Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	R-C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CEN	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) COMPLETE DATE
{L 000}	Initial Comments An unannounced Revisit survey was conducted at Deanwood Rehabilitation and Wellness Center from August 29, 2022 through August 31, 2022. Survey activities consisted of a review of 45 sampled residents. The facility's census on the first day was 219. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and 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 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	{L 000}	DEANWOOD REHABILIOTATION AND WELLNESS CENTER: Disclaimer: Facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Department directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrongdoings.	9/07/22

Health Regulation & Licensing Administration

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

TITLE Administrator

(X6) DATE 9/6/22

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{L 000}	Continued From page 1 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 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	{L 000}		9/0722

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{L 000}	Continued From page 2 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	{L 000}		/9/07/22
{L 051}	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents.	{L 051}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #126 was assessed by Unit manager on 9/2/22 for adverse reaction noted. Resident suffered no negative outcome. MD/RP updated on 9/2/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit conducted by Unit manager to ensure Licensed nurses are administering medication via inhaler correctly. All findings will be corrected immediately.	

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{L 051}	Continued From page 3 This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 45 sampled residents, facility staff failed to: ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol (anticholinergic) Inhaler for Resident #126; develop a comprehensive care plan with measurable goals, timeframes and approaches to address Resident #155's and #237's discharge plans; and revise/update the comprehensive care plan with goals and approaches for Residents' #134 discharge and Resident #182's perma-cath. Residents' #126, #155, #237, #134 and #182. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: " ... Clinical Care Coordinator, DON and Unit Managers will conduct house wide audit to ensure that the nurses are administering inhalers correctly to the residents... Also, they will ensure that licensed nurses are competent in administering medications via inhaler ..." " ... Licensed clinical team members conducted house wide audit on 04/22/22 to ensure that the residents have a person-centered comprehensive care plan ..." " ... Unit Managers and Supervisors will audit resident clinical records ... on a weekly basis. Any issues found will be corrected by 08/24/22 ..." " ...Resident #182 ... care plan will be updated to include dialysis perma-cath site on the resident	{L 051}	MEASURES TO PREVENT RECURRENCE: Targeted in service was provided to employee #7 on 8/31/22 by Unit Manager on the importance of accurately following the steps when administering medication. Coaching and counseling was provide to employee #7 on 8/31/22 All Licensed nurses will be rein serviced by staff educator / Designee on the importance of following a all step process when administering medication via inhaler to the residents and ensure the resident complies with each step. Unit managers will conduct rounds on their units during their shifts to ensure medication via inhaler is administered correctly. All findings will be corrected immediately. Supervisors will conduct random rounds during their shift, to monitor Licensed nurses to ensure they are administering medication via inhaler correctly. All findings will be corrected immediately Another in service is being provided by Pharmscript to re-educate licensed nurses on proper medication administration, including metered dose inhaler.	9/07/22

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{L 051}	Continued From page 4 chest immediately, but not later than 08/24/22." " ... House wide audit will be conducted by the ADON (Assistant Director of Nursing), Clinical care coordinator, Unit Managers and Supervisors to ensure that care plans are revised ..." " ...In-service will be provided by staff educator/designee to all licensed nursing staff on the need to ensure that all residents' comprehensive care plans are revised ..." The facility's date of alleged compliance was 08/24/22. Review of the facility's policy, "Proper Administration Medication-Metered Dose Inhaler", requires staff to "instruct residents/patients to rinse their mouths [after using inhalers]..." Review the facility's policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... It is the policy of [Facility Name] to develop and implement person-centered care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care... A comprehensive, individualized care plan will ... be reviewed and revised by the interdisciplinary team..." 1. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol (anticholinergic) Inhaler for Resident #126. According to the Mayo Clinic, Ipratropium and Albuterol (anticholinergic) (Inhalation Route) Proper Use ...When you have finished all your	{L 051}	MONITORING CORRECTIVE ACTION: DON/Designee will conduct random rounds weekly ,to monitor Licensed nurses to ensure they are administering medication via inhaler correctly to the residents. This audit will will be done weekly x4 then monthly x3. All Findings will be addressed immediately and reported to QAPI Committee. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #155 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP updated on 9/2/22. Resident #237 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/02/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected DON/ADON/Designee conducted house wide audit to ensure that residents comprehensive care plans are updated/ revised. All findings will be corrected immediately.	9/07/22

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{L 051}	Continued From page 5 doses, rinse your mouth with water ..." (Last updated 08/01/22). https://www.mayoclinic.org/drugs-supplements/ipratropium-and-albuterol-inhalation-route/proper-use/drg-20062048 Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, and Cardiomegaly. During an observation on 08/30/22 at approximately 11:00 AM, Employee #6 (Licensed Practical Nurse) failed to have Resident #126 rinse her mouth after administering two puffs of Ipratropium Albuterol [Aerosol] Solution (metered dose inhaler). The employee instead gave the resident water and instructed her to rinse her mouth but neglected to tell her not to swallow and spit it out. Also, the employee failed to provide a container for the resident to spit into after cleaning her mouth. Review of the Quarterly MDS dated 06/17/22 showed facility staff coded the resident with a Brief Interview Mental Status summary score of "9", indicating moderately impaired cognition. Review of the medical record showed a physician's order dated 05/11/22 that instructed staff to administer, "Ipratropium -Albuterol [Aerosol] Solution 20-100 MCG/ACT (micrograms/actuation) 2 puffs inhale orally every 4 hours for SOB (shortness of breath)". During a face-to-face interview conducted at the time of the observation, Employee #6 (Licensed Practical Nurse) was asked why he failed to instruct Resident #126 not to swallow the water	{L 051}	MEASURES TO PREVENT RECURRENC; DON/Designee, Unit Managers, Clinical care coordinator, supervisors and social services team members will be rein-serviced by the facility's staff educator / designee on the importance of developing a comprehensive care plan for the residents. Unit managers will audit charts of residents on a weekly basis to ensure residents have their comprehensive care plan in place. All findings will be corrected immediately. Supervisors will audit charts during their shifts weekly to ensure that residents have all comprehensive care plans in place. All findings will be corrected immediately. Social services team will ensure weekly that they develop a comprehensive care plan for residents who are due for discharge. All findings will be corrected immediately.	9/07/22

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{L 051}	Continued From page 6 after rinsing her mouth and not providing her with a container to spit the water into. The employee failed to provide an answer. During a face-to-face interview on 08/30/22 at approximately 11:15 AM, Employee #7 (Staff Educator) stated that Employee #6 was educated on 06/21/22 about how to correctly administer metered-dose inhalers to patients, including rinsing their mouths afterwards. 2. Facility staff failed to develop a care plan to address Resident #155's and #237's discharge plan. 2A. Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder. Review of the medical record showed: 05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in WDC (Washington District of Columbia) NE (North East) on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her." A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to	{L 051}	MONITORING CORRECTIVE ACTION: Clinical team members (DON, Unit manager) Social services, MDS coordinator will audit charts to ensure that residents have comprehensive care plan in place. This audit will be done weekly x4, then monthly x3. All findings will be corrected immediately. CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #182 is in the hospital. Resident #134 no longer resides in the facility. Discharged to another facility 9/1/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. Unit managers conducted house wide audit to ensure that residents with permacath for dialysis treatment have revised care plan to include the site of the perma cath. Licensed social worker conducted house wide audit to ensure discharge planning is reflected in care plan. All findings will be corrected immediately. Licensed nurses will ensure they assess permacath site daily. All findings will be addressed immediately.	9/07/22

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{L 051}	Continued From page 7 be discharged to another facility; and no for active discharge planning already occurring for the resident to return to the community. 08/11/22 [Care Plan Meeting Note] "Care plan meeting held today for [Resident #155] ...The SW answered questions about [Resident #155]'s behavior and why other facilities may continue to reject his transfer ...The family asked how can that be removed and the DON (Director of Nursing) stated that we must report the behaviors so the facility can properly work with [Resident #155]." Review of the comprehensive care plan showed no documented evidence that facility staff developed a discharge care plan with goals and approaches to address Resident #155 and the residents' responsible party's wishes for him to be discharged from the facility. During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) stated, "Once his (Resident #155) family became involved, they wanted him to go to [Facility Name]. He was not accepted at [Facility Name]. He is not appropriate for housing due to his diagnoses". No further comment was made related to a discharge care plan being created for the resident. 2B. Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease. Review of the medical record revealed: 06/16/22 [Social Work Progress Note] "The SW	{L 051}	IDT team members(clinical team, unit managers, DON, QA/IP director) and other department heads will assist during daily morning meeting to ensure that care plans are updated/ revised to indicate a person centered care. All findings will be corrected immediately. MEASURES TO PREVENT RECURRENCE; Unit manager/Supervisors will audit charts of residents using perma cath for dialysis treatment to ensure the care plan indicates the site of the perma cath. Licensed social workers will audit charts of residents due for discharge to ensure that their care plans are updated to reflect discharge plans and goals. This audit must be conducted weekly x4, then monthly x3.All findings will be corrected immediately and reported to QA committee.	9/07/22

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{L 051}	Continued From page 8	{L 051}		9/07/22

accompanied [Resident #237] to [Facility Name] Assisted Living Facility. The SW and resident took a tour and completed an assessment with the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged."

07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled."

08/01/22 [Social Work Progress Note] "The SW met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive assessment. This is to assist him in locating the most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]."

A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community.

During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 acknowledged that no care plan has been developed to address the residents discharge plan.

3. Facility staff failed to update/revise Resident #134's discharge care plan to reflect discharge

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{L 051}	Continued From page 9 plans and goals. Resident #134 was re- admitted to the facility on 02/15/22 with diagnoses that included Eating Disorder and Schizophrenia. Review of the medical 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 progress notes revealed: 07/15/22 "The out of State Referral was completed and returned to New Jersey today. It was sent via email to [Family representative]. The package has been filed in [Resident #134's] chart." 08/16/22 " ... Text: IDT (interdisciplinary team)/ Care plan meeting held today 8/16/22. The RP (responsible party), [Family Representative] was present via telephone ...The SW (social worker) is working with [Resident #134] towards her transfer to a LTC (long term care) facility in NJ (New Jersey). The SW will continue to work with [Resident #134] until her transition is complete ...resident's sister joining via phone ... no concerns at this time Social worker is working with the family regarding transfer to out of state, continues with current plan of care. 08/25/22 "The SW attended another hearing today, 8/25/2022 with [Resident #134] and [Representative's Name] to inform [Judge] that she would like to transfer [Resident #134] to [Facility Name]. The discharge date is September 1, 2022. The SW has submitted the requested	{L 051}		9/07/22

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{L 051}	Continued From page 10 information to [Facility Name]'s Admission Coordinator ..." Review of the comprehensive care plan for Resident #134, showed no evidence that facility staff updated the discharge care plan to reflect plans to be discharged from the facility. During a face-to-face interview conducted on 08/31/22 at approximately 1:50 PM, Employee #3 acknowledged the finding. 4 .Facilty staff failed to update/revise Resident #182's care plan to address his use of a right chest perm-a-cath for dialysis. Resident #182 was admitted to the facility on 11/30/21 with multiple diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, and Anemia in Chronic Kidney Disease. Review of the Quarterly MDS dated 06/14/22 showed facility staff coded: the resident had a Brief Interview for Mental Status summary score of "14" indicating the resident was cognitively intact and for receiving dialysis while a resident. Review of the resident's medical record showed the following: 08/16/22 [Physician's order] - "Dialysis: Tuesday, Thursday, Saturday every day shift" 08/24/22 [Nursing Note] - "Pre Dialysis Note: Resident alert and verbally responsive. Resident went to dialysis at 5:55 am. Travel by wheelchair. Right PC (perm-a-cath) site intact with dressing no bleeding, no swelling or redness noted." Review of Resident #182's care plan on 08/30/22	{L 051}		9/07/22

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{L 051}	Continued From page 11 at approximately 1:00 PM revealed that the facility staff had not updated the resident's care plan to address his use of a right chest perm-a-cath for dialysis as indicted in their Plan of Correction. During a face-to-face interview on 08/30/22 at approximately 3:00 PM, Employee #4 (2nd Floor Unit Manager) stated that the resident had a right chest perm-a-cath. The Employee could not explain why the resident's right chest perm-a-cath wasn't included in his comprehensive care plan.	{L 051}		9/07/22
{L 052}	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in	{L 052}	CORRECTIVE ACTION FOR THE AFFCECTED RESIDENTS: Resident #155 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22.MDS coding will be updated to reflect ongoing discharge planning. Resident #237 was assessed from head to toe by unit manager on 9/2/22.Resident suffered no negative outcome. MD/RP updated on 9/2/22.MDS coding will be modified to reflect discharge plan from the facility IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit conducted by MDS team to ensure that residents due for discharge have accurate coding. All findings will be corrected immediately.	

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

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{L 052}	Continued From page 12 his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 45 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) for Residents' #155 and #237. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: "... MDS Coordinators will conduct weekly house wide audit to ensure that MDS staff are coding correctly... resident with desire to return to the community..." The facility's date of alleged compliance was	{L 052}	MEASURES TO PREVENT RECURRENCE: MDS coordinators will be rein-serviced by staff educator / Designee on the importance of proper coding for residents who are due for discharge. licensed social services team will be rein - serviced on the importance of ensuring that their coding reconciles with what MDS is coding. All discrepancies will be rectified by the Lead MDS and the social services team House wide audit will be conducted by MDS and Social services team to ensure that all residents due for discharge are coded correctly. All findings will be corrected immediately. Social services team will present a list of residents due for discharge to the MDS team during stand up meeting daily to enable the MDS team verify their coding to ensure accuracy. All findings will be addressed immediately. The social services team will read the names of residents who are due for discharge and those who are in the process of discharge daily during morning meeting to alert every department to verify their documentation. All Findings will be addressed immediately.	9/07//22

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{L 052}	Continued From page 13 08/24/22. 1. Facility staff failed to accurately code Resident #155's MDS dated 07/18/22 to reflect the residents overall expectations to be discharged from the facility. Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder. Review of the medical record showed: 05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in WDC (Washington District of Columbia) NE (North East) on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her." A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to be discharged to another facility; and no active discharge planning already occurring for the resident to return to the community. The evidence showed that facility staff failed to accurately code the MDS to reflect that discharge planning was occurring.	{L 052}	MDS team and social services team will reconcile coding for residents who are due for discharge or residents who are in the process of discharge every morning during morning meeting to ensure accuracy in coding. All findings will be corrected immediately. MONITORING CORRECTIVE ACTION MDS Regional consultant will audit MDS coding for residents due for discharge and those in the process of discharge to ensure coding are done accurately. This audit will be carried out weekly x4, then monthly x3. All findings will be corrected immediately.	9/07//22

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{L 052}	Continued From page 14 During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) acknowledged that the MDS should have been coded to show, "expects to be discharged to another facility/institution." 2. Facility staff failed to accurately code the MDS dated 08/15/22 to reflect Resident #237's discharge plan(s) from the facility. Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease. Review of the medical record revealed: 06/16/22 [Social Work Progress Note] "The SW accompanied [Resident #237] to [Facility Name] Assisted Living Facility. The SW and resident took a tour and completed an assessment with the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged." 07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled." 08/01/22 [Social Work Progress Note] "The SW met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive assessment. This is to assist him in locating the	{L 052}		9/07/22

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{L 052}	Continued From page 15 most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]." A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community. The evidence showed that facility staff failed to accurately code Resident #237's MDS to reflect that discharge planning was occurring. During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 acknowledged that the MDS was not coded to reflect the residents plan to be discharged to the community.	{L 052}		9/07/22
{L 128}	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side	{L 128}		

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{L 128}	Continued From page 16 effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, facility staff failed to accurately reconcile controlled medications in one (1) of 16 medication carts. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: "...The Director of Nursing will create a new control substance form that will enable accurate reconciliation and accounting of all controlled substances..." The facility's date of alleged compliance was 08/24/22. The facility's policy and procedures for the storage of controlled substances revised on 08/2020 documented, "... At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and...documented on a Control Count Sheet (or similar form) or in accordance with facility policy..."	{L 128}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this deficient practice. IDENTIFICATIONIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this deficient practice. MEASURES TO PREVENT RECURRENCE: Targeted in service provided on 8/29/22 to employee #8 and employee #2 on the importance to accurately reconcile controlled substance. Coaching and counseling provided to employee #8 8/29/22. All Licensed nurses will be rein- serviced on the importance of accurately reconcile controlled medication by staff educator /Designee Unit managers will ensure that Licensed nursed are accurately reconciling controlled medications daily. All findings will be addressed immediately. Supervisors will ensure during their shifts that Licensed nurses are accurately reconciling controlled medication . All findings will be addressed immediately. DON/Designee will conduct weekly random rounds to ensure that Licensed nurses are accurately reconciling controlled substance. All findings will be corrected immediately.	9/07//22

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{L 128}	Continued From page 17 During an observation on 08/29/22 at approximately 10:50 AM of unit 5 North's Medication Cart #2, a blister packet of Oxycodone-APAP (Acetaminophen) (narcotic pain reliever) 5-325 mg (milligrams) was observed with 15 tablets remaining. However, review of the "Controlled Drug Administration Record" showed, "Drug: Oxycodone; amount received 30 on 8/20/22"; amount remaining, "14." During a face-to-face interview conducted at the time of the observation, Employee #2 (Director of Nursing) and Employee #8 (Licensed Practical Nurse) were unable to explain the discrepancy in the amount of Oxycodone on hand and the amount recorded on the Controlled Drug Administration Record.	{L 128}	MONITORING CORRECTIVE ACTION: DON/Designee will conduct rounds and audit carts to ensure Licensed nurses are accurately reconciling controlled medication. This audit will be conducted weekly x4, then monthly x3. All Findings will be corrected immediately and reported to QAPI committee.	9/07/22
{L 535}	3270.2 Nursing Facilities The facility shall conduct a discharge assessment of each resident within fourteen (14) days after admission and twice annually thereafter. The discharge assessment shall include: This Statute is not met as evidenced by: Based on record review and staff interview, for three (3) of 45 sampled residents, facility staff failed to: (1) have a discharge plan for one resident; (2) record/document information related to the resident's discharge plan to the community in the clinical record;(3) ensure the residents discharge needs were adequately identified and the results developed into a discharge plan. Residents' #134, #155 and #237.	{L 535}	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident # 182 is hospitalized Resident #134 no longer reside in the facility, discharged to another facility on 9/1/22	

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{L 535}	Continued From page 18 The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: " ... Licensed Social Worker will ensure that discharge planning for Resident #155 is updated to ensure that there are no delays in discharge process ..." " ... Licensed Social Worker will ensure that the needs for Resident #237 are adequately identified to prevent delays in the discharge process ..." " ... Unit Manager/Supervisor will audit charts of residents due for discharge to ensure the licensed social worker has discharge plan in place ..." The facility's date of alleged compliance was 08/24/22. 1. Facility staff failed to update/revise Resident #134's comprehensive care plan and discharge plan to address the resident's goals for care and treatment preferences and identified needs. Resident #134 was re-admitted to the facility on 02/15/22 with diagnoses that included Eating Disorder and Schizophrenia. Review of the medical 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.	{L 535}	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this deficient practice. Unit Managers conducted house wide audit to ensure that residents with perma cath for dialysis treatment have revised care plan to include the site of the perma cath and interventions. Licensed nurses will assess permacath site daily. All findings will be addressed immediately. Licensed social worker conducted house wide audit to ensure discharge planning is reflected in the care plan. All findings will be corrected immediately.	9/07/22

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{L 535}	Continued From page 19 Review of the progress notes revealed: 07/15/22 "The out of State Referral was completed and returned to New Jersey today. It was sent via email to [Family representative]. The package has been filed in [Resident #134's] chart." 08/16/22 " ... Text: IDT (interdisciplinary team)/ Care plan meeting held today 8/16/22. The RP (responsible party), [Family Representative] was present via telephone ...The SW (social worker) is working with [Resident #134] towards her transfer to a LTC (long term care) facility in NJ (New Jersey). The SW will continue to work with [Resident #134] until her transition is complete ...resident's sister joining via phone ... no concerns at this time Social worker is working with the family regarding transfer to out of state, continues with current plan of care. 08/25/22 "The SW attended another hearing today, 8/25/2022 with [Resident #134] and [Family Representative] to inform [Judge] that she would like to transfer [Resident #134] to [Facility Name]. The discharge date is September 1, 2022. The SW has submitted the requested information to [Facility Name]'s Admission Coordinator ..." There was no documented evidence that facility staff updated/revised Resident #134's discharge plan and care plan to address: goals for care; treatment preferences; resident and caregiver support and education that must be addressed prior to discharge. During face-to-face interview conducted on 08/30/22 at 3:37 PM, Employee #5(Social Worker) stated, "I sent the 'Interstate Compact'	{L 535}	MEASURES TO PREVENT RECURRENCE: Staff educator / Designee will re in service all licensed nurses to ensure that care plan for resident with perma cath reflect the site of the perma cath used for dialysis treatment and interventions. Licensed social services team will be reeducated by staff educator / Designee to always ensure they update the discharge plans and goals of the resident. Unit managers will audit care plans of residents on perma cath weekly to ensure the care plan reflects the site on which the perma cath is located for dialysis treatment and interventions. All findings will be addressed immediately. Licensed social services team will conduct weekly audit to ensure that they update discharge care plan to reflect discharge plans and goals. All findings will be corrected immediately. DON/Designee will audit care plans weekly to ensure that the social services team are updating discharge care plan to reflect discharge plans and goals and that residents with perma cath has a care plan that indicates the site and interventions. All findings will be corrected immediately.	9/07//22

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{L 535}	Continued From page 20 form to the nursing facility. There were a few things that were not answered and it was sent back the next day. Maybe I didn't look carefully enough [at the form]." 2. Facility staff failed to create a discharge plan for Resident #155. Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder. Review of the medical record showed: 05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in WDC (Washington District of Columbia) NE (North East) on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her." A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to be discharged to another facility; and no for active discharge planning already occurring for the resident to return to the community. 08/11/22 [Care Plan Meeting Note] "Care plan meeting held today for [Resident #155] ...The SW answered questions about [Resident #155]'s	{L 535}	IDT team members(clinical team, unit managers, DON, QA/IP director) and other department heads will assist during daily morning meeting to ensure that care plans are updated/ revised to indicate a person centered care. All findings will be addressed immediately. Unit manager/Supervisors will audit charts of residents using MEASURES TO PREVENT RECURRENCE; perma cath for dialysis treatment to ensure the care plan indicates the site of the perma cath and interventions. Licensed social workers will audit charts of residents due for discharge to ensure that their care plans are updated to reflect discharge plans and goals. This audit must be conducted weekly x4, then monthly x3. All findings will be corrected immediately and reported to QA committee.	9/07//22

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{L 535}	Continued From page 21 behavior and why other facilities may continue to reject his transfer ...The family asked how can that be removed and the DON (Director of Nursing) stated that we must report the behaviors so the facility can properly work with [Resident #155]." There was no evidence in Resident #155's medical record that facility staff documented a discharge plan that included: the discharge destination; ensuring the location met the resident's health and safety needs; addressing the resident's goals for care and treatment preferences; and identifying resident education and rehabilitation needs that must be addressed prior to discharge. During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) stated, "Once his (Resident #155) family became involved the wanted him to go to [Facility Name]. He was not accepted at [Facility Name]. He is not appropriate for housing due to his diagnoses." No further comment was made related to a discharge plan being created for the resident. 3. Facility staff failed to create a discharge plan for Resident #237. Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease. Review of the medical record revealed: 06/16/22 [Social Work Progress Note] "The SW accompanied [Resident #237] to [Facility Name]	{L 535}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #155 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP updated on 9/2/22. Resident #237 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22 IDENIDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected DON/ADON/Designee conducted house wide audit to ensure that residents comprehensive care plans are updated/ revised. All findings will be addressed immediately.	9/07/22

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{L 535}	Continued From page 22 Assisted Living Facility. The SW and resident took a tour and completed an assessment with the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged." 07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled." 08/01/22 [Social Work Progress Note] "The SW met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive assessment. This is to assist him in locating the most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]." A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community. There was no documented evidence that facility staff completed Resident #237's discharge paperwork in a timely manner for the resident's placement at an assisted living facility. There is also no evidence that facility staff documented: the discharge plan; timely completion of the comprehensive assessment; the resident's goals for care and treatment preferences; or the resident's education and rehabilitation needs that	{L 535}	MEASURES TO PREVENT RECURRENC; DON/Designee, Unit Managers, Clinical care coordinator, supervisors and social services team members will be rein-serviced by the facility's staff educator / designee on the importance of developing a comprehensive care plan for the residents. Unit managers will audit charts of residents on a weekly basis to ensure residents have their comprehensive care plan in place. All findings will be corrected immediately. Supervisors will audit charts during their shifts weekly to ensure that residents have all comprehensive care plans in place. All findings will be corrected immediately. Social services team will ensure weekly that they develop a comprehensive care plan for residents who are due for discharge. All findings will be corrected immediately.	9/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	R-C 08/31/2022

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

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{L 535}	Continued From page 23 must be addressed prior to discharge. During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 stated, "He (Resident #237) is too advanced for [Facility Name]. I am contacting [Facility Name] to get an assessment ...He has a case worker in the community."	{L 535}	MONITORING CORRECTIVE ACTION: Clinical team members (DON, Unit managers) Social services team ,MDS coordinators will audit charts of residents to ensure that residents have comprehensive care plan in place. This audit will be done weekly x4, then monthly x3. All findings will be corrected immediately.	9/07/22