FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland
If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.
Phone: 703-564-7318; email: jdowney@jeffdowney.com

Bridgepoint Sub-Acute and Rehab – Capitol Hill
223 7th Street NE
Washington DC 20002

Facility Characteristics:

- Skilled nursing facility with 117 beds located within a hospital
- Directed by Andrew Davis and Charletta Washington
- Website at www.united-medicalcenter.com
- The For Profit Corporation's Legal Name is DCA Capitol Hill SNF LLC
- Current Director is Swenda Beitpoulice
- Operational/Managerial Control is done by Marc Ferrell
- As of 2018 Bridgepoint is a three star facility, which is average on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The District of Columbia Department of Health inspects nursing homes including UMNC. Periodically they do inspections as complain surveys which should be public record. You can write to Phillip Husband at Department of Health, 899 North Capitol Street, NE, Suite 247, Washington DC 20002 or email directly to Phillip.Husband@dc.gov.   There is no initial fee for submitting a FOIA request. However, a public body may charge fees for searching, reviewing, and reproducing records as provided in 1 DCMR § 408. You may include in your request letter a specific statement limiting the amount of fees you are willing to pay. You

may request a waiver or reduction of fees in your request letter. You must include a statement describing how the requested records will be used to benefit the general public. Pursuant to DC Official Code § 2-532(b), if the public body determines that a waiver or fee reduction is in the public interest, i.e., furnishing the records primarily benefits the general public, a waiver or reduction may be granted.

Having already researched United Medical Nursing Center and obtained FOIA responses, I am posting their statements of deficiencies here, in a searchable format. Keep in mind that these surveys may have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any questions about this or any other facility you may be interested in researching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the eFOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. BUILDING ______ B. WING _____	**05/30/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	**223 7TH STREET NE WASHINGTON, DC 20002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** Based on observations and staff interview for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to respect the resident's dignity when an employee knocked on the resident's room door and entered without waiting for permission to enter (Resident #81). The findings include: On May 22, 2017, at approximately 3:32 PM, during a face-to-face interview with Resident #81, the resident was asked, Do staff treat you with respect and dignity? The resident replied, They knock on the door and come in the room. They don't wait for me to tell them to enter. During the interview, Employee #13 knocked on the door to the resident's room and entered the room without waiting for permission to enter. The resident then stated, See that is what I'm talking about. The concern was brought to Employee #13's attention at the time of the occurrence. He/she acknowledged the finding. Facility staff failed to respect the resident's dignity when he/she knocked on the resident's room door and entered without waiting for permission to enter.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observations made on May 22, 2017, at approximately 10:30 AM and on May 25, 2017, at approximately 11:00 AM, it was determined that the facility failed to maintain resident's environment in a comfortable manner as evidenced by a broken wall clock above elevators #1 and #2 on the sixth floor, missing pull cords in five (5) of 43 residents' rooms, dusty window blinds in six (6) of 43 residents' rooms, missing covers from the over-the-bed light in three (3) of 43 residents' rooms, marred walls in 12 of 43 residents' rooms, marred floors in five (5) of 43 residents' rooms, broken floor tiles in four (4) of 43 residents' rooms, stained ceiling tiles in four (4) of 43 residents' rooms, marred entrance doors in eight (8) of 43 residents' rooms and a damaged access ramp and walkway in front of the facility. The findings include: 1. The wall clock located between elevators #1 and #2 on the 6th floor was not functioning. 2. Pull cord missing from over-the-bed light in rooms #6155, #6135, #6119, #6116, #4127 3. Window blinds dusty in rooms #6143, #6135, #6116, #5146, #5139, #4130. 4. The over-the-bed light cover was missing in rooms #6135, #5144, #4130. 5. Walls were marred in rooms #6142, #6135, #6119, #6118, #5153, #5146, #5145, #5142, #5133, #5128, #5106, #4123. 6. Floors were marred in rooms #6125, #6105, #5145, #5143, #5142. 7. Floor tiles were uneven or damaged in rooms #6125, #6105, #5143, #5142. 8. Stained ceiling tiles in rooms #6118, #5146, #5139, #5125 9. Ceiling tile was missing in room # 5146. 10. Entrance door to rooms #5149, #5143, #5142, #5125, #5123, #5119, #5111, #5106, were marred 11. The access ramp and the handicap/wheelchair walkway at the front of the facility are cracked in several areas and are in disrepair. The observations made, in the presence of Employee #8 and Employee #9, were acknowledged.
F 0272 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for two (2) of 38 stage 2 sampled residents, it was determined that facility staff failed to code the resident's Minimum Data Set (MDS) as being edentulous (no teeth); and failed to accurately code the MDS under Section N (Medications) for one (1) resident who was administered an anti-anxiety medication (Residents' #10 and #150). The findings include: 1. Facility staff failed to code the resident's Minimum Data Set (MDS) for having no teeth. During a face-to-face interview with Resident #10 on May 23, 2017, it was determined through observation that the resident was edentulous. On May 24, 2017, a review of documentation in the Dental Care Notes, last entry dated 11/23/15 revealed the following: Annual exam: edentulous. Subsequently, a review of the resident's quarterly Minimum Data Set (MDS) with an Assessment Reference Date(s) of January 18, 2017, and April 14, 2017, was conducted. Section L Oral/Dental Status -Item L0200, Dental B- natural teeth or tooth fragment(s) (edentulous) was not coded. During a face-to-face interview conducted at 12:00 PM on May 24, 2017, Employee #7 reviewed the documents mentioned above. Employee #7 acknowledged the finding after reviewing the MDS assessments. 2. Facility failed to accurately code the Minimum Data Set (MDS) under Section N (Medications) for Resident #150, who received an anti-anxiety medication. On May 26, 2017, a review of Resident #150's medical record revealed a physician's orders [REDACTED]. A subsequent review of Resident #150 Medication Administration Record [REDACTED]. According to the quarterly MDS assessment reference date of April 27, 2017, Section N0410B was coded with a zero (0), indicating Resident #150 had not received an antianxiety medication in the last seven (7) days preceding the assessment. During a telephone interview conducted on June 6, 2017, at approximately 9:00 AM, Employee #7 acknowledged the findings. Facility staff failed to code the MDS for the resident receiving an antianxiety medication in the last seven (7) days preceding the Assessment Reference Date (ARD) of April 27, 2017.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews for one (1) of 38 Stage 2 sampled residents, it was determined that facility staff failed to initiate an integrated plan of care for hospice and the nursing home. Resident #30.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **095027**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/30/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	**223 7TH STREET NE** **WASHINGTON, DC 20002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) The findings include: The facility staff failed to initiate an integrated plan of care for both providers (hospice and the nursing home) for Resident #30. A review of the physician's orders [REDACTED]. admitted to (hospice agency name) under routine NH (Nursing Home) care . is a DNR (Do Not Resuscitate), DNI (Do Not Intubate), DNH (Do Not Hospitalize. Dx. (Diagnosis) [MEDICAL CONDITION], no labs, procedures or skilled nursing without (hospice agency name) approval. On May 25, 2017, at approximately 1:00 PM, a review of Resident #30's plan of care failed to reveal the facility staff initiated a plan of care related to hospice care. Furthermore, the medical record contained no information identifying the particular services provided by the nursing facility and those furnished by the hospice staff, to address the expressed desire and hospice needs. The medical record lacked documented evidence of an integrated care plan for hospice. During the face-to-face interview conducted at 10:00 AM on May 25, 2017, Employee #5 reviewed and acknowledged the finding.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview for two (2) of 38 stage 2 sampled residents, it was determined that facility staff failed to ensure that one (1) resident was seen by the psychiatrist as ordered by the physician; and failed to act appropriately on a physician's orders [REDACTED].#59 and #150). The findings include: 1.Facility staff failed to ensure Resident #59 was seen by the psychiatrist as ordered by the attending physician. The physician's orders [REDACTED]. On May 26, 2017, a review of the clinical record revealed that from March 31, 2017, until the time of record review, Resident #59 was not seen by a psychiatrist to address the paranoid behavior. During a face-to-face interview conducted on May 25, 2017, at approximately 2:00 PM, Employee #5 acknowledged the findings. 2. Facility failed to act on a physician's orders [REDACTED].#150). A review of Resident #150's medical record revealed a physician's orders [REDACTED]. On May 26, 2017, a review of the 'Progress Notes' dated January 26, 2017, revealed the facility staff documented the following entries: Resident continued to have episodes of agitation, aggression, and confusion. Speaking of (family member) in a negative manner. Restless while in room. Several attempts to get out of bed. [MEDICATION NAME] 0.5mg administered times one which was effective. Resident relaxed and calm. No further outbursts at this time. New orders for Psych consult sic. The clinical record lacked documented evidence that Resident #150 was seen by a psychiatrist to address the documented behaviors. During a face-to-face interview conducted on May 26, 2017, at approximately 11:00 AM, the surveyor asked Employee #4 whether a psychiatric consult for Resident #150 was ever scheduled and completed. After reviewing the resident's chart and electronic records, Employee #4 said he/she could not find a psychiatric consult for Resident #150. There were no indication that the physician's orders [REDACTED].#150 was ever scheduled.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview for one (1) of 38 stage 2 sampled residents, it was determined that facility staff failed to provide the necessary care and services to maintain good grooming and personal hygiene for Resident #26 as evidenced by observations of dirty fingernails. The findings include: On May 22, 2017, through May 25, 2017, the surveyor observed Resident #26 lying in bed watching television. The resident's fingernails were noted to have dark substance under the nailbeds. On May 24, 2017, a review of Resident #26's Quarterly Minimum Data Set (MDS) dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 13, coded as cognitively intact under Section C (Cognitive Patterns). In ADLs (activities of daily living) Section G0110 J- Personal Hygiene (how resident maintains personal hygiene (excludes baths and showers)), revealed self-performance code of 3- Extensive Assistant (resident involved in activity, staff provide weight bearing support) and support code of 2. One-person physical assistance. On May 25, 2017, at approximately 11:15 AM, Employees #2 and 18 asked to observe Resident # 26's fingernails and provide insight into the resident's daily grooming routine. Both employees stated that daily grooming included nail care. Furthermore, Employees' #2 and 18 acknowledged the finding and offered an explanation for the oversight. According to Employees' #2 and 18, a new CNA (certified nursing assistant) worked with the resident. The staff member allegedly responsible for the care of Resident #26, had received education regarding overall cleanliness, to include fingernail. The facility staff presented the surveyor a copy of the signed attendance sheet. Facility staff failed to ensure that Resident #26's fingernails were clean.
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an isolated observation during a medication pass on May 24, 2017, it was determined that the nurse failed to administer medication via gastrostomy tube consistent with accepted standards of practice (Resident #72). The findings include: Lippincott Manual of Nursing Practice Ninth Edition stipulates: General Procedures and Treatment Modalities for Enteral Feeding: Procedure Guidelines 20-1 step number seven (7): Using a catheter tipped syringe, inject 20 cc-30 cc of air while listening with a stethoscope positioned at the epigastric area (laterally) .confirmation of proper tube placement. In the 'performance phase' Step two (2): fill catheter tipped syringe with formula (medication) and allow fluid to flow in by gravity. Facility policy SAR.CS.725 titled Administering Medications via [DEVICE] effective date December 2014 stipulates, check tube placement .attach 60ml syringe containing approximately 10cc air .Auscultate the abdomen while injecting the air from syringe .to check the placement of the tube in the stomach .remove (the) plunger from (the) syringe, attach (the) syringe to tube, pour medication(s) into (the) syringe and allow to flow by gravity . On May 24, 2017, at approximately 9:00 AM, a medication pass observation conducted revealed the nurse failed to administer medications via gastrostomy tube consistent with accepted standards of care and facility policy. The resident was observed lying in bed with his/her Gastrostomy tube ([DEVICE]) connected to a tube feeding pump infusing an enteral feeding. The nurse stopped the tube feeding, disconnected the [DEVICE] from the feeding pump, removed the connector tip from the [DEVICE], removed the plunger from a 60cc piston syringe, connected it to the tube and instilled a measured amount of water into the syringe. Then the nurse inserted the plunger into the distal end of the syringe and pushed the water into the [DEVICE]. Upon query regarding the use of gravity for the administration of hydration and medications via [DEVICE], the nurse replied Yes, I am supposed to let it flow by gravity, I guess I'm just nervous. From that point of the observation, the nurse administered water and medications per [DEVICE] via gravity. Additionally, the nurse failed to check for correct tube placement via auscultation of the resident's abdomen before administering fluids and medication. During a face-to-face interview with Employee #3 and #12 on May 24, 2017, at approximately 9:00 AM, the employees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **095027**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/30/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	**223 7TH STREET NE WASHINGTON, DC 20002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) acknowledged the findings.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations made on May 25, 2017, at approximately 11:00 AM, it was determined that the facility staff failed to maintain resident environment free of accident hazards as evidenced by elevated water temperatures in five (5) of 43 resident's rooms, a missing light switch cover in one (1) of 43 resident's rooms, and a damaged handicap and emergency access ramp and walkway in front of the facility; and failed to ensure that resident's environment remained free of accident hazards as evidenced by one (1) resident who was observed with a hacksaw in his/her room (Resident #59). The findings include: 1. Water temperatures exceeded 110 degrees Fahrenheit in five (5) of 43 resident's rooms to include rooms #6155, #6149, #6143, #6105, #5156. 2. The cover to the light switch cover located in the bathroom of resident room #6135 was missing, and its electrical wires were exposed. 3. The access ramp and the handicap/wheelchair walkway at the front of the facility are cracked in several areas and are in disrepair. On May 25, 2017, at approximately 11:00 AM, Employees #8 and 9, present at the time of observations acknowledged the findings. 2. Facility staff failed to ensure that resident's environment remained free of accident hazards as evidenced by one (1) resident who was observed with a hacksaw in his/her room. On May 22, 2017, at approximately 10:45 AM, the survey accompanied Resident #59 to his/her room to have a private interview regarding care and services rendered during the resident's stay at the facility. As the conversation grew, Resident #59 pulled out an item from a plastic bag and asked the surveyor if he/she could identify it. The item was a selfie stick, which can be attached to a cell phone to take pictures of oneself. During the conversation/observation, the surveyor observed a small hacksaw, approximately 12 inches long in a plastic bag. When asked about intentions for the hacksaw, Resident #59 responded that he/she bought the hacksaw yesterday (Sunday, May 21, 2017) at a flea market as a gift for Employee #14, who works in the maintenance department. Resident #59 said that when he/she sees Employee #14, he/she is going to give him/her the hacksaw. When asked if facility staff knew he/she had a hacksaw, Resident #59 said No. It is noteworthy to mention that Resident #59's had many bags [DIAGNOSES REDACTED] the room. At approximately 3:00 PM on May 22, 2017, this surveyor observed Resident #59 hand over the hacksaw to Employee #14. On May 22, 2017, at approximately 3:00 PM, during a face-to-face interview, Employees #4 and 5 stated that they were unaware that Resident #59 had a hacksaw in his/her possession.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview for one (1) of 38 stage 2 sampled residents, it was determined that the facility staff failed to consistently monitor behaviors for one (1) resident, receiving [MEDICATION NAME] (antianxiety medication)(Resident #150). The findings include: On January 18, 2017, the facility admitted Resident #150 with [DIAGNOSES REDACTED]. On May 26, 2017, a review of Resident #150's medical record revealed a physician's orders [REDACTED]. Further review of the Progress Notes revealed that on 20 occasions, between the months of January 2017 and May 2017, the resident exhibited periods of agitation. The nursing staff administered [MEDICATION NAME] 0.5 mg in response. The medical record lacked documented evidence that the facility staff monitored the resident's target symptoms (agitation) and the effect of the medication, such as the resident is no longer agitated. Also, facility staff was unable to provide the surveyor with the Behavior Monitoring Flow records for the months of March, April, and May 2017. During a face-to-face interview conducted on May 26, 2017, at approximately 12:00 PM, Employee #10 acknowledged the findings.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Store, cook, and serve food in a safe and clean way** Based on observations made on May 22, 2017 at approximately 9:30 AM, and on May 24, 2017 at approximately 2:00 PM, it was determined that the facility failed to maintain kitchen utensils and the dietary environment under sanitary conditions as evidenced by two (2) of five (5) dented steam table wells covers, one (1) of one (1) soiled and dented 20-gallon soup pan, two (2) of three (3) dented third pans, one (1) of one (1) soiled and dented cooking pot and a kitchen floor the was soiled and damaged with broken tiles in several areas. The findings include: 1. Two (2) of five (5) dented steam table wells covers 2. One (1) of one (1) 20-gallon soup pan bottom was soiled and dented 3. Two (2) of three (3) third pans dented 4. One (1) of one (1) cooking pot soiled and dented. 5. The entire kitchen floor tiles were marred and damaged. On May 22, 2017, at approximately 2:00 PM, Employee #6, present at the time of observations, acknowledged the findings.
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation and staff interviews, it was determined that the facility staff failed to ensure (1) medication was not stored and available beyond the expiration date. The findings include: The facility staff failed to ensure one (1) medication was not stored and available beyond the expiration date. On May 26, 2017, at approximately 10:45 AM, the surveyor conducted a medication storage observation. During the inspection of the medication refrigerator located in the fourth-floor nursing station on the following was observed: One (1) vial of unopened Epogen (medication used to increased red blood cells) with an expiration date of March 2016. Employee #5 acknowledged the findings at the time of the observation.
F 0463 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's room or bathroom and bathing area.** Based on observations made on May 22, 2017 at approximately 10:45 AM, it was determined that the facility failed to maintain a resident's call bell in good working condition as evidenced by a malfunctioning call bell in one (1) of 43 resident's rooms. The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **095027**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/30/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGEPOINT SUB-ACUTE AND REHAB CAPITOL HILL	**223 7TH STREET NE WASHINGTON, DC 20002**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0463 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) The call bell in resident room #6118 did not initiate an alarm when it was activated, one (1) of 43 resident rooms surveyed. This observation was made during an initial tour of the facility.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interview for two (2) of 38 stage 2 sampled records, it was determined that the dentist failed to record the correct date of a dental examination on the dental progress notes for one (1) resident; and failed to transcribe an order for [REDACTED]. The findings include: 1.The dentist failed to record the correct date of a dental examination on the dental progress notes for Resident #10. During a face-to-face interview with Resident #10 on May 23, 2017, at 1:30 PM, it was observed that Resident #10 was edentulous (had no teeth). On May 25, 2017, a review of the dental progress notes revealed the last entry was dated 11/23/15 Annual exam: edentulous. The record lacked evidence of a dental entry for 2016. During a face-to-face interview at approximately 3:00 PM on May 24, 2017, the surveyor asked Employee #2 whether the resident had an oral evaluation in 2016. The employee stated, I will speak with the dentist. I thought he/she had seen the resident last year. In a follow-up face-to-face interview with Employee #2 at approximately 10:30 AM on May 25, 2017, the employee stated, I spoke with the dentist, and he/she confirmed the resident received a dental evaluation last year, and the date of the note on the record was incorrect. The note was written in 2016 and not 2015. Employee #2 presented the surveyor with a page titled Dental Care Notes. There were several entries on the page. The last two entry dates were for 11/17/15 and 11/23/15. Employee #2 acknowledged the finding. 2. Facility staff failed to transcribe an order for [REDACTED]. On May 26, 2017, review of the record revealed a physician's orders [REDACTED]. A subsequent review of the May 2017 Treatment Administration Record (TAR) revealed the treatment order was recorded. On May 26, 2017, at approximately 9:45 AM, the surveyor observed a tube of Hydraguard labeled with resident's name. During the face-to-face interview on May 26, 2017, at approximately 9:55 AM Resident #172 and Employee #16 acknowledged that the facility staff uses Hydraguard on the resident's skin. During a subsequent face-to-face interview conducted on May 26, 2017, at 10:00 AM, Employee #15 acknowledged that the treatment order for Hydraguard was not transcribed onto the May 2017 TAR. The medical record lacked documented evidence the facility staff transcribed the order to the May 2017 TAR, allowing nursing staff to sign-off the administration of the skin cream to the resident.