provide Cross reference 483 Failure to ensurremailable to ensurremains as in sa reference CFR 483. Failure to ensurremaintained in good reference CFR 483. Failure to ensurremaintained in accompaintained in accompossional standaremailable to ensurremaintained in accompossional standaremailable to ensurremailable	re the necessary services was a good hygiene and to carry out ang. Cross reference CFR re provision of necessary care comote healing of wound (s). R 483.25(c), F314 re that the resident environment accident hazards as is possible. R 483.25, F323 re that a resident receives a care for respiratory care. B.25(k), F328 re that sufficient staff was quality care and services. B.30 (a), F353 re that medications were a stored. Cross reference F431 re all essential resident care afe operating condition. Cross T0, F456 re that the call bell system was working condition. Cross	F	193	483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN Refer to page 162 for response.		

CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	095027	B. WING			09/	23/2015
ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		7	00 CONSTITUTION AVE. NE		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY					(X5) COMPLETION DATE
Committee identified measures to addres	d and developed corrective s the concerns identified during	F	193	483.75(d)(1) (2) GOVERNING BODY FACILITY POLICIES/APPOINT ADMN Refer to page 162 for response.		
2:20 PM a face-to-fa approximately 2:28 and #4. The employ	ace interview was conducted at PM with Employee 's #2, #3, yees made the following					
Assessment and As conference conduct he/she was not awa	surance Review Committee ed on September 18, 2015 that re that there was a problem					
a potential problem current knowledge report of ventilator depends to make necessary and the language of the l	could arise as a result of his/her egarding the care and treatment ent residents, it seem very hard changes. As a result of the (IJ) a plan of correction was g physical assessment and e respiratory system and inducted by the Respiratory urse Practitioner in order to dge base of staff and safety of					
	Continued From page Committee identified measures to address the survey process. F520. On Tuesday Septem 2:20 PM a face-to-fa approximately 2:28 and #4. The employ responses related to during the survey: Employee #4 st Assessment and As conference conduct he/she was not awa regarding the reside current knowledge regarding the reside to make necessary of the survey in the surv	OINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 165 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 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	CORRECTION Dentification Number: Dentificat	OPPORT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 165 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 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	ROVIDER OR SUPPLIER ONT SUB-ACUTE AND REHAB CAPITOL HILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAY BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 165 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 2:22 PM with Employee 's #2, #3, and #4. The employees made the following responses related to the 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 thereapist and the Nurse Practitioner in order to increase the knowledge base of staff and safety of	CORRECTION O95027 B. WING

NAME OF PROVIDER OR SUPPLIER BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL SUMMANY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MAY SEPRECED BY YILL REGULATORY TAG (EACH DEPICENCY MAY SHOULD BE CARREST OF THE OPEN SHOULD BE CA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
RRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL PRAPID PROPID PRAPID PRAPID PROPID PRAPID PROPID PRAPID PRAPID PROPID PRAPID PROPID PRAPID PRAPID PRAPID PROPID PRAPID PRAPID PROPID PRAPID PRAPID PRAPID PRAPID PRAPID PRAPID PRAPID PRAPI			095027	B. WING			09/	23/2015
FREETY TAG (EACH DEFICIENCY MUST SE PRECEDE BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) F 493 Continued From page 166 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 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 once a shift, and that the internal ventilator			ND REHAB CAPITOL HILL		70	00 CONSTITUTION AVE. NE	,	
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 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	PRÉFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REGULATORY	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
	F 493	dependent. Employee #3 and Employee #6 did not identify and educated to staff ventilator decented by the staff ventilator decented by the staff ventilator decented by the staff ventilator of the st	and #4 acknowledged that be the required skills to be the nursing personnel needed apendent residents in the facility. In the facility staff should be outlined the when a Rapid Response is the in the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be formal in the area that requires the original state into the area that requires the original state in the graphism and that they are in the graphism and that the external residents did not have a battery was low, and stated that the the that is assigned to that will check the external ventilator and that the internal ventilator	F.	493	POLICIES/APPOINT ADMN		

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		095027	B. WING	<u> </u>	09/23/2015	
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 493	facility was under re- Employee #3 ac document nor assess administration of pa Employee #3 ac staff were not follow weights for resident weight loss. And sta be the reason for so At this time, it was of Administrator, the D failed to provide nec lacked supervision of ventilator services; of staff accurately asse who received ventila physician when the changes, failed to ac with pain concerns; senous conditions re receiving ventilator as staff who worked wi needs and ventilator training to help prov and failed to ensure coded. It was determined the recognize and identi-	and #3 acknowledged that the enovation in some areas. Cknowledged that staff did not as residents prior to and after the in medication. Cknowledged that the facility ing the facility policy regarding is with significant unplanned atted that the new scales might one of the discrepancy. Determined that the irrector of Nursing and Educator residents who required failed to ensure that the nursing ressed and monitored residents after services, failed to notify the resident experienced acute sand failed to intervene on related to the care of residents and failed to ensure that the resident requiring special received education and ide quality care and services that CAAs were accurately	F 49	483.75(d)(1) (2) GOVERNING BODY FACILIT POLICIES/APPOINT ADMN Refer to page 162 for response.	Y	

	F CORRECTION	IDENTIFICATION NUMBER:	1 ` ′		COMPLETED
		095027	B. WING		09/23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL	7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 493 F 514 SS=E	and implement appridentified quality det 483.75(I)(1) RES RECORDS-COMPL. The facility must maresident in accordar standards and practically organ. The clinical record resident's assessment sassessment services provided; the screening conducted notes. This REQUIREMENT. Based on record refour (4) of 60 samp that the facility staff records in accordant standards and practical physician failed to dintervention for would see the services provided.	ropriate plans of action to correct ficiencies. ETE/ACCURATE/ACCESSIBLE intain clinical records on each nice with accepted professional tices that are complete; need; readily accessible; and	F 493		
	in the clinical record resident's change in	es were accurately documented is and to document one (1) a condition, and subsequently a called. Residents # 43, #108,			

	CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		095027	B. WING			09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002	1 00/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	1. The physician fai intervention for wou #43. On September 18, 2 a review of the adm revealed that Resid facility on April 22, 2 s history and physic the resident's diag ulcer and Immobility Review of the physical August 31, 2015 revision following: "Cleans saline, pat dry with care dressing Ag [stressing daily." Review of the 'Worecords revealed that dressing changes with the physician's order; care documentation & Plan' section of the September 10, 2015. "Continue dry prote absorbing agent -pr Solution- once daily On September 18, 2 a telephone interviee Employee #9 regard documentation and	led to document accurate and care treatment for Resident 2015 at approximately 12:15 PM, ission note revealed and ent #43 was admitted to the 2011. A review of the physician 'all dated May 1, 2015 revealed nosis included a Stage 3 sacral //. cian 's orders signed and dated realed an order that directed the esacral ulcer wound with normal gauze. Apply Maxorb [wound silver] and cover with dry und Care Specialist Evaluation 'at the resident was not receiving rith Normal Saline as per instead, the following wound observed in the 'Assessment the August 20, 2015 and 5 notes described the following: ective dressing once daily, silver in [as needed], Dakin 's cleanse." 2015 at approximately 4:26 PM, wwas conducted with ding the aforementioned treatment. He/she explained, "I be receiving dressing changes	F	514	483.75(I)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE Response to #1, Residents 43 1. There was no adverse effect to the wound heaprocess because the 'actual' treatment being of was saline. The error was in the report submit 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 month review and reconciliation to ensure accuracy. Review reports submitted by consulting wound physician with signed physician order in medic record. 4. The RCCs or designee will audit the TAR to e all orders are documented and implemented audit findings will be reported to Risk Manage Subcommittee for three (3) months and a quar summary to Quality Assurance Committee un 100% compliance is demonstrated for three (3 months.	of I sal sure The ment terly til	11.10.2015

	F CORRECTION	IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION G	(X3) DATE SI	
		095027	B. WING _		09	/23/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 514	meant to switch my was reviewed on S 2. Facility staff faile of two residents' na documented in the #108 and 138. A. On September 1 PM, a review of the Resident #108 was December 19, 2014 Respiratory Failure Review of the Administration Recident Medicat Administration Reducumentation that spelled differently. spelled two differer On September 16, a face-to-face inter Employees #4 and and acknowledged reviewed on September 1 PM, a review of the Resident #138 was August 14, 2015 w Chronic Respirator Review of the Administory revealed done in the Review of the Review of the Administory revealed done in the Review of the Review of the Review of the Administory revealed done in the Review of the Administory revealed done in the Review of the Review of the Administory revealed done in the Review of th	or notes to saline. "The record reptember 18, 2015. The detect of the correct spelling arms were accurately clinical records for Residents' The fact of the facility on the facility on the detect of the facility on the findings. The record was facility on the facility on the diagnosis that included the facility on the diagnosis that included	F 5	14 483.75(I)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIB Response to #2A, 2B, Residente 1. Immediately upon notification, the resident #108 and #138 were on the medical record. 2. An audit of the medical records and none were found to have be 3. The MDS Audit Tool was revise verification of the spelling of residents and uring admission, utilizing all avinformation by the MDS Coordine 4. Results of the MDS audit will Management Subcommittee for a quarterly summary to Quality Committee until 100% compliant for three (3) months.	he names of corrected within was reviewed een affected. Indicate the corrected within was reviewed een affected within was reviewed een affected.	11.10.2015

	F CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED	'
		095027	B. WING		09/23/201	15
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	(5) LETION ATE
F 514	Controlled Medication Set [MDS] dated Auresident 's name was resident 's name was the clinical record. On September 16, 2 a face-to-face interviewed in September 16, 2 a face-to-face interviewed on September 17, 2 a facility staff failed Resident #132 's charapid response was a face-to-face in Nursing Center, P9/2013 stipulates: "Staff Nurse: 1. Anyous Emergency Cart to the Resident 's chart more room-anyone can broated the change wiphysician about the response. 4. The SI rapid response emetraffic. 5. The SNF Collowing: a. Change include the disposition the 24 hour report the resident, c. SNF supervisor 's report.	on Record ' and Minimum Data gust 23, 2015 revealed the as spelled differently. The as spelled two different ways in 015 at approximately 1:40 PM, iew was conducted with ding the aforementioned iewed the records and indings. The record was aber 10, 2015. If to document the events of lange in condition, subsequently is called. If the speciations of the SNF one on the unit can bring the he resident 's room. 2. The Charge Nurse who ll give report to the house events leading up to the rapid NF Supervisor will record on the regency form and direct staff charge Nurse will complete the in Condition Nurse 's notes to on of the resident, b. Document to include the disposition of Supervisor document on	F 514	483.75(I)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE Response to #2, B, Residents #108 and # Refer to page 171 for response.	138	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING		-	09/:	23/2015
	SUMMARY ST (EACH DEFICIENCY MUST	ID REHAB CAPITOL HILL ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG	70 W	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE VASHINGTON, DC 20002 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
	<u></u>		DEFICIENCY)				
F 514	14 Continued From page 172 with diagnoses to include Anoxic Brain Injury, Coronary Artery Disease Status post Acute Myocardial Infarction (AMI), Diabetes Mellitus, Sacral Decubitus Ulcer and Sepsis. [This was a closed record review]		, F:	514	483.75(I)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE Response to #2, B, Residents #108 and #13 Refer to page 171 for response.	88	
		er Form dated June, 2015, R [Cardiopulmonary					

	CORRECTION	IDENTIFICATION NUMBER:					PLETED
		095027	B. WING_			09/	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AI	ND REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE (ASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	facility 's protocol, needed] from the st writer made rounds [his/her] indwelling {physician 's name foley size 16F [Frer At 4:30AM, the CN/started [his/her] AM bathed [him/her] in The writer went to [finger stick and rest [milligrams/deciliter administered of Norobserved. At approwent to hanf [his/het then found the resid Supervisor was not in-house doctor not scene, 911 called a with the police offic 73/49, 144 and 66/4911 came and took take resident with the [indicates the heart no electrical activity [Emergency Medica corpes of the reside pronounced death to The Supervisor con Detective [name] ca 6AM and asked the	AM Rounds were made as per every 2 hr [hours] and PRN [as art of the shift. At 4AM the on the patient and observed catheter leaking. Call placed to] to get an order to change the high] to 18F, but no call back yet. A [Certified Nursing Assistant] I rounds, [He/she] washed and bed. [He/she] finished at 5AM. him/her] at 5:10 AM and took the	F	514	483.75(I)(1) RES RECORDS COMPLETE/ACCURATE/ACCESSIBLE Response to #2, B, Residents #108 and # Refer to page 171 for response.	138	
		nce that the nursing					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION		TE SURVEY MPLETED
		095027	B. WING		09	9/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514 F 520 SS=E	condition and the ra specified in the facili Facility staff failed to change in condition, response was called A face-to-face interv Employees #2 and # regarding the aforen acknowledged the fi reviewed on Septem 483.75(o)(1) QAA C QUARTERLY/PLAN	atted Resident #132 's change in pid response events as ity 's policy. In document Resident #132 's and subsequently a rapid l. It iew was conducted with f3 on September 21, 2015 mentioned findings. He/she and indiges. The clinical record was aber 21, 2015. OMMITTEE-MEMBERS/MEET IS	F 51		EET	
	assurance committee nursing services; a p facility; and at least staff. The quality assessm meets at least quarter respect to which quarter activities are necess implements appropriate identified quality defined the records of such disclosure is respected.	ain a quality assessment and e consisting of the director of obysician designated by the 3 other members of the facility's ment and assurance committee early to identify issues with ality assessment and assurance early; and develops and late plans of action to correct iciencies. Letary may not require disclosure the committee except insofar as elated to the compliance of such equirements of this section.		·		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		095027	B. WING		09/23/2015
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F 520	correct quality deficitions basis for sanctions. This REQUIREMEN Based on observative staff interviews, it was Quality Assessment Committee failed to revise appropriate or physician when there condition; to provide maintenance services sanitary, orderly, and that resident assess initiated and revised ensure that services facility must be provided to maintenance with eactive accordance with eactive accordance with eactive accordance with the attained/maintained physical, mental, and accordance with the and plan of care; to were provided to maintenance accordance with the and plan of care; to were provided to maintenance accordance with the and plan of care; to were provided to maintenance accordance with the and plan of care; to were provided to maintenance accordance with the and plan of care; to were provided to maintenance accordance with the and plan of care; to were provided to maintenance accordance with the accordance with t	by the committee to identify and encies will not be used as a a a a a a a a a a a a a a a a a a	F 52	 483.75(o)(1) QAA COMMITTEE MEMBERS/M QUARTERLY/PLANS See immediate corrective actions for all a concerns cited A preliminary meeting was held with dep managers responsible for areas of concereview existing systems and processes; breakdown in systems and processes; breakdown in systems and processes; deffectiveness of current protocols and, pound procedures. The Dir. Of Quality Assurance will revise program to: Identify root causes for areas concerns cited; Determine resources need data collection, analyses, monitoring; Deaction plans relevant to process and systemsure sustainability; and facility-wide edit QAPI process. All quality assessment findings and status/outcomes of action plans will be re Executive Team and Governing Body at intervals to ensure Nursing Center is opermaintaining substantial compliance with regulations, DCMR chapter 32, and other professional standards. 	reas of artment m to dentify etermine licies the QA of ded for relop erns to ication on 11.10.2015 & ongoing ported to scheduled rating and all Federal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING			09/:	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 00 CONSTITUTION AVE. NE VASHINGTON, DC 20002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	daily basis to include regulation; to ensure labeled and stored; care equipment was ensure that the resid in a safe and operat facility maintained at to ensure that location Assessment informat (MDS) under Section with state and local	rse staffing information on a e all components per the e that medications were properly to ensure all essential resident in safe operating condition; to dent call system was maintained ing condition; to ensure that the n effective pest control program; on and date of Care Area ation on the Minimum Data Sets in V was complete; to comply laws and regulations; and to ords in accordance with	F	520			
	The findings include	:			483.75(o)(1) QAA COMMITTEE MEMBERS/MEI QUARTERLY/PLANS	द्य	
		ation survey from September 9 - ing areas of concern were			Refer to page 176 for response.		
	 Failure to ensure that facility staff notified the attending physician when a resident did not receive a vaccine as ordered. 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 						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE A	ND REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BI	
F 520	railure to ensuarranged by the fact qualified persons it is written plan of ca (3) (ii), F282 Failure to ensuand the facility proservices to attained practicable physical well-being, in accoassessment and plass. 25, F309 Failure to ensuprovided to maintal activities of daily lival 483.25(a) (3), F312 Failure to ensuand treatment to proceed to ensure the failure to ensure mains as free of Cross reference Classifications acceptable parametrol body weight. Crossification Failure to ensuproper treatment and Cross reference 48 Failure to ensuproperly labeled and 483.60 (b), (d), (e), Failure to ensuequipment was in seference CFR 483.60 (c), (d), (e), Failure to ensuequipment was in seference CFR 483.60 (c), (d), (e), Failure to ensuequipment was in seference CFR 483.60 (c)	are that services provided or cility must be provided by a accordance with each resident 're. Cross reference 483.20 (k) are that each resident received wided the necessary care and d/maintained the highest al, mental, and psychosocial redance with the comprehensive an of care. Cross reference are the necessary services was in good hygiene and to carry out wing. Cross reference CFR are provision of necessary care romote healing of wound (s). FR 483.25(c), F314 are that the resident environment accident hazards as is possible. FR 483.25, F323 are that a resident maintains exters of nutritional status, such as a reference 483.25 (i), F325 are that a resident staff was a quality care and services. 33.25(k), F328 are that sufficient staff was a quality care and services. 33.30 (a), F353 are that medications were and stored. Cross reference F431 are all essential resident care safe operating condition. Cross	F	483.75(o)(1) QAA COMMITTEE MEN QUARTERLY/PLANS Refer to page 176 for res		त्त ा

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		095027	B. WING		<u> </u>	09/	23/2015
	ROVIDER OR SUPPLIER	ID REHAB CAPITOL HILL		70	REET ADDRESS, CITY, STATE, ZIP CODE O CONSTITUTION AVE. NE ASHINGTON, DC 20002	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 520	reference CFR 483. Failure to ensure effective pest control 483.70(h)(4), F469 Failure to compregulations. Cross Failure to ensure maintained in accorprofessional standa 483.75, F514. Failure to ensure Area Assessment in Sets (MDS) under S483.20, F272 On Tuesday Septem 2:20 PM a face-to-fa approximately 2:28 and #4. The employ responses related to during the survey: Employee #4 st Assessment and Asconference conduct he/she was not awaregarding the reside Employee #3 st a potential problem	working condition. Cross 70, F463 re that the facility maintained an oll program. Cross reference ly with state and local laws and reference CFR 483.75, F492 re that clinical records were dance with accepted rds. Cross reference CFR e that location and date of Care aformation on the Minimum Data section V was complete. CFR The program of the province of the province of the quality concerns identified attended that during the Quality and surrance Review Committee and on September 18, 2015 that are that there was a problem and that there was a problem and that the lends are that could arise as a result of his/her and are and treatment are that the care and treatment.	F	520	483.75(o)(1) QAA COMMITTEE MEMBERS/ME QUARTERLY/PLANS Refer to page 176 for response.	ET	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095027	B. WING_			09/2	23/2015
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, 2 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 520	result of the Immedicorrection was deveral assessment and do system and In-serving Respiratory therapis order to increase the safety of the resider dependent. Employee #3 are Employee #6 did not identify and educate to staff ventilator deto staff ventilator defin called for a resident what documentation. Employee #2 are Resident Care Area program problem sit and that the program information to popul the date and location found. Employee #3 actime there is one (1) Medicare A resident process of exploring join the wound team	anake necessary changes. As a late Jeopardy (IJ) a plan of eloped regarding physical cumentation of the respiratory ces were conducted by the st and the Nurse Practitioner in the knowledge base of staff and ents who are ventilator. In the stand the Nurse Practitioner in the knowledge base of staff and ents who are ventilator. In the stand the required skills to enthe the required skills to enthe enthe enthe personnel needed pendent residents in the facility. In the facility staff should be outlined the when a Rapid Response is in the facility and by who and a should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the should be completed. In the facility and by who and the facility and by who and the should be completed. In the facility and by who and the facility and the fa	F5	483.75(o)(1) QAA COMMITT QUARTERLY/PLANS	TEE MEMBERS/MEI 76 for response.	ET	

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095027	B. WING			09/	23/2015	
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	ID REHAB CAPITOL HILL		70	TREET ADDRESS, CITY, STATE, ZIP CODE OO CONSTITUTION AVE. NE /ASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 520	a battery or that the the respiratory thera particular resident walarms once a shift, alarms are checked Employee #2 ar facility was under re Employee #3 ac document nor assess administration of paid and staff were not follow weights for residents weight loss. And stabe the reason for so At this time, it was defined to provide necestated supervision for ventilator services; fastaff accurately asses who received ventilator services; fastaff who worked with pain concerns; serious conditions receiving ventilator staff who worked with	ventilator residents did not have battery was low, and stated that pists that is assigned to that vill check the external ventilator and that the internal ventilator every four (4) hours. In #3 acknowledged that the novation in some areas. Exhowledged that staff did not is residents prior to and after the in medication. Exhowledged that the facility ing the facility policy regarding is with significant unplanned ted that the new scales might me of the discrepancy.	F	520	483.75(o)(1) QAA COMMITTEE MEMBERS/MEI QUARTERLY/PLANS Refer to page 176 for response.	ET		

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

and PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		B. WING _		09/23/2015		
	ROVIDER OR SUPPLIER POINT SUB-ACUTE AN	D REHAB CAPITOL HILL		STREET ADDRESS, CITY, STATE, ZIP CODE 700 CONSTITUTION AVE. NE WASHINGTON, DC 20002	1 0011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	It was determined th Assurance Committe identify the necessal needed to provide so residents; and devel	ge 181 and services and failed to ere accurately coded. at the Quality Assessment and ee failed to recognize and ry care concerns and services afe and competent care to oped and implement action to correct identified	F 52	483.75(o)(1) QAA COMMITTEE MEMBERS/ME QUARTERLY/PLANS Refer to page 176 for response.	ET	

(X2) MULTIPLE CONSTRUCTION