Printed: 06/26/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025	
NAME OF PROVIDER OR SUPPLIER  Bridgepoint Sub-Acute & Rehab National Harborside		STREET ADDRESS, CITY, STATE, ZIP CODE 4601 Martin Luther King Jr Avenue SW Washington, DC 20032		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0695	Provide safe and appropriate respiratory care for a resident when needed.			
Level of Harm - Minimal harm	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776			
or potential for actual harm  Residents Affected - Few	Based on record review and staff interviews, for one (1) of eight (8) sampled residents, facility staff failed to provide Resident #67 with the necessary respiratory care per the residents comprehensive care plan and the facility's policy after decannulation of her tracheostomy (trach) tube.			
	The findings included:			
	The facility's Unplanned Decannulation: Risk Assessment, Precautions and Interventions policy with an effective date of December 2014 documented:			
	- An unplanned decannulation is an unplanned removal or dislodgement of an artificial airway prior to its scheduled removal.			
	- If unplanned decannulation occurs, the following will take place: call a Rapid Response (RRT); assess if the patient is stable without the trach tube, if not, the trach tube will be immediately reinserted to establish a patent airway by a qualified practitioner.			
	Resident #67 was admitted to the facility on [DATE] with multiple diagnoses that included: Encounter for Tracheostomy, Acute and Chronic Respiratory Failure with Hypercapnia, and Pyothorax Without Fistula,			
	Review of the resident's medical record revealed a Physician's order dated 10/15/24 directing, Aspiration safety precautions, every shift; Monitor area under trach mask for signs of discoloration\edema\redness every shift; Trach care twice a day (BID) and as needed (PRN), two times a day for airway management; Maintain neck collar in place, check skin under neck collar every (q) shift for any changes and report to medical doctor (MD)/Nurse Practitioner (NP), every shift for safety; High Risk Airway, every day and night shift, post 'High Risk Airway' sign at resident's bedside; FIO2 (fraction of inspired oxygen): 28%, Trach type Shiley, Trach size: 6.5 cuffless, every shift for Respiratory Failure, wean FIO2 as tolerated and to keep saturations greater than 92%.  A physician's order dated 10/16/24 directed, Suction trach as needed, every shift.			
	An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded the resident as; severely impaired cognitive skills for decision making; received oxygen therapy, suctioning, and tracheostomy care.			
	(continued on next page)			

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 095024

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	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILLTIDLE CONSTRUCTION	
For information on the nursing home's pl  (X4) ID PREFIX TAG  F 0695  Level of Harm - Minimal harm or potential for actual harm	IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
For information on the nursing home's pl  (X4) ID PREFIX TAG  F 0695  Level of Harm - Minimal harm or potential for actual harm	9	STREET ADDRESS, CITY, STATE, ZI	P CODE
(X4) ID PREFIX TAG  F 0695  Level of Harm - Minimal harm or potential for actual harm	Bridgepoint Sub-Acute & Rehab National Harborside		sw
F 0695  Level of Harm - Minimal harm or potential for actual harm	lan to correct this deficiency, please cont	act the nursing home or the state survey	agency.
Level of Harm - Minimal harm or potential for actual harm	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
	A Care plan focus area last reviewer her trach device.  Goal: [Resident #67] will continue to through the next review date.  Interventions: Educate resident to use [Resident #67] and representative (safety. Provide alternative activities)  A care plan focus area last reviewer self-decannulation, airway mass, and Goal: [Resident #67] will have a part Interventions: Tube out procedures call a Rapid Response immediately the resident is able to breathe spon provide oxygen via nasal cannulated dressing. Keep head of bed (HOB) for at least 24 hours. Monitor/documn A physician's order dated 12/12/24 4x/week x 30 days.  A 12/17/24 at 11:19 AM Pain Assess A 12/17/24 at 2:06 PM General Procesident #67): Patient alert, awake provided. writer called in room [ROG gauze not in place, the trach tie loos the gauze. No distress noted.  A 12/17/24 at 3:00 PM: Speech The Upon arrival, the patient had self-conditions and the patient had self-conditions.	and on 11/26/24 documented: [Resident of the monitored closely so as not to allow anderstand the risk of removing the track RP) educated on risk of removing trace to keep her attention away from the track don 12/02/24: [Resident #67] has a Hand mittens.  Itent and intact airway though the review the track and intact airway using an obturator of taneously and there are no signs/sympo maintain O2 saturation greater than \$30-45 degrees and monitor the residement for signs of respiratory distress.  Idirected, Speech Language Pathology assment in Advanced Dementia (PAINA) gress Note written by Employee #4 (Rand non verbal. Vitals stable. Medicat DM NUMBER]A for trach concern. On see holding the trach half way out. Write the properties of the reach and attempted to vocalize, indicating particular and attempted to vo	#67] is at risk for decannulating ow her harm self via decannulation ch device. Frequent rounds. h. Frequent rounding to ensure ach. igh-Risk Airway due to (d/t) w period. If tube is coughed out, the tube cannot be reinserted and otoms of acute respiratory distress, 32%. Cover stoma site with a nt with pulse oximetry and end-tidal or (SLP) evaluation and treat  D): score, 0. egistered Nurse assigned to ed as prescribed. Total care assessment, writer noticed the or tightened the neck tie and placed every gen mask.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 095024	A. Building B. Wing	03/05/2025	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bridgepoint Sub-Acute & Rehab National Harborside		4601 Martin Luther King Jr Avenue Washington, DC 20032	SW	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0695	- Patient resting comfortably at this time after decannulation.			
Level of Harm - Minimal harm or potential for actual harm	- [Resident #67] self-decannulated again.			
Residents Affected - Few	- The nurse said that the tube was	halfway out.		
	- The two nurses working on 1 sout	th re-inserted the tube successfully.		
	- The patient is resting comfortably	, no distress noted.		
	An email correspondence from Em 12/20/24 at 1:21 PM documented:	ployee #4 (Registered Nurse/RN) to Er	mployee #1 (Administrator) dated	
	- On 12/17/24, I arrived in 156A, the patient was in bed with no shortness of breath, no distress.			
	- The gauze around the [trach] site about 2 centimeters (cm).	wasn't in place and the trach was loos	e, the trach halfway out, visibly	
	- The writer tightened the necktie a	nd fixed the gauze to avoid irritation.		
	Review of an employee statement written by Employee #5 (RN), dated 12/20/24 documented:			
	- One of the therapists came to me	therapists came to me and asked if I was [Resident #67's] nurse, I said not but went to the room. esident with a loose trach tie and the trach [tube] was slightly out, no acute respiratory distress		
	- I saw the resident with a loose tra was noted.			
	- I called [Employee #4].			
	- The nurse adjusted the trach [tube	e] and trach tie.		
	- I left the room, leaving the nurse a	and the therapist in the room.		
	An anonymous Complaint, DC~13353, was submitted to the State Agency on 12/26/24.			
[Resident #67] for a speech therapy so come out and was resting on the oxyg resident had a history of picking at her walked in, and did not perform any hall jammed the trach back in. The resident		103/05/25 at 10:24 AM, Employee #3 (SLP) stated, I was going in to see py session and when I walked in, I saw her trach [tube] had completely oxygen mask. I alerted the nursing staff so they can call respiratory. The t her trach, so I was very worried. I stayed in the room and two nurses y hand hygiene. One nurse pinned down the resident while the other sident winced in pain when the trach was back in the way that they did. vital signs or anything and then they both left. I was very worried and		
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER  Bridgepoint Sub-Acute & Rehab National Harborside		STREET ADDRESS, CITY, STATE, ZI 4601 Martin Luther King Jr Avenue	
Bridgepoint Sub-Acute & Rehab National Harborside		Washington, DC 20032	
For information on the nursing home's plan to correct this deficiency, please conta		tact 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 0695  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a face-to-face interview on 03/05/25 at 10:33 AM, Employee #5, stated, That day (12/17/24), one of the therapists came to me and said that [Resident #67] needed help. I went to the room and saw that the patient's trach [tube] was halfway out. I called her nurse, [Employee #4], who went into the room. [Employee #4] saw the trach [tube] was out and she reinserted it back in. She said she had it from there and I left the room. I left the patient, the nurse and the therapist in the room. When asked what the facility's protocol is for when a resident's trach tube is out, Employee #5 responded, We are supposed to call rapid response, if the respiratory therapist is not around. A rapid response was not called that day for Resident #67.  During a telephone interview on 03/05/25 at 10:40 AM, Employee #4 stated, I was in another room, my colleague [Employee #5] called me and said she needed me in room [ROOM NUMBER]. I went into the		
	room, I saw that [Resident #67]'s trach collar necktie was loose, and the trach [tube] was halfway out. I remember there was one white lady was in there, a therapist, who was standing there. What I did was, I moved [Resident #67]'s hands, tied the necktie and readjusted the trach [tube] back in place, and then went back to my duties. When asked the facility's protocol for when a trach tube comes out, Employee #4 responded, The facility's process is to not reinsert trach, we would call respiratory. The male RT (Respiratory Therapist) who was on the unit that day, was not on the floor at that time. I didn't call him because the trach [tube] did not come out completely. When asked if she checked for airway patency or oxygenation status before readjusting Resident #67's trach tube back in place, Employee #4 stated, No. Someone reported something to the Administration was made aware that something happened because they wrote me up and gave me an in-service.		
	Employee #2 (Director of Nursing/I protocol is if a tube is dislodged, ca team to come, if the trach tube is or breathing and oxygen and if require nose or mouth. Once the respirator the bedside. If not able to, the residube. Each resident with an airway exactly what to do. Whether the trastaff would be the one to first check	cted on 03/05/25 at 12:49 PM with Em DON) and Employee #6 (Director of Re Ill a rapid response. While waiting for re ompletely out, cover the trach with gau- ed, provide the resident with supplement y therapist arrives, they do their assessi- lent would get transferred out. Nurses a has a Tube Out intervention protocol we chat tube is partially or completely out, a k for airway in order to make the deternance to all nurses at the annual skills fair.	spiratory) Employee #6 stated, The espiratory therapist or the response ze dressing, monitor the resident's ntal breathing via an Ambu bag via sment and reinsert the trach tube at are not trained to reinsert a trach written in their care plans that states respiratory therapist or trained nination to reinsert the trach tube or
	, ,	n 03/05/25 for training/competencies shed practitioner who can reinsert a resid	
	It should be noted that Resident #67 did not suffer any harm from this deficient practice.		
	Cross Reference 22B DCMR Section	on 3215.3	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS CITY STATE ZID CODE	
Bridgepoint Sub-Acute & Rehab National Harborside			4601 Martin Luther King Jr Avenue SW	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0726	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.			
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 43776	
Residents Affected - Few	Based on record review and staff interviews, for one (1) of eight (8) sampled residents, facility staff failed to demonstrate competencies and skills to provide safe nursing care and services as evidenced by a nurse, who was not trained to do so, reinserting Resident #67's tracheostomy tube after decannulation.			
	The findings included:			
	The facility's Unplanned Decannulation: Risk Assessment, Precautions and Interventions policy with an effective date of December 2014 documented:			
	<ul> <li>- An unplanned decannulation is an unplanned removal or dislodgement of an artificial airway prior to its scheduled removal.</li> <li>- If unplanned decannulation occurs, the following will take place: call a Rapid Response (RRT); assess if the patient is stable without the trach tube, if not, the trach tube will be immediately reinserted to establish a patent airway by a qualified practitioner.</li> </ul>			
	Resident #67 was admitted to the facility on [DATE] with multiple diagnoses that included: Encounter for Tracheostomy, Acute and Chronic Respiratory Failure with Hypercapnia, and Pyothorax Without Fistula,			
	Review of the resident's medical record revealed the following Physician's orders dated 10/15/24 di Aspiration safety precautions, every shift; Monitor area under trach mask for signs of discoloration\edema\redness every shift; Trach care twice a day (BID) and as needed (PRN), two ti day for airway management; Maintain neck collar in place, check skin under neck collar every (q) sl any changes and report to medical doctor (MD)/Nurse Practitioner (NP), every shift for safety; High Airway, every day and night shift, post 'High Risk Airway' sign at resident's bedside; FIO2 (fraction oxygen): 28%, Trach type: Shiley, Trach size: 6.5 cuffless, every shift for Respiratory Failure, wean tolerated and to keep saturations greater than 92%.		for signs of d as needed (PRN), two times a der neck collar every (q) shift for every shift for safety; High Risk s bedside; FIO2 (fraction of inspired	
	An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff code impaired cognitive skills for decision making; received oxygen therapy, suctioning, and trache			
A Care plan focus area last reviewed on 11/26/24: [Resident #67] is at risk for decannulating the device.			k for decannulating her trach	
	Goal: [Resident #67] will continue to be monitored closely so as not to allow her harm self via dec through the next review date.			
	Interventions: Educate resident to understand the risk of removing the trach device. Frequent rounds. [Resident #67] and representative (RP) educated on risk of removing trach. Frequent rounding to ensure safety. Provide alternative activities to keep her attention away from the trach.		h. Frequent rounding to ensure	
	(continued on next page)			

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER  Pridagogist Sub Acute & Robots National Harboraida		STREET ADDRESS, CITY, STATE, ZI 4601 Martin Luther King Jr Avenue	
Bridgepoint Sub-Acute & Rehab National Harborside		Washington, DC 20032	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0726	A care plan focus area last reviewed on 12/02/24: [Resident #67] has a High-Risk Airway due to (d/t) self-decannulation, airway mass, and mittens.		
Level of Harm - Minimal harm or potential for actual harm	Goal: [Resident #67] will have a pa	tent and intact airway though the review	w period.
Residents Affected - Few	Interventions: Tube out procedures: Keep extra trach tube and obturator at bedside. If tube is coughed out, call a Rapid Response immediately, reinsert airway using an obturator. If the tube cannot be reinserted and the resident is able to breathe spontaneously and there are no signs/symptoms of acute respiratory distress, provide oxygen via nasal cannula to maintain O2 saturation greater than 92%. Cover stoma site with a dressing. Keep head of bed (HOB) 30-45 degrees and monitor the resident with pulse oximetry and end-tidal for at least 24 hours. Monitor/document for signs of respiratory distress.		
	A 12/17/24 at 2:06 PM General Progress Note written by Employee #4 (Registered Nurse assigned to Resident #67): Patient alert, awake and non verbal. Vitals stable. Medicated as prescribed. Total care provided. writer called in room [ROOM NUMBER]A for trach concern. On assessment, writer noticed the gauze not in place, the trach tie loose holding the trach half way out. Writer tightened the neck tie and placed the gauze. No distress noted.		
	A 12/17/24 at 3:00 PM: Speech Therapy Note documented:		
	- Upon arrival, the patient had self-decannulated with trach [tube] near oxygen mask.		
	- No signs of respiratory distress.		
	- Alerted the nurse, two nurses entered the room and reinserted the trach.		
	- The patient made a wincing face and attempted to vocalize, indicating pain.		
	12/17/24 at 3:40 PM Respiratory Treatment Care Assessment:		
	- Trach intact.		
	<ul> <li>- Patient resting comfortably at this time after decannulation.</li> <li>- [Resident #67] self-decannulated again.</li> <li>- The nurse said that the tube was halfway out.</li> <li>- The two nurses working on 1 south re-inserted the tube successfully.</li> </ul>		
	- The patient is resting comfortably	, no distress noted.	
	An email correspondence from Employee #4 (Registered Nurse/RN) to Employee #1 (Administrator) dated 12/20/24 at 1:21 PM documented:		
	·	e patient was in bed with no shortness	of breath, no distress.
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER  Bridgepoint Sub-Acute & Rehab National Harborside		STREET ADDRESS, CITY, STATE, ZIP CODE  4601 Martin Luther King Jr Avenue SW Washington, DC 20032	
		<b>0</b> /	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0726  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few			e, the trach halfway out, visibly  2/20/24 documented:  rse, I said not but went to the room.  out, no acute respiratory distress  y on 12/26/24.  LP) stated, I was going in to see her trach [tube] had completely so they can call respiratory. The ed in the room and two nurses in the resident while the other is back in the way that they did. The first I was very worried and the facility's protocol is for cosed to call rapid response, if the

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Bridgepoint Sub-Acute & Rehab National Harborside		4601 Martin Luther King Jr Avenue	
Bridgepoint Sub-Acute & Netrab National Harborside		Washington, DC 20032	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0726  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a telephone interview on 03 colleague [Employee #5] called me room, I saw that [Resident #67]'s tremember there was one white lad moved [Resident #67]'s hands, tied back to my duties. When asked the responded, The facility's process is Therapist) who was on the unit that [tube] did not come out completely. before readjusting Resident #67's t something to the Administration was gave me an in-service.  A face-to-face interview was condu Employee #2 (Director of Nursing/I protocol is if a tube is dislodged, cateam to come, if the trach tube is cobreathing and oxygen and if require nose or mouth. Once the respirator the bedside. If not able to, the residube. Each resident with an airway exactly what to do. Whether the trastaff would be the one to first check not. We teach the tube out procedules was trained to be a qualified dislodgement/decannulation.	2/05/25 at 10:40 AM, Employee #4 states and said she needed me in room [RC] arch collar necktie was loose, and the tay was in there, a therapist, who was state the necktie and readjusted the trach [a facility's protocol for when a trach tubes to not reinsert trach, we would call rest tay, was not on the floor at that time. When asked if she checked for airway trach tube back in place, Employee #4 as made aware that something happen and the provided the resident with gauted on 03/05/25 at 12:49 PM with Employe) and Employee #6 (Director of Refull a rapid response. While waiting for nompletely out, cover the trach with gauted, provide the resident with supplement the provided that the resident with supplement to the provided that the resident with supplement to the provided that the resident with supplement to the provided that the provided that the determinant of the provided that the determinant of the provided that the determinant of the provided that the provided that the determinant of the provided that the provided the provided that the provided that the provided that the provided that the	ed, I was in another room, my rOM NUMBER]. I went into the rach [tube] was halfway out. I anding there. What I did was, I tube] back in place, and then went e comes out, Employee #4 spiratory. The male RT (Respiratory I didn't call him because the trach y patency or oxygenation status stated, No. Someone reported ed because they wrote me up and apployee #1 (Administrator), espiratory) Employee #6 stated, The espiratory therapist or the response ize dressing, monitor the resident's notal breathing via an Ambu bag via sment and reinsert the trach tube at are not trained to reinsert a trach written in their care plans that states a respiratory therapist or trained mination to reinsert the trach tube or incoved no documented evidence lent's tracheostomy in the event of

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Facility ID: 095024

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