STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 53 sampled residents, facility staff failed to complete a thorough investigation for a facility-reported incident (FRI) that alleged a facility staff removed a 10-tablet blister pack of Resident #38's narcotic pain medication.The findings included:Resident #38 was admitted to the facility on [DATE] with diagnoses that included: Pressure Ulcer of Sacral Region Stage 4, Anoxic Brain Damage; Epilepsy; and Muscle Weakness.Review of the resident's medical record revealed the following:A physician's order dated 08/21/25 that directed: Tramadol (narcotic pain reliever) HCl oral tablet 50 mg (milligram), give 50 mg via PEG-Tube (Percutaneous Endoscopic Gastrostomy tube) every 8 hours for moderate to severe pain.The Medication Administration Records (MAR) for August 2025 and September 2025 showed that facility staff documented that they administered Tramadol HCl oral tablet 50 mg via PEG-Tube (every 8 hours for moderate to severe pain at 2:00 AM, 10:00 AM, and 6:00 PM from 08/21/25 to 09/09/25.A FRI submitted online to the State agency on 09/01/25 documented in part:On 09/01/25, at around 8:05 AM, it was reported that Tramadol HCL Oral Tablet 50 mg (milligram) bubble pack belonging to [Resident #38] was missing. [Nurse Practitioner/NP] made aware. This is the initial report, investigation ongoing. A final report received on 09/18/25 at 4:45 PM that documented in part:This is the final report to the self-report that was submitted on 09-01-2025 regarding the missing Tramadol HCL Oral Tablet 50 mg (10 tablets) bubble pack belonging to [Resident #38]. The nurse involved was interviewed (Employee #30) and a statement was obtained. [Employee #30] was unable to explain and account for the missing narcotics.During the investigation, staff were interviewed, and statements were obtained. Investigation shows that [Employee #30] was still in possession of the narcotics as evidenced by her signatures on the MAR and narcotic sheet.At the completion of a thorough investigation, the facility was able to substantiate that 10 tablets of Tramadol 50 mg bubble pack were missing and cannot be accounted for based on the narcotic count sheet reconciliation. Employee #30 has been separated from the facility to meet facility expectations regarding proper handling of controlled substances.Review of the facility's investigation documents on 05/04/26 showed that thorough investigation of the incident was not conducted as evidenced by:No documented evidence that Employee #30 did not work at the facility during the investigation period for the incident;No documented evidence to show that facility staff investigated why the times and dosages of the resident's Tramadol on the Controlled Drug Receipt/Record Disposition Form were inconsistent with the physician's order. During a face-to-face interview on 05/06/26 at approximately 3:00 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no further comments.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) of 53 sampled residents, facility staff failed to revise and update Resident #112's care plan with goals and interventions to address a left medial lower leg and right knee abrasions. The findings included: Review of the facility's Pressure Ulcer/Injury Risk Assessment policy dated 05/24/24 documented in part: Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. The interventions must be based on current, recognized standards of care. The effects of the interventions must be evaluated. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Resident #112 was admitted to the facility on [DATE] with multiple diagnoses that included Pressure Ulcer of Sacral Region, Encephalopathy, Chronic Respiratory Failure with Hypoxia and Iron Deficiency Anemia. Review of the resident's medical record revealed the following:09/18/24 at 8:03 PM admission Summary: [AGE] year-old female admitted to unit at 6.56 PM. 09/18/24 admission Braden Scale for Predicting Pressure Ulcer Sore Risk: Score, 11.0, High risk. 09/19/24 at 10:03 AM admission Skin and Wound Note:Wound: 1 - midline abdomenPrimary Etiology: SurgicalStage/Severity: Partial ThicknessWound Status: Present on AdmissionSize: 1 (centimeters (cm) x 1 cm x 0.1 cm. Calculated area is 1 square (sq) cm.Wound: 2 - sacrumPrimary Etiology: PressureStage/Severity: Stage 3Wound Status: Present on AdmissionSize: 2 cm x 3.5 cm x 0.1 cm. Calculated area is 7 sq cm. A care plan focus area [Resident #112] has pressure ulcer of the sacral area related to (r/t) disease process and immobility with goals and interventions was initiated on 09/21/24. A care plan focus area , [Resident #112] has actual impairment to skin integrity of the mid abdomen r/t surgical wound with goals and interventions was initiated on 09/21/24. An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded the following: Brief Interview for Mental Status not conducted because resident rarely/never understood; and had one stage 3 pressure ulcer/injury over bony prominence.10/01/24 at 8:53 AM Skin and Wound Note:New right knee and left medial lower leg abrasions. 10/08/24 at 9:19 AM Skin and Wound Note:Right knee and left medial lower leg abrasions slowly improving in epithelium. Midline abdominal surgical wound slowly improving in stable epithelium. Sacral PI wound continues to evolve, with improvement in slough bone now exposed. A Complaint, #2592261, received by the State Agency on 08/15/25 documented in part:The purpose for this correspondence is to request the Department of Health to investigate to determine if [facility name] has adequate and appropriate policies, procedures and or protocol in place to mitigate the development of skin breakdown and pressure ulcers. The evidence showed that facility staff failed to update Resident #112's care plan after she developed right knee and left medial lower leg abrasions on 10/01/24. During a face-to-face interview on 04/22/26 at 1:10 PM, Employee #2 (Director of Nursing/DON) reviewed Resident #112's care plan, acknowledged the findings and stated, Updating the care plan is up to the unit managers, supervisors and the interdisciplinary team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, record review, and staff and family interview, for one (1) of 53 sampled residents, the facility failed to ensure that: (1) Resident 43's gown and linen were dry and free from stains, and incontinent care was provided in a timely manner. And (2) Resident #43 was turned and repositioned in a timely manner. (Resident #43)The findings included: Resident#43 was admitted to the facility on [DATE]. The resident has a history of Cerebral Infarction, Muscle Weakness, and Stage 3 and Stage 4 Pressure Ulcers.A review of a quarterly Minimum Data Set assessment dated [DATE] documented that the resident did not have a Brief Interview for Mental Status summary score, indicating the assessment was not conducted. The resident was coded for being dependent on staff for activities of daily living, always incontinent of bowel, having a urinary catheter, and having one Stage 3 and one Stage 4 pressure wound. 1. An observation on 04/29/26 at 10:20 AM showed the resident lying in bed with light red wet spots on his gown and bed linen. The resident was also noted to have dry, brown colored stool on his left thigh. The complainant (daughter) was at the bedside during the observation.During a face-to-face interview on 04/29/26 at approximately 10:25 AM, the complainant stated that she often finds her father needing care. During a face-to-face interview on 04/29/26 at 10:30 AM, Employee #21 (assigned RN) stated that the resident's gown and linen may be wet and stained by medication. The employee said she may have accidentally spilled medication while administering it. During a face-to-face interview on 04/29/26 at 10:35 AM, Employee #22 (assigned CNA) stated that he made rounds on the resident when he first arrived at 7 AM. The employee said at that time the resident's bed was clean and he did not need incontinent care. Additionally, the employee then said, I'm here now to provide care. 2. A care plan dated 03/30/26 documented in part, Focus - [Resident #43 has pressure ulcers related to disease process (Chronic respiratory failure, chronic kidney disease, diabetes.immobility.Intervention- The resident needs assistance to turn/reposition at least every 2 hours or more often as needed or requested.A complaint intake (# 2739155) submitted to the State Agency on 04/08/26 documented in part, I am writing to you with urgent concerns regarding my father,[Resident #43], especially following his recent diagnoses of sepsis, pneumonia, and dehydration at [Hospital's name].In light of these developments, we are requesting several critical adjustments to his care.The implementation of a strict and visible 2-hour repositioning schedule, which is vital due to his prolonged immobility.During a telephone interview at approximately 1 PM on 04/27/26, the complainant stated that the staff does not turn and reposition her dad for hours. The complainant also said that she often turns her dad if the staff does not turn him within 3 hours. She said that the last time she had to turn him was last week. Additionally, the complainant stated that she has talked with the Administration many times about her concern, but nothing has changed. Multiple observations at approximately 4:50 AM, 8:50 AM, 9:55 AM, and 10:20 AM on 04/29/26 showed Resident #43 lying supine. The resident was awake, non-verbal, and the tracheostomy site was clean.During a face-to-face interview on 04/29/26 at approximately 5:00 AM, Employee #24 (assigned night-shift CNA) stated that he had just completed care for the resident, which included a bed bath. During a face-to-face interview at approximately 1 PM on 04/29/26, Employee #22 (assigned dayshift CNA) stated that he conducted his first observation of the resident at around 7 AM, when he arrived; he did not reposition the resident. He did, however, reposition the resident after he provided care for activities of daily living, which began around 10:30 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 53 sampled residents, facility staff failed to order a wound consult and treatment for a resident who was observed with blisters on his right buttock. Subsequently, five (5) days later, the resident was observed with a Stage 3 pressure ulcer to his right buttock. Resident #38.The findings included: A review of the facility policy entitled Pressure Ulcer/Injury Assessment, reviewed 12/2025 that documented: Steps in the Procedure:Gather assessment tools and documentation and conduct the assessment in the manner most appropriate to the resident's condition and willingness to participate. If necessary, allow the resident to take rest periods during the assessment. Conduct a structured pressure ulcer/injury risk assessment using a facility-approved tool. Conduct a comprehensive skin assessment with every risk assessment. a.When conducting a skin assessment, provide for the resident's privacy. b.Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. c. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin. Resident #38 was admitted to the facility on [DATE] with diagnoses that included: Pressure Ulcer of Sacral Region, Stage 4; Type 2 Diabetes Mellitus without Complications, Metabolic Encephalopathy; Muscle Weakness (Generalized); and Encounter for Attention to Gastrostomy. Review of Resident #38's medical record revealed: Physician's orders dated 05/30/25 that directed, Inspect the skin of all admissions and if the resident develops a wound during stay, evaluate and treat as indicated; Turn and reposition every 2 hours. A physician's order dated 06/25/25 that directed: Shower/Complete bed bath, every Wednesday and Saturday. A quarterly minimum data set assessment dated [DATE] that documented, Resident #38 was at risk for developing pressure ulcers and had one Stage unhealed Stage 4 pressure ulcer that was present upon admission. A skin and wound note signed by [Employee # 27/Nurse Practitioner for Wound Care Team] dated 02/03/26 that documented: . Assessment/Plan: Focused wound examination completed today. Stage 4 pressure injury to the sacrum is improving in size. Increase in undermining noted as above. The tissue to the wound bed is healthy, beefy red. Bone exposure persists, though wound is stable. No, immediate concerns for infection at this time. -Continue with the treatment recommendations above. Of note, on 02/04/26 there was no documented evidence that any other wound except the sacral wound was assessed or treated by the wound care team. A care plan initiated on 04/15/25 that documented: Focus: [Resident #38] has actual pressure ulcer development r/t immobility and fragile skin. Goal [Name of Resident #38] will have no complications r/t (related to) pressure ulcer of the sacrum through the review date. Interventions: Administer medications as ordered; Monitor/document for side effects and effectiveness; Administer treatments as ordered and monitor for effectiveness; Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. The resident needs to turn/reposition at least every 2 hours, more often as needed or requested; The resident requires low air loss mattress; Treat pain as per orders prior to treatment/turning etc. to ensure The resident's comfort; Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. An e-Interact change in condition progress note dated 02/04/26 that documented in part:Situation: Change in condition/s(CIC) reported are/were skin wound or ulcer.During the assessment noticed open blister on the Rt. (right) side of the gluteal area. Cleanse(d) the wound with cleanser and apply xeroform dressing. Obtained wound consult; responsible party notified. No pain or distress noted. Primary Care Provider responded with the following feedback: Cleanse the wound with cleanser and apply xeroform dressing. Obtained wound consult. Review of the physician's orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2026 showed no documented evidence that the Xeroform or wound consult were ordered as indicated on e-Interact progress note. Review of the progress notes (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0686 Level of Harm - Actual harm Residents Affected - Few	from 02/04/26 to 02/09/26 showed no documented evidence that facility staff followed the procedure steps of using an assessment tool for assessing pressure ulcers/ injuries as documented in their policy. A wound assessment report dated 02/09/26 documented: Wound Evaluation Date: 02/09/2026.Location: Right buttock.Measurements: Length: 2.30 cm (centimeters) Width: 1.00 cm; L (length) x W (width): 2.30 cm2 (centimeters squared); Depth: 0.30 cm.Etiology: Pressure Ulcer/Injury, Stage/Severity: Stage 3. Acquired in House: Yes.Date Wound Acquired: 02/09/2026. A physician's order dated 02/09/26 directed: Right buttock wound; Cleanse with wound cleanser, apply silver alginate, cover with bordered dressing daily and prn every day shift.During an observation of wound care rounds on 05/21/26 at 10:26 AM with Employee #27 (Consultant Wound Care Nurse Practitioner), it was noted that Resident #38 had three wounds: a Stage 4 sacral wound, a Stage 4 right buttock wound, and a Stage 2 left heel wound. During a face-to-face interview on 04/21/2026 10:29 AM with Employee #27, he stated that currently, Resident #38 was being seen weekly by the wound care team for three (3) pressure ulcers/injuries: a Stage 4 sacral wound (present on admission), a facility-acquired Stage 4 wound to the right buttock (started off as a Stage 3), and a facility-acquired Stage 2 pressure injury (opened blister) to the left heel. When asked if facility staff had made him aware of a blister on Resident #38's right buttock prior to 02/09/26, he stated, No. I first observed the Stage 3 pressure ulcer to the right buttock during wound care rounds for the resident on 02/09/26. A few weeks later, after closely reviewing my pictures of the wound from 02/09/26, I saw that there was slightly exposed bone visible, and I re-staged the wound as a Stage 4 pressure ulcer. When asked if a blister could progress to a Stage 3 pressure ulcer within 5 days, he stated , It is possible. A blister is a Stage 2 pressure injury that can be the first sign of more serious deep tissue injury underneath the skin. With residents who have fragile skin, such as Resident #38, lying in the same position, moisture, lack of proper treatment to the blister, and shearing of skin, could cause a blister to advance to a Stage 3 or Stage 4 pressure ulcer in a short period of time. During a face-to-face interview on 04/29/26 at 12:53PM, Employee #21 (Registered Nurse) stated that she noticed an open blister on Resident #30's right buttock during incontinent care (on 02/04/26). She further stated that she contacted the resident's representative and the physician immediately. Employee #21further stated that the physician told her to clean the wound, apply Xeroform dressing, and enter a wound consult in the resident's medical record. She commented further that she entered the treatment and wound consult orders and documented in an e-Interact progress note in the resident's medical record. When asked, Employee #21 was not able find the wound consult or the treatment orders that she stated she had entered on 02/04/26 in Resident #38's medical record. When asked if she used the assessment tool for pressure ulcers/injuries per facility policy, Employee #21 reported that she was not familiar with an assessment tool. During a face-to-face interview on 05/05/26 at 12:12 PM, Employee #28 (Wound Care Nurse) stated that all residents with wounds receive daily wound care (cleaning the wounds and changing wound dressings) daily by the wound care nurses. If the wound gets soiled or the dressing falls off, they are changed as needed by the nurses. Employee #28 added that when new skin areas are observed by staff, the nurse can either call the physician or notify the wound care nurses. Regarding Resident #38, Employee #28 stated that the resident was seen by the wound care nurse daily and that she entered the orders for a wound consult and for wound treatment orders on 02/09/26 for the Resident's right buttock after observing the wound with the wound care treatment team. She further commented that she was never made aware that Resident #38 was observed with a blister to his right buttock by the nurse on 02/04/26. Employee #28 also stated that she had not noticed any skin alterations to the resident's right buttock prior to 02/09/26, when it was documented at a Stage 3. Of note, there was no documented evidence that facility staff followed the procedure steps for assessing pressure ulcers/ injuries as documented in their policy. When asked if she used the assessment tool when assessing resident's wounds, , Employee #28 stated that she was not familiar with the assessment tool per the facility's policy. During a face-to-face interview on 05/05/26 at 3:59 PM, Employee #2 (Director of Nursing), stated that she was not familiar with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0686 Level of Harm - Actual harm Residents Affected - Few	assessment tool referred to in the facility's policy. The nurse assigned to the resident and the wound care nurses assess the wounds and document their findings in the progress notes. The evidence showed that Employee #21 first observed a blister on Resident #38's right buttock on 02/04/26 and notified the resident's primary care physician. However, there is no documented evidence that the facility staff followed their pressure ulcer injury policy. ,wound consult or the treatment for Xeroform to be applied to the area were ever ordered as specified by the physician. However, there is no documented evidence that the facility staff followed their pressure ulcer injury policy. Subsequently, 5 days later, on 02/09/26, the right buttock blister was assessed to be a Stage 3 pressure ulcer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, staff interview, and family interview, the facility's staff failed to ensure that a resident with a tracheostomy was accompanied by nursing staff during a podiatry appointment for one of the 53 sampled residents. (Resident #43) Resident #43 was admitted to the facility on [DATE] with multiple diagnoses, including Aphasia, Chronic Respiratory Failure, Tracheostomy, and Muscle Weakness.A physician order with a re-order date of 01/31/26 instructed, On Trach collar: FI02:28%, Trach Type: [NAME], Trach Size: XL 7 every shift. Trach and suction care by a respiratory therapist and a nurse every shift.A quarterly Minimum Data Set assessment dated [DATE] showed that the resident did not have a Brief Interview for Mental Status summary score, indicating that the assessment was not conducted. Additionally, the resident was coded for requiring maximum staff assistance with all activities of daily living, tracheostomy care, and suctioning. The resident was also coded for receiving respiratory services. A nursing note dated 02/05/26 at 5:48 pm documented in part, Resident went for the podiatry appointment, and back at 3:30 [PM] by [Name of company] transportation. Resident Alert [at] this time, vital signs within normal limits. A compliant intake (#2739155) submitted to the State Agency dated 02/09/26 documented in part, I am writing to you with profound concern regarding my father,[Resident #43's name], transportation to his podiatry appointment on Thursday, February 5th. It was deeply distressing to learn that he, an incapacitated patient with a tracheostomy, was reportedly transported without any accompanying supervision or support from Bridgepoint staff. This lapse was brought to my attention by the nurse manager at [Name of Podiatry Department], who contacted me after the appointment. She expressed significant alarm over the lack of awareness regarding my father's tracheostomy. The [Name of office] staff were unprepared to handle a potential airway emergency, such as the need for suction, due to the absence of appropriate equipment and prior notification. This oversight placed my father, who is unable to advocate for himself, in a precarious and potentially life-threatening situation.Multiple observations from 04/20/26 to 04/29/26 showed the resident lying in bed with head of bed at a 90-degree angle. The resident was noted to have a tracheostomy tube. The secretions from the tracheostomy were thin and clear, no smell noted, no redness noted at the stoma site, Fraction of Inspired oxygen at 28% via tracheostomy collar, tracheostomy ties were clean and secure, and the split gauze under the tracheostomy tube was clean. During a face-to-face interview on 04/29/26 at approximately 9:00 AM, Employee #23(RN/Unit Manager) stated that the resident was sent to the podiatry appointment without a nurse or tracheotomy supplies. The employee said it was an oversight because they thought the transportation company that took the resident to the appointment would have provided supervision during the appointment. Additionally, the employee stated that the facility now ensures that a nurse accompanies any residents with respiratory needs on appointments. During a face-to-face interview on 04/29/26 at approximately 10 AM, the complainant stated that she was called by a nurse from the Podiatry office. The nurse left her a voice message that said the resident was sent to the office without an employee from the facility or tracheostomy supplies. The nurse also said that if the resident required suctioning, the office would not have been able to provide that type of care. Additionally, the complainant stated that Employee #23 approached her and apologized, saying it was an oversight to send the resident out without a nurse. During a telephone interview on 04/29/26 at approximately 1 PM, a customer service representative from the transportation company stated that the paramedic may stay with a patient (1st) during an appointment. However, if they are (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled to transport another patient (2nd), then they will drop the first patient off at their appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 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** Number of residents sampled: Number of residents cited: Based on record review, staff interview, and family interview, the facility failed to ensure Employee #22 (CNA) did not remove a soiled sacral dressing and replace it with a clean gauze for one of 53 sampled residents. (Resident #43)Resident#43 was admitted to the facility on [DATE]. The resident has a history of Cerebral Infarction, Muscle Weakness, and Stage 3 and Stage 4 Pressure Ulcers.A care plan with a review date of 12/18/25, documented in part, Focus [Resident #43 has pressure ulcers related to disease process (Chronic respiratory failure, chronic kidney disease, diabetes.immobility.Intervention- administer treatments as ordered and monitor for effectiveness [LPN, RN, or NP]. A wound assessment report dated 02/24/26 documented in part, Location-sacrum, measurements length 4.00 cm (centimeters), width-6.00 cm, depth 2.90 cm. Observation- Stage 4.A physician order with a reorder date of 03/03/26 instructed, Sacrum wound: Cleanse with wound cleanser, apply collagen to wound bed, hydrogel moistened rolled gauze [packing dressing] to undermining from 7 o'clock to 5 o'clock, cover with bordered dressing daily and as needed.A complaint intake (#2739155) submitted to the State Agency on 03/09/26 document in part, I also need to report a new and very concerning incident that occurred on Friday, 03/06/26, afternoon involving my father [Resident #43]. During a personal care session, a Certified Nursing Assistant [Employee #22] was assisting him with hygiene and wound dressing changes. I observed the CNA using the same pair of gloves to clean fecal matter and then immediately remove my father's old wound dressing. This practice raised immediate concerns about cross-contamination and adherence to proper infection control protocols. Furthermore, a specific dressing, which I refer to as a rolling glaze, appeared to be significantly stuck to my father's skin and underlying tissue. The CNA attempted to remove it by forcefully pulling it. I made eye contact, and the CNA then sprayed wound-cleaning solution directly onto the stuck dressing. Without allowing any time for the solution to penetrate or loosen the adhesive, the CNA immediately pulled the dressing again, causing my father's skin to bleed noticeably.During a face-to-face interview at 7:30 AM on 04/29/26, Employee #21(CNA) stated that he does not provide wound care. He said that he assists the nurse with positioning during wound care. And he will also notify the nurse if a resident's wound is soiled or if it comes off during bathing. During a face-to-face interview at approximately 9 AM on 04/29/26, Employee #23 (RN/Unit Manager) stated that no family notified her that a CNA was providing wound care. Additionally, the employee stated that it is not in the CNA's scope of practice to provide wound care. During a face-to-face interview starting at approximately 10 AM, the complainant stated that Employee #22 (CNA) has changed the resident's sacral wound dressing on several occasions. The complainant said that during one dressing change, the employee did not change his gloves after removing the sacral dressing, which was soiled with stool. Instead, he started providing wound care. He attempted to pull out the rolling gauze [packing dressing inside the sacral wound] without moistening it, but it was stuck, so he used a spray to loosen it. The wound did bleed. He covered the wound with gauze and taped it. He did not sign or date the dressing. During the interview, the complainant demonstrated how the employee provided wound care. Also, Employee #2 (DON) and Employee #23 (RN/Unit Manager) were present during the interview and demonstration. During a face-to-face interview at approximately 9 AM on 04/30/26, Employee #2 stated that she spoke with Employee #22, who stated that one time while he was providing incontinent care, he noticed that the resident's sacral dressing was soiled with feces. He removed the soiled dressing, cleaned the area, replaced it with a clean gauze, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	secured it with tape. The employee stated that the resident was suspended until an investigation because the resident was working outside of his scope of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095027	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgepoint Subacute 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, for one (1) of 53 sampled residents, facility staff failed to ensure proper storage of Resident #43's medication. The findings included:According to the manufacturer, Novo Nordisk, medical guidelines for Ozempic stated, Recommended Storage Conditions for Ozempic Single-patient-use pens (with multiple weekly doses): After first use of the Ozempic pen, the pen can be stored for 56 days at controlled room temperature 15 C to 30 C (59 F to 86 F) or in a refrigerator 2 C to 8 C (36 F to 46 F).https://www.ozempic.comResident #43 was admitted to the facility on [DATE] with diagnoses that included: Morbid (Severe) Obesity and Chronic Obstructive Pulmonary Disease (COPD).Review of Resident #43's medical record revealed:A physician's order dated 10/29/25 that directed: Ozempic 2 mg/(milligram)/ dose. Subcutaneous Solution Pen-injector 8 mg/3ml (milliliters) (Semaglutide). Inject 2 mg subcutaneously in the morning every Wed (Wednesday) for 90 days. Give weekly.During observation of the medication storage refrigerator on 04/22/26 at 10:20 AM, it was noted that Resident #43 had an open box of Ozempic (Semaglutide, a weight-loss medication) multi-use pens. Handwritten on the box was Opened 11/02/25. The evidence showed that Resident #43's Ozempic medication pen was stored for use beyond the manufacturers recommended 56 days. The medication should have been discarded on 02/11/26.During a face-to-face interview with Employee #33 on 04/22/26 at 10:20 AM, acknowledged the findings and stated that she was unsure how long a pen of Ozempic can be used after being opened.