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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 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)

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

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care plan focus area last reviewed on 11/26/24 documented: [Resident #67] is at risk for decannulating her trach device. Goal: [Resident #67] will continue to be monitored closely so as not to allow her harm self via decannulation 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. 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. Goal: [Resident #67] will have a patent and intact airway though the review period. 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 physician's order dated 12/12/24 directed, Speech Language Pathology (SLP) evaluation and treat 4x/week x 30 days. A 12/17/24 at 11:19 AM Pain Assessment in Advanced Dementia (PAINAD): score, 0. 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: - 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. A12/17/24 at 3:40 PM Respiratory Treatment Care Assessment: - Trach intact. (continued on next page)

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Patient resting comfortably at this time after decannulation. - [Resident #67] self-decannulated again. - The nurse said that the tube was halfway out. - The two nurses working on 1 south re-inserted the tube successfully. - 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: - 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 wasn't in place and the trach was loose, the trach halfway out, visibly about 2 centimeters (cm). - The writer tightened the necktie and 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 and asked if I was [Resident #67's] nurse, I said not but went to the room. - I saw the resident with a loose trach tie and the trach [tube] was slightly out, no acute respiratory distress was noted. - I called [Employee #4]. - The nurse adjusted the trach [tube] and trach tie. - I left the room, leaving the nurse and the therapist in the room. An anonymous Complaint, DC~13353, was submitted to the State Agency on 12/26/24. During a face-to-face interview on 03/05/25 at 10:24 AM, Employee #3 (SLP) stated, I was going in to see [Resident #67] for a speech therapy session and when I walked in, I saw her trach [tube] had completely come out and was resting on the oxygen mask. I alerted the nursing staff so they can call respiratory. The resident had a history of picking at her trach, so I was very worried. I stayed in the room and two nurses walked in, and did not perform any hand hygiene. One nurse pinned down the resident while the other jammed the trach back in. The resident winced in pain when the trach was back in the way that they did. They did not check the resident's vital signs or anything and then they both left. I was very worried and reported it to my supervisor. (continued on next page)

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 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. A face-to-face interview was conducted on 03/05/25 at 12:49 PM with Employee #1 (Administrator), Employee #2 (Director of Nursing/DON) and Employee #6 (Director of Respiratory) Employee #6 stated, The protocol is if a tube is dislodged, call a rapid response. While waiting for respiratory therapist or the response team to come, if the trach tube is completely out, cover the trach with gauze dressing, monitor the resident's breathing and oxygen and if required, provide the resident with supplemental breathing via an Ambu bag via nose or mouth. Once the respiratory therapist arrives, they do their assessment and reinsert the trach tube at the bedside. If not able to, the resident would get transferred out. Nurses are not trained to reinsert a trach tube. Each resident with an airway has a Tube Out intervention protocol written in their care plans that states exactly what to do. Whether the trach tube is partially or completely out, a respiratory therapist or trained staff would be the one to first check for airway in order to make the determination to reinsert the trach tube or not. We teach the tube out procedure to all nurses at the annual skills fair. Review of Employee #4's record on 03/05/25 for training/competencies showed no documented evidence that she was trained to be a qualified practitioner who can reinsert a resident's tracheostomy in the event of dislodgement/decannulation. It should be noted that Resident #67 did not suffer any harm from this deficient practice. Cross Reference 22B DCMR Section 3215.3

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43776 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: - 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 the following Physician's orders 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%. An Annual Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded; severely impaired cognitive skills for decision making; received oxygen therapy, suctioning, and tracheostomy care. A Care plan focus area last reviewed on 11/26/24: [Resident #67] is at risk for decannulating her trach device. Goal: [Resident #67] will continue to be monitored closely so as not to allow her harm self via decannulation 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. (continued on next page)

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Goal: [Resident #67] will have a patent and intact airway though the review period. 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. - Patient resting comfortably at this time after decannulation. - [Resident #67] self-decannulated again. - The nurse said that the tube was halfway out. - The two nurses working on 1 south re-inserted the tube successfully. - 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: - On 12/17/24, I arrived in 156A, the 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The gauze around the [trach] site wasn't in place and the trach was loose, the trach halfway out, visibly about 2 centimeters (cm). - The writer tightened the necktie and 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 and asked if I was [Resident #67's] nurse, I said not but went to the room. - I saw the resident with a loose trach tie and the trach [tube] was slightly out, no acute respiratory distress was noted. - I called [Employee #4]. - The nurse adjusted the trach [tube] and trach tie. - I left the room, leaving the nurse and the therapist in the room. An anonymous Complaint, DC~13353, was submitted to the State Agency on 12/26/24. During a face-to-face interview on 03/05/25 at 10:24 AM, Employee #3 (SLP) stated, I was going in to see [Resident #67] for a speech therapy session and when I walked in, I saw her trach [tube] had completely come out and was resting on the oxygen mask. I alerted the nursing staff so they can call respiratory. The resident had a history of picking at her trach, so I was very worried. I stayed in the room and two nurses walked in, and did not perform any hand hygiene. One nurse pinned down the resident while the other jammed the trach back in. The resident winced in pain when the trach was back in the way that they did. They did not check the resident's vital signs or anything and then they both left. I was very worried and reported it to my supervisor. 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 #676] 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. (continued on next page)

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	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Sub-Acute & Rehab National Harborside	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. A face-to-face interview was conducted on 03/05/25 at 12:49 PM with Employee #1 (Administrator), Employee #2 (Director of Nursing/DON) and Employee #6 (Director of Respiratory) Employee #6 stated, The protocol is if a tube is dislodged, call a rapid response. While waiting for respiratory therapist or the response team to come, if the trach tube is completely out, cover the trach with gauze dressing, monitor the resident's breathing and oxygen and if required, provide the resident with supplemental breathing via an Ambu bag via nose or mouth. Once the respiratory therapist arrives, they do their assessment and reinsert the trach tube at the bedside. If not able to, the resident would get transferred out. Nurses are not trained to reinsert a trach tube. Each resident with an airway has a Tube Out intervention protocol written in their care plans that states exactly what to do. Whether the trach tube is partially or completely out, a respiratory therapist or trained staff would be the one to first check for airway in order to make the determination to reinsert the trach tube or not. We teach the tube out procedure to all nurses at the annual skills fair. Review of Employee #4's record on 03/05/25 for training/competencies showed no documented evidence that she was trained to be a qualified practitioner who can reinsert a resident's tracheostomy in the event of dislodgement/decannulation. It should be noted that Resident #67 did not suffer any harm from this deficient practice. Cross Reference 22B DCMR Section 3210.4