Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING _____ B. WING _____	10/20/2017

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

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L 000	Initial Comments The annual licensure survey was conducted at Bridgepoint Sub-Acute & Rehab National Harbor from October 12, 2017 through October 20, 2017. The following deficiencies are based on observation, record review and staff interviews. The census during the survey was 69 residents. A complaint investigation for C-18-004, DC00003454 was also conducted during this survey period of October 12, 2017 through October 20, 2017. 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	L 000	Please being typing here:	

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L 000	Continued From page 1 ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - 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	L 000		
L 024	3206.3 Nursing Facilities Policies shall be reviewed by the committee at least annually with written notations, signatures, and dates of review. This Statute is not met as evidenced by: Based on record review, and interview it was determined that the facility failed to comply with applicable federal, state, and local laws and	L 024	1. Facility's policies and procedures are being reviewed and revised and a sign-in sheet will be completed by Department Directors and Administrator after review and revision. 2. To identify other residents that have the potential to be affected:	

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L 024	Continued From page 2 regulations, as evidenced by failure to provide evidence that facility policies were reviewed annually. The findings include: District of Columbia Municipal Regulations for Nursing Facilities: "Policies shall be reviewed by the committee at least annually with written notations, signatures and dated of review." On October 19, 2017, at approximately 1:15 PM, during a policy review, it was revealed that the policies in the policy manual signature page were last signed and dated January 1, 2006. During a face-to-face interview on October 19, 2017, at approximately 2:30 PM Employee #2 who acknowledged the findings.	L 024	• Policies and procedures will be reviewed by the Department Directors and Administrator and revisions will be made as needed. 3. Systemic changes and measures: • In-service will be presented to Department Directors, Unit Managers, and RN Supervisors on importance of annual policy and procedure reviews, and signing-off on the reviews. • Tickler system will be established for annual review and signing-off on review. 4. Monitoring for performance and compliance: • Monitoring of upcoming review date will be placed on agenda and discussed quarterly at the Quality Assurance Committee Meeting.	11/30/17
L 055	3211.4 Nursing Facilities Beginning January 1, 2011, each facility shall have either a physician, physician assistant, or an advanced practice registered nurse, excluding hours per week attributed to medical director duties, available on-site for a minimum of two tenths (0.2) hours per week for each resident at the facility. This Statute is not met as evidenced by: Based on observations, policy/record review, and interviews, it was determined that the facility staff failed to comply with applicable federal, state, and	L 055	1. A memorandum is being issued to physicians requiring them to sign the "Physician Sign-In Book", when they come to the facility to provide care to a resident. 2. To identify other residents who have the potential to be affected: • Physicians are being informed that they need to sign-in when they come to the facility.	

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L 055	Continued From page 3 local laws and regulations, as evidenced by the staff's failure to ensure sufficient physician staff was available to provide available onsite physician hours for each resident weekly. The findings include: District of Columbia Municipal Regulations for Nursing Facilities -3211.4 : Beginning January 1, 2011 each facility shall have either a physician, physician assistant, or an advanced practice registered nurse, excluding hours per week attributed to medical director duties, available onsite for a minimum of two- tenths(0.2) hours per week or each resident at the facility. A review of the physician sign-in log on October 18, 2017, revealed no physician tracking hours were documented after April 2017. The facility failed to ensure that there were 0.2 hours per week physician hours per week from April 2017 to October 2017. During a face-to-face interview conducted on October 18, 2017, at approximately 3:00 PM, Employee#2 acknowledged the findings.	L 055	3. Systemic changes and measures: • Unit Secretary will reinforce to physicians, physician assistants, and advance practice nurses to sign-in when they visit residents. • Administrator will review sign-in book monthly. 4. Monitoring for performance and compliance: • The Administrator will present findings of review of the "Physician Sign-In Book", to the Quality Assurance Committee for 3 consecutive months, and quarterly thereafter.	
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on October 12, 2017 at approximately 9:15 AM, it was determined that the facility failed to store and serve foods under sanitary conditions as	L 099	1. 1. Based on record reviews and residents' interviews, there was no evidence that residents were affected by this practice. Facility ordered mobile freezer which was delivered November 13, 2017. 2. To identify other residents that have the potential to be affected, residents' records were reviewed, including residents 24-Hour report for a period of 72 hours to ascertain if there were signs and symptoms of food-borne illness. Residents did not exhibit any signs and symptoms of food-borne illness.	

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L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on October 12, 2017 at approximately 9:15 AM, it was determined that the facility failed to store and serve foods under sanitary conditions as	L 099	• Policy includes adding a third point to take temperatures, the time ranges excluded "defrost" periods, and section addressing how to handle the freezer in the event it has malfunctioned. The policy also defines, based on FDA recommendations, that temp of food in the freezer is recorded as the ambient temperature on the unit. The policy also addressed the proper method of thawing products which include the use of drip pans. • Dietary employees were given a training of how to use the new temperature logs. This includes a module on how to properly correct errors on the document, Staff were required to demonstrate a correct entry on the log, as well as an incorrect entry on the log with appropriate steps of action indicated for each example. • Senior Leadership, Directors, and Managers were in-serviced on the overview of Food Service s, on the new temperature monitoring tool and its use within the department. • Food temperature logs will be recorded daily and findings reported to findings will be reported at daily "Flash Meetings" to the CEO and Administrator Sub-Acute. • Daily rounds in food storage area will be conducted to ensure food is properly thawing in correct pan, dated and labeled.	

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L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on October 12, 2017 at approximately 9:15 AM, it was determined that the facility failed to store and serve foods under sanitary conditions as	L 099	4. To monitor for performance and compliance: • Monitoring tools will be presented at the monthly Quality Assurance Committee meetings for three (3) consecutive months of 100% compliance and Quarterly thereafter. 2. 1. Six of six dented pans have been discarded. 2. To identify other residents that have the potential to be affected: • The cooking pans in the kitchen were viewed and inspected for any indentation. No other dented pans were found. 3. Systemic changes and measures to be taken: • The pans will be viewed daily by the Executive Chef/Manager and dented pans will be discarded. • Director of Food Services will view all pans weekly and inventory the number of pans on hand. • Monthly orders for pans will be made to ensure appropriate number of pans. 4. Monitoring for performance and compliance: • Monitoring tool will be presented at the monthly Quality Assurance Committee Meetings for 3 months to determine compliance, and quarterly thereafter.	

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L 099	Continued From page 4 evidenced by out of range temperatures in one (1) of one (1) walk-in freezer and six (6) of six (6) dented sixth pans. The findings include: 1. The internal temperature of the walk-in freezer was at 40 degrees Fahrenheit. Food items such as vegetables, meats, seafood were soft to the touch and unfrozen. 2. Six (6) of Six (6) sixth pans were dented. These observations were made in the presence of Employee #9 and/or Employee #7 who confirmed the findings.	L 099	3. Systemic changes and measures implemented: • Education curriculum was developed and staff were in-serviced on the curriculum which included an overview of dietary services, education of food borne illness, temperature control standards, Equipment cleaning, maintenance, and sanitizing practices. Competency was verified through a test where a 100% rating was required • Policy and Procedure Number FNS 300 was drafted and approved for Food and Nutrition Services and implemented.	
L 170	3228.2 Nursing Facilities Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees. This Statute is not met as evidenced by: Based on staff interview and a review of records, facility staff failed to ensure a podiatrist conducted in-service training for nursing employees. The findings include: District of Columbia Municipal Regulations for Nursing Facilities: "Podiatry services shall include direct services to residents, as well as consultation and in-service training for nursing employees." A review of the in-service training files revealed no podiatry in-services were provided during the	L 170	1. The facility's podiatrist will provide in-service training for Licensed Nursing Staff. 2. To identify other residents that may be affected: • Licensed Nursing Staff will receive in-service training from facility's podiatrist. 3. Systemic changes and measures: • Licensed Nursing Staff will receive in-service training from facility's podiatrist. • Facility will maintain a calendar of meetings and in-services to ensure training is provided. 4. Monitoring for performance and compliance: • Monitoring and review of the in-service calendar will be presented at Quality Assurance Committee Meeting for 3 months and quarterly thereafter.	

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L 170	Continued From page 5 survey look-back period. During a face-to-face interview conducted on October 19, 2017, at approximately 3:00 PM, Employee#2 acknowledged the findings.	L 170		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on October 17, 2017 at approximately 2:00 PM, it was determined that the facility failed to maintain resident's environment in good condition as evidenced by marred walls in 12 of 22 resident's rooms, marred doors in four (4) of 22 resident's rooms and stained ceiling tiles in two (2) of 22 resident's rooms. The findings include: 1. Walls were marred in 13 of 22 resident's rooms including rooms #309, #313, #317, #324, #333, #334, #335, #336, #337, #338, #339, #340, #343. 2. Entrance doors and /or bathroom doors were marred in resident's rooms #312, 317, 333, 343. four (4) of 22 resident's rooms. 3. Ceiling tiles located in the bathroom of resident room #305 and #321 were stained, two (2) of 22 resident's rooms.	L 214	1. 1. Walls in room numbers 309, 313, 317, 324, 333, 334, 335, 336, 337, 338, 339, 340, and 343 will be repaired. 2. Entrance doors and bathroom doors to room numbers 312, 317, 333, and 343 will be repaired. 3. Ceiling tiles in room numbers 305 and 321 were replaced. 2. To identify other residents that may be affected: • Facility Plant Operations, Maintenance Department and Environmental Services Directors did a walk-through of the facility to identify areas that would need repair. The team will utilize the electronic work order system for tracking purposes. 3. The systemic changes that will be made include: • A revised monitoring tool has been developed to capture deficient items residents' rooms and common areas. • A walk-through will be conducted weekly by the Environment of Care (EOC) Rounds team.	

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L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on October 17, 2017 at approximately 2:00 PM, it was determined that the facility failed to maintain resident's environment in good condition as evidenced by marred walls in 12 of 22 resident's rooms, marred doors in four (4) of 22 resident's rooms and stained ceiling tiles in two (2) of 22 resident's rooms. The findings include: 1. Walls were marred in 13 of 22 resident's rooms including rooms #309, #313, #317, #324, #333, #334, #335, #336, #337, #338, #339, #340, #343. 2. Entrance doors and /or bathroom doors were marred in resident's rooms #312, 317, 333, 343. four (4) of 22 resident's rooms. 3. Ceiling tiles located in the bathroom of resident room #305 and #321 were stained, two (2) of 22 resident's rooms.	L214	• The Maintenance Supervisor will provide report of deficient findings to the EOC Committee. • For all items found deficient, work orders for repairs will be generated. • Reports will be provided to Administrator for review, assessment, and determination of work order completion. 4. Monitoring for performance: • EOC Rounds reports will be presented monthly at the Quality Assurance Committee Meeting for three months and quarterly thereafter. • Monitoring will continue until 90% compliance is sustained. 1. 1. The Care Plan for resident #48 was updated to reflect his skin condition. 2. The Care Plan for resident # 6 was updated to reflect his altercation with another resident and interventions to prevent any further contact with the reporting resident. 3. The Care Plan for resident # 77 was updated with goals and approaches to address the resident's visual impairment condition. 2. Charts of all other residents with skin conditions, those with potential to abuse other residents and with visual problems or impairments were reviewed and updated as needed to ensure that Care Plans are properly initiated for their care.	

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L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations made on October 17, 2017 at approximately 2:00 PM, it was determined that the facility failed to maintain resident's environment in good condition as evidenced by marred walls in 12 of 22 resident's rooms, marred doors in four (4) of 22 resident's rooms and stained ceiling tiles in two (2) of 22 resident's rooms. The findings include: 1. Walls were marred in 13 of 22 resident's rooms including rooms #309, #313, #317, #324, #333, #334, #335, #336, #337, #338, #339, #340, #343. 2. Entrance doors and /or bathroom doors were marred in resident's rooms #312, 317, 333, 343. four (4) of 22 resident's rooms. 3. Ceiling tiles located in the bathroom of resident room #305 and #321 were stained, two (2) of 22 resident's rooms.	L 214	3. Systemic change to be implemented: • Re-education of Licensed Nursing Staff on importance of implementing interventions for residents identified with skin alteration, and initiating Care Plans for residents with potential for abuse and residents with visual impairment. • Unit Manager and RN Supervisor will be re-educated on importance of initiating or updating Care Plans on all residents with skin alteration to reflect current interventions, • Random audits of Care Plans for residents with skin alteration will be conducted biweekly for 3 consecutive months, to ensure they are initiated and updated. 4. Monitoring for performance. • Audits will be presented at monthly Quality Assurance Committee Meeting for review for compliance for 3 consecutive months and quarterly thereafter.	

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L 214	Continued From page 6 These observations were made in the presence of Employee #11 who confirmed the findings.	L 214	1. Upon identification of a nonfunctional call bell in room #317 and 324, Plant Ops repaired, tested, and confirmed functionality of the call bell system in both rooms.	
L 306	3245.10 Nursing Facilities A call system that meets the following requirements shall be provided: (a)Be accessible to each resident, indicating signals from each bed location, toilet room, and bath or shower room and other rooms used by residents; (b)In new facilities or when major renovations are made to existing facilities, be of type in which the call bell can be terminated only in the resident's room; (c)Be of a quality which is, at the time of installation, consistent with current technology; and (d)Be in good working order at all times. This Statute is not met as evidenced by: Based on observations made on October 17, 2017 at approximately 2:00 PM, it was determined that the facility failed to maintain call bells in resident's rooms in good working condition as evidenced by call bells in two (2) of 22 resident's rooms that failed to activate when tested. The findings include: Call bells located in resident room #317 and #324 failed to emit an alarm when tested, two (2) of 22 resident's rooms.	L 306	2. To identify other residents that have the potential to be affected: • Rounds were immediately conducted by the DON and Unit Managers on all other rooms to ensure that the call bells were functional. There were no additional findings. • The Director of Plant Operations will perform an audit of the call bell system on all units for functionality to ensure no other resident was potentially impacted by the same deficient practice. 3. Systemic changes and measures to be taken: • The Director of Plant Operations, EVS Supervisor and Unit Managers will perform monthly environmental rounds. The rounds will include testing the call bell system in randomly selected rooms. The team will utilize the electronic work order system for tracking purposes. 4. Monitoring for performance and compliance: • The Director of Plant Operations will monitor the completion of work orders. Findings, analysis and corrective actions will be reported to Environment of Care Committee and Quality Assurance Committee, quarterly. Monitoring will continue until 90% compliance is sustained for three (3) consecutive months.	

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L 306	Continued From page 7 These observations were made in the presence of Employee #11 who confirmed the findings.	L 306		
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation and record review on October 12, 2017, at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by temperatures from one (1) of one (1) walk-in freezer that reached 40 degrees Fahrenheit. The findings include: The internal temperature of the walk-in freezer was at 40 degrees Fahrenheit on October 12, 2017 at approximately 9:15 AM. A review of the temperature log for the walk-in freezer revealed that the internal temperature reached 28 degrees Fahrenheit on October 10, 2017 and 30 degrees Fahrenheit on October 12, 2017. These observations were made in the presence of Employee #9 who confirmed the findings.	L 442	1. 1. Based on record reviews and residents' interviews, there was no evidence that residents were affected by this practice. Facility ordered mobile freezer which was delivered 11-13-17. This equipment was utilized while the facility freezer was being repaired. 2. To identify other residents that have the potential to be affected, residents' records were reviewed, including residents 24-Hour report for a period of 72 hours to ascertain if there were signs and symptoms of food-borne illness. Residents did not exhibit any signs and symptoms of food-borne illness. 3. Systemic changes and measures implemented: • Education curriculum was developed and staff were in-serviced on the curriculum which included an overview of dietary services, education of food borne illness, temperature control standards, Equipment cleaning, maintenance, and sanitizing practices. Competency was verified through a test where a 100% rating was required. • Policy and Procedure Number FNS 300 was drafted and approved for Food and Nutrition Services and implemented.	

Health Regulation & Licensing Administration

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	HFD02-0023	A. BUILDING: _____ B. WING _____	10/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEPOINT SUBACUTE AND REHAB	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) COMPLETE DATE
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation and record review on October 12, 2017, at approximately 9:15 AM, it was determined that the facility failed to maintain essential equipment in good working condition as evidenced by temperatures from one (1) of one (1) walk-in freezer that reached 40 degrees Fahrenheit. The findings include: The internal temperature of the walk-in freezer was at 40 degrees Fahrenheit on October 12, 2017 at approximately 9:15 AM. A review of the temperature log for the walk-in freezer revealed that the internal temperature reached 28 degrees Fahrenheit on October 10, 2017 and 30 degrees Fahrenheit on October 12, 2017. These observations were made in the presence of Employee #9 who confirmed the findings.	L 442	• Policy includes adding a third point to take temperatures, the time ranges excluded "defrost" periods, and section addressing how to handle the freezer in the event it has malfunctioned. The policy also defines, based on recommendations, that temp of food in the freezer is recorded as the ambient temperature on the unit. The policy also addressed the proper method of thawing products which include the use of drip pans. • Dietary employees were given a training of how to use the new temperature logs. This includes a module on how to properly correct errors on the document, Staff were required to demonstrate a correct entry on the log, as well as an incorrect entry on the log with appropriate steps of action indicated for each example. • Senior Leadership, Directors, and Managers were in-serviced on the overview of Food Services, on the new temperature monitoring tool and its use within the department. • Food temperature logs will be recorded daily and findings will be reported at daily "Flash Meetings" to the CEO and Administrator Sub-Acute. • Daily rounds in food storage area will be conducted to ensure food is properly thawing in correct pan, dated and labeled.	

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