DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. BUILDING ______ B. WING ______	10/21/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification Quality Indicator Survey was conducted on October 15, 2015 through October 21, 2015. The following deficiencies are based on observation, record review, resident and staff interviews for 30 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass)	F 000		12/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11-20-15

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

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F 000	Continued From page 1 MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set MRR - Medication Regimen Reviews Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		12/31/15

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F 279	Continued From page 2 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 40 sampled residents, it was determined that facility staff failed to develop a comprehensive care plan with goals and approaches to address one (1) resident ' s respiratory needs for ventilator services. Resident #58. The findings include: A review of Resident #58 ' s clinical record revealed diagnoses that included " Respiratory Failure; Vent [Ventilator] Dependent. " Review of the October 2015 physician ' s orders revealed the following ventilator settings: "AC [Assist Control -ventilator mode of the way a breath is delivered], RR [Respiratory Set Rate - breaths per minute] 12, TV [tidal volume- The amount of volume inhaled in the lungs] 400, FIO2 [fraction of inspired oxygen- percent of oxygen a patient is inhaling] 40%,	F 279	1. Resident # 58 was not affected by the deficient practice of no respiratory care plan in the clinical record. The respiratory care plan was put into the chart immediately upon identification of the omission. Other residents on the unit charts were assessed and care plans were found to be compliant. 2. Other resident with the potential to be affected by the deficient practice will be identified upon admission and/or with change in status for ventilator services (i.e. settings, etc.) All residents on ventilators charts were reviewed and showed respiratory care plans were in place appropriately with goals and approaches. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Upon admission physician orders will be reviewed for specific vent settings and other interventions to be rendered by the care team. • Manager will activate a comprehensive care plan with goals and approaches for residents with respiratory needs for ventilator/ respiratory services.	12/31/15

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F 279	Continued From page 3 PEEP [Positive End Expiratory Pressure -maintains lung expansion to help get oxygen from the lungs into the bloodstream.] 5. " Under Respiratory Treatments of Section O- Special Treatments, Procedures, and Programs of Resident #58 ' s Significant Change Minimum Data Set dated August 2, 2015, the resident was coded as having a " ventilator or respirator. " Review of the nursing notes dated October 17-21, 2015 revealed that the resident was receiving ventilator services. The clinical record lacked evidence of a care plan to address the resident ' s respiratory needs and/or ventilator services. On October 20, 2015 at approximately 2:35 PM, a face-to-face interview was conducted with Employee #3, who was asked to provide the care plan that addressed the resident ' s respiratory needs. He/she reviewed the record and acknowledged that there was no care plan to address the respiratory needs of the resident. The record was reviewed on October 20, 2015.	F 279	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
F 286 SS=D	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for 30 of 30 residents with MDS assessments in a sample of 57 residents; it was determined that facility staff failed to ensure the MDS (Minimum Data Set) assessments were readily and easily	F 286	1. There were no residents affected by the deficient practice of lack of access to the MDS. 2. Other resident with the potential to be affected by the deficient practice will be identified upon staff attempt to access MDS data. MDS Coordinator held an immediate in-service for staff on the unit on the process for accessing the MDS.	12/31/15

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F 286	Continued From page 4 accessible to all professional staff members, including consultants. The findings include: According to Chapter 2.3 of the MDS 3.0 RAI Manual " In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record. Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident." On October 19, 2015 at approximately 10:15 AM, a clinical record review was conducted for Resident #51. At this time, Employees #8 and #11 were was asked to access the MDS, as the facility maintains the MDS electronically. Both employees stated that they could not access the MDS system. A face-to-face interview was conducted with Employee #3 in the presence of Employee #2 on October 19, 2015 at approximately 10:20 AM. He/she was asked to access the MDS for review. He/she explained that he/she had access, but would call the MDS Coordinator to assist. Employee #2 explained that he/she was unaware that all the nurses needed access to the MDS, but would work on providing access for the staff.	F 286	The QA nurse implemented a listing of remaining staff to do ongoing in service to enable MDS access. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The QA nurse will identify all nursing staff required to have access to the MDS and receive pass code to access the MDS. • The QA nurse, MDS Coordinator, and/or designee will in-service the licensed staff on how to accurately access the MDS data in ECS (Electronic Charting System). • An audit tool has been developed to randomly monitor compliance of staff's ability to access 15 months of MDS, along with consultants, on demand. • QA nurse will work in collaboration with the IT department to obtain pass codes. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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F 286	Continued From page 5 There was no evidence that facility staff ensured that all staff and consults had access to the MDS system for review.	F 286		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 287	1. There were no residents affected by this deficient practice. All late MDS transmission were submitted and accepted. 2. Other resident with the potential to be affected by the same deficient practice of late transmissions will be identified upon admission to the SNF, including the current residents in the SNF, in need of data transfer. MDS Coordinator reviewed all MDS data for transfer and those that were defiant were successfully transmitted and resolved on each resident. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The facility will ensure that the alternate MDS Coordinator has the appropriate identification so that all MDS transmittals are submitted at the appropriate times as outlined by the regulatory guidelines.	12/31/15

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F 287	Continued From page 6 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that facility staff failed to electronically transmit a Minimum Data Set [MDS] Assessment to the Centers for Medicare and Medicaid Services [CMS] System to reflect one (1) resident's status, who had returned to the facility. Resident #51. The findings include: Chapter 5.2 of the MDS 3.0 RAI Manual, "Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days). Tracking Information Transmission: For Entry and Death in Facility Tracking records, information must be transmitted within 14 days of the Event	F 287	• The facility will ensure that the alternate MDS Coordinator be available to assist in completing and transmitting scheduled Medicaid MDS, particularly when there is an increase in the number of Medicare residents admitted to the SNF. • The senior MDS Coordinator will activate the alternate MDS Coordinator in a timely manner to maintain compliance of all MDS transmission. • The Senior MDS Coordinator will review and ensure compliance of discharge and entry tracking is maintained, per guidelines. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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F 287	Continued From page 7 Date (A1600 + 14 days for Entry records and A0200 + 14 days for Death in Facility records)." On October 20, 2015 at approximately 10:10 AM, a review of the clinical record revealed that Resident #51 was discharge and readmitted to the facility as follows: · Transfer out of the facility on August 26, 2015 for vomiting · Returned to the facility on September 10, 2015. There was no evidence that facility staff completed and submitted Discharge and Entry Tracking information for Resident #51. On October 20, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #10. Employee #10 was asked to provide Resident #51's most recent MDS for review. The most recent MDS presented was the Admission MDS, dated August 11, 2015. Employee #10 further stated, "The resident had six different entries in the system and that MDS was in the hold status; therefore, it was not transmitted." There was no documented evidence that facility staff transmitted the MDS assessment information for Resident #51.	F 287		
F 309 SS=D	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	F 309		12/31/15

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F 309	Continued From page 8 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for three (3) of 30 sampled residents, it was determined that facility staff failed to provide the necessary care and services to ensure resident's attain or maintain the highest practicable state of well-being as evidenced by: failure to obtain a physician ' s order to flush intravenous access sites for two (2) resident ' s and failed follow physician ' s order to obtain a dietary consult and laboratory test for one (1) resident. Residents' #13, 74, and 82. The findings include: Lippincott, Williams & Wilkins, 2010 stipulate, " Performance phase: 1.Clean the port of the saline lock with alcohol. Insert a normal saline syringe need into the port and aspirate slightly. 2. Inject normal saline solution slowly to flush the reservoir of saline or heparin solution and blood ...5. Insert medication tubing, administer the drug, and infuse at the prescribed rate. 6. After drug or solution administration, insert the saline syringe and flush the reservoir slowly. Remove the syringe while still pushing the plunger of the syringe to ensure positive pressure. " (p. 91). 1. Facility staff failed to obtain a physician ' s order to flush an intravenous access sites Resident #13 who received medication intravenously.	F 309	1. Resident's, 13 and 82, were not affected by the deficient practice of not having a flush order for IV medications. Other residents on the unit MARs were checked for compliancy with S.AS.H (saline, administration, saline, heparin) IV process. 2. Other residents having the potential to be affected by the same deficient practice of not having flush orders will be identified by reviewing the physician orders upon admission or any subsequent IV medication orders or changes. All residents receiving IV medications MARs and charts were reviewed to ensure S.A.S.H orders were received and IV form was utilized. No other deficits noted. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Infusion medication administration record will be utilized by the nursing staff.	12/31/15

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Continued From page 9

A review of the physician ' s orders revealed the following:
" Meropenem [antibacterial medication] 250 mg intravenous q (every) 12 hours [until] 10/21/15 for UTI (urinary tract infection) "

A review of the October 2015 Medication Administration Record revealed that the resident received nine (9) doses of Meropenem, as evidenced by the staff signatures in the allotted signature boxes, from October 16 - 20, 2015 which indicated the medication was given as prescribed.

A face-to-face interview was conducted on October 20, 2015 at approximately 4:00 PM with Employee #11. He/she stated, " I flush with 10 milliliters(mls) of normal saline before and after I administer the medication. " He/she further acknowledged that there was no order written to flush and he/she didn ' t document that it was done.

There was no evidence that facility staff obtained an order to flush the intravenous line of Resident #13. The record was reviewed on October 20, 2015.

2. Facility staff failed to follow a physician ' s orders to obtain a dietary consult and laboratory test for Resident #74.

A review of the resident ' s clinical record revealed the following Physician ' s orders:

" (1) Weigh pt. (patient) every 2 weeks x 4 weeks due to weight loss = 9lb in one month. Dietician consult for weight loss. (3) TSH (Thyroid

F 309

- Audit tool developed for random audits will be done by nurse manager to ensure S.A.S.H (saline, administration, saline, heparin) orders are in place.
- Staff will be re-educated on the importance of obtaining flush orders for any IV medication order that is written but does not have a flush order.

4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.

1. Resident #74 was not affected by the deficient practice. There were no further incidence of lab work and dietary consults not carried out per physician orders for other residents on the unit.

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F 309	Continued From page 10 Stimulating Hormone), Prealb (Pre-albumin) & albumin [levels] in am. " A review of the resident ' s clinical record failed to reveal any evidence of a dietary consult and/or reports of the requested laboratory tests (TSH, Pre-albumin and albumin). A face-to-face interview was conducted with Employee #2 at approximately 11:30 AM on October 20, 2015. After reviewing the record the employee acknowledged the Physician 's orders had not been carried out. The record was reviewed on October 20, 2015. 3. Facility staff failed to obtain a physician ' s order to flush an intravenous access site for Resident #82 who received medication intravenously. A review of the physician ' s orders revealed the following: " Meropenem 500 mg intravenous q (every) 8 hours until 10/18/15 last dose ...for Pneumonitis " A review of the October 2015 Medication Administration Record revealed that the resident received 11 doses of Meropenem as evidenced by the staff signatures in the allotted signature boxes from October 15 - 18, 2015 which indicated the medication was given to the resident. A face-to-face interview was conducted on October 19, 2015 at approximately 2:58 PM with Employee # 8. He/she stated, "[Resident name] has a peripheral IV (intravenous line) in the left hand. I flush with normal saline 10mls. I give the	F 309	2. Other residents having the potential to be affected by the same deficient practice will be identified upon admission and/or physician orders. All residents with dietary and lab orders were checked and carried out, as ordered. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Nursing staff to notify dietician that an order for consultation has been written. • Dietary consults will be carried out within 72 hours to prevent delay in treatment. • Lab values will be checked daily to monitor for compliance with physician notification, whether normal or abnormal. • Audit tool developed to monitor physician lab notification compliance. • The 24 hour chart check process will be re-inserviced to track if orders are complete and accurate.	12/31/15

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F 309	Continued From page 11 medication and I flush again with ns 10mls and that was it. It [an order to flush] should have been here [on the medication administration record]. I did not document the SAS (saline, antibiotic, saline). " There was no evidence that facility staff obtained an order to flush the intravenous line of Resident #82. The record was reviewed on October 19, 2015.	F 309	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. Resident # 80 was not affected by the deficient practice of non-monitoring of anti-psychotic medication usage. The behavior monitoring flow record was implemented upon recognition of omission. 2. Other residents with the potential to be affected by the same deficient practice will be identified by written orders for anti-psychotic medications. All residents receiving anti psychotics, MARs were reviewed to see if behavioral monitoring was in place. Behavioral flow sheets were in place. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The admission nurse will review physician orders for the presence of antipsychotic medication and immediately implement the Behavior Monitoring Flow Record to track behaviors.	12/31/15

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F 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 sampled residents, it was determined that facility staff failed to ensure that Resident # 80 was free from unnecessary medications as evidenced by failure to adequately monitor the resident who received antipsychotic drugs. The findings include: A review of the Resident # 80 ' s clinical record revealed that he/she was admitted with diagnoses which included; respiratory failure, aspiration pneumonia hypertension, and psychosis. Physician's orders dated and signed October 2, 2015 included; Geodon (an antipsychotic used to treat schizophrenia) 20 mg GT [gastrostomy tube] [by mouth] BID [two times a day] and Haldol (an antipsychotic used to treat schizophrenia) 10 mg GT [gastrostomy tube] q12 hrs. [every 12 hours] for psychosis. The October 2015 Medication Administration Record (MAR) indicated resident was receiving the prescribed medications. A review of the Resident #80 ' s October 2015 Behavior Monitoring Flow Record [Nurses' notes] and or Treatment Records failed to reveal any evidence that Resident # 80 was being monitored for signs of psychotic behaviors. A face-to-face interview was conducted with	F 329	• The QA nurse/designee will re-inservice nursing staff on the importance of monitoring for episodes of psychotic behaviors and/or noted changes (better or worsening). • Monthly audit tool will be implemented to ensure that we are in compliance. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15

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F 329	Continued From page 13 Employee #2 at approximately 11:00 AM on October 21, 2015. When queried regarding the lack of documentation related to the behavioral monitoring he/she acknowledged that it was not being done. The record was reviewed on October 21, 2015.	F 329	1. The one pan of raw chicken that was stored above a package of beef was removed at the time of survey. The one and one half pans of tuna fish that was stored for use beyond the expiration date was removed at the time of survey. 2. No resident was affected by this deficient practice. All other food items were checked for proper storage, preparation, distribution and being served under sanitary conditions. No other issues were found. 3. The Director of Food Services or designee will reeducate staff on the preparing and serving food under sanitary conditions. The Director of Food Services or designee audit daily to assure compliance. 4. The Director of Food Services or designee will report the finding these daily audits at the Quality Assurance Committee meeting quarterly.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a tour of the dietary services on October 16 and 20, 2015, it was determined that the facility failed to prepare and serve food under sanitary conditions: one (1) pan of improperly stored raw chicken and beef, and one (1) expired pan of tuna fish. The findings include: 1. One (1) of one (1) pan of raw chicken was stored above pan that contained a package of beef. 2. One (1) of one (1) half pan of tuna fish was stored for use beyond the expiration date. These observations were made in the presence	F 371		12/31/15

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F 371	Continued From page 14 of Employee # 9 who acknowledged these findings.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview for two (2) of 30 sampled residents, it was determined that the facility staff failed to act upon reported recommendations from the Medication Regimen Reviews (MRR) by the pharmacist for Resident # ' s 39 and 80. The findings include: 1.The facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #39. A " Physician ' s Order " signed and dated October 1, 2015 directed, " Citalopram 10 mg Tablet (Celexa)1 tab[tablet] via G-Tube [gastrostomy tube] every day for depression"	F 428		12/31/15

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F 428	Continued From page 15 A review of the August 11, 2015 pharmacy consultation report read: " Resident #39 has received citalopram 10 mg for management of depressive symptoms since 7/20/13. Please consider gradual dose reduction, perhaps decreasing to 5mg daily while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms. " There was no evidence that the pharmacist's August 11, 2015 recommendations were acted upon by the physician. A face-to-face interview was conducted with Employee #4 on October 21, 2015 at approximately 11:15 AM. He/she acknowledged the aforementioned findings. The record was reviewed on October 21, 2015. 2. The facility staff failed to act upon reported irregularities from the Medication Regimen Reviews (MRR) by the pharmacist for Resident #80. A "Physician ' s Order" signed and dated October 2, 2015 directed: " Geodon 20mg /gt [by gastrostomy tube] BID [twice a day] for psychosis; and Haldol 10mg /gt [by gastrostomy tube] q12 hrs. [Every 12 hours] for psychosis. " A review of the Pharmacy consultation report revealed, " [Resident #80] receives two antipsychotic medications Haloperidol, Ziprasidone HCL [Geodon] concomitantly. Please consider gradual dose reduction of haloperidol with eventual discontinuation while monitoring for re- emergence of target and or withdrawal	F 428	1. Resident's, 39 and 80, were not affected by the deficient practice of facility not acting upon pharmacy recommendation for gradual reduction and /or discontinuation of anti-psychotic medication. Nurse Practitioner immediately corrected the irregularity on identified residents. 2. Other residents with the potential to be affected by the same deficient practice will be identified upon presentation of report by consultant pharmacist. Nurse Practitioner will continue to review consultation reports to accept and/or decline recommendations in collaboration with the physician and psychiatrist. Nurse practitioner reviewed all pharmacy recommendations and corrected all irregularities to meet the need of all residents on psychotics. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Behavioral monitoring tool will continue to be utilized with shift to shift completion by nursing staff, as warranted.	12/31/15

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F 428	Continued From page 16 symptoms. The combined use of two or more antipsychotic medications complicates the drug regimen and increases the potential adverse for adverse events. " There was no evidence that the pharmacist's October 13, 2015 report of irregularity recommendations were acted upon by the physician. A face-to-face interview was conducted with Employee #4 on October 21, 2015 at approximately 11:15 AM. A query was made regarding whether the pharmacist ' s MRR was addressed. Employee #4 acknowledged the aforementioned findings. The record was reviewed on October 21, 2015.	F 428	• DON/Nurse Managers will review monthly pharmacy consultation reports, immediately upon receipt. • Nurse practitioner/Primary Physician/Psychiatrist will address all pharmacy recommendations by indicating if the recommendation irregularities were declined or accepted. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	1. Resident #1 was not affected by deficient practice of expired medications on cart. There was no documentation of resident utilization of the expired medications and medications were removed from the cart immediately once noted. Other residents' medications were not expired. 2. Other residents having the potential to be affected by the same deficient practice of expired medications will have all medications checked for expiration dates prior to medication administration. All medication carts were reviewed to inspect for expired medications. No expired medication noted.	12/31/15

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F 431	Continued From page 17 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that facility staff failed to discard expired medications stored in one (1) of two (2) medication carts on Nursing Unit 1. The findings include: The medication storage observations were done on October 16, 2015 at approximately 1:00 PM and revealed the following: Resident #1 had three (3) tablets of Lorazepam 1mg stored for use. The expiration date on the package was 9/30/2015. The observation was made in the presence of Employee #4. He/she acknowledged the findings.	F 431	3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Nurses will be re-educated on importance of utilizing all medications in a timely manner to prevent expired medications in cart. • Nursing staff will be re-educated to monitor for expiration dates of all medications prior to administering to the resident. • Audit tool developed to monitor medication/narcotic expiration dates compliance. • Expired medications will be removed in the appropriate manner from the medication cart. • All medication cart s will be randomly checked for compliance of non-expired medication boarding. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 18 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	1. The four bottle of Salinaax eye wash flush that were observed stored for use with an expired date were removed and discarded at the time of the survey. 2. No resident was affected by this deficient practice. No other expired eye wash flush was found. 3. The Director of Food Services or designee will audit the eye wash stations monthly for expired eye wash flush to assure compliance. 4. Results of these audits will be reported at the Quality Assurance meetings quarterly by the Director of Food Services or designee.	12/31/15

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F 441	Continued From page 19 Based on observations and interviews during the initial tour of the kitchen on October 20, 2015 it was determined that the facility failed to help prevent the spread of infection as evidenced by failure to ensure that eye wash solution was not stored beyond the expiration date in four (4) of four (4) bottles observed; and one (1) nurse failed to sanitize his/her hands prior to the administration of antibiotic eye ointment for one (1) resident. Resident # 53. The findings include: 1. Facility staff failed to ensure that eye wash solution was not stored beyond the expiration date in the main kitchen. During the initial tour of the kitchen on October 20, 2015 at approximately 8:30 AM, it was determined that the facility failed to help prevent the spread of infection. Four (4) of four (4) bottles of Salinaax 16 fl oz (eye wash flush) were observed stored for use with an expiration date of June 2015. These observations were made in the presence of Employee #13 who acknowledged these findings during the survey. 2. During medication pass observations Employee # 8 failed to sanitize his/her hands prior to administering eye ointment to Resident # 53. A review of the Physician ' s order dated October 7, 2015 directed, " Erythromycin ophthalmic	F 441	1. Resident # 53 was not affected by the deficient practice of not sanitizing hands before the administration of eye antibiotic ointment. No other observations of improper hand sanitizing noted. 2. Other residents having the potential to be affected by the deficient practice will be identified upon personal care or medication administration. Licensed staff was immediately re-educated on the infection control policy. Random observation of medication pass revealed no infection control deficits. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Audit tool has been generated to randomly monitor hand hygiene (secret shoppers). • Nursing staff will be re-educated on the importance of glove usage, hand washing/sanitizing before, during, and after resident care/medication administration. • Infection control policy will be reviewed at staff meetings.	12/31/15

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F 441	Continued From page 20 5mg/1gm ointment bid [twice a day] [times] 7 days for left red eye. On October 15, 2015 at approximately 10:00 AM, Employee #8 was observed administering medications to Resident #53 via a gastrostomy tube with gloved hands. Employee #8 then proceed to administer an eye ointment medication to the resident ' s left eye, touching and holding the resident ' s lower lid without first sanitizing his/her hands. There was no evidence that facility staff sanitized his/her hands before administering eye ointment to the residents left eye to help prevent the spread of infection.	F 441	4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition as evidenced by: (4) of six (6) burners failure to ignite on the stove in the main kitchen. The findings include: During observational rounds in main kitchen on October 20, 2015 at approximately 10:00 AM four	F 456	1. Employee acknowledged that four out of six burners failed to ignite on the stove during the time of survey. The vendor was called to repair the stove. 2. No resident was affected by this deficient issue. All other essential equipment was checked for safe operating conditions. No other issues were found. 3. Upon inspection by the vendor, it was determined that the stove in its present condition needed to be replaced. The Director of Food Services has ordered a new stove and it will be delivered within the next 60 days.	12/31/15

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F 456	Continued From page 21 (4) of six (6) burners failed to ignite. These observations were made on October 20, 2015 at approximately 10:00 AM in the presence of Employee #9 who acknowledged the findings.	F 456	4. The Director of Food Services or designee will audit the essential equipment in the kitchen for safe operating conditions weekly. The result of this audit will be reported at the Quality Assurance Committee meeting by the Director of Food Services or designee quarterly.	
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 30 sampled residents, it was determined that the facility failed to promptly notify the attending physician of the laboratory [lab] findings for Resident # 5 . The findings include: A review of the Physician's orders dated August 14, 2015 directed, "Prolactin Level on 8/17/15 then q (every) 6 months." A review of the clinical record lacked evidence of Prolactin lab results. On October 20, 2015 Prolactin laboratory results for Resident #5 were presented, however, the results were obtained on October 19, 2015 subsequent to this surveyor's query. The results were observed to be within normal range. There was no documented evidence that the physician had been notified of the laboratory results for August 20, 2015 to present.	F 505	1. Resident #5 was not affected by the deficient practice of non physician notice, as lab value was normal. No other reporting of non-notification of labs. 2. Other residents having the potential to be affected by the same deficient practice will be identified upon delivery of results by the laboratory. The resident laboratory book was reviewed to assess if residents with lab orders were carried out and physician notified. No deficit noted. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The nursing staff will be re-educated on the importance of reviewing all resident labs daily and reporting immediately to the physician (whether normal or abnormal). • RCC or designee to monitor that all lab work is signed off by physician/NP.	12/31/15

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F 505	Continued From page 22 A face-to-face interview was conducted on October 20, 2015 at approximately 10:00 AM with Employee #2. He/she acknowledged the findings. The record was reviewed on October 20, 2015.	F 505	•Audit tool generated to monitor compliance of lab signatures by MD/NP on all lab reports. •Nurse will document physician notification in the chart, whether results are normal or abnormal. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 30 sampled residents, it was determined that the facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: the facility staff ' s failure to maintain an accurate clinical record for one (1) resident document tube feedings as ordered by the physician; and failed to document an accurate acquired date of a pressure ulcer for one (1) resident. Residents' #51. The findings include:	F 514	1. Resident # 51 was not affected by the deficient practice inaccurate transcribing of tube feeding order. Other residents with tube feeding orders were transcribed accurately. 2. Other residents having the potential to be affected by the deficient practice of not having accurately transcribed tube feeding orders will be identified when the MAR and the physician tube feeding orders are reconciled. Residents with tube feeding orders were reviewed for accuracy. Feeding orders were found to betranscribe accurately.	12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHABILITATION HADLEY	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23 1. A. Facility staff failed to accurately transcribe Resident #51 ' s tube feeding orders onto the Medication Administration Record [MAR] as written by the physician. On October 20, 2015 at approximately 10:10 AM, a review of the clinical record revealed that Resident #51 was re-admitted to the facility on October 19, 2015 with diagnoses that included Gastrointestinal Bleeding, Respiratory Failure, and Heparin Induced Thrombocytopenia, after being transferred to the emergency room for vomiting on October 7, 2015. Review of the physician ' s orders revealed an order dated October 19, 2015 that directed the following, " Enteral feeding: Formula Nutren 1.5 continuous rate 50 cc [cubic centiliters]/hr [hour] via feeding pump ... " Review of the October 2015 Medication Administration Record [MAR] revealed that licensed staff transcribed the order as follows: " GT [Gastrointestinal] feeding: Nutren 1.5 @ 50 mls [milliliters]/hr via GT x [for] 24 hrs [hours]. " The transcribed order was recorded as " 24-hours as opposed to the physician ' s order that read " continuous. " On October 20, 2015 at approximately 10:20 AM, a face-to-face interview was conducted with Employee #8, regarding the aforementioned findings. He/she reviewed the clinical record and acknowledged the findings. The record was reviewed on October 20, 2015. 1B. Facility staff failed to document an accurate acquired date of a pressure ulcer.	F 514	3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • Dietician and nursing staff will work collaboratively to ensure orders are transcribe correctly. • Nursing staff were re-inserviced on the importance of carrying out the 24 hour chart check to capture potential transcription errors. • The nurse will contact physician to clarify tube feeding orders to ensure correct feeding amounts. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings. 1. Resident # 51 was not affected by the deficient practice of lack of date of an acquired pressure ulcer. No other resident records were without appropriate date of pressure ulcer acquirement. 2. Other residents having the potential to be affected by the deficient practice of not having a date of pressure ulcer acquirement will be identified on wound and skin assessment rounding. The wound and skin	12/31/15

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F 514	Continued From page 24 Review of the nursing note dated September 17, 2015 at 8:00 AM revealed the following: " ... 3.2 x 8 cm [pressure ulcer] on sacral area. Area cleaned with dry dsg [dressing]. [Doctor named] notified with orders for skin consult ... " Review of the 'Wound Care Rounds ' sheet dated September 30, 2015 revealed the following: " Wound Type-Pressure, Location of Wound-Sacrum, Stage of Wound - Unstageble, Acquired September 23, 2015, Measurements - 3x3 cm ... " The clinical record revealed inconsistencies in the date that the pressure ulcer was acquired. The nursing note recorded a date of September 17th and the " Wound sheet revealed an acquired date of September 23rd. On October 20, 2015 at approximately 10:20 AM, a face-to-face interview was conducted with Employee #3 who was asked to explain when the sacral wound was acquired. He/she reviewed the clinical record and explained that the acquired date was on September 17, 2015. The record was reviewed on October 20, 2015.	F 514	assessment tool was reviewed and was found to have all accurately documented acquirement dates. 3. The following systemic changes will be implemented to ensure the deficient practice will not recur: • The nurse will immediately document in the clinical record the date in which the pressure ulcer was identified with accurate measurements. • The Quality Nurse will re-educate the nursing staff on the importance of correct wound care documentation to prevent inconsistencies. • Audit tool generated to do random audits for compliance with wound acquirement date. • The wound nurse will monitor the wound rounding sheet for documentation of wound acquirement dates and measurements and incorporate in the clinical record. 4. The quality assurance process will be utilized to maintain and sustain compliance. The findings will be presented at the quarterly QA meetings.	12/31/15