STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced facility reported incident/complaint survey was conducted at this facility from December 30, 2022 to January 12, 2023. Survey activities consisted of observations, record review, and resident and staff interviews. The facility's census during the survey was 237 and the sample included six (6) residents. Facility reported incident DC00011427 and Complaint DC00011462. Deficiencies were cited related to both investigations. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32 requirements for Long Term Care Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility	F 000	Deanwood Rehabilitation and Wellness Center LLC makes its best efforts to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth on the statement of the deficiencies. This plan of correction (POC) is prepared and/ or executed because it is required by State and Federal laws.	

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

Joyce D. Raphael | Interim Administrator | 2/23/2023

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.

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F 000	Continued From page 1	F 000		

CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue
Dl- Deciliter
DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident

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F 000	Continued From page 2 Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	F 000		02.24.23
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview, the facility failed to ensure that Resident #2 received incontinent care in a timely manner for one (1) of six (6) sampled residents. The findings included:	F 558	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** A head-to-toe assessment was done by the charge nurse on 1.15.23 for Resident #2 and no new issues were noted. No negative outcomes were noted from this deficient practice.	

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F 558	Continued From page 3 Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, chronic pain, and major depression. Review of the District of Columbia's complaint intake #DC00011462 documented," ...my mother has endured ... being left uncleaned for multiple instances of 12 + hours or more .... " During an observation on 01/10/23 around 11:00 AM. Resident #2 was seen brushing her teeth while sitting in bed. The resident was asked how did she like the care provided by staff? She stated that staff take a long to provide incontinent care when she has a bowel movement. When asked if she could remember when that happened? She stated, "It happens all the time. Yesterday (01/09/22), I had to wait 2 hours and 15 minutes to be changes. I told them at 9:15 AM and they came at 11:30 AM." When asked if she had to wait longer than 2 hours and 15 minutes prior to 01/09/22? Resident stated, "Yes, I waited overnight one time, but I can't remember the date." Review of the Resident #2's medical record revealed the following: 07/19/22 [physician order] instructed, "Incontinent care by 2 persons every shift." 11/13/22 (revision date) Care Plans documented: Focus area- [Resident's name] had bladder and bowel incontinence r/t (related to uncontrol urges, morbid obesity and physical limitations. Interventions: Check the resident every 2 hours and as required for incontinence. [Resident's	F 558	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** All current residents have the potential to be affected. A unit-wide audit will be done no later than 2.17.23 by the Unit Manager for all residents on the unit where Resident#2 resides, to ensure they received incontinent care in a timely manner. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education will be done by the Staff Educator through Healthcare Academy for all nurses and CNAs on importance of providing timely incontinent care. This will be completed no later than 2.23.23 **4. MONITORING CORRECTIVE ACTION** Unit Managers will conduct rounds on their units to ensure requests for incontinence care are addressed timely. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23

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F 558	Continued From page 4	F 558		02.24.23

name] cannot participate in toileting and requires total assistance with incontinence care/management at this time ..."

Focus area - [Resident's name] has an ADL (activity of daily living) self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity and she is a 2 person assist. Interventions- 2 staff to sign ADL form, [Resident's name] most (sp) be assisted by 2 persons at all times ..."

12/17/22 [Quarterly Minimum Data Set] documented, Resident #2 had a Brief Interview for Mental Status summary score of "15" indicating the resident had an intact cognitive status. The resident was coded for frequently incontinent of stool, always incontinent of urine, and being totally dependent of two or staff members for toilet use.

01/09/23 [Resident Care Monitoring] Log documented that incontinent care was provided at 10:40 AM.

During a face-to-face interview on 01/10/23 at approximately 11:30 AM, Employee #10 (Certified Nursing Assistant - CNA) reported that the resident informed her around 8:30 AM that she needed incontinent care. According to the employee, she did not provide care at 8:30 AM because she had to feed residents, prepare two residents for dialysis, and wait until another certified nursing assistant could assist her. Employee #10 then reported that she provided incontinent care a few hours later.

During a face-to-face interview on 01/10/22 at 12:15 PM, Employee #11 (Unit Manager) stated

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F 558	Continued From page 5 that she was made aware of the delay in staff providing incontinent care. According to her, she asked the certified nursing assistant why it took 2 hours to provide incontinent care for Resident #2. She was told by the certified nursing assistant that she had to feed residents, prepare two residents for dialysis, and wait for another nursing assistant to assist Resident #2. Employee #11 was asked which was the highest priority for her staff, changing an incontinent resident or making sure a resident was ready for dialysis. She said, "Get residents ready for dialysis".	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, facility staff failed to ensure that Resident #2's Minimum Data Set (MDS) assessment was coded to reflect her current dental status at the time of the assessment for one (1) of six (6) sampled residents. The findings included: Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, and hypertension. Review of the Dental Consult dated 04/06/22 documented, " ... fractured ...[teeth] #19, #20, and # 30 ...pt (patient) referral to [hospital's name] for treatment."	F 641	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The MDS for resident#2 was corrected on 1.13.23 and coded for obvious or likely cavity or broken natural teeth. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All current residents have the potential to be affected. A house wide audit will be done by the Director of Nursing/designee no later than 2.21.23 for all MDS completed from 9.19.22 to 2.15.23 to ensure that current residents with broken teeth/cavity were coded correctly. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education was done on 2.15.23 for the MDS coordinator by the MDS Director to ensure that the MDS coding reflects the resident's Dental status correctly.	

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F 641	Continued From page 6 Review of Resident #2's Annual MDS dated 05/05/22 documented, "The resident had a Brief Interview for Mental Status summary score of "15" indicating that the resident had an intact cognitive status. The resident was also coded for obvious or likely cavity or broken natural teeth. Review of the resident's Quarterly MDS dated 09/19/22 revealed the resident was not coded for dental issues including broken teeth. During a face-to-face interview on 01/12/22 at 2:05 PM, Employee #7 (MDS Director) stated that if the resident had broken teeth at the time of the assessment on 09/19/22, it should have been recorded. He then said he would assess the resident and correct the MDS.	F 641	**4. MONITORING CORRECTIVE ACTION** An audit will be done by the Director of Nursing/designee to ensure that MDS is coded accurately to reflect the resident's current dental status. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Meal Preference for Resident# 2 was updated on 01/10/23 with the resident's dietary preferences to avoid gravy. Care plan for Resident #2 was updated to ensure meal preferences on 2.23.23 are followed. The resident did not have any negative outcome from the deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. Food Services Manager or designee will audit menu preferences to ensure that residents are provided with food of their choice/preference. The audit will be completed no later than 2.21.23. Any negative issues will be corrected upon discovery.	

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F 656	Continued From page 7 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, the facility failed to develop a care plan to with goals and approaches to address Resident #2's dietary preference (no gravy on food) for one (1) of six (6) sampled residents. The findings included: Review of the District of Columbia's complaint	F 656	3. **MEASURE TO PREVENT REOCURRENCE** Education was done by the Staff Educator/designee for the dietitians and Food service manager on 2.15.23 to ensure the residents preferences are followed as per the plan of care. 4. **MONITORING CORRECTIVE ACTION** The Dietitian will audit resident's dietary preferences to ensure the resident's dietary preference is followed. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23

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F 656	Continued From page 8	F 656		

intake #DC00011462 submitted to the State Agency on 01/09/23 documented," ...my mother has endured ... "[Staff] ignoring dietary request ..."

Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, and hypertension.

During an observation on 01/11/23, at approximately 10:30 AM, Resident #2 was sitting in her bed watching television. The resident was asked, how she liked the food served in the facility? She stated, "They put gravy on everything, and I've told the dietician (Employee #13) that I don't like gravy on my food several times. He said he would make dietary aware, but I keep getting gravy on my food. It just happened 2 days ago (01/09/23)."

Review of the resident's medical record showed the following:

10/28/21 [Physician Order] instructed, "No added salt, consistent carbohydrate, regular texture, thin consistency diet ..."

12/17/22 [Quarterly Minimum Data Set] documented, Resident #2 had a Brief Interview for Mental Status summary score of "15" indicating the resident had an intact cognitive status. And the resident was coded for receiving a therapeutic diet.

Resident #2's current and resolved care plans failed to address her preference not to have gravy added to her meals.

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F 656	Continued From page 9 A review of the resident's menu located in the facility's dietary department lacked documented evidence of the resident's preference to not have gravy on her food. During a face-to-face interview on 01/11/23, at approximately 2:00 PM, Employee #13 (Dietician) stated that he doesn't include residents' dietary preferences in their care plan. Because the resident's preferences are reflected on the resident's menu in the dietary department. During a face-to-face interview on 01/11/23 at approximately 3:00 PM, Employee #14 (Food Service Director) stated he was not aware that Resident #2 did not want gravy added to her foods. He said he would update her menu located in the dietary department to include her preference. The employee was asked if gravy was served on 01/09/23? He stated, "Yes".	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and interviews with staff at a local clinic, for one (1) of the six (6) sampled residents, the facility staff failed to provide adequate supervision for a resident during a staff-escorted visit to a local	F 689	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Employee#4 was terminated on 12/29/22. The details of Resident #1 were provided to the local authorities, police, Adult Protective Services, and the Detectives assigned to his case for the investigation. The facility continues to check with the detectives, local hospitals, and the resident's listed contact for updates. Resident has not been located as of 2.23.23 2. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. A house-wide audit was done by the ADON from 12.29.22 till 2.15.23 and no other residents that went for appointments with escorts were affected and there were no incidents of elopement.	

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F 689	Continued From page 10 orthopedic clinic. Subsequently, Resident #1 eloped on 12/29/22 and had not been located by the close of this survey on 01/12/23. The findings included: Resident #1 was admitted to the facility on 01/31/23 with multiple diagnoses including peripheral vascular disease, alcohol abuse, and a history of falling. Review of DC Intake Form # DC00011427 submitted to the State Agency on 12/29/22 at 6:46 PM documented, "Resident is 78 years old male who left the facility this AM [12/29/22] at about 8:00 AM for orthopedic appointment ...with escort [Employee #4's name]. Call received from [Employee #3] at about 1:00 PM [stating] that the resident left the clinic while the escort went to use the restroom ... [Employee #4] said he came outside looking for the resident, but he could not find the resident. 8 staff members [from the nursing home] ...immediately drove to the appointment address. [Conducted] a 20-block radius search ...Resident could not be found ...DC police department were notified at about 3:48 PM. Review of the Resident #1's medical record the following: Review of Resident #1's Quarterly Minimum Data Set dated 11/04/22 revealed the following: Section C (Cognitive Patten) the resident had a Brief Interview for Mental Status summary score of "9" indicating Resident #1 had moderately impaired cognitive functioning. Section E (Behavior) - the resident was not coded for rejection of care or wandering.	F 689	**3. MEASURE TO PREVENT REOCURRENCE** Staff Educator will complete education for all escorts no later than 2.23.23 to ensure that they follow the protocols set for safely escorting residents on appointments. **4. MONITORING CORRECTIVE ACTION** An audit will be done by Medical Records/designee to check with the escort and resident if applicable, to ensure there was no lapse in supervision during the appointment. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23

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DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

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Section G (Functional Status) the resident was coded for requiring the supervision of one person for walking in the room, walking in the corridor, locomotion on the unit, and locomotion off the unit.
Section P (Restraints and Alarms) the resident was not coded for using restraints or alarms.

12/29/22 at 6:34 PM [Nursing Note] documented, "[Resident #1] ... left the facility this AM at about 8:00 AM for orthopedic appointment ... with escort [Employee #4, Certified Nursing Assistant] ... Call received from [Employee #4] at about 1:00 PM that [Resident #1] left [orthopedic] clinic while [Employee #4] went to use the restroom ... [Employee #4] reported that when he came out of the restroom, he could not find the resident ... [Employee #4] said he [went] outside to looking for the [Resident #1], but could not find [him] ..."

12/29/22 at 7:35 PM [Social Worker's Note] documented, " ... [Two Detectives names listed] have been assigned to this case from the Missing's Person's Division ... the incident number is 22-189-228.

12/30/22 [Situation, Background, Assessment, and Request Form] documented, "Resident left the doctor's office after [an] orthopedic appointment while the escort was in the restroom ...[on] 12/29/22 ...The escort reported that when he came out of the restroom, he could not find the resident ..." It should be noted that this document had an effective date of 12/29/22 at 4:35 PM.

12/30/22 at 10:50 PM [Social Worker's Note] documented, " ... [Detective's name] ...shared that upon his visit to the [orthopedic clinic] front

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desk attendant ...shares that [Employee #4] was previously sleeping and was using their desk phone to call [facility's] transportation ...[Resident #1] created a follow-up appointment ... then proceeded to walk out of the office ...[Employee #4] yelled, "hey, hey" twice to [resident's name] ... [Employee #4] quickly abandoned the effort [to locate the resident] and returned [to the orthopedic office] to call for transportation ... [Employee #4 left] when transportation arrived ...The detective also shared that he followed up with [Employee #4] and informed him that he knew that he was being dishonest about his claim of using the restroom when the resident eloped ..."

01/04/23 at 5:12 PM [Social Worker's Note] documented, " ...[Detective's name] ... stated that has requested for social workers at the Department of Human Services to check the local shelters ... in addition, officers have been calling hospitals daily ... This social worker shared with [detective] that she and a group of staff members have canvased Washington DC on 01/04/23 in an effort to locate [resident's name] ... [Detective's name] also shared that will be making referrals to APS [Adult Protective Services] and the governing body that houses [Employee #4's] certified nursing assistant license ..."

01/06/23 at 4:14 PM [Social Worker's Note] documented, "This social worker spoke with [detective's name] at 3:29 PM. He shared that the Metropolitan Police Department has yet to find [resident's name]. He shared that APS informed him that [Employee #4] being terminated is sufficient action to satisfy any investigation they would conduct. He also shared that he filed a formal compliant with DOH [Department of

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Health] Board of Nursing against [Employee #4] ... He shared that his contact a DHS (Department of Human Services) stated that [Resident #1] has not signed into any shelters, and the morgue has not reported anyone matching his description ... DHS has passed out flyers to all of the men's shelters in the District."

1/12/23 at 10:03 PM [Social Worker's Note] documented, "This social worker spoke with [detective' name]. The detective asked this social worker for a dental consult of [resident's name]. The social worker provided him the assessment via email."

Review of Resident #1's current and resolved care plans lacked documented evidence the resident was an elopement risk or wander from 02/02/22 to 12/28/22.

Review of the facility's investigation notes revealed the following:
12/29/22 at 11:00 AM [Employee #5's (Driver) written statement] documented," On 12/29/22 I took [resident's name out to an appointment ...along with has (sp) escort [Employee #4's name] After dropping [resident's name and Employee #4's name] off at his appointment. A hour later [Employee #4's name] called and [said] he was [ready to be picked up]. After [Employee #4's name] got on the bus. I asked him [where] was you client [resident] at and he [said] he walked away from him, he and I then roded (sp) around looking for him, and we couldn't find him.

12/29/22 at 2:15 PM [Employee #4's written statement] documented, "I was on escort with [resident's name] at [orthopedic clinic's name]. After his consultation we sat at the waiting room

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of the clinic waiting for driver [transportation] ... to come take us back. I went to the restroom ... but on returning I didn't find the resident. The receptionist told me he just stepped out. I went out and searched around the building but couldn't find him. I called Deanwood to report it, but it fell on the answering machine. The driver came at about 1:30 PM and we left for [Deanwood].

Review of administrative record Employee #4's personnel file revealed the employee received new-hire orientation training on 06/02/22 that included an in-service titled, "Resident Safety while on Medical Appointment". The employee scored 100 percent on the post-test. Review of the teaching material included a memorandum dated 01/26/22 from the Transportation Director that instructed escorts, " ... never to leave the resident un-attended. If you must go to the restroom, ask the nurse or attendant if they can keep an eye on the resident for you. You cannot under any circumstance leave the resident alone ..."

During a face-to-face interview on 12/30/22 at approximately 5:30 PM, Employee #2 (Previous DON) stated that Employee #4 was terminated following the elopement incident because he should never have left the resident unattended. And after speaking with the police and clinic staff, they determined that the employee was not honest about what happened when the resident eloped.

During a face-to-face interview on 01/03/23 at approximately 11:15 AM, Employee #5 (Driver/Transportation) stated that an hour after he dropped Resident #1 and Employee #4 to the clinic, Employee #4 called him to tell him he was

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ready to be picked up. Employee #5 said that when Employee #4 boarded the bus he noticed the resident was not with him, so he asked where the resident was. Employee #4 told him the resident had walked away. After he was informed the resident had walked away, they drove around the area looking for the resident, but they could not find him. Employee #5 stated that they left the area to pick up another resident. However, they returned to the area to look for Resident #1 again after being instructed to do so by his supervisor (Employee #6). They were still not able to find the resident, so they drove back to the facility. After returning to the facility, he picked up eight employees and took them to the clinic to continue looking for the resident.

During a telephone interview on 01/03/22 starting at 3:47 PM, Employee #4 stated that he took Resident #1 to an orthopedic appointment on 12/29/22. The employee said after the resident was seen by the staff, the resident was sitting in the lobby, so he went to the bathroom. And when he came back to the lobby, he saw the resident "rushing out the door". He then ran after the resident and told him to come back but the resident refused. Employee #4 was asked did he physically try to stop the resident? The employee stated, "No, I was told in a training not to touch residents when they refuse and not to force them." Employee #4 was also asked did he ask the clinic staff to keep an eye on the resident while he went to the bathroom? The employee said, "No, I told the resident." Additionally, the employee stated, "I called the facility and got the answering machine. I left a message" about the resident "walking away" and then he called the driver and told him "I can't find my patient come quickly."

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F 689	Continued From page 16 During a face-to-face interview on 01/09/23 at 1:56 PM, clinic staff stated that the aide (Employee #4) slept and was on the phone while the resident was in the office. Clinic staff stated that the resident left the office after he made his follow-up appointment. Clinic staff was asked where was the aide when the resident made his follow-up appointment? She said that he was using the desk phone. Following the resident's exit, the aide ran behind him and returned to the office five minutes later without the resident. Clinic staff said that when the aide returned, he did not tell them that the resident had walked away. As he waited for transportation to arrive, the aide fell asleep in the lobby for approximately 40 minutes before he was picked up. When asked if the aide used the bathroom while he was in the clinic? She said, "No." There was no evidence that facility staff provided adequate supervision for a Resident #1 during a staff-escorted visit to a local orthopedic clinic appointment.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726	1. **CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** A head-to-toe assessment was done by the charge nurse on 1/15/23 for Resident#2. The resident did not have any negative outcome from this deficient practice. An education was done for employee# 12 on 2/15/23 to ensure medication administration is witnessed by the licensed nurse and to ensure that medications refused are not left unattended at the resident's bedside.	

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F 726	Continued From page 17 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility's staff failed to follow standard of practice when administering medications for one (1) of six (6) sampled residents (Resident #2). The findings included: Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including hypertension, osteoarthritis, major depressive disorder, and chronic pain. During an observation on 01/11/23 at approximately 10:30 AM, Resident #2 was sitting in her bed watching television. There were multiple pills inside a plastic medicine cup located on the bedside table positioned in front of the	F 726	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All current residents have the potential to be affected by this deficient practice. A house wide audit will be completed by the Unit Managers no later than 2.21.23 to ensure no medications are left unattended by the resident's bedside. Any negative findings will be corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education will be completed no later than 2.23.23 for all licensed nurses by the Staff Educator/designee to ensure that medications are not left unattended. **4. MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers/designee to ensure that medications are not left unattended by the resident's bedside. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23

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resident. According to Resident #2, she wasn't ready to take the pills when the nurse administered them earlier. The resident then proceeded to take her medication.

Review of the resident's medical record revealed the following:

11/13/22(revision date) [Care Plan] documented, "Focus area- [Resident's name] receives 9 or ... medications ...Interventions - administer medications as ordered ..."

12/17/22 [Quarterly Minimum Data Set] documented, the resident had a Brief Interview for Mental Status summary score of "15" indicating the resident had intact cognitive function. The resident was coded for refusal of care 1-3 days during this assessment period.

Employee #12 signed the [Electronic Medication Administration Record] on 01/11/23, indicating she administered the following medications at 10:00 AM: Prozac 10 mg (milligrams), Bupropion 300 mg, Percocet 5-325 mg, Odefsey 200/25-25 mg, Norvasc 5 mg, Metoprolol 5 mg, Calcium D 600-400 mg, Thiamine 100 mg, and Folic Acid 1 mg.

During a face-to-face interview on 01/11/22 at approximately 10:40 AM, Employee #12 (Licensed Practical Nurse) stated that she left the resident's morning medications on the bedside table since the resident didn't want them at the time she was administering medications When asked, is it standard practice for staff to leave medications unattended on a resident's bedside table? Employee #12 said, "No, I should have taken the medication with me."

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F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#2 went for the dental appointment on 2.13.23 and will continue to follow up with the dentist for further recommendations. No negative outcomes were noted from this deficient practice. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All current residents that have dental consults have the potential to be affected. A house wide audit will be completed by the ADON/designee no later than 2.21.23 to ensure that, the most recent dental recommendations documented are being carried out. Negative findings if any, will be corrected upon discovery. **3. MEASURE TO PREVENT REOCCURRENCE** The dentist will be educated by the Administrator/designee before 2.21.23 on the importance of communicating with the clinical team about dental recommendations and the facilities protocols on this type of communication. An education will be completed for the Licensed Nurses and Unit Secretaries by 2.23.23 by the Staff Educator/ designee to ensure dental recommendations are carried out timely and the dental appointments are scheduled in a timely manner.	

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F 791	Continued From page 20 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and resident interview, the facility failed to ensure that Resident #2 received dental services in a timely manner for one (1) of six (6) sampled residents. The findings included: Resident #2 was admitted to the facility on 06/26/14. The resident had a history of multiple diagnoses including type 2 diabetes mellitus, morbid obesity, chronic pain, and major depression. Review of the District of Columbia's complaint intake #DC00011462 submitted to the State Agency on 01/09/23 documented," ...my mother has endured ... "[Staff] not taking a dental condition seriously to the point now that my mother is losing teeth ..." During an observation on 01/10/22 around 11:00 AM. Resident #2 was seen brushing her teeth while sitting in bed. She was asked if she had any concerns regarding her teeth. The resident said one of her lower left side teeth cracked in November [2022] when she was flossing. Three to four weeks later, she saw a dentist who advised her to have the tooth extracted. The resident was then asked had she seen a dentist prior to December 2022. She stated that she had but could not remember the date.	F 791	4. **MONITORING CORRECTIVE ACTION** An audit will be done by the ADON/designee to ensure all dental recommendations documented on the dental visit summary, are followed in a timely manner. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. Negative findings if any, will be corrected upon discovery. Date of Compliance: 02/24/2023	02.24.23

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Review of the Resident #2's medical record revealed the following:

04/06/22 [Dental Consult] documented, " ... fractured ...[teeth] #19, #20, and # 30 ...pt (patient) referral to [hospital's name] for treatment."

09/19/22 [Quarterly Minimum Data Set] documented, "The resident had a Brief Interview for Mental Status summary score of "15" indicating that the resident had an intact cognitive status. The resident was not coded for dental issues including broken teeth.

11/01/22 to 12/01/22 - review of nursing and physician progress notes lacked documented evidence of the resident complaining of broken teeth or dental pain.

12/02/22 at 6:23 AM [Nursing Note] documented, "Resident wants to go out to see a dentist or a dentist should come see here because one of her tooth that needs refill broke yesterday night ... she denies pain but confirm a little sore."

12/16/22 at 12:14 PM (14 days later) [Physician order] instructed, "Schedule dental appointment for tooth extraction at [hospitals name] ... please ask the unit secretary to schedule this appointment ASAP (as soon as possible)."

12/16/22 at 2:18 PM [Nursing Note] documented, "[Dentist name] gave instruction to schedule resident for tooth extraction at [hospital's name] dentistry. Resident's son notified and was told he will be informed when we have the actual date of

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appointment. Resident denies pain at this time ..."

12/19/22 [Dental Consult] documented, " ... recommendations ext (extractions) [of teeth] #19, #20, #30."

12/23/22 [Consult and/or Appointment] form showed the facility staff made an appointment for treatment on 02/02/23 at 2:00 PM. It should be noted that the appointment to have the resident seen for her dental treatment was scheduled 10 months after the initial referral on 04/26/22.

During a face-to-face interview on 01/11/23 at approximately 11:00 AM, the dentist stated that she examined Resident #2's teeth on 04/06/22. Following the resident's dental exam, a referral was written for staff to send the resident to a local hospital for treatment. On 12/16/22, Employee #8 (Clinical Coordinator) contacted her and requested another dentist to send the resident to since the local hospital was unable to accommodate them. When asked if she was aware of the resident's dental concern on 12/02/22, the dentist replied that she was not made aware until 12/19/22. That's when she came to examine the resident again. However, the dentist explained that when Employee #8 (Clinical Coordinator) called her on 12/16/22, he didn't mention the most recent concern. When Employee #8 called, she thought he was discussing her referral of 04/06/22.

During a face-to-face on 01/11/23 at 2:50 PM, Employee #9 (Unit Secretary) stated that she did not schedule the appointment on the referral dated 04/06/22 because no one told her. According to her, nursing staff or the clinical coordinator informs her when to schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 23 appointments for residents. During a face-to-face interview on 01/11/23 at approximately 3:00 PM, Employee #8 (Clinical Coordinator) stated that the dentist did not document the referral (04/06/22) on the appropriate paperwork, so the appointment was not scheduled.	F 791		