DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No. 19 and 19 an		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		095019	B. WING				1/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	at Deanwood Rehal from August 29, 202 Survey activities cor sampled residents. first day was 219. After analysis of the that the facility was requirements of 42 Requirements for Lot The following deficit observation, record interviews. The following is a diand/or acronyms the report: AMS - Altered MARD - Assessme AV- Arteriovenous BID - Twice- a-B/P - Blood Prom - Centime CFR- Code of CMS - Centers Services CNA- Certified CRF - Communication CRNP- Certified D.C District of Contraction of the cont	evisit Survey was conducted bilitation and Wellness Center 22 through August 31, 2022. Insisted of a review of 45 The facility's census on the findings, it was determined not in compliance with the CFR Part 483, Subpart B, and ong Term Care Facilities. encies are based on review, and resident and staff irectory of abbreviations at may be utilized in the lental Status ent Reference Date us day essure eters of Federal Regulations for Medicare and Medicaid di Nurse Aide hity Residential Facility Registered Nurse Practitioner of Columbia of Columbia Municipal	{F C	000}	DEANWOOD REHABILITATION AND WELLNESS CENTER Disclaimer: Facility submits this plan of correction under procedures established by the Department Health in order to comply with Department directives to change conditions which the department alleges are deficient under start regulations related to Long terr. This should not be construed a either a waiver of the facility's appeal or to challenge the according severity of the alleged deficient or any admission of any wrongdoings.	of the ge nt te m care. as right to uracy	09/07/22
LABORATORY	DIRECTORIS OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Any deficiency statement ending with a 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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING		COMP	(X3) DATE SURVEY COMPLETED	
		095019			ı	-C 31/2022	
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019	DDE		
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{F 000}	DMH - Departm DOH- Departm EKG - 12 lead I EMS - Emerger F - Fahrenhei FR French G-tube- Gastro HR- Hour HSC - Health HVAC - Heating ID - Interdis IPCP- Infection Program LPN- License L - Liter Lbs - Pound MAR - Medica MD- Medica MD- Medica MD- Medica MD- Minimu Mg - milligra M- minute mL - milligra M- minute mL - milligra M- minute NP - Mationa NP - Nationa NP - Nurse O2- Oxyg PASRR - Preadr Review Peg tube - Percu Gastrostomy PO- by mouth POA - Powe	nent of Mental Health hent of Health Electrocardiogram hey Medical Services (911) it stomy tube Service Center y ventilation/Air conditioning stual disability ciplinary team on Prevention and Control ed Practical Nurse s (unit of mass) tion Administration Record al Doctor Im Data Set Ims (metric system unit of mass) ers (metric system measure of grams per deciliter leters of mercury ht al canula logical al Fire Protection Association Practitioner gen mission screen and Resident staneous Endoscopic	{F 0	00}		9/07/22	

-	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED R-C	
		095019	B. WING		1	31/2022	
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	RD- Registered RN- Registered ROM Range RP R/P - Respons SBAR - Situation Recommendation SCC Special Sol- Solutio TAR - Treatmet Ug - Microgr. Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment more ident's status. This REQUIREMENT by: Based on record retwo (2) of 45 samplifailed to accurately (MDS) for Resident The findings include Review of the facility response to the state	ndicator Survey ed Dietitian Nurse of Motion sible party Background, Assessment, Care Center on ot Administration Record am ments y of Assessments. Ust accurately reflect the AT is not met as evidenced eview and staff interview, for ed residents, facility staff code the Minimum Data Set s' #155 and #237.	{F 000}	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #155 was assessed head to toe by unit manager 9/2/22, resident suffered no outcome. MD/RP notified on 9/2/22.MDS coding will be uperflect ongoing discharge plangesident #237 was assessed head to toe by unit manager 9/2/22.Resident suffered no outcome. MD/RP updated on 9/2/22.MDS coding will be more to reflect discharge plan from facility by 9/07/22 IDENTIFICATION OF OTHE WITH THE POTENTIAL TO AFFECTED: All residents residing in the flave the potential to be affer thouse wide audit conducted team to ensure that resident discharge have accurate confindings will be corrected improved.	d from on negative pdated to anning. d from on negative n hodified n the ERS BE facility cted. d by MDS ds due for ding. All	9/07/22	
	" MDS Coordinate wide audit to ensur	ors will conduct weekly house e that MDS staff are coding with desire to return to the					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		095019	B. WING_			08/3	1/2022	
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DEALINEO	OD DEMARK ITATION A	AID WELL MESS CENTED		50	000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	OD REHABILITATION A	ND WELLNESS CENTER		W	ASHINGTON, DC 20019			
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{F 641}	Continued From page		{F 6	341}	RECURRENCE:		9/07/22	
	08/24/22.	alleged compliance was d to accurately code Resident			MDS coordinators will be rein-s- by staff educator / Designee on importance of proper coding for residents who are due for disch	the		
	#155's MDS dated	07/18/22 to reflect the			residents who are due for discri	aiye.		
	residents overall ex from the facility.	pectations to be discharged			Licensed social services team varieties re-educated on the importance ensuring that their coding recor	of		
	11/18/19, with diagr	admitted to the facility on noses that included: Chronic rension and Major Depressive			with that of MDS for accuracy purposes. Any discrepancies w rectified by the Lead MDS cool and the social services team	ill be		
	(social worker) subilifacility Name] nursing facility] on scall from [facility reproduced more inform [Figure 1.55]. The SW call as sent an email rewith what document can send it to her." A Quarterly MDS difacility staff coded (Cognitive Patterns impairment; in Section Assessment and Gibe discharge planning resident to return to	ork Progress Note] "The SW mitted a transition packet to sing home in [local skilled 5/12/22. The SW received a presentative] the admissions acility Name] because she mation regarding [Resident ed and left a voicemail as well questing that she be specific station she needs so the SW ated 07/18/22, revealed that the following: In Section C (Participation in oal Setting), not expected to nother facility; and no active already occurring for the other community.			House wide audit will be condu MDS team and Social services reconcile the coding in the MDS ensure that all residents due for discharge are coded correctly, findings will be corrected imme. Social services team will prese of residents due for discharge to MDS team during stand up medaily to enable the MDS team witheir coding to ensure accuracy findings will be corrected imme. The social services team will remanded in the social services team wi	team to a and read the eting verify y. All diately. ead the eform the eng		
		ved that facility staff failed to a MDS to reflect that discharge						

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{F 641}	planning was occur During a face-to-far 08/31/22 at 11:50 A Worker) acknowled been coded to show another facility/inst 2. Facility staff failed dated 08/15/22 to r discharge plan(s) for Resident #237 was 07/19/19 with multi Gastro Esophagea Esophagitis, Gout, Virus (HIV) Diseas Review of the med 06/16/22 [Social Waccompanied [Resident and continue process and will continue pro	ce interview conducted on AM, Employee #3 (Social Idged that the MDS should have w, "expects to be discharged to itution." and to accurately code the MDS reflect Resident #237's from the facility. It admitted to the facility on the included: If Reflux Disease without and Human Immunodeficiency	{F 6	41}	MDS team and social service will reconcile coding for resid who are due for discharge or residents who are in the prodischarge every morning dur morning meeting to ensure a in coding. All findings will be corrected immediately.	ents ess of ing	9/07/22

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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER	•	50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
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{F 656} SS=D	via telephone to coassessment. This most appropriate progether to assist [Facility Name]." A Quarterly MDS of facility staff coded (Cognitive Pattern Q (Participation in no active discharge the resident to return the evidence shound accurately code Resident discharge plan During a face-to-fo 8/31/22 at approacknowledged that reflect the resident community. Develop/Impleme CFR(s): 483.21(b) Comp §483.21(b) Comp §483.21(b) Comp §483.21(b) Comp §483.10(c)(3), the objectives and time medical, nursing, needs that are ideassessment. The describe the follows:	#237] and [Transition Worker] is to assist him in locating the blacement. The SW's will work him in transitioning him to dated 08/15/22, showed that the following: In Section C is), cognitively intact; in Section Assessment and Goal Setting), in e planning already occurring for turn to the community. wed that facility staff failed to resident #237's MDS to reflect inning was occurring. acce interview conducted on eximately 1:41 PM, Employee #3 and the MDS was not coded to to the plan to be discharged to the interview Care Plan (1) rehensive Care Plans is facility must develop and orehensive person-centered in resident, consistent with the forth at §483.10(c)(2) and it includes measurable interview to meet a resident's and mental and psychosocial entified in the comprehensive comprehensive care plan must		656)	MONITORING CORRECTIVE ACTION MDS Regional consultant will a MDS coding for residents due of discharge and those in the prodischarge to ensure codlings a accurately. This audit will be calculated to QA Committee All of will be corrected immediately. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #155 was assessed head to toe by unit manager 9/2/22, resident suffered no negative outcome. MD/RP uron 9/2/22. Resident #237 was assessed head to toe by unit manager 9/2/22, resident suffered no negative outcome. MD/RP uron 9/2/22, resident suffered no negative outcome. MD/RP no negative.	or cess of re done arried and indings R THE ed from on pdated d from on	9/07/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C	
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{F 656}	or maintain the resided physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the reunder §483.10, include treatment under §483 (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation with resident's represental (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was assellocal contact agencial entities, for this purpoportion, as appropriate, requirements set for section. This REQUIREMENT by: Based on record review (2) of 45 sample failed to develop a comeasurable goals, ti	ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized is the nursing facility will FPASARR a facility disagrees with the RR, it must indicate its ent's medical record. the the resident and the stive(s)- eals for admission and eference and potential for cilities must document as desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the the in paragraph (c) of this T is not met as evidenced wiew and staff interview, for ed residents, facility staff comprehensive care plan with meframes and approaches to 1.55's and #237's discharge	{F 6	56}	IDENTIFICATION OF OTHE WITH THE POTENTIAL TO AFFECTED: All residents residing in the finave the potential to be affect DON/Designee conducted he wide audit to ensure that rescomprehensive care plans a updated/revised. All findings corrected immediately.	acility sted ouse idents'	9/07/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ' '	PLE CONSTRUCTION G	COMPI	LETED
		095019	B. WING _		08/3	31/2022
Ì	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
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{F 656}	Review of the facility response to the state the recertification state the received and the received and the residents have a pecare plan" " Unit Managers resident clinical recissues found will be the facility's date of 08/24/22. Review the facility's date of 08/24/22. Review the facility's revised of the policy of [Facility implement person-resident that include provide effective at meet professional states and the recipient of the meet professional states and the recipient failed address Resident states and the recipient failed	by's Plan of Correction in terment of deficiencies from survey that ended on 04/20/22, all team members conducted in 04/22/22 to ensure that the erson-centered comprehensive and Supervisors will audit cords on a weekly basis. Any ecorrected by 08/24/22"	{F 65	MEASURES TO PREVENT RECURRENCE DON/Designee, Unit Manage Clinical care coordinator, so and social services team might be rein-serviced by the staff educator / designee or importance of developing a comprehensive care plan for residents. Unit managers will audit chart serviced immediately. Supervisors will audit chart their shifts weekly to ensur residents have all comprehensidents have all comprehensidents have all comprehensidents have all comprehensidents in place. All find corrected immediately. Social services team will enthey develop a comprehen plan for residents who are discharge. All findings will corrected immediately.	gers, upervisors embers facility's the or the arts of to ensure ehensive gs will be s during e that lensive ings will be nsure that sive care due for	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
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{F 656}	(Washington District East) on 5/12/22. The state of the coordinator from [Faneeded more inform #155]. The SW called as sent an email receivith what document can send it to her." A Quarterly MDS data facility staff coded the (Cognitive Patterns) impairment; in Section Assessment and Gobe discharged to an discharge planning resident to return to 08/11/22 [Care Plan meeting held today answered questions behavior and why or reject his transfer that be removed an Nursing) stated that so the facility can purpose the facility can purpose the state of the companion documented evideveloped a discharged from the During a face-to-face 08/31/22 at 11:50 Assessment and Companion and Companion documented evideveloped a discharged from the During a face-to-face 08/31/22 at 11:50 Assessment and Companion and Compa	of Columbia) NE (North the SW received a call from the admissions actility Name] because she the call of the second of the swell questing that she be specific that the following: In Section C the following: In Section C the second of the se	{F 6	56)	MONITORING CORRECTIVE ACTION: Clinical team members (DON, manager) Social services, MD coordinator will audit charts to ensure that comprehensive caplans have been developed by services team to ensure compfor residents who are due for discharge. This audit will be divectly x4, then monthly x3. A findings will be corrected immand reported to QAPI Commit	Unit S oure y social liance one Il ediately	9/07/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G		MPLETED R-C
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{F 656}	became involved, ([Facility Name]. He Name]. He is not a his diagnoses". No related to a discha the resident. 2. Facility staff faile address Resident ; Resident #237 wa: 07/19/19 with mult Gastro Esophagea Esophagitis, Gout, Virus (HIV) Diseas Review of the med 06/16/22 [Social V accompanied [Res Assisted Living Fa took a tour and co the DONHe was placement and aft to be a very good needed to continu process and will c Name] until [Resid discharged." 07/28/22 [Social V patient and SW, d but no specific pa otherwise stable a stable and cough/ 08/01/22 [Social V met with [Resident	hey wanted him to go to was not accepted at [Facility ppropriate for housing due to further comment was made rge care plan being created for ad to develop a care plan to #237 discharge plan. s admitted to the facility on iple diagnoses that included: al Reflux Disease without and Human Immunodeficiency	{F 6	56)		9/07/22

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{F 656} {F 657} SS=D	most appropriate plat together to assist hir [Facility Name]." A Quarterly MDS da facility staff coded the (Cognitive Patterns) Q (Participation in A no active discharge the resident to return During a face-to-face 08/31/22 at approximate acknowledged that the developed to address plan. Care Plan Timing and CFR(s): 483.21(b)(2) A combedity of the comprehensive (ii) Developed within the comprehensive (ii) Prepared by an includes but is not lie (A) The attending p (B) A registered nur resident. (C) A nurse aide with resident. (D) A member of for (E) To the extent prother resident and the An explanation must medical record if the control of t	to assist him in locating the acement. The SW's will work in in transitioning him to ted 08/15/22, showed that the following: In Section C, cognitively intact; in Section assessment and Goal Setting), planning already occurring for in to the community. The interview conducted on mately 1:41 PM, Employee #3 in care plan has been as the residents discharge and Revision (2)(i)-(iii) Thensive Care Plans in the prehensive care plan must assessment. The plans interdisciplinary team, that inited to	{F 6	557}	CORRECTIVE ACTION FO AFFECTED RESIDENTS: Resident #182 is in the hos Resident #134 no longer re the facility. Discharged to a facility 9/1/22.	pital. sides in	9/07/22	

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{F 657}	not practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the finite of the second assessments. This REQUIREMEN by: Based on record revitwo (2) of 45 sample failed to revise/update plan with goals and and #182. The findings include Review of the facility response to the state the recertification sustipulated: " Resident #182 include dialysis per chest immediately, the second indicated of the second ind	e development of the e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced view and staff interview, for de residents, the facility staff te the comprehensive care approaches. Residents' #134 d: v's Plan of Correction in ement of deficiencies from arvey that ended on 04/20/22, care plan will be updated to na-cath site on the resident but not later than 08/24/22." lit will be conducted by the rector of Nursing), Clinical nit Managers and Supervisors plans are revised"	{F 6	57}	IDENTIFICATION OF OTH WITH THE POTENTIAL TO AFFECTED: All residents in the facility is potential to be affected. Unit managers conducted wide audit to ensure that rewith permacath for dialysis treatment have revised car include the site of the permand interventions. Charge nurses will assest the perma cath prior to and dialysis. All findings will be addressed immediately. Licensed social worker conhouse wide audit to ensure discharge planning is reflecare plan. All findings will is corrected immediately.	nave the nouse esidents e plan to ha cath the site of diafter enducted ected in	9/7/22	
	The facility's date of	falleged compliance was					1	

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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
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{F 657}	O8/24/22. Review the facility por Team Meeting (Care 03/2022 documented individualized care prevised by the interding 1. Facility staff failed #134's discharge carplans and goals. Resident #134 was a 02/15/22 with diagnor Disorder and Schizor Review of the medic A Quarterly Minimur 06/21/22 in which facognitively intact and occurring. Review of the progress of	plicy entitled, "Interdisciplinary Plan Meeting)" revised d, " A comprehensive, lan will be reviewed and disciplinary team" Ito update/revise Resident re plan to reflect discharge re- admitted to the facility on loses that included Eating phrenia. al record showed: In Data Set (MDS) dated cility staff coded the following: It active discharge planning less notes revealed:	{F 6	557}	MEASURES TO PREVENT RECURRENCE: Staff educator / Designee will reservice all licensed nurses to en that care plan for resident with cath reflect the site of the permetath and interventions for dialy treatment. Licensed social services team reeducated by staff educator / Designee to always ensure the update the discharge plans and of the resident. Unit managers will audit care presidents on perma cath weekly ensure the care plan reflects the on which the perma cath is locand interventions for dialysis treatment. All findings will be addressed immediately. Licensed social services team conduct weekly audit to ensure they update discharge care plan reflect discharge plans and goafindings will be addressed immediately. DON/Designee will audit care weekly to ensure that the social services team are updating discare plan to reflect discharge plans and goals and that residents we perma cath has a care plan that indicates the site and intervent for dialysis treatment. All finding be addressed immediately.	sis will be y I goals lans of y to e site ated will that in to als. All plans charge plans with at itions	9/07/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE S COMPLI	ETED
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{F 657}	with the family regard continues with currer 08/25/22 "The SW at today, 8/25/2022 witl [Representative's Nashe would like to transpace [Facility Name]. The 1, 2022. The SW has information to [Facility Coordinator" Review of the compressident #134, show staff updated the displans to be discharged During a face-to-face 08/31/22 at approxin #3 acknowledged the 2. Facilty staff failed #182's care plan to a chest perm-a-cath for Resident #182 was 11/30/21 with multip Stage Renal Diseas Dialysis, and Anemia Review of the Quart showed facility staff Brief Interview for Mof "14" indicating the intact and for receiver the stage of the continuation of the continu	ning via phone no Social worker is working ding transfer to out of state, nt plan of care. Ittended another hearing h [Resident #134] and ame] to inform [Judge] that hisfer [Resident #134] to discharge date is September his submitted the requested ty Name]'s Admission Tehensive care plan for hved no evidence that facility charge care plan to reflect hed from the facility. The interview conducted on hately 1:50 PM, Employee he finding. To update/revise Resident haddress his use of a right	{F 6	557}	IDT team members(clinical temanagers, DON, QA/IP directother department heads will aduring daily morning meeting ensure that care plans are uprevised to indicate a person care. All findings will be address immediately. MEASURES TO PREVENT RECURRENCE; Unit manager/Supervisors with charts of residents using perfor dialysis treatment to ensure a care plan indicates the site of perma cath and interventions. Licensed social workers will charts of residents due for doing to ensure that their care plan updated to reflect discharge and goals. This audit must be conducted weekly x4, then more x3. All findings will be correctimediately and reported to committee.	tor) and assist to dated/sentered essed Il audit ma cath re the fine the ischarge is are plans enouthly ted	9/07/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING	<u> </u>	R-C 08/31/2022	
	ROVIDER OR SUPPLIER	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
{F 657} {F 660} SS=E	the following: 08/16/22 [Physician's Thursday, Saturday of Resident alert and very went to dialysis at 5:8 Right PC (perm-a-cano bleeding, no swell review of Resident at approximately 1:00 staff had not updated address his use of a dialysis as indicted in During a face-to-face approximately 3:00 Funit Manager) stated chest perm-a-cath. The explain why the residents wasn't included in his Discharge Planning CFR(s): 483.21(c)(1) Shanner Planning CFR(s): 483.21(c)(1) Discharge planning contraction of factors of residents to be active discharge planning than the resident's discontraction of factors of residents to be active discharge planning contraction of factors of residents to be active discharge planning than the resident's discontraction of factors of residents to be active discharge planning than the portal planning than the plan	corder] - "Dialysis: Tuesday, every day shift" ote] - "Pre Dialysis Note: erbally responsive. Resident 55 am. Travel by wheelchair. th) site intact with dressing ling or redness noted." #182's care plan on 08/30/22 of PM revealed that the facility if the resident's care plan to right chest perm-a-cath for in their Plan of Correction. It interview on 08/30/22 at PM, Employee #4 (2nd Floor of that the resident had a right the Employee could not dent's right chest perm-a-cath is comprehensive care plan. Process (i)-(ix) arge Planning Process relop and implement an oldenning process that focuses charge goals, the preparation thive partners and effectively ist-discharge care, and the leading to preventable accility's discharge planning insistent with the discharge 3.15(b) as applicable and-ischarge needs of each	(F 657)		ide in	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 660}	development of a resident. (ii) Include regular identify changes the discharge plan. The updated, as needed (iii) Involve the interest of the person (s) capacity required care, as discharge needs. (v) Involve the resident's person(s) capacity required care, as discharge needs. (v) Involve the resident representative in the discharge plan and resident representative in the discharge required (vii) Document the about their interest regarding returning (A) If the resident to the community referrals to local cappropriate entities (B) Facilities must cappropriate entities (C) If discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not be feasible made the determination of the discharge to not not be feasible made the determination of the discharge to not not not not not not not not not	re-evaluation of residents to hat require modification of the he discharge plan must be ed, to reflect these changes. erdisciplinary team, as defined ii), in the ongoing process of scharge plan. giver/support person availability or caregiver's/support y and capability to perform part of the identification of sident and resident the development of the id inform the resident and tative of the final plan. esident's goals of care and inces. at a resident has been asked at in receiving information ing to the community. Indicates an interest in returning the facility must document any contact agencies or other es made for this purpose. It update a resident's are plan and discharge plan, as sponse to information received ocal contact agencies or other es. To the community is determined the facility must document who	{F €	660}	Resident #237 was assessed in head to toe on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22. Discorre plan will be created by 9/6 care plan will be created by 9/6 with the POTENTIAL TO BE AFFECTED; All residents residing in the fact have the potential to be affected house wide audit conducted be Licensed social worker team to ensure that they create a disciplan for residents who are due discharge. Findings will be contimmediately.	charge 07/22. S E cility ed, y o narge	9/07/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C		
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i	ROVIDER OR SUPPLIER	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 660}	representatives in se provider by using dat limited to SNF, HHA, patient assessment of measures, and data the data is available, the post-acute care sassessment data, dadata on resource use the resident's goals of preferences. (ix) Document, compon the resident's need record, the evaluation needs and discharge evaluation must be discharge plan to fact to avoid unnecessard discharge or transfer This REQUIREMEN by: Based on record returne (3) of 45 samp failed to: (1) have a resident; (2) record/of to the resident's discharge needs we the results develope Residents' #134, #1 The findings include Review of the facility response to the stati	lecting a post-acute care a that includes, but is not IRF, or LTCH standardized lata, data on quality on resource use to the extent. The facility must ensure that standardized patient ta on quality measures, and is relevant and applicable to of care and treatment. Idete on a timely basis based ids, and include in the clinical in of the resident's discharge plan. The results of the liscussed with the resident or ative. All relevant resident incorporated into the cititate its implementation and by delays in the resident's community in the residents. The incorporated into the cititate its implementation and by delays in the resident's community incorporated into the community incorporated into a discharge plan.	{F 6	660}	MEASURES TO PREVENT RECURRENCE: Licensed social services team rein-serviced by staff educator Designee on the importance of creating discharge planning in timely manner. Licensed social services team members will read the names residents due for discharge in stand up/morning meeting so the MDS and clinical team mewill verify documentation and All findings will be corrected immediately Unit managers will monitor clin dashboard every morning at sup meeting to see if any residue for discharge. The Unit mewill work with the social serviteam to ensure discharge plataking place timely. All finding be corrected immediately. During interdisciplinary meeti (nursing, social services, MD activities) care plan review we conducted and members of the will ensure discharge plannin moving as stipulated. All finding be corrected immediately.	of the that embers coding. nical stand lent is nanager ices nning is yill length that is not be the team g is	9/07/22

on the ment of the same of the		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			SURVEY LETED
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	Continued From pa	{F 6	60}	MONITORING CORRECTIVE ACTION: Licensed social worker will ensu	uro that	9/07/22	
	to ensure that there process"	for Resident #155 is updated are no delays in discharge			they create a discharge plan for resident upon admission and elements the discharge goals and plans in the care plan. This audit will	r the nsure reflect	
	needs for Resident to prevent delays in			done weekly x4, then monthly a findings will be corrected imme and reported to QAPI committee	3. All diately		
	" Unit Manager/Supervisor will audit charts of residents due for discharge to ensure the licensed social worker has discharge plan in place"		i				
	The facility's date of 08/24/22.	of alleged compliance was					
	#134's comprehens	ed to update/revise Resident sive care plan and discharge e resident's goals for care and ces and identified needs.					
		s re-admitted to the facility on noses that included Eating cophrenia.					
	Review of the med	ical record showed:					
	A Quarterly Minimum Data Set (MDS) dated 06/21/22 in which facility staff coded the following: cognitively intact and active discharge planning occurring.						
	Review of the prog	ress notes revealed:					
	completed and ret	of State Referral was urned to New Jersey today. It to [Family representative]. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BI		LE CONSTRUCTION	COMPLETED R-C
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	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
(F 660)	package has been fill chart." 08/16/22 " Text: ID Care plan meeting he (responsible party), [present via telephone is working with [Resistransfer to a LTC (lor (New Jersey). The S [Resident #134] until resident's sister joi concerns at this time with the family regar continues with currer 08/25/22 "The SW atoday, 8/25/2022 wit [Family Representat would like to transfe Name]. The discharge 2022. The SW has sinformation to [Facili Coordinator" There was no docur staff updated/revise plan and care plan to treatment preference support and education prior to discharge. During face-to-face 08/30/22 at 3:37 PM Worker) stated, "I staff form to the nursing things that were not	ed in [Resident #134's] OT (interdisciplinary team)/ eld today 8/16/22. The RP (Family Representative] was eThe SW (social worker) dent #134] towards her ing term care) facility in NJ (W will continue to work with I her transition is complete ining via phone no e Social worker is working ding transfer to out of state, int plan of care. Ittended another hearing th [Resident #134] and tive] to inform [Judge] that she ir [Resident #134] to [Facility ge date is September 1, submitted the requested tity Name]'s Admission mented evidence that facility d Resident #134's discharge to address: goals for care; es; resident and caregiver ton that must be addressed interview conducted on M, Employee #5(Social ent the 'Interstate Compact' facility. There were a few that answered and it was sent Maybe I didn't look carefully	{F 66	0}	9/07//22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	CON	R-C
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(F 660)	Continued From page 2. Facility staff failer for Resident #155.	ge 19 d to create a discharge plan	{F 66	50)		9/07/22
	Resident #155 was 11/18/19, with diagr Pancreatitis, Hyper Disorder. Review of the medi 05/19/22 [Social W (social worker) sub [Facility Name] nurs	ork Progress Note] "The SW mitted a transition packet to				
	East) on 5/12/22. T [facility representat coordinator from [F needed more inforr #155]. The SW call as sent an email re	he SW received a call from				
	facility staff coded (Cognitive Patterns impairment; in Sec Assessment and G be discharged to a	tion Q (Participation in foal Setting), not expected to nother facility; and no for active already occurring for the				
	meeting held today answered question behavior and why reject his transfer	in Meeting Note] "Care plan of or [Resident #155]The SW ins about [Resident #155]'s other facilities may continue to The family asked how can and the DON (Director of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	CON	E SURVEY MPLETED R-C
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		
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{F 660}	so the facility can #155]." There was no evid medical record that discharge plan that destination; ensur resident's health at the resident's goal preferences; and and rehabilitation prior to discharge. During a face-to-fo 08/31/22 at 11:50 Worker) stated, "Obecame involved Name]. He was not appropridiagnoses." No furning a face-to-fo 108/31/22 at 11:50 Worker) stated, "Obecame involved Name]. He was not appropridiagnoses." No furning a face-to-fo 108/31/22 at 11:50 Worker) stated, "Obecame involved Name]. He was not appropridiagnoses."	at we must report the behaviors properly work with [Resident lence in Resident #155's at facility staff documented a at included: the discharge ing the location met the and safety needs; addressing les for care and treatment identifying resident education needs that must be addressed	{F 66			9/07//22
	for Resident #237 Resident #237 wa 07/19/19 with mu Gastro Esophage Esophagitis, Gou Virus (HIV) Diseas Review of the me 06/16/22 [Social accompanied [Re Assisted Living F	as admitted to the facility on tiple diagnoses that included: al Reflux Disease without t, and Human Immunodeficiency				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	СОМІ	SURVEY PLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AVI WASHINGTON, DC 20019		
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{F 660}	placement and after to be a very good needed to continue process and will continue process and second process a	age 21 s very happy about the er the assessment it appeared fit. The SW took information e and complete the application ontinue to work with [Facility lent #237] is successfully Vork Progress Note] "Met with ischarge planning in progress betwork needed now. Patient is and is in no distress, Vitals emphysema controlled." Vork Progress Note] "The SW at #237] and [Transition Worker] complete his comprehensive is to assist him in locating the placement. The SW's will work him in transitioning him to dated 08/15/22, showed that I the following: In Section C as), cognitively intact; in Section a Assessment and Goal Setting), ge planning already occurring for urn to the community. cumented evidence that facility esident #237's discharge nely manner for the resident's assisted living facility. There is that facility staff documented: in; timely completion of the ssessment; the resident's goals ment preferences; or the ion and rehabilitation needs that and prior to discharge.	{F 6	60)		9/07/22

			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C	
		095019	B. WING _				31/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019			
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{F 660}		e interview conducted on	{F 6	60}	,		9/07/22
	stated, "He (Residen [Facility Name]. I am	nately 1:41 PM, Employee #3 It #237) is too advanced for It contacting [Facility Name] to It has a case worker in the					
{F 726} SS=D	Competent Nursing		{F 7	26}	CORRECTIVE ACTION FO THE AFFECTED RESIDEN		
	the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each resident assessmen and considering the	re sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by ts and individual plans of care			Resident #126 was assessed Unit manager on 9/2/22 for adverse reaction to medical Resident suffered no negat outcome. MD/RP updated 6/9/2/22.	tion. ive on	
	accordance with the at §483.70(e). §483.35(a)(3) The folicensed nurses have and skill sets necess needs, as identified assessments, and of §483.35(a)(4) Provided the set of th	acility assessment required acility must ensure that be the specific competencies sary to care for residents' through resident lescribed in the plan of care. ding care includes but is not			IDENTIFICATION OF OTH WITH THE POTENTIAL TO AFFECTED: All residents residing in the facility have the potential to affected. House wide audit conducted by Unit manage ensure Licensed nurses are administering medication vinhaler correctly.	be be r to e	
	implementing reside to resident's needs. §483.35(c) Proficier The facility must en to demonstrate com						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SH CREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		D BE	(X5) COMPLETION DATE
{F 726}	needs, as identified assessments, and d This REQUIREMEN by: Based on observati interview, for one (1 facility staff failed to was competent on h Bromide Aerosol (ar Resident #126. The findings include Review of the facility response to the staff the recertification sustipulated: " Clinical Care Convising) and Unit M wide audit to ensure administering inhale Also, they will ensure competent in admininhaler" The facility's date on 08/24/22. Review of the facility Administration Med requires staff to "insining their mouths [According to the Malbuterol (anticholity Proper Use When	through resident lescribed in the plan of care. IT is not met as evidenced ion, record review and staff) of 45 sampled residents, ensure the facility's nurse now to administer Tiotropium inticholinergic) Inhaler for id: by's Plan of Correction in tement of deficiencies from survey that ended on 04/20/22, coordinator, DON (Director of flanagers will conduct house that the nurses are ers correctly to the residents fre that licensed nurses are histering medications via f alleged compliance was by's policy, "Proper lication-Metered Dose Inhaler", struct residents/patients to fafter using inhalers]" ayo Clinic, Ipratropium and hergic) (Inhalation Route) in you have finished all your mouth with water" (Last	{F 7	726}	MEASURES TO PREVENT RECURRENCE: Targeted in service was provided employee #6 on 8/31/22 by Unit Manager on the importance of at following the steps when administed medication. Coaching and count was provide to employee #6 on 8 and the county of the coun	ccurately stering seling 8/31/22 serviced the of the dication ds on nsure stered rected n rounds ensed nistering . All diately.	9/07/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CHITICICATION AND MEED.		DISTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
{F 726}	https://www.mayo atropium-and-albu e/drg-20062048 Resident #126 wa 11/16/21 with mul Chronic Obstructi and Cardiomegals During an observapproximately 11: Practical Nurse) frinse her mouth a Ipratropium Albut dose inhaler). The resident water an mouth but neglect spit it out. Also, the container for the cleaning her mouth a Brief Intervacion of "9", indiccognition. Review of the me physician's order staff to administe [Aerosol] Solution (micrograms/actu 4 hours for SOB During a face-to-time of the obser why he failed to	as admitted to the facility on tiple diagnoses including ve Pulmonary Disease, Asthma, y. ation on 08/30/22 at 200 AM, Employee #6 (Licensed failed to have Resident #126 after administering two puffs of ero! [Aerosol] Solution (metered e employee instead gave the dinstructed her to rinse her sted to tell her not to swallow and the employee failed to provide a resident to spit into after	{F 7	726}	MONITORING CORRECTIVACTION: DON/Designee will conduct rounds ,to monitor Licensed to ensure they are administ medication via inhaler corrected residents. This audit will done weekly x4 then month findings will be corrected immediately and reported to Committee.	random I nurses ering ectly to I will be Iy x3. All	9/07/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, .		CONSTRUCTION	(X3) DATE S COMPL R-	ETED
		095019	B. WING				1/2022
	ROVIDER OR SUPPLIER	D WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 1000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 726}	providing her with a cinto. The employee far During a face-to-face approximately 11:15 Educator) stated that	e 25 container to spit the water alled to provide an answer. interview on 08/30/22 at AM, Employee #7 (Staff Employee #6 was educated by to correctly administer	{F 7	' 26}	CORRECTIVE ACTION FOR TAFFECTED RESIDENT: No resident was affected by this deficient practice.	:	9/07/22
(F 755) \$S=D	rinsing their mouths a Pharmacy Srvcs/Pro- CFR(s): 483.45(a)(b) §483.45 Pharmacy S The facility must pro-	cedures/Pharmacist/Records (1)-(3) services vide routine and emergency to its residents, or obtain	{F	755)	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the factorial to be affected this deficient practice.	≣ ility	
	§483.70(g). The faci personnel to adminis permits, but only und a licensed nurse. §483.45(a) Procedur pharmaceutical servi that assure the accu dispensing, and adm biologicals) to meet §483.45(b) Service (must employ or obta pharmacist who- §483.45(b)(1) Provid aspects of the provis the facility.	lity may permit unlicensed ter drugs if State law ler the general supervision of res. A facility must provide ices (including procedures rate acquiring, receiving, hinistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed les consultation on all sion of pharmacy services in lishes a system of records of on of all controlled drugs in			MEASURES TO PREVENT RECURRENCE: Targeted in service provided of 8/29/22 to employee #8 and employee #2 on the importance accurately reconcile controlled substance by staff educator. Coaching and counseling provemployee #8 on 8/29/22. All Licensed nurses will be rein-serviced on the importance accurately reconcile controlled medication by staff educator /Designee.	e to rided to se to	
		on of all controlled drugs in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION S		PLETED R-C	
		095019	B. WING _		08/	/31/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 755}	reconciliation; and §483.45(b)(3) Deterrorder and that an acis maintained and per This REQUIREMEN by: Based on observation interviews, facility streconcile controlled medication carts. The findings include Review of the facility response to the state the recertification sustipulated: "The Director of N control substance for reconciliation and assubstances" The facility's date of 08/24/22. The facility's policy storage of controlled substances when keys are transall controlled substaitems, is conducted anddocumented of similar form) or in apolicy" During an observation of the state of the st	mines that drug records are in count of all controlled drugs eriodically reconciled. T is not met as evidenced on, record review and staff aff failed to accurately medications in one (1) of 16 d: y's Plan of Correction in ement of deficiencies from arvey that ended on 04/20/22, oursing will create a new orm that will enable accurate accounting of all controlled alleged compliance was and procedures for the disubstances revised on ed, " At each shift change, or afferred, a physical inventory of ances, including refrigerated by two licensed personnel on a Control Count Sheet (or accordance with facility	{F 75	Unit managers will ensure Licensed nursed are accoreconciling controlled medaily. All findings will be immediately. Supervisors will ensure of shifts that Licensed nurse accurately reconciling of medication. All findings of corrected immediately. DON/Designee will conduct random rounds to ensure Licensed nurses are accoreconciling controlled sure All findings will be correctioned immediately.	during their es are ontrolled will be luct weekly e that curately bstance.	9/07/22	
		ion on 08/29/22 at 0 AM of unit 5 North's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED R-C	
		095019	B. WING		<u> </u>	1	1/2022
	ROVIDER OR SUPPLIER	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867} SS=F	Medication Cart #2, a Oxycodone-APAP (Apain reliever) 5-325 mobserved with 15 table. However, review of the Administration Record Oxycodone; amount amount remaining, "1 During a face-to-face time of the observation Nursing) and Employ Nurse) were unable to the amount of Oxycodomount recorded on Administration Record QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality at \$483.75(g) Quality at \$483.75(g)(2) The quassurance committed (ii) Develop and implication to correct ider This REQUIREMEN' by: Based on observation interviews, the facility comprehensive quality performance improve implemented to correct identation.	a blister packet of cetaminophen) (narcotic ng (milligrams) was lets remaining. The "Controlled Drug d" showed, "Drug: received 30 on 8/20/22"; 14." Interview conducted at the on, Employee #2 (Director of yee #8 (Licensed Practical to explain the discrepancy in done on hand and the the Controlled Drug rd. The interview conducted at the on, Employee #2 (Director of yee #8 (Licensed Practical to explain the discrepancy in done on hand and the the Controlled Drug rd. The interview conducted at the on, Employee #2 (Director of yee #8 (Licensed Practical to explain the discrepancy in done on hand and the the Controlled Drug rd. The interview conducted at the interview assessment and assurance. The interview conducted at the interview assessment and assurance. The interview conducted at the interview assessment and assurance. The interview conducted at the interview and assurance and ement assessment and assurance. The interview conducted at the interview and assurance and ement (QAPI) plan was extituted to ensure that the interview and staff y failed to ensure that the interview and ement (QAPI) plan was extituted to ensure that the interview and interview and staff y failed to ensure that the interview and interview and staff y failed to ensure that the interview and interview a	{F 7	(55)	MONITORING CORRECTIVE ACTION: DON/Designee will conduct ro and audit carts to ensure Licer nurses are accurately reconcil controlled medication. This audie conducted weekly x4, then monthly x3. Findings will be coimmediately and reported to Committee. F 867 CORRECTIVE ACTION FOR THE AFFIRESIDENT: No resident was affected by this deficient practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected by this deficient practice. MEASURES TO PREVENT RECURRED QAPI / QAA will ensure that the facility maintain and implement an effective comprehensive quality assurance and performance program that will show that of deficiencies are adequately addressed findings will be corrected immediately. QA committee will ensure that the staff implementing plans that are put in place address deficiencies. Any findings will is corrected immediately.	ected API ECTED THE THE the staff at areas ed. All are e to	9/0722

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C	
095019		B. WING			08/31/2022		
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
(F 867)	A review of the facility 03/26/22 to 04/20/22 cited for the following F641 - Accuracy of A F656 - Develop/Imple Plan F657 - Care Plan Tim F660 - Discharge Pla F726 - Competent Ni F755 - Pharmacy Services/Procedures F867 - QAPI Program Faith Attempt The aforementioned during the Revisit Su Review of the Plan or compliance date of 0 facility staff would condeficient practices from the implement the combelow: Under F641 - "Monit Rehab Director and lead will conduct audis done accurately. The weekly x4, then monitorected immediate the QAPI committee. Under F656 - Monitorector and lead will conduct audis done accurately. The page 10 committee. Under F656 - Monitorector F657 - "Monitorected immediates."	y's previous survey dated showed that the facility was deficiencies: ssessments ement Comprehensive Care ming and Revision unning and Process urse Staffing //Pharmacist/Records n/Plan, Disclosure/ Good deficiencies were cited again urvey that ended on 08/31/22. If Correction with a 18/24/22, revealed that nitinuously monitor their om the prior survey and failed rective actions as indicated oring Corrective Actions - MDS (Minimum Data Set) dits to ensure that all coding this audit will be conducted athly x3. Findings will be ally, and report presented to the prior Corrective Actions not coring Corrective Actions not coring Corrective Actions not coring Corrective Actions -	{F 8	867)	Re-inservice will be provided to the Adminis DON, Unit managers, MDS, QA, Social Set other IDT on the Quality Assurance and Pel Improvement process by the Staff Educator Re-inservice and education will be provided MDS, Social Services and Rehab Director accuracy of coding the MDS by the Staff Educator Services and Rehab Director accuracy of coding the MDS by the Staff Educator Assessments Audit tool, Developing and Implementing on the following audit tools: Accurate Assessments Audit tool, Developing and Implements and Revision Audit tool, Discharge and Process Audit tool, Competent Nurse: Audit tool, Pharmacy Services/Procedures audit tool as part of the QAPI program to in resident care and facility systems and procedings will be completed immediately. MONITORING AND CORRECTIVE ACTION Facility staff will continuously monitor the deficient practices and implement the compactions as indicated below: Under Accuracy of Assessments Monitoring Rehab Director and MDS (Minimum Datatical Section of the QAPI committee) and report presented the QAPI committee by 9/7/22. Under Development/Implement Compreher Plan, the DON/Designee will do a house of audit to ensure Comprehensive Care pland developed and implemented. This audit weekly x 4, and monthly x 3. Any negative be corrected immediately and reported to committee.	rvices, and formance r by 9/7/22 d to the on ducator by are the QA acy of aplementing Plan planning Staffing (Records approve esses, All coding ucted ll be ad to ensive Care of indings will take place of findings will take place of findings will findings will be a findings will	
	DON (Director of Nu	oring Corrective Actions - irsing)/Designee will conduct OS nurses will complete					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			ROVIDER OR SUPPLIER	ND WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 867}	monthly audit to valid person-entered complace, that are revised weekly x4, then mondocrected immediated committee." Under F660 - "Monito Licensed Social Servesidents' chart to ender in discharge planning documentation about This audit will be commonthly x3. Findings presented to QAPI." Under 726 - "Monito DON/Designee will densure that nurses a correctly This audit x4, then monthly x3. immediately and reprommittee." Under 755 - "Monito DON/Designee will densure that the nurse medication sheet act substances are alway will be conducted we findings will be committed to the QAPI team last met During the exit confidence."	late that all residents have brehensive care plan in ad This audit will take place thly x3. Findings will be by and reported to QAPI coring Corrective Actions - vices Director will audit asure that there are no delays g, that there is adequate the resident's discharge plans. Inducted weekly x4, then a will be corrected, and report conduct random rounds to be administering medication at will be conducted weekly. Findings will be corrected orted to the QAPI conduct audits on all units to es are using the controlled curately and that all control asys accounted for. This audit eekly x4, then monthly x3. ected immediately and 1 committee."	{F 8	667)	Under Care Plan Timing and Revision, the DON (Director of Nursing)/Designee will contrandom audit to validate that all residents har person-centered comprehensive care plan in that are revised. This audit will take place we then monthly x3.All Findings will be corrected immediately and reported to QAPI committee. Under Discharge Planning and Process the Licensed Social Services Director will audit residents' chart to ensure that there are not discharge planning, that there is adequate documentation about resident's discharge plaudit will be conducted weekly x4, then monifindings will be corrected, and report present QAPI committee. Under Competent Nursing Staff, the DON/Dwill conduct random rounds to ensure that nurses are administering medica correctly. This audit will be conducted weekl x4, then monthly x3. All findings will be committee. Under Pharmacy, the DON/Designee will conducted on all units to ensure that the nurses are active accurately a control substances are always accounted for audit will be conducted weekly x4, then monifindings will be corrected immediately and rethe QAPI committee. These corrective actions and planned audits monitored, tracked and trended by the QAPI committee. These corrective actions and planned audits monitored, tracked and trended by the QAPI to improve systems and processes. Continuelicient practice identified will be corrected immediately and placed on a performance improvement plan.	ve place, place, ekly x4, dec. elays in ans. This thly x3. All ted to esignee ation y ected are using and that all r. This thly x3. All eported to swill be director, if meeting ued	9/7/22	

PRINTED: 09/01/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ R-C B. WING 095019 08/31/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5000 NANNIE HELEN BURROUGHS AVE. NE **DEANWOOD REHABILITATION AND WELLNESS CENTER** WASHINGTON, DC 20019 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 9/07/22