Health Regulation & Licensing Administration (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: _ C B. WING 04/20/2022 HFD02-0017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5000 NANNIE HELEN BURROUGHS AVE. NE DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** 8/24/22 L 000 L 000 Initial Comments On March 26, 2022, an unannounced complaint survey was initiated at this facility. After review of facility documentation and conferring with CMS-Philadelphia management, this survey was converted into an annual recertification survey on March 29, 2022. This survey took place onsite at the facility from March 26, 2022 - April 20, 2022. Survey activities consisted of a review of 105 Deanwood Rehabilitation and sampled residents. The facility's census during wellness center the survey was 255. Disclaimer: The facility submits this plan of The following complaints were investigated during correction under procedures this survey: DC00010689, DC00010640, established by the department of DC00010663, DC00010638, DC00010532, Health in order to comply with the DC00010531, DC00010525, DC00010503, departments directives to change DC00010493, DC00010435, and DC00010365. conditions which the department alleges are deficient under state The following facility reported incidents were regulations related to Long term investigated during this survey: DC00010721, care. This should not be DC00010720, DC00010719, DC00010717, construed as either a waiver of DC00010694, DC00010656, DC00010651. the facility's right to appeal or to DC00010645, DC00010644, DC00010636, challenge the accuracy or DC00010634, DC00010618, DC00010584, severity of alleged deficiencies or DC00010575, DC00010576, DC00010565, any admission of any wrongdoing. DC00010547, DC00010539, DC00010540, DC00010485, DC00010464, DC00010471, DC00010443, DC00010438, DC00010412. DC00010405, DC00010400, DC00010373. DC00010335, DC00010334, DC00010332. DC00010330, DC00010328, and DC00010314. Federal and Local deficiencies were cited related to the investigation of: DC00010721, DC00010694, DC00010656, DC00010689, DC00010663, DC00010651, DC00010640, DC00010634, DC00010584, DC00010576. DC00010565, DC00010525, DC00010503. DC00010485, DC00010464, DC00010443, DC0001010435, DC00010405, DC00010365,

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ` '	(X3) DATE SURVEY COMPLETED	
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	DC00010336, DC00010334, DC00010330, DC00010314,					
	care at 42 CFR 483(c	fy substandard quality of c)(2)(3)(4) F610 and 42 CFR ne extended survey was 0, 2022.				
	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. Substandard quality of care was identified at F689 and F610 and the survey team conducted the extended survey on April 20, 2022.					
	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:					
	AV- Arteriovenous BID - Twice- a-da B/P - Blood Pres cm - Centimet CFR- Code of I CMS - Centers fo Services CNA- Certified CRF - Community CRNP- Certified R D.C District of	ay ssure ers Federal Regulations r Medicare and Medicaid Nurse Aide / Residential Facility degistered Nurse Practitioner Columbia Columbia Municipal				

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L 000	Continued From pag	e Z				
	DI- Deciliter					
	DMH - Departmen	nt of Mental Health				
	DOH- Department of Health					
	EKG - 12 lead Ele	J				
	EMS - Emergency	Medical Services (911)				
	F - Fahrenheit FR French					
G-tube- Gastrostomy tube		my tube				
	HR- Hour					
		ervice Center				
		entilation/Air conditioning				
	ID - Intellectua					
		linary team				
		Prevention and Control				
	Program					
		Practical Nurse				
	L - Liter					
	,	unit of mass)				
		n Administration Record				
	MD- Medical D					
	MDS - Minimum [
		(metric system unit of mass)				
	M- minute	(matria ayatam magayra af				
	mL - milliliters (metric system measure of				
	,	ns per deciliter				
		rs of mercury				
	MN midnight	is of filercury				
	N/C- nasal c	eanula				
	Neuro - Neurologi					
		re Protection Association				
	NP - Nurse Pra					
	O2- Oxygen					
	, , ,	sion screen and Resident				
	Review	Jordon and Modiadin				
	Peg tube - Percutane	eous Endoscopic				
	Gastrostomy					
	PO- by mouth					
	_	f Attorney				
		's order sheet				

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L 000	Recommendation SCC Special C Sol- Solution	d Dietitian Nurse f Motion ble party Background, Assessment, are Center Administration Record	L 000	CORRECTIVE ACTION FOR AFFECTED RESIDENTS:	8/24/22	
	administrative records: (a)Payroll records; (b)Reports of fire inspection of the second of the sec	sections; sections; sequired to be maintained and Code, construction and aions of the fire alarm system ar inspections; arocedures; are spread ratings of carpets,		Resident #404 went to the ho on 2/21/22 and later expired. Resident #82 was assessed of 4/26/22 by clinical coordinator resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident placed on monitoring for aggressive behantil evaluated by psychiatrist Resident taken by DC police custody on 7/20/22, currently the facility. Resident # 151 was assessed 4/26/22, resident suffered no negative outcome. Resident icurrently on 1:1 monitoring for aggressive behavior Resident #408 was sent to the on 2/17/22 and did not return facility	en ER	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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L 015	services; (i)Radiation survey reapplicable; (j)Summaries and aninvolving residents, svisitors; and (k)Policies and proceoperation of the facility This Statute is not maked on observation interview, Governing established and impless the management and were followed and acand implemented to: abuse and altercation	eports of x-ray equipment, if alyses of each incident taff and dures governing the cy.	L 015	Resident # 3 was discharge home on 3/29 Resident # 126 was assessed on 4/26/202 Unit Manager, resident suffered no negative outcome. MD/RP notified on Resident # 164 was assessed on 4/26/202 Unit Manager, resident suffered no negative outcome. MD/RP notified 4/26/22 Resident # 183 was assessed by Unit Mar on 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/22 Resident # 409 was discharged to another facility 9/8/21 Resident # 56 was assessed post fall in the parking lot, resident suffered a hematoma left forehead on 4/7/22. RP/MD notified on Resident #304 was assessed on 4/26/22, respiratory distress, resident suffered no negative outcome. MD/RP notified on 4/26/26.	22,by ve 22,by ve nager ve er ne on the 4/7/22	8/24/22
	(1) resident who sust unknown origin; adec resident who sustain the appropriate respii on hand for care and trained on how to car laryngectomies; and staff maintained the il Incident/Accident Repone (1) resident. The survey was 255. The findings include: 1. In the area of Free and Exploitation, Adn residents were free frinjury) and neglect as	ain a dislocated hip of suately supervise one (1) ed a fall with injury; ensure ratory medical supplies were treatment; ensure staff were e for two (2) residents with a so ensure the administrative integrity of an cort (investigative report) for e census on the first day of dom from Abuse, Neglect, ninistration failed to ensure om abuse (willful infliction of e evidenced by: failure to iction of serious injury of		IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED;' All residents residing in the facility ha potential to the affected. Licensed clinical team members (LPN conducted house wide audit on 4/22/ensure that the residents have a person-centered comprehensive care residents with dentures have them are be, assistance with wearing the denturesidents with non-compliant behavior documentation on the implementation residents are supervised and monitor resident with respiratory diagnosis has equipment handy. Findings will be cons/24/22	ve the N/RN) 2022 to e plan, that and if need ures, that ar have as and tha that that that that that	

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L 015 Continued From page 5 implement person center care measures for Resident #151 who had incidences of aggressive behavior towards one (1) resident and willful infliction of injury to one (1) resident sustained a dislocated hip. During the face-to-face interview on 04/20/22 approximately at 6:01 PM. Employees #63 and #2 were made aware of the findings. 2. In the area of Free of Accident Hazards/Supervision/Devices, the Administration failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents are evidental efforts one (1) resident infliction or estimity to one (1) resident receives a dequate supervision and assistance devices to prevent accidents, as evidenced by: Respiratory therapist will work with central supply coordinator weekly to ensure that the bear provided in service by staff educator or residents with egressive behavior. ADON/Designee will audit residents clinical record weekly to ensure that the nurses are revising and updatients with dentures are assisted by C N A to wear them during their shifts. Respiratory therapist will work with central supply coordinator weekly to ensure that residents with fentures are assisted by C N A to wear them during their shifts. Respiratory therapist will work with central supply coordinator weekly to ensure that residents with reprivatory diagnosis always have their equipment handy. Facility's van driver has been provided in service by staff educator on residents with residents with respiratory diagnosis are provisional order. Respiratory therapist will ensure that residents the records always maintain their integrity. Weekly audits will be confected Findings will be addressed by 8/24/22 Governing body will ensure that residents with residents records always maintain their integrity. Weekly audits will be confected. Findings will be addressed by 8/24/22 Governing body will e	DEANWO	OD REHABILITATION AN	ID WELLNESS CEN				
implement person center care measures for Resident #151 who had incidences of aggressive behavior towards one (1) resident and willful infliction of injury to one (1) resident and willful infliction of injury to one (1) resident post hip replacement. Subsequently, the resident sustained a dislocated hip. During the face-to-face interview on 04/20/22 approximately at 6:01 PM. Employees' #63 and #2 were made aware of the findings. 2. In the area of Free of Accident Hazards/Supervision/Devices, the Administration failed to ensure that each resident receives adequate supervision and assistance devices to prevent accident alteration resulting in serious injury to one (1) resident; resident-to-resident alteration resulting in front of the facility and subsequently sustained a fall resulting in harm to one (1) resident fallure to supervise one (1) resident thile residents at the resident and fall resulting in harm to one (1) resident status post left hip replacement, who subsequently sustained a dislocated hip of unknown origin; failed to secure one (1) resident swheelchair during a van transport; failed to implement care plan interventions to help prevent one (1) resident and interventions to help prevent one (1) resident interventions to help prevent one (1) resident and interventions to help prevent one (1) resident twith a history of falls. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
3. In the area of Respiratory Care, the Administration failed to ensure Resident #3's	L 015	implement person cer Resident #151 who have behavior towards one infliction of injury to or ensure staff received centered care to one replacement. Subset sustained a dislocated During the face-to-face approximately at 6:01 #2 were made aware 2. In the area of Free Hazards/Supervision/failed to ensure that eadequate supervision prevent accidents as resident-to-resident a serious injury to one (resident-to-resident at one (1) resident; faresident while seated front of the facility and fall resulting in harm; resident-centered interesidents who subtilised to implement to help part a history of falls. During the face-to-face approximately at 6:01 #2 were made aware 3. In the area of Responses.	anter care measures for ad incidences of aggressive (1) resident and willful the (1) resident; and failed to training to provide person (1) resident post hip quently, the resident displayed hip. The interview on 04/20/22 The provide person (1) resident displayed hip. The interview on 04/20/22 The providence of the findings. The providence of the findings of the findings. The providence of the providence of the finding in the providence of the providenc	L 015	In-service will be provided to all licer clinical staff members, Rehab staff a A 's by staff educator / Designee to that a person-centered care plan for resident is implemented as indicated 8/24/22 In- service will be provided to the cli team, housekeeping team, environn team, activities team on how to provider residents with aggressive behavior residents with aggressive behavior residents with aggressive behavior record weekly to ensure that the nurrevising and updating resident's per centered care plans. Any issues four corrected by 8/24/22 Charge nurses, supervisors / designensure that residents with dentures assisted by C N A to wear them during shifts. Respiratory therapist will work with central secondinator weekly to ensure that resident verspiratory diagnosis always have their equiphandy. Facility's van driver has been provided in sestaff educator on resident's safety while riding the respiratory diagnosis are provided care physicians' order. Findings will be addressed by 8/24/22 DON/ Designee will ensure that residents realways maintain their integrity. Weekly audit conducted. Findings will be addressed by 8/24/22 Governing body will ensure that reside respiratory therapist will ensure that reside respiratory therapist will ensure that reside respiratory therapist will ensure that reside respiratory problems are assessed during the ensure that they are in no form of respirator Findings will be addressed by 8/24/22 Governing body will ensure the DON is aud for accuracy weekly. Findings will be addressed by 8/24/22 Governing body will ensure the DON is aud for accuracy weekly. Findings will be addressed by 8/24/22	nsed and C N ensure in a d by inical nental vide care for. clinical ses are sonnow will be nee will are ing their ing their ing their ing the van. It residents per d by 8/24/22 et al. It with neir shift to y distress.	

Health Regulation & Licensing Administration

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airway (stoma) was not occluded by a medical device (Heat Moisture Exchanger (HME) subsequently, causing the resident to be transferred to the Emergency Room (ER) for dislodgment.(2) keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy (lary-tube) and stoma (airway) subsequently, the resident had to be transferred to the ER for a replacement; (3) Obtain/provide Resident #3 with HMEs; (4) failed to change and clean respiratory equipment in accordance with the physician's orders; failed to obtain an order for the use of a "button" (HME) for Tracheostomy Status for one (1) resident. Residents "43 and Resident #304. During the face-to-face interview on 04/20/2022 approximately at 6:01 PM, Employees' #63 and #2 were made aware of the findings. 4. In the areas of Medical records and in accordance with accepted professional standards and practices, the facility must maintain medical records on each residentthe governing body failed to ensure a resident's regord contained.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
accurate information as evidenced by failure to: accurately record information on a Treatment administration record for one (1) resident; maintain the integrity of an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident; and ensure resident's medical record were accurately documented for three (3) residents. Residents' #3, #126, #164, #404, and #408. During the face-to-face interview on 04/20/22 approximately at 6:01 PM, Employees' #63 and	L 015	airway (stoma) was not device (Heat Moisturn subsequently, causin transferred to the Emdislodgment; (2) keep medical equipment in necessary to care for laryngectomy (lary-tu subsequently, the rest to the ER for a replace Resident #3 with HM clean respiratory equithe physician's orders for the use of a "butto Status for one (1) respiratory equithe physician's orders for the use of a "butto Status for one (1) respiratory equithe physician's orders for the use of a "butto Status for one (1) respiratory equithe physician's orders for the use of a "butto Status for one (1) respiratory were made aware 4. In the areas of Meaccordance with access and practices, the factorial failed to ensure a respiratory record information accurately record information accurately record information record maintain the integrity Report" related to a latercation resulting in resident; and ensure were accurately docuresidents. Residents' #408. During the face-to-face purpose a substantial face-to-face purpose face-to-face face-to-fa	and toccluded by a medical exchanger (HME) g the resident to be be ergency Room (ER) for a supply of respiratory the facility that was and treat Resident #3's be) and stoma (airway) sident had to be transferred bement; (3) Obtain/provide Es; (4) failed to change and ipment in accordance with significant for Tracheostomy ident. Residents' #3 and ce interview on 04/20/2022 I PM, Employees' #63 and of the findings. dical records and in the epted professional standards solility must maintain medical dentthe governing body ident's record contained as evidenced by failure tocormation on a Treatment for one (1) resident; of an "Incident/Accident resident-to-resident neserious injury to the resident's medical record imented for three (3) #3, #126, #164, #404, and ce interview on 04/20/22	L 015	educator / Designee to licensed nurs N A's, restorative team and Rehab so how to provide care to residents with replacement Charge nurses and respiratory theral assess residents with respiratory dia during their shift to ensure the stoma occluded. Findings will be corrected 8/24/22. MONITORING CORRECTIVACTIONS: DON/Designee will audit residents' chart on a weekly basis to ensure that there is person centered care plan in place that addresses the residents medical needs. The will also ensure that resident are monitored and supervise avoid resident to resident altercation and that resident with respiratory diagnosis has their respiratory equipment handy. This audit will take pweekly x4, then monthly x3. Findings will be corrected immediately and reported to	taff on hip pist will gnosis is not by VE A a n ney nts ed to as ave lace	8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED		
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L 017	L 017 3203.7 Nursing Facilities			L 017			8/24/22	
	Each administrative r least five (5) years from this Statute is not meased on record reviracility staff failed to rof posted nurse staffing years from the date of the findings include: The findings include: During a review of the Directly Responsible 04/14/22, the writer as show proof that it man posted nurse staffing. During a face-to-face 04/14/22 at approxim #20 (Regional Directle stated the facility was they maintained 18 measurements. 3210.4 Nursing Facility A charge nurse shall following: (a) Making daily reside and emotional status required nursing interview (b) Reviewing medical completeness, accurate the status reduced the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness, accurate the status required nursing interview (b) Reviewing medical completeness (c) accurate the status required nursing interview (c) accurate the status	ecord shall be retained from the date of creation. et as evidenced by: ew and staff interview, the tain administrative recong data for at least five (of creation. e "Report of Nursing Stafor Resident Care" forms sked the facility staff to intained 18 months of the data. interview conducted on ately 3:43 PM, Employer of Human Resources) is unable to provide proof nonths of "Report of Nursible for Resident Care" ties be responsible for the ent visits to assess physicand implementing any evention;	ne ord (5) ff s on e that sing	L 051	L017 starts here: CORRECTIVE ACTION FOR THE AFF RESIDENT: No resident was affected by this practic IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED: REVENT RECURRENCE: In-service will be provided by Staff Educator /Designee to the Staffing coo always ensure that the total number of worked per day for the nursing staff wh providing direct patient care is recorded that all staffing records must be mainta 8/24/2022. Human Resources Manager assistant staffing records to ensure the staffing is recording the actual number of nursind directly responsible for resident's care. Any negative findings will be corrected than 8/24/22 MONITORING CORRECTIVE ACTION Human Resources Director will conduct ensure that the staffing coordinator is preport of nursing staff directly responsible residents care correctly. Findings will be corrected no later than Human Resource Manager will ensure staffing records are preserved monthly issues found will be corrected by 8/24/2. The Administrator will ensure staffing records are preserved monthly issues found will ensure staffing records are preserved monthly issues found will be corrected by 8/24/2.	rdinator to hours oo are d. Also , ined by will audit coordinator ng staff no later IS: t audit to costing a cole for 8/24/22. that . Any 22.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		HFD02-0017	B. WING		04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE		
		5000 NA	NNIE HELEN BU	IRROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	IGTON, DC 2001			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
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L 051 Continued From page 8			L 051	L 051 STARTS HERE:	3/29/22 8/24/22	
	(c)Reviewing residen	ts' plans of care for		Resident # 3 was discharged or	13/29/22 0/2-1/22	
	appropriate goals and approaches, and revising			Decident #27 was assessed fro	m hood to	
	them as needed;	a approaches, and revising		Resident #27 was assessed fro		
	arom do moddod,			toe on 4/26/22 by Unit manager		
	(d)Delegating respon	sibility to the nursing staff for		suffered no negative outcome. I notified on 4/26/22. Residents of		
		g care of specific residents;		need will be addressed.	leritai	
				lieed will be addressed.		
	(e)Supervising and e	valuating each nursing		Resident # 50 was assessed from	om head to	
	employee on the unit	; and		toe on 4/26/2022, resident suffe		
				negative outcome. MD/RP notif		
		or of Nursing Services or his		4/26/2022.care plan indicate tw		
	•	med about the status of		assist with ADL	o person	
	residents.			Resident # 56 was assessed from	om head to	
	This Statute is not m			toe on 4/7/22, resident suffered		
		ew and staff interview, for 14		hematoma on the left forehead.		
		ents, facility staff failed to:		notified on 4/722.	,	
		g care plan interventions; (2)				
		plans with appropriate s; (3) follow facility policy to		Resident #81 was assessed fro	m head to	
		esident's active clinical		toe by Unit Manager on 4/26/22	t, resident	
	_	e a licensed nurse was		suffered no negative outcome. I	MD/RP	
		administer Tiotropium		updated on 4/26/22.		
	Bromide Aerosol Inha					
				Resident # 82 was assessed from		
	Residents' #3, #27, #	50, #56, #81, #82, #126,		toe on 4/26/22 by Unit manager		
	#132, #151, #155, #1	80, #181, #403 and #404.		suffered no negative outcome.N		
				notified on 4/26/22.Resident tak		
	The findings include:			police on 7/20/22, currently not	in the	
				facility.		
	Review the facility's p			Desident # 400		
		m Meeting (Care Plan		Resident # 126 was assessed f		
		2022 documented, " It is		to toe on 4/26/22, resident suffe		
		Name] to develop and ntered care plan for each		negative outcome. MD/RP notif	ieu on	
		the instructions needed to		4/26/22.	om bood	
		person-centered care that		Resident #132 was assessed fr		
		andards of quality care"		to toe on 4/26/22, resident suffernancial		
	moot protossional ste	area as or quarry sure		negative outcome. MD/RP notif 4/26/22 Care plan updated to in		
	Policy Title: "Correction	on in Resident Medical		indwelling catheter use.	luicate	
	Records" revised 03/2			mowening cameter use.		

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L 051	"Procedure and Im there is an error or manifold the resident of the commentation or clinical staff that manifold the commentation or clinical staff that manifold the commentation or clinical staff will right documentation if it is error in documentation or clinical staff will right documentation if it is error in documentation appears medical chart, staff who made error error, the staff will addition to correction and add thout. After the paper error above, the medical san addendum for conneeded or appropriated implement care of Resident #3 was additionally alignant Neoplasm Larynx, Acquired Abstracheostomy Status An Admission Minimal 12/03/21 showed that following: In Section I (Active Displacement of the comment of the comme	plementation- Whenever nultiple errors observed in ecords or clinical chart. The s follows: The medical staff nade error in the resident cord must strike the error in then document the reason on in being strike and signing the error in the electronic eresident, the medical staff ght an addendum for correct needed or appropriate. If the on occurred in resident(s) the medical staff or clinical evill draw a line across the lad his/her initial to the needate the error is crossed that the behavior of the end of the e	L 051	Resident #151 was assessed of 4/26/22, resident suffered no new outcome. MD/RP notified on 4/26 Resident # 155 was assessed if head to toe on 4/26/22, resident suffered no negative outcome. In notified on 4/26/22. Resident # 180 was assessed if head to toe on 4/26/22 by Unit manager, resident suffered no noutcome. MD/RP notified on 4/26 Resident #404 was sent to the lon 2/21/22 and later expired. Resident #403 expired 3/18/22 Resident # 181 was assessed is manager on 4/26/22, resident son negative outcome. MD/RP non 4/26/22	egative 26/2022. rom t MD/RP rom negative 26/22 nospital oy Unit uffered

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L 051	and Programs) - the receiving tracheostor services. The resider respiratory therapy so Review of Resident # the following: 11/30/21 [Hospital Didocumented, "larynge total laryngectomy, late 10/27/21Do not occupatient is a neck breat 12/02/21 at 3:31 PM documented, "He was secondary to larynge requirementPast malaryngeal mass, statu" 12/04/21 [Physician's occlude stoma in necessity occlude stoma sin necessity occlude stoma sin necessity occlude stoma sin necessity occlude stoma sin necessity occlude stoma in necessity	I Treatment, Procedures, resident was coded for my care and speech therant was not coded for ervices. It's medical record reveal scharge Summary] Eal cancer s/p (status postaryngectomy tube clude stoma in neck, the ather" [physician progress note] is recently hospitalized al cancer with tracheostomedical historylarge is post total laryngectomic is order] instructed, "Do notek. The [patient] is neck is order] instructed, "Please usting from in and around is a day) with moist gauze ould not be covered). Ethensive care plan with a 1 showed the following: t's name] has lary tube r/terminated.	my es et to	L 051	IDENTIFICATION OF OTH WITH THE POTENTIAL TO AFFECTED: All residents residing in the facility have the potential to affected. House wide audit conducted DON/ Designee, to ensure residents with dental needs addressed, that care plan interventions are implement as indicated, that residents active records are updated indicated, that residents are assisted with wearing dent at mealtimes, that resident aggressive behavior interventions are implement that comprehensive care plan are accurate, that residents speech deficit issues are addressed, and that staff members are competent in administering medications residents. Any issues will be addressed by 8/24/22.	D BE b be ed by s are nted s l as e ures 's nted, lans s with	8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L 051	infection through the Interventions- lari-tub daily, assist with coug Further review of Rescare plans lacked docinterventions to addreuse of a lary-tube and 12/03/22. During a face-to-face 2:25 PM, Employee # stated that he include Resident #3's use of include interventions stoma site care. 2. Facility staff failed address Resident #27 was ad 05/06/20 with the folloand End-stage Renal Review of a progress showed, "Resident widuring the shift and heen advised not to straw, not to drink hot avoid spicy foods" Review of Resident # plan showed a focus potential for Dental or related carious teeth, on 05/06/20 Assist needed. Observe for oral cavity, chewing a of oral pain treatments.	review date. e care daily, change HME gh as needed ident #3's comprehensive cumented evidence of less care for Resident #3's if HME from 12/01/22 to interview on 04/13/22 at left (Clinical Coordinator) d interventions to address a lary-tube, but he did not to address the resident's to revise the care plans to left's dental needs. mitted to the facility on lowing diagnoses: Diabetes Failure. note dated 03/16/22 leas seen by [Dentist name] lead tooth extractionHas luck on candies or through a left or carbonated drinks to 27's comprehensive care larea, "[Resident Name] has left oral cavity health problem left poor oral hygiene" initiated	L 051	MEASURES TO PREVENT RECURRENCE: In service will be provided educator/ designee to the staff on the importance of residents care plans to reperson center care. In service will be provided educator to licensed nurs on the importance of make changes to a resident's acrecord as indicated and that the information in the is accurate. In - service will be provided Licensed nursing staff on importance of ensuring the residents with dentures he them on, and that C N A's residents in wearing dented during meals. Unit managers, supervised Designee will ensure week residents are free from all neglect and that the resides supervised and monitored safety. Findings will be accepted by 8/24/22.	d by staff e nursing f revising flect d by staff ing staff ing staff ing ctive to ensure e records ed to all the the tat ave s assist ures ors / ekly that ouse and ents are d for

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L 051	revise Resident #27's resident's tooth extra aftercare. During a face-to-face 04/16/22, at approxin Employee #8 (Nurse the findings. 3. Facility staff failed intervention of having Nurse Aides) for activassistance (ADL) for Review of a Facility Freceived on 11/22/21 made by [Resident #8 AM, a CNA hit her a bar of soap wrappe was interviewed; shresident's room at 9:2 was ready to be changes. The CNA said shand assist her becausassist, but resident reprovide care to her; the proceeded to provide resident" Resident #50 was ad 06/26/14 with multiple Morbid Obesity, Anxiotic Disorder and Major Desident #50 was revealed the following revealed the following revealed the following the state of the state o	d that facility staff failed to a care plan to include the ction (on 03/16/22) and interview conducted on mately 1:15 PM with Manager), he acknowledged to implement the care plan two (2) CNAs (Certified ities of daily living Resident #50. Reported Incident (FRI) and documented, "allegation of 11/15/21 that at 11:30 for times on her left knee with doin a towel" The CNA resaid she went to 20PM and asked her if she ged and Ms. Lambright said the called the nurse to come are resident is two persons fused two persons to the CNA then said she incontinent care to mitted to the facility on a diagnoses that included: ety Disorder, Mood Affective epressive Disorder. 50's medical record	L 051	In service will be provided to educator/Designee to all lick staff on the need to develop comprehensive care plan for residents and ensure they a updated as required by 8/2. In service will be provided to licensed nursing staff by stateducator / Designee on the importance of ensuring that respiratory medical equipmedican and always available. In service will be provided to educator/Designee to all lick staff on the importance of addressing residents' intrust behavior completely and to maintain the integrity of all incident/accident reports. In-services will be provided respiratory therapist/ designall licensed nurses on how assess residents with respin diagnosis and to ensure the documentation reflects their findings,	ensed of a property and a property a	8/24/22

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L 051	for Mental Status (BI indicating intact cogn 01/30/20 (Revision d #50] has an ADL self (related to) limited Romobility, morbid obes staff participation to rathe resident requires personal hygiene car 11/16/20 (Creation D abuse 2 CNAs to p 11/17/20 [Physician's ADL care all shift" 11/16/21 at 9:40 AM 9.30 PM (11/15/21), to room 229 B because refusing her to finishing entering the room, the shouting, cursing the hit her on the thigh. The resident and there we was she in any pain or released the CNA and cleaning the resident The evidence showe implement the care point to the complement of the care point of the complement the care point of the care point of the complement the care point of the care	e following: a Brief Interview MS) summary score of "13", iition. ate) [Care Plan] "[Resident -care performance deficit r/t DM (range of motion), limited sity the resident requires 2 eposition and turn in bed, total assistance with e" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift" ate) [Care Plan] "Alleged provide ADL care all shift"	L 051	Unit Manager will ensure withat residents with dental neare addressed. Any issues found will be corrected by 8/24/22. Charge nurses will ensure to N A 's are providing care (A according to the resident's plan. Two persons to assist ADL must be implemented issues found will be correct 8/24/22. Unit managers will ensure to charge nurses follow the farm policy to make changes in residents active record well Any issues found will be compared by 8/24/22. Charge nurses will ensure to residents with dentures have them on and that C N A 's a assisted residents with weat dentures during meals. An issues found will be correct 8/24/22.	that C DL) care t with Any ed by that cility ekly. rrected that ve	8/24/22

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L 051	make changes in the clinical record. During a review of the approximately 5:35 P notes dated 04/06/22 was observed outside the floor. Upon the ini was observed with a her forehead. When a informed the staff tha something off the floor wheelchair" However, upon review notes on 04/08/22 at information related to recorded, "On 4/6/20. Security [Employee # patio when she obsersuddenly rolling into the chased after the where resident ran into a canduring interview, "My rolling from the building unable to stop it and in the control of the pation of the control of the con	to follow facility policy to Resident #56's active e chart on 04/07/22 at M, the nursing progress at 18:37 recorded "Resident e, in the parking lot, and on tial assessment, resident hematoma to the left side of asked what occurred, she at she was attempting to get er and slid out of her w of the nursing progress 9:56 AM the following the resident's incident was 22 at 18:37 read, "The 46] was coming from the ved resident's wheelchair he parking lot. The Security elchair and resident, but and fell. Resident said wheelchair suddenly started and into the parking lot, I was not a car and hit my head." interview with Employee #7 AM, he stated, with the strying to document what was trying to document the ce that when facility staff documentation in Resident ecord that it was done in	L 051	Unit managers will audit charts to ensure that residents compressive I where applicable. Any issues to be corrected by 8/24/22. Unit managers / Designee will expected by 8/24/22. Unit managers / Designee will expected by 8/24/22. Unit managers / Designee will expected as new and are reviewed and revised as new any issues found will be corrected by 8/24/22. DON/Designee will conduct round are administering medication viccorrectly. Any issues found will be corrected by 8/24/22. Supervisors will conduct rounds weekly basis to ensure that nuradministering medication via informed will be corrected by 8/25/25/25/25/25/25/25/25/25/25/25/25/25/	ehensive behavior bund will ensure that they eded. ted by ends nurses a inhaler ted by son a ses are haler ssues 22. In g their residents will be eveekly to with and	8/24/22

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L 051	5. Facility staff failed address Resident #81 with apmealtimes. During an observation approximately 1:30 Fresident was observed asked if she liked the resident reported that okay, but she wanted she eats. The writer with her in the facility Resident #81 was accomply with the she with the she with the she cats. The writer with her in the facility Resident #81 was accomply with the she with th	to develop a care plane of sinclude assisting oplying her dentures at a plane of the plane of th	When was when ere cit. caled y had tance: y from dent erson.	L 051	Unit managers will ensure that residents with intrusive behavi monitored and supervised ever shift. Any issues found will be corrected by 8/24/22. Unit managers will ensure that residents with speech deficit a assessed by speech therapist followed up as indicated. Any if found will be corrected by 8/24. Charge nurses will ensure that document on residents' refusal care during their shift and notif R/P. Any issues found will be corrected by 8/24/22. Unit manager will ensure there comprehensive care plan in plant address resident's behavior of smearing bathroom with feces urinating on the floor is revised updated weekly. Findings will laddressed by 8/24/22.	or are ry re and issues 1/22. t they I of ry the e is a ace to and	8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLE	
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L 051	evidenced by weaking CVA. Interventions in hygiene, grooming, deating as neededE self-care" "Focus: [Resident #8 cavity health problem (CVA). [Resident #81 included assist with cog/02/21[Denture Qudocumented: 1) Patient is satisfied withe denture, 4) Dentu Unit Nurse and Denti Og/02/2021 [Dentist N with fit and esthetics. 10/29/21 at 8:00 AM (Speech Therapy) St small bites/sips at slocheck for pocketing, sclear to cough/throat 02/06/22 at 7:52 PM (Consistent Carbohydthin liquid consistence) During a second obsep M, Resident #81 was The resident was not When asked about the stated, "No one put the series were series with the compression of t	a for ADL Self-care defices to right side related cluded: Assist with daily ressing, oral care, and incourage to participate of related to health condition of the related to health condition	to y e in ral tion ntions" ist]) s in by d Frate ons, eat, HO lire, 1:45 ray. 81 ed ded	L 051	DON/Designee will conduct ro weekly to ensure licensed nurse competent with the administrat medications via inhaler. Finding be addressed by 8/24/22 Staff educator/ Designee will ensure that competency check list is a and that licensed nurses can accurately carry out return demonstration on how to admin medications especially medical administered via inhaler. Charge nurses will ensure during shift that implementation of the of care is implemented and documented. Findings will be addressed by 8/24/22. DON/ADON/Designee will ensure with aggressive behavior are rupdated. Findings will be addressed. Findings will be addressed. Findings will be addressed.	ses were tion of gs will ensure accurate nister ations ing their e refusal eure esidents evised/	8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		HFD02-0017	B. WING			C 20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN 5000 NAN	INIE HELEN BUI	RROUGHS AVE. NE		
	T	WASHING	STON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page	e 17	L 051			8/24/22
	1:51 PM, Employee # acknowledged that R comprehensive care the resident with putt	e interview on 04/01/22 at #2 (Director of Nursing/DON) tesident #81's plan did not include assisting ing in her dentures at he would update the care				
	plans to address Res	vise the comprehensive care sident #82's physically towards another resident altercation).				
	Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "The charge nurse observed [Resident 404] sitting on the floor besides his roommate's bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him on the chin and he fell"					
	09/15/21with multiple	Imitted to the facility on e diagnoses that included: Stage Renal Disease and ng Loss.				
	Review of Resident # revealed:	#82's medical record				
	facility staff coded, a indicating intact cogn	ed 01/31/22 that showed BIMS summary score, "14", itive response. In section E ent was coded for not				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 (X4) ID PREFEX 17AG (EACH DEFICIENCY MUST BE PRECEDED BY FULL 17AG (EACH OFFICIENCY MUST BE PRECEDED BY FULL 17AG (EACH OFFICIENCY MUST BE PRECEDED BY FULL 17AG (EACH OFFICIENCY) PREFIX 17AG PREFIX 17AG PREVIDERS PLAN OF CORRECTION CONFICE TION AND OF CORRECTION 17AG PREFIX 17AG MONITORING CORRECTIVE ACTIONS: DON/Designee will ensure that residents dental and speech need are addressed, that necessary changes are made in the residents cellinical record as indicated, that residents have complete comprehensive care plans that are revised as needed, and that licensed staff members are competent in administering medication via inhaler. This audit will be conducted weekly x4, then monthly x3, findings will be addressed and reported to QAPI committee. Review of the comprehensive care plan on		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELLEN BURROUGHS AVE. NE WASHINGTON, DC 20019 (X4) ID PREFIX TAG CRACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY L 051 Continued From page 18 exhibiting physical or behavior symptoms towards others. 02/18/22 (Created date) [Care Plan focus area] "[Resident #82] is verbal[ly] abusive to staff using profamities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." 02/22/22 at 2:20 PM [Nurses Note] "[Resident #82] told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell" Review of the comprehensive care plan on				71. 201221110.			;
DEANWOOD REHABILITATION AND WELLNESS CEN SUMMARY STATEMENT OF DEFICIENCIES WASHINGTON, DC 20019			HFD02-0017	B. WING		1	
Continued From page 18 LO51 Continued From page 18 Exhibiting physical or behavior symptoms towards others. Colorable profanities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." Colorable to the ped, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell" Review of the comprehensive care plan on Complete Complete Conservation of Consertion Complete Cons	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAJ ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE L 051 Continued From page 18	DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X4) ID	SUMMARY STA		· ·		V	(X5)
exhibiting physical or behavior symptoms towards others. 02/18/22 (Created date) [Care Plan focus area] "[Resident #82] is verbal[[y] abusive to staff using profanities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." 02/22/22 at 2:20 PM [Nurses Note] "[Resident #82] told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell" Review of the comprehensive care plan on	PRÉFIX	,		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
exhibiting physical or behavior symptoms towards others. 02/18/22 (Created date) [Care Plan focus area] "[Resident #82] is verbal[ly] abusive to staff using profanities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." 02/22/22 at 2:20 PM [Nurses Note] "[Resident #82] told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell" Review of the comprehensive care plan on	L 051	Continued From page	e 18	L 051			8/24/22
"[Resident #82] is verbal[ly] abusive to staff using profanities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." O2/22/22 at 2:20 PM [Nurses Note] "[Resident #82] told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell" Review of the comprehensive care plan on			behavior symptoms towards			IVE	
04/05/22 lacked documented evidence that		"[Resident #82] is verbal[ly] abusive to staff using profanities related to: cognitive impairment Provide privacy/remove to private area. Provide supervision in social gatherings/recreation Psych consult Remain calm and avoid angry reactions if exhibits behavior. Set limits for acceptable behavior." 02/22/22 at 2:20 PM [Nurses Note] "[Resident #82] told the charge nurse "I hit him (Resident #404) because he came to my bed to bother me that man keeps coming over to my bed side and when I asked him to go back to his side of the bed, he punched me on my stomach and chest and I punched him [Resident #404] on the chin and he fell"			residents dental and speed are addressed, that necess changes are made in the resident's clinical record as indicated, that residents had complete comprehensive or plans that are revised as not and that licensed staff mentare competent in administed medication via inhaler. This will be conducted weekly x monthly x3, findings will be addressed and reported to	ch need sary ave sare eeded, nbers ering saudit 4, then	
		04/05/22 at 2:59 PM,	Employee #7 acknowledged				
During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and made no further comment.		address Resident #12	26's needing 2 person				
04/05/22 at 2:59 PM, Employee #7 acknowledged		dated 12/27/21 docur from wheelchair to be	acility Reported Incident) nented "During a transfer od by two staff, resident ght leg and the leg scratched				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I DIN SI CONNECTION	BENTI IO, NION NOMBER.	A. BUILDING: _			
	HFD02-0017	B. WING			C 20/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE		
DEANWOOD REHABILITATION AND W	VELLNESS CEN'	INIE HELEN BUI STON, DC 20019	RROUGHS AVE. NE		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
against the 1/4 side rail; resident suddenly sway h scratched against the following: Review of the Admission (MDS) dated 11/17/21, restaff coded the following: In Section C (Cognitive P for Mental Status (BIMS) indicating moderately implicating moderately implicating assist" Review of the nursing profize assistance resident suddenly sway h scratched against the 1/4 service as for two-person platransfers. During a face-to-face intered (A/20/22 at 10:45 AM, Er Nurse Aide) stated, "It was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21). Nobody was the scratched was transferred her [Resident 12/23/21]. Nobody was the scratched was transferred her [Resident 12/23/21]. Nobody was the scratched was transferred her [Resident 12/23/21].	resident sustained a ateral right leg; resident the edge of the 1/4 side are of the incident; writer atted to the facility on agnoses including Heart at Artificial Knee Joint, ination. Minimum Data Set evealed that the facility externs): Brief Interview Summary Score "11", paired cognition. Status): Transfer equiring "Two-person or gress note dated cumented, "During a to bed by two staff, her right leg and the leg side rail" S's care plan revealed develop a to address the resident hysical assist with	L 051			8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C / 20/2022
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DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'		RROUGHS AVE. NE		
	Г	WASHING	STON, DC 2001		PRESTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 051	Continued From page	20	L 051			8/24/22
	_	to develop a comprehensive Resident #132's use of an heter.				
		M, Resident #132 was velling urinary catheter with				
	02/11/22 with diagnos	eadmitted to the facility on ses that included: Urinary imer's, Dementia, Epilepsy ss (Generalized).				
	A review of the Quarterly Minimum Data Set (MDS) for Resident #132 dated 02/17/22 revealed that facility staff coded the resident in the following manner: In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition.					
	In Section H (Bowel a Appliances: Indwelling	•				
	A review of Resident revealed:	#132's medical record				
	"[Resident #132] has to dementia, impaired 02/11/22 at 11:11 PM "resident, readmitte assessment done: Sk	ed) [Care Plan focus area]: urinary incontinence related I mobility" [Nurses Note - Late Entry]: d in evening Head-to-toe in is warm to touch, and ey catheterResident is				

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C C	
HFD02-0017 B. WING 04/20/2	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	· ,	TE SURVEY MPLETED
				7. BOILDING.			0
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
DE 41114/0	OD DELLA DIL ITATIONI AL	UD WELLNESS SENT	5000 NANNII	E HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN	WASHINGTO	ON, DC 20019)		
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L 051	Continued From pag	e 22		L 051			8/24/22
	firmly held, contrary to E0200. Behavioral Stockhavioral symptoms (e.g., hitting, kicking, grabbing, abusing out this type occurred 1 to symptoms directed to threatening others, so at others) - "Behavior days", Impact on Ressignificant risk for phimpact on others physical injury? "yes"	ptions or beliefs that are to reality) - "yes" ymptoms: Physical structed towards others pushing, scratching, hers sexually) - "Behaviors 3 days", verbal behaviors of this type occurred 4 to sident Put the resident ysical illness or injury? "yout others at significant rise; significantly intrude on the resident of the sident in the resident in	r of oral ng o 6 t at res"; sk of the				
	disrupt care or living 12/08/21 at 11:18 AM 0730AM, the [Securi [Receptionist's Name assaulting another re front of the building. receptionist ran to the both residents [Res He said, 'the man jun building for no reason him. I don't know who [Resident #71] was a mark observed on the Review of the Care F 07/27/21 (Revision d #151] at risk for chan related to: agitation	I [Nurses Note] " At ty Officer's Name] and the observed resident [#15] esident [Resident #71] at The security officer and the residents and separates and separates and separates and the resident #71] was interview upped on me in front of the n. I have never spoken to the tere this came from assessed and small scrate back of his left hand" Plan revealed: ate) Focus area, "[Residences in behavior problems	e 1] the he d ed. e o ch				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED		
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	ROVIDER OR SUPPLIER	•	5000 NANN	RESS, CITY, STA IIE HELEN BU TON, DC 2001	RROUGHS AVE. NE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
L 051	acts characterized by kicking and hitting 10/20/21 (Revision of #151] uses psychotromanagement, Paran Monitor/record occur symptoms violency staff/others) and document of the staff revised the care interventions to addraggressive behavior (Resident #71) after altercation (on 12/08) During a face-to-face 04/05/22 at 2:59 PM the finding and state on 1:1 in January of further incidences of altercations. 10. Facility staff faile comprehensive pers addressed Resident the resident's complaresulted in an emerging staff of the st	ic manner in which residy inappropriate behavior ate) Focus area, "[Reside opic medications r/t behavior of Schizophrenia rence of for target behave e/aggression towards ument per facility protocolor of the problem Combative, ciple staff members, tryin the Administration area 1:1 staff monitoring for sor sitter is available" #151's comprehensive can ented evidence that facility eplans to include ess the resident's physical towards another resident aresident-to-resident (21). #21. Interview conducted on the plans to include and the resident aresident manual tresident and the plans to include towards another resident (21). #22. Interview conducted on the plans to include and the plans to include towards another resident (21). #23. Interview conducted on the plans to include and the plans to include the plans to include and the resident and the plans to include the plans to include and the plans to include the plans to include and the plans to include the plans the plans to include the pla	dent avior vior ol" ent ent eg to and eafety eare eity cally ent edged put eny	L 051			8/24/22		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CEN 5000	ET ADDRESS, CITY, STA NANNIE HELEN BU HINGTON, DC 2001	RROUGHS AVE. NE		
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L 051	Dysphagia, Orophary Lack of Coordination, Hemiparesis Followin Cerebrovascular Dise Side. Review of the Quarte (MDS) dated 02/18/2: coded the following: In section B (Hearing Speech Clarity "1" "U Makes self-understood understood-difficulty or finishing thoughts I given time." Ability to understand understands" In Section C (Cognitiv Interview for Mental S indicating severe cog A.Review of the docu SLP Evaluation and F 11/02/21 and signed I revealed the following "Diagnoses" "Cognitiv Dysphagia, Orophary In the section titled "F Language & Commun Expression = 50%n Conversation = 50%, characteristics = Non	e diagnoses that included: ngeal Phase, Unspecified Hemiplegia and g Unspecified ease Affecting Left Dominant rly Minimum Data Set 2, showed that facility staff , Speech, and Vision), nclear Speech" d "1-Usually communicating some words out is able if prompted or others "1- Usually re Patterns) BIMS (Brief Status) Summary Score "05" nitive impairment. ment titled "Speech Therapy Plan of Treatment" dated by the residents' providers, g: In the section titled five communication deficit, ngeal phase" Receptive/Expressive nication Abilities" "Verbal naking needs known= 50%, Functional speech	L 051			8/24/22

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NAME OF PROVIDER OR SUPPLIER A. BUILDING: COMPLETED	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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			HFD02-0017	B. WING		_	
FOOD MANNIE HELEN BURBOULD AVE. NE	NAME OF PRO	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWOOD REHABILITATION AND WELLNESS CEN' 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	DEANWOO	OD REHABILITATION A	ID WELLNESS CEN'				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETE
		documented evidence developed a comprel care plan that address communication deficition. During a face-to-face 04/14/22 at approxim (Director of Nursing) speech and he gets of #2 reviewed the care findings. B. Review of the document Background, Assessimment of Background, Assessimment Background, Assessimment Background, President is aler Resident complaint of abdomen. NP (Nurse be transferred to the evaluation. Writer call at 3:23 PM and left we [Hospital name]." Review of a Discharge showed, "Resident we discharged on 3/31/2 being discharged her follow up with a cardialso need an echo of Resident #155's care evidence that the factomprehensive personal discharged and the follow up care. During a face-to-face 04/18/22 at 11:43 AM of Nursing) stated, "Total plants and the follow up care."	e that the facility staff lensive person-centered sed the resident's t. Interview conducted on lately 1:00 PM, Employee #2 stated, "He has slurred rustrated quickly." Employee plan and acknowledged the Imment titled "Situation, ment and Request (SBAR) I" dated 03/30/22 at 6:40 thank verbally responsive for chest pain radiating to the Practitioner) ordered to mospital for further led 911 at 3:15 PM, arrived lith resident at 4:04 PM to Resident #155] is modynamically stable to cologist as outpatient. He will intratient." plan lacked documented lity's staff developed a mon-centered care plan that mit's complaint of chest pains are required. interview conducted on Interview c	L 051			8/24/22

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			D MINIC		С
		HFD02-0017	B. WING		04/20/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	IRROUGHS AVE. NE 9	
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICE (ENCY)	ULD BE COMPLETE
L 051	Continued From page	e 26	L 051		8/24/22
	#180's behavior of fre bathroom floor, smea feces.	plan to address Resident equently urinating on the ring the bathroom with			
	11/16/17 with the follous Unspecified Demention				
	dated 03/03/22, the reunder Section C (Cog	rterly Minimum Data Set esident was coded "15" gnitive Patterns), a BIMS he was cognitively intact.			
		(Behavior), the resident cating that no behavior oited.			
		Functional Status, the s "1", indicating he required use, with one-person			
	Under Section H (Bla resident was coded a	•			
	H0200 (Urinary Toilet	ing Program) = No			
	H0300 (Urinary Incon was frequently incont	tinence) = 2, indicating he inent			
	H0400 (Bowel Contin frequently incontinent	ence) = 2, indicating he was			
	H0500 (Bowel Toiletin	ng Program) = No			

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	B) DATE SURVEY COMPLETED	
C		
HFD02-0017 B. WING 04/20/2	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
L 051 Continued From page 27	8/24/22	

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PRINTED: 07/27/2022 FORM APPROVED

Health Regulation & Licensing Administration

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN (X4) ID SUMMARY STATEMENT O BERICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 500 NANNE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 LOS1 Continued From page 28 Employee #4 (Educator), she confirmed the finding and was not able to provide documented evidence that facility staff developed a comprehensive care plan with goals and interventions to address Resident #180's behavior of frequently urinating on the bathroom dior, smearing the bathroom with feces. 12. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler. The allure, and End Stage Renal Disease. During a medication administration observation on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. During a medication administrating medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 in (Rhaler) in the inhaler for Resident #181. It should be noted the resident received the medication (finabler) in the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNEI HELBRI BURROUGHS AVE. NE WASHINGTON, DC 20019 (A) 10 (EACH DERICHONY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) L 051 Continued From page 28 Employee #4 (Educator), she confirmed the finding and was not able to provide documented evidence that facility staff feated to ensure the facility's nurse was competent on how to administer the Tiotropium Bromide Aerosol Inhaler for too one (1) resident. Resident #181. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. How to administer the inhaler for Resident #181. Should be noted the								С	
SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES DIP PROVIDERS PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCE OT 1 THE APPROPRIATE DATE OF TAG DIP PROVIDERS PLAN OF CORRECTION COMPLETE CACTION SHOULD BE CACH DEFICIENCY DIP PREFIX CROSS-REFERENCE OT 1 THE APPROPRIATE DATE DEFICIENCY L 051 Continued From page 28 L 051 Employee #4 (Educator), she confirmed the finding and was not able to provide documented evidence that facility staff developed a comprehensive care plan with goals and interventions to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces. 12. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler for to one (1) resident. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. Its bloud be noted the			HFD02-0017		B. WING		(-	
CALI DEPARTMENT OF DEFICIENCIES DEPARTMENT OF DEFICIENCIES DEPARTMENT OF CORRECTION CALIFORNIA CA	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
WASHINGTON, DC 20019 CAJID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION PROFIT TAG REGULATORY OR LSC IDENTIFYING INFORMATION PROFIT TAG REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFY OR LSC IDENT	DE 411140	OD DELLA DIL ITATIONI AN	ID WELLNESS SENT	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE			
PREFIX TAG	DEANWO	OD REHABILITATION AN	ND WELLNESS CEN	WASHINGT	ON, DC 2001	9			
Employee #4 (Educator), she confirmed the finding and was not able to provide documented evidence that facility staff developed a comprehensive care plan with goals and interventions to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces. 12. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler for to one (1) resident. Resident #181. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee affs. It should be noted the inhaler for Resident #181. It should be noted the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE	
finding and was not able to provide documented evidence that facility staff developed a comprehensive care plan with goals and interventions to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces. 12. Facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler for to one (1) resident. Resident #181. Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, Heart Failure, and End Stage Renal Disease. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 inhout administer the inhaler for Resident #181. It should be noted the	L 051	Continued From page	e 28		L 051			8/24/22	
Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease).	LUSI	Employee #4 (Educa finding and was not a evidence that facility comprehensive care interventions to addressed behavior of frequently floor, smearing the base of the presence of the unit mone and show me had administer that typ (RN-Unit Manager) constructed Employee inhaler for Resident #1 Resident #181. When administer the reside Aerosol Inhaler. The waiting for the unit mome and show me had administer that typ (RN-Unit Manager) constructed Employee inhaler for Resident #1 resident	tor), she confirmed the able to provide document staff developed a plan with goals and less Resident #180's y urinating on the bathroathroom with feces. If to ensure the facility's ton how to administer Aerosol Inhaler for to on 181. Idmitted to the facility or the diagnoses including Pulmonary Disease, As administeration observation asked why she did nont's Tiotropium Bromide employee stated, "I'm anager (Employee #43) how to do it. I don't know to do it. It should be noted ame to the unit and #45 how to administer the 181. It should be noted medication (inhaler) in manager and surveyor. In order dated 03/18/22 in Bromide Monohydrate mcg(microgram)/act 2 set a day for COPD (Chro	oom thma, e. tion #45 ns to te) to w how #43 the d the the e.				0/24/22	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	E SURVEY PLETED	
		HFD02-0017		B. WING		0.4	C 4/20/2022
NAME OF P				RESS, CITY, STA	TE. ZIP CODE	1 0	#/ L 0/ L 0 L
				, ,	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		TON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page	e 29		L 051			8/24/22
	for March 2022 revea Tiotropium Bromide I Solution 2.5mcg(microrally one time a day	aled that the following: Monohydrate Aerosol rogram)/act 2 spay inha					6,2 .,,22
	Employee #45 signed her initials indicating that she administered Resident #181 Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally at 9:00 AM on 03/18/22, 03/21/22-3/24/22, and 03/26/22 - 03/28/22.		at				
	Review of Treatment Administration Record and Vital Summary sheet documented that Resident #181's oxygen saturation rate ranged from 96-98% on room air from 03/18/22 to 03/21/22 and respiration rate ranged from 17 to 20 breaths per minute from 03/18/22 to 03/24/22.		dent 22				
	approximately 11:45 that 03/29/22 was the Tiotropium Bromide I because she did not When ask why did shadministered prior to an error." The employed	03/29/22? She said, "It yee also stated that she are she did not know ho	eed ered haler r it. was e did				
	#403's refusal care p						
	dated 03/21/22, docu resident was observe sitting the commode	acility Reported Inciden imented "At 10:45 AN ed in her room bathroon and was unresponsive. (Bowel Movement) was	M n				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	· /	ATE SURVEY MPLETED	
				B. WING			С
		HFD02-0017		B. WING			04/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN			RROUGHS AVE. NE		
		WASHING	TON, DC 2001		CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page	∋ 30		L 051			0/04/00
		n assessment, resident as transferred to her bed					8/24/22
	02/10/22, with multipl Respiratory Failure w Obstructive Pulmona	e-admitted to the facility le diagnoses including vith Hypercapnia, Chron ry Disease, Unspecified and Right Heart Failure lure.	ic I,				
	Review of the Admission Minimum Data Set (MDS) dated 02/16/22, revealed that facility staff coded the following:						
	In Section C (Cognitive Patterns): a Brief Interview for Mental Status (BIMS) Summary score "08", indicating moderately impaired cognition		′				
	In Section E (Behavior) E0100 Potential indicators of psychosis "None of the above" E08000 Rejection of Care -Presence & Frequency "0- Behavior not exhibited"						
	"Limited assistance" in physical assist"; "Train requiring "Two-person room "Limited assistated physical assist"; "Toili assistance" requiring assist"; "Personal hygorequiring "One-personal requiring "One-personal requirin	"One-person physical giene "Limited assistanc	ance" k in rson ce"				
	and Programs) O010	0 Respiratory Treatmen actioning and Tracheost	nts				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		OATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN		5000 NANN		RROUGHS AVE. NE	'	0412012022
			WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page	e 31		L 051			8/24/22
	Review of the physic following:	ian's orders revealed the	:				0,2 1,22
		ing by mouth) diet NPO s via PEG (percutaneou omy) tube"	S				
	Review of the care plan with a focus area of "[Resident #403] is resistive/noncompliant with treatment/care (Refusing ADL's, Shower, Trach mask, g-tube feeding) related to diseaseResident is NPO (Nothing by mouth) Daughter is feeding resident regular food despite education" revised date 02/16/22 "If resists care, leave and return later, provide education to patient and family, Psych (Psychiatry) consult as ordered"		ch nter s n to				
	Review of the nursing the following:	g progress notes reveale	ed .				
	03/09/22 at 11:24 PM medications"	1 "Resident refused all					
	03/10/22 at 11:15 AM "Change Inner Cannula Every Shift every 4 hours Refused" 03/11/22 at 11:12 AM "Suction Trach Every 4 Hours and as Needed every 4 hours Refused"		a				
	oxygen via trach (Tra resp (respiratory) dis	"sitting on the bed refunctions. It is notedResident uction and neb (nebulize	gn of				
	medical record show	ented evidence in the ing that facility staff follow an to leave and return la and provide education t	ter				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:).	CONSTRUCTION		E SURVEY PLETED	
		HFD02-0017	B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CEN	STREET ADDRESS, CITY, STAT 5000 NANNIE HELEN BUR VASHINGTON, DC 20019	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 051	04/13/22 at 11:20 Al Nurse) acknowledge "When she (Resider trach care and thenSometimes I would 14. Facility staff faile nursing skills sets to evidenced by failure intrusive behavior w resulted in serious in Review of a Facility 02/23/22, document observed [Resident besides his roomma nurse noticed blood and mouth. The nurs #404's] left ear and tear or abrasion incl #82] was interviewed coming over to my bhim to go back to his me on my stomach a on the chin and he for Review of a Complate documented, "fam they say their father nursing home in the Name] in an inter #404] was attacked Name]. [Resident #4 March 20 (2022)"	e interview conducted on M, Employee #9 (Registere ed the finding and stated, at #403) first came, we did she started refusing d teach." In the documentary of the assure resident safety as to address Resident #404 hich led to an altercation the floor to the floor te's The charge nurse 404] sitting on the floor te's bed #420A; the chargen floor f	ent 's nat ated rge ar kin in in in fter			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE COMP	
				,	c
	HFD02-0017	B. WING		04/	20/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE		
DEANWOOD REHABILITATION AND W	VELLNESS CEN'	NNIE HELEN BUF GTON, DC 20019	RROUGHS AVE. NE		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Patient assaulted in nurs was assaulted 02/22/202 facility by another resider head trauma with bleedin and mouth. He was trans hospital and later died Resident #404 was admin 12/06/16 with diagnoses Unspecified Dementia win Disturbances, Vascular Disturbances, Vascular Disturbances Ischemic Attack. During a tour conducted approximately 3:00 PM of document was observed the nurses station that standard the nurses station that standard the nurses station wondering, elopement, standard the following: Review of Resident #404 revealed the following: 12/16/21 [Quarterly MDS coded a BIMS summary severe cognitive impairm In Section E (Behavior), psychosis, no physical bedirected towards others (pushing, scratching, grab sexually), verbal behavior towards others (e.g., threscreaming at others, cursing daily"	sing home. Beneficiary 22 in skilled nursing nt. He sustained blunt ng noted on his left ear sferred to an acute itted to the facility on that included: ithout Behavioral Dementia without and Transient Cerebral on 03/28/22 at of unit 4 south, a facility taped to a partition at tated, " Updated on of Residents for Daily a. Room #420D [Resident ral traits confusion, sleeping in other peoples 4's medical record 6] showed facility staff score of "03", indicating nent. no potential indicators of ehavioral symptoms (e.g., hitting, kicking, boing, abusing others oral symptoms directed eatening others, sing at others) occurred	L 051			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.1.1		is a training training area.	A. BUILDING: _				
		HFD02-0017	B. WING			C 20/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AL			TE, ZIP CODE			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'	NNIE HELEN BU GTON, DC 2001	RROUGHS AVE. NE 9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 051	Continued From pag	e 34	L 051			8/24/22	
	(how resident walks room), "Supervision assist" and no function	onal Status), walk in room between locations in his/her with one person physical onal limitation in range of					
	In Section P (Restrai wander/elopement a						
	wander/elopement alarm, "Used daily" Care Plan: 07/27/21 (Revision date) ["Resident #404 is at risk for Elopement: cognitive impairment, dementia Observed wondering at the adjacent unit on 5/28/2021. Wandering to the adjacent unit on 7/3/21. Redirected easily. Wandering to the adjacent unit on 6/8/2021. Easily redirected. Wondering on 7/11/2021. Redirected. Wondering to the adjacent unit 7/27/2021, Easily redirected Avoid leaving unattended or unobserved for long periods of time. Hourly elopement/wandering monitoring and location."						
	Review of the Daily E showed the following	Behavior Documentation g:					
		" Elopement attempts. ng in other people's bed ant."					
	02/03/22 at 1:12 PM bed. Behaviors are c	" sleeping in other people constant."					
	02/07/22 at 1:52 PM bed. Behaviors are c	" sleeping in other people's constant."					
	02/09/22 at 1:47 PM bed. Behaviors are c	"sleeping in other peoples constant."					
	02/10/22 at 12:17 PM	M "sleeping in other					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
			A. BUILDING: _			
		HFD02-0017	B. WING		04/2	; 20/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	IIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(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	(X5) COMPLETE DATE
L 051	Continued From page	e 35	L 051			8/24/22
	peoples bedBehavi	ors are constant."				
	02/11/22 at 11:16 AM bed. Behaviors are co	" sleeping in other people onstant."				
	02/13/22 at 12:32 PM peoples bedBehavi					
	02/14/22 at 2:10 PM bedBehaviors are c	"sleeping on other peoples constant."				
	02/16/22 at 1:28 PM "sleeping on other peoples bedBehaviors are constant."					
	02/18/22 at 2:19 PM bedBehaviors are c	"sleeping on other people's constant."				
	02/19/22 at 1:18 PM bedBehaviors are c	"sleeping on other peoples constant."				
	02/20/22 at 12:23 PM peoples bedBehavi					
	(SBAR): 02/21/22 at a resident got hit by his observed [Resident # roommate's bed (420 out of his left ear, face [Resident #82] what hit him because he cadepartment arrived at with [Resident #404] by two ambulance att [Physician Name] and made aware."	nappened, resident stated 'I name to my bed.' DC fire the unit at 3:10 am and left in a stretcher accompanied rendants to [Hospital Name]. d RP (representative) was				
	This evidence showe					
	a. Although the facility	y had a care plan in place to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STA	TE. ZIP CODE	•	
			5000 NANNIE HELEN BU	•		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHINGTON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION	ID L PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 051	Continued From page address Resident #4 resident units; there care plan was updat residents intrusive be resident rooms and a be a facility staff failed room numbers of resident #404's bethow Resident #404's residents such as put for physical injury, in activity, upset that he in their bed. c. Although the staff was being monitored wandering into other in their beds. There	de 36	L 051 er ther by s risk ng	DEFICIE		8/24/22
	04/04/22 at 12:48 Pl Coordinator) stated, plan updates, creatin During care plan rev at orders, nurse's no updates as needed.' aware that Resident behaviors of going in and sleeping in othe #7 stated, "I was ne nurses on the unit. I a wanderer, I was no into rooms or else hi would have been up and have specific inta about the, "4 South	e interview conducted on M, Employee #7 (Clinical "I am responsible for careing and updating interventi iews, I do a 30-day look bites, psych notes and make When asked if he was #404 had documented no other resident's rooms resident's beds, Employer made aware by the knew him [Resident #404 of aware that he was going s [Resident #404] care pladated to reflect that behavior and the sident's for Daily atton" that stated Resident M, Employed the sident's for Daily atton" that stated Resident M, Employed the sident was sident when the sident was siden	ons. Pack Re ee as g an Vior			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	
		HFD02-0017	B. WING		04/20/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'		RROUGHS AVE. NE		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES	FON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPR DEFICIENCY)	BE COMPLETE	
L 051	Continued From page 37 #404's behavior, Employee #7 stated, "I didn't see it."		L 051	L 052 STARTS HERE: CORRE ACTIONS FOR THE AFFECTE		
				RESIDENTS.		
L 052	52 3211.1 Nursing Facilities		L 052	Resident # 404 was sent to the on 2/21/22, did not return to the		
	Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:			Resident # 82 was assessed from to toe on 4/26/22, resident suffer negative outcome. MD/ RP upd Resident is on 1;1 monitoring a	ered no ate.	
	(a)Treatment, medica supplements and fluid rehabilitative nursing			supervision until seen by psych Resident taken by DC police int custody on 7/20/22. Currently n	iatrist. o	
		imize pressure ulcers and romote the healing of ulcers:		facility, Resident # 56 was assessed from the facility in the facility is a second from the facility in the facility in the facility is a second from the facility in the facility in the facility is a second from the facility in the facility in the facility is a second from the facility in the facility in the facility is a second from the facility in the facility in the facility in the facility is a second from the facility in		
	(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;			to toe on 4/7/22, resident suffer hematoma to the left forehead I updated. An employee has bee assigned to monitor residents in the building.	MD/RP n	
	(d) Protection from a	ccident, injury, and infection;		Resident #61 was assessed he on 4/26/22, resident suffered no		
	(e)Encouragement, a self-care and group a	ssistance, and training in activities;		outcome. MD/PR updated. Resident will be taken to the da for monitoring.	y room A	
	(f)Encouragement an	d assistance to:		Resident # 72 was assessed from		
	` '	and dress or be dressed in g; and shoes or slippers, and in good repair;		to toe on 4/26/24,resident suffe negative outcome. Resident wil daily to the day room B for mon	l be taken	
	(2)Use the dining roo	m if he or she is able; and		Resident # 118 was assessed f to toe on 4/26/22, resident suffe		
	(3)Participate in mean recreational activities	~		negative outcome. MD/RP notif 4/26/22. Medication is administe according to physician order.	ied on	
	(g)Prompt, unhurried	assistance if he or she		,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE S		
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L 052	Continued From page	e 38	L 052	Resident # 151 was asses	sed on	0/24/22	
	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			4/26/22, in no negative . Nupdated. Resident is on 1;	ID/RP	8/24/22	
				and supervision until asse psych doctor.	ssed by		
				Resident # 183 was asses 4/26/22, in no negative ou RP updated. Bus driver hatrained on how to keep res	tcome MD/ is been		
	j)Prompt response to for help.	an activated call bell or call		the van while transporting hospital. Resident#133 was offered	them to the		
This Statute is not met as evidenced by: Based on observation, record review, resident and staff interview, facility staff failed to ensure			resident continue to refuse updated and documentation				
	sufficient nursing time was given to ensure: (1) Resident #404 received adequate supervision to prevent an altercation with Resident #82, resulting in serious injury; (2) adequate supervision of Resident #56, who sustained a fall outside in front of the facility resulting in harm; (3) adequate supervision of Resident #61 to prevent multiple falls with an injury; (4) adequate supervision and monitoring of Resident #72 to prevent an altercation with Resident #188; (5) adequate supervision of Resident #151 to prevent altercations with Resident #71 and #67; (6) Resident #183's wheelchair was properly secured during a van transport, resulting in a fall; (7) adequate supervision of Resident #409 to prevent an injury of unknown origin (dislocated hip); (8) Resident #81 received assistance with applying her dentures before meals; (9) Resident #82 was seen by audiology to address his ability to hear when communicating with others; (10) Resident #113 received showers; (11) Resident #118's pain medication was administered in accordance with the physician's order; (12) Resident #236's pain			Resident #236 was assess 4/26/22 from head to toe be manager, resident suffered outcome. MD/RP notified Resident assessed for paradministration of pain median medians.	y Unit d no negative on 4/26/22. in prior to		
	was assessed before	e administering Tylenol (pain ent #3 was provided with					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O		` ′	CONSTRUCTION	(X3) DATE S		
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PREFIX	Continued From page stoma site care; and nebulizer inhaler was the physician. The findings include: Review of the facility "Resident-to-Resider revised in 01/2022 do resident is observed aggressive to having the potential for abus assessment of strate incidents from occurr Interdisciplinary Team actions may include reduce negative outcon 1:1 monitoring t with the interventions deescalate behaviors nurses/manager" Review of the facilitie Management" revised "The relief of pain in priority. It is also our for signs and sympton pain management an resident as comfortal resident need for pain in management and resident need for pain in the page of the signs and sympton pain management and resident need for pain in the page of the signs and sympton pain management and resident need for pain in the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton pain management and resident need for pain the page of the signs and sympton page of the signs a	policy entitled, at Altercation/Incidents administered as ordered as ordered as ordered as ordered as policy entitled, at Altercation/Incidents accumented, " When a correct in the provided by the commented as being aggressive behavior or ing other residents, an gies to prevent such in (IDT) These immed monitor and adjust calones aggressor place the care plan will be upon the care	has he iate ire to ed dated I	PREFIX	(EACH CORRECTIVE ACTION SHOULD	TH THE ave the cted house monitored the facility, vior are ow how to slocation, ents with at residents shower are plan is t licensed bain prior to and that is done	8/24/22	
	will proceed as follows: -Assess for signs and symptoms of pain which		ch					
	include verbal and no							
	- Vital signs if approp							
	-note the type of pain -Location of pain							
	-Characteristics of the throbbing etc.)	e pain (sharp, stabbing						
		ically on a scale od 0-10 on chart to determine p						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED		
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L 052	or as requested by re-Medicate for pain -Monitor the effective through reassessmer -Document nursing a intervention, behavior assessment; and resinterventions." 1. Facility staff failed received adequate sualtercation with Residinjury. Review of a Facility F 02/23/22, documented observed [Resident 4 besides his roommate nurse noticed blood of and mouth. The nurse #404's] left ear and metear or abrasion inclue #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he feel Review of a Complain documented, "famil they say their father woursing home in the I Name] in an interview #404] was attacked were residued.	cologic approach as ne sident. ness of pain medication of the sessesment, nursing of resident during pain ident response to to ensure Resident #40 apervision to prevent an lent #82, resulting in selection (FRI) d, "The charge nurse 04] sitting on the floor e's bed #420A; the chan [Resident #404's] left the assessed [Resident mouth and there was no ding his face [Reside the said, "that man keeped side and when I asked side and when I asked side and when I asked side and I punched II" Int dated 03/26/22 by is hoping for answers was brutally beaten at a District. [Representative we we that his father [Reside while living at the [Facility in the said in the property in the property is the property in the property is the property in the property in the property is the property in the propert	n 194 n 194 n 194 n 195	L 052	In service will be provided to escorts by staff educators or importance of ensuring that the are safe while riding the van In-service will be provided be educator/ designee to clinical staff, housekeeping, and envistaff on the importance of entresidents are supervised / more for safety reasons. In -service will be provided be educator/ designee will provided be educator/ designee will provided be educator of assessing resignest administration of pain more ensure to documents pain leterator of the interest of the educator of designee on the interest of the educator of designee on the interest of the educator of designee to all chance of the educator of the educa	the he residents by 8/24/22. y staff I staff, activities vironmental suring that conitored always y staff de in service to an the dent pre and dedication and vel. y staff mportance to entures have	8/24/22
	#404] was attacked v	-	ty				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	,	
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HFD02-0017 B. WING 04/20/202	22	
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DEANWOOD REHABILITATION AND WELLNESS CEN' 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	MPLETE DATE	
Review of a Complaint dated 03/31/22 documented, "Avoidable death. Comments: Patient assaulted in nursing home. Beneficiary was assaulted 02/22/2022 in skilled nursing facility by another resident. He sustained blunt head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died" Resident Background Information: A. Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss. Resident #82's Quarterly Minimum Data Set (MDS) dated 01/31/22 showed that facility summary score of "14", indicating intact cognitive response, no physical or behavior symptoms directed towards others, required supervision with one person physical assist for activities of daily living (ADLs), used a walker for mobility and received antipsycholic medications. B. Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Disturbances and Transient Cerebral Ischemic Attack. Review of Resident #404's medical record revealed the following: 12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment.	24/22	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
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L 052	In Section E (Behavior psychosis, no physical directed towards other pushing, scratching, sexually), verbal behavior towards others (e.g., screaming at others, "1 to 3 days", wander daily" In Section G (Function (how resident walks be room), "Supervision wassist" and no function motion In Section P (Restrain wander/elopement all Care Plan: 07/27/21 (#404 is at risk for Eloimpairment, dementiate the adjacent unit on 5 adjacent unit on 7/3/2 Wandering to the adjacent unit on 7/3/2 Wandering to the adjacent unit on 8 adjacent unit on 9 adja	or), no potential indicators of all behavioral symptoms ers (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred ring behaviors "occurred ring behaviors in his/her with one person physical ring and limitation in range of ring and limitation in range of ring and ring arm,"Used daily" (Revision date) ["Resident perment: cognitive a Observed wondering at 6/28/2021. Wandering to the 21. Redirected easily. accent unit on 6/8/2021. Indering on 7/11/2021. Indering on 7/11/2021. Indering on 7/11/2021. Indering on ring periods of ent/wandering monitoring and rehavior Documentation in the people's bed " Elopement attempts. In other people's bed	L 052	Charge nurses /supervisor will ensure during their shift that C N A 's , rest aides and rehab team are providing residents with hip replacement corr Findings will be corrected by 8/24/2 In-service will be provided by staff edesignee on the importance of asseresident for hearing needs and scheappointment for the resident to see audiologist as soon as possible. Charge nurses/ designee will ensure interact with the resident during the ensure they are not having difficulty. Findings will be addressed by 8/24/2 Unit manager/ Supervisors will ensure their shift that charge nurses assessing residents prior to and poadministration of pain score is in periodings will be corrected by 8/24/2 Respiratory therapist / designee will that residents with respiratory diagrassessed for respiratory distress evensure their stoma are not occluded that they have enough supply to me respiratory needs. Findings will be a by 8/24/22. Charge nurses/ supervisors will enduring their shift that residents who are redirected, supervised, and mo Findings will be corrected by 8/24/2	corative g care to ectly. 122 educator/ essing edule the re they ir shift to to hear; 122 ure sare st hat lace. 122 I ensure nosis are very shift, d and eet their corrected sure wander nitored,	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					URVEY ETED		
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L 052	bed. Behaviors are concept behav	onstant." ' sleeping in other peoponstant." 'sleeping in other peoponstant." 'sleeping in other peoponstant." " sleeping in other peoponstant." 'sleeping on other peoponstant." Isleeping on other peoponstant."	oples oples oples oples oples oples	L 052	Resident with a BIMS score of above will be notified to inform charge nurse or C N A if a resintruding into their rooms. Surresident will be redirected and monitored. Rounds will also be by charge nurses, unit manage CNA 's to ensure no one is in into the rooms of residents will sleeping. Findings will be add by 8/24/22. Unit manager / supervisor will rounds during their shift to encharge nurses are administer medication via inhaler correct Findings will be corrected by	m the sident is che made gers and truding ho are dressed I conduct sure ing cly.	8/24/22
		Assessment Request 22 at 4:00 AM showed, lent got hit by his					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
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DEANWO	OD REHABILITATION AT	WASHING	TON, DC 2001	9		
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L 052	roommate Backgro Resident Reports Pa indicators of pain evidunchanged Skin/W blank) Assessmer Additional comments am The writer obso on the floor near roor with blood coming out writer immediately not 911. DC (District of C [Resident #82] also s [Resident #404]. The what happened, resident came to my bed.' at the unit at 3:10 am #404] in a stretcher a ambulance attendant [Physician Name] an made aware." 02/21/22 at 4:16 AM Progress Note] "The While making routine was observed sitting 420 A. Resident was the left side of his fact made, he was assess Resident could not do is his base line. A qui Range of motion exe applied to the left sid monitored T. (temper (respirations) 18, B.F. Spoe (sp) (oxygen sa 02/21/22 at 1:43 PM placed to [Hospital N	und: Altered mental status in? 'No'. Non-verbal dent? 'No'. Functional Status ound Status- (area was left at (area was left blank) At approximately 02:30 erved [Resident #404] sitting mmate's bed (420 bed A) at of his left ear, face. The otify the supervisor and called columbia) police. I saw eitting on his walker facing writer asked [Resident #82] dent stated 'I hit him because DC fire department arrived a and left with [Resident accompanied by two as to [Hospital Name]. d RP (representative) was	L 052	MONITORING CORRECT ACTIONS: DON/ Designee will conduthouse wide audit to ensure nurses are assessing residefore and after administe pain medication, that the medications are administe according to the physician order, that charge nurses assessing residents for he deficit, monitoring and sup residents for safety inside front of the building, that rear assisted with wearing the dentures during meals, the residents are given their shon their assigned days. The will be conducted weekly a monthly x3, findings will be addressed immediately an reported to QAPI Committee.	ct e that elents ring red esare aring ervising and in esidents cheir at nowers is audit e4, then ed	
		rse's Name] who stated				

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resident (#404) is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP made aware." During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed" This evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other residents rooms and sleeping in other residents rooms and sleeping in other resident's beds. a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds). b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior impacted other	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) L 052 Continued From page 45 resident (#404) is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP made aware." During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D (Resident #404) Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed" This evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other residents rooms and sleeping in other residents rooms and sleeping in other residents the care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds). b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior; impacted other				WASHINGT	ON, DC 2001	9			
resident (#404) is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP made aware." During a tour conducted on 03/28/22 at approximately 3:00 PM of unit 4 south, a facility document was observed taped to a partition at the nurses station that stated, " Updated on 08/10/2021 4 South List of Residents for Daily Behavior Documentation. Room #420D [Resident #404] Common behavioral traits confusion, wondering, elopement, sleeping in other peoples bed" This evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other residents rooms and sleeping in other residents rooms and sleeping in other resident's beds. a. Although the facility had a care plan in place to address Resident #404's wandering on to other resident units; there was no evidence that the care plan was updated/revised to address the residents intrusive behavior (wandering into other resident rooms and sleeping in their beds). b. Facility staff failed to document the names, room numbers of residents who were affected by Resident #404's behavior; and failed to assess how Resident #404's behavior impacted other	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETE	
residents such as putting himself or others at risk for physical injury, intrusion on their privacy or activity, upset that he in their room and sleeping in their bed. c. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that	L 052	resident (#404) is crit intubated and about (intensive care unit). During a tour conduct approximately 3:00 F document was obser the nurses station that 08/10/2021 4 South I Behavior Documenta #404] Common behawondering, elopemented" This evidence showe knowledge of and do intrusive behavior of rooms and sleeping in a. Although the facility address Resident #4 resident units; there we care plan was update residents intrusive be resident rooms and sleeping in b. Facility staff failed room numbers of res Resident #404's behave Resident #404's behave Resident #404's residents such as pur for physical injury, into activity, upset that he in their bed. c. Although the staff was being monitored wandering into other	tically ill, he has been to be transferred to ICU RP made aware." Ited on 03/28/22 at PM of unit 4 south, a facility wed taped to a partition at stated, " Updated on List of Residents for Dailition. Room #420D [Residented Traits confusion, at, sleeping in other people of the traits are plan in placed to the tresident shaded a care plan in placed of the traits was no evidence that the eddrevised to address the enautor (wandering into other shade). It of document the names idents who were affected avior; and failed to assess behavior impacted othe ting himself or others at trusion on their privacy of in their room and sleep record that Resident #40 hourly, he was still foun resident rooms and sleep	at a	L 052	DEFICIENC	Y)	8/24/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN	ANNIE HELEN BUR NGTON, DC 20019	ROUGHS AVE. NE		
0(1) 15	QUIMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	CODDECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 'Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page	e 46	L 052			9/24/22
	manage the residents	s behavior.				8/24/22
	04/04/22 at 12:48 PM Coordinator) stated, 'plan updates, creatin During care plan revi at orders, nurse's not updates as needed." aware that Resident behaviors of going in and sleeping in other #7 stated, "I was nev nurses on the unit. I ha wanderer, I was no into rooms or else his would have been upon and have specific interabout the, "4 South L Behavior Documenta	interview conducted on I, Employee #7 (Clinical 'I am responsible for care g and updating interventions. ews, I do a 30-day look back tes, psych notes and make When asked if he was #404 had documented to other resident's rooms resident's beds, Employee er made aware by the knew him [Resident #404] as t aware that he was going is [Resident #404] care plan lated to reflect that behavior erventions. When asked ist of Residents for Daily tion" that stated Resident bloyee #7 stated, "I didn't				
	2. Facility staff failed to provide adequate supervision for Resident #56 while in the front of the building in the non-smoking area, resulting in					
	DC Department of He follows: "[Resident Nation 15 who presents with Failure, [Hypertension Disease]. On April 6, resident was observed and on the floor. Upon resident was observed left side of her forehed occurred, she information."	incident report submitted to ealth dated 04/07/22 read as ame]with a BIMS score of COPD, Diabetes, Heart n], and [End Stage Renal 2022, around 17:15, ad outside, in the parking lot, on the initial assessment, and with a hematoma to the ead. When asked what eed the staff that she was nething off the floor and slid				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017		B. WING		04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		E HELEN BUI ON, DC 2001!	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 052	out of her wheelchair not have any compla assisted back into the her room for further in assessments. Neuro everything was within (Certified Registered made aware of the fato transfer the reside evaluation. 911 was a to take the resident was transferred to [N updated for resident retrieving items from wheelchair and she wimportance of not be for safety" Resident #56 was ad 11/20/19 with diagnostage Renal Disease Diabetes Mellitus, Ch Disease (COPD), He Absence of Right and The Quarterly MDS of C0500 BIMS Score scoded as a "15" indic cognitively intact. Unresident was coded a Under Section G Fur was coded as requirione-person physical locomotion on and of hygiene. Under Secti Limitation in range of coded as having implower extremities. Un	ints of pain. She was the wheelchair and taken nerventions and check was conducted, an normal limits CRNP Nurse Practitioner) was all and an order was obtain to the hospital for furticalled arrived at the fact to the hospital. Resider ame of Hospital] Care to seek assistance with the floor while in the vas educated on the anding over while in the vas educated on the inding over while in the case which included Endor, Hypertension, Type 2 aronic Obstructive Pulmorart Failure, Acquired at Left Leg Below the Knowed Resident #56 was atting that she was der Section E Behavior, as no behaviors exhibite inctional Status, the residing extensive assistance assist under bed mobilitif unit, dressing and personners and control of the case o	en up to and ained her acility int e plan chair chair chair the d. Hent e with Ey, sonal as frices,	L 052			8/24/22

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		UED00 0047		B. WING			C	
		HFD02-0017		D. WING			04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN			RROUGHS AVE. NE			
			WASHINGT	ON, DC 2001	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 052	Continued From page	e 48		L 052			8/24/22	
	Review of the nursing follows:	g progress notes read as	3					
	she observed resider rolling into the parkin after the wheelchair a into a car and fell. Re'My wheelchair sudde building into the park and into a car and hit assessment done; A the left forehead. No discoloration observe Practitioner)was not to transfer to the near 04/07/22 at 11:04 AM Progress Note] "sefall and f/u (follow up she had a negative h knee X-R (Xray), and	coming from the patio went's wheelchair suddenly g lot. The Security chas and resident, but resident said during intervenly started rolling from ting lot, I was unable to so my head." Head to toe hematoma was observe skin tear, no bleeding, not be decided and she gave an orest ER"	ed t ran iew, the top it d on o lurse order t s/p ER, ight					
	[Hospital Name] at 10 S/P (status post) fall. remains on left foreho Nose bleeding obser- responsive. Denied per hospital transfer (computed tomograp	I "Resident returned from D:15 AM in stable condition on assessment, swelling ead with discoloration nowed. Resident is alert arpain. Able to communicate records, a head CAT hy) Scan was don which dence of brain injury."	on ng oted. nd ite.					
	conducted on 04/08/2 AM. She stated that	ew with Resident #56 wa 22, at approximately 10:3 someone from Activities bing her outside (pushing	30					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER	=p. ` ´	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	5000 NANNIE HELEN BI WASHINGTON, DC 200			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LISC IDENTIFYING INFORMATION	1111111	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 052	wheelchair). The stabrakes on the wheel down and she hit he the wheelchair hit a During a face-to-face #22 (Activities Aide) approximately 2:15 I member who helped wheelchair on 04/05 Employee #22 and I the facility, and he s [Resident #56], on the foot of the steps past the guardaril and pointe arrow on the ground where le left the resiresident told him she and went inside and around and saw [Rerolling down the parl her and her wheelch [Resident #56's] whe parked at the far-rigl parking lot), and she concrete. During an interview 04/11/22 at 11:30 All unlock the wheelchair was coming from Bit They pushed me ou He (Employee #22) wheelchair, and he to wheelchair. He did not the wheelchair. I	off member did not put the chair. The wheelchair role read on the concrete a car and she fell over.	e e staff nt). de ft at ng n v pot ft d d satch se the and de. I de. ng. he go as on			8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI	D	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING _		04	C / 20/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY	, STATE, ZIP CODE			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		BURROUGHS AVE. NE			
			WASHINGTON, DC 2	20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATION	1 11=117	PROVIDER'S PLAN ((EACH CORRECTIVE.	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
L 052	Continued From pag	e 50	L 052			8/24/22	
	happened."						
	04/13/22 at 11:40 AM	with Resident #56 on Λ, she stated, "I did not tu nd after the staff member	ırn				
	Employee #22 said t wheelchair before he lock [Resident #56's] because she was he they had not gotten t him "I got it from h [Resident #56] turne	on 04/13/22 at 12:20 PM, hat he normally locks the leaves a resident but did wheelchair on 04/06/22, ading to the smoking area to that area when she told here". He said that he third her wheelchair around a the other side of the buil sident #80] was.	d not a, d nks after				
	that facility staff prov for Resident #56 and the front of the buildi Subsequently, Resid seated in her wheeld parking lot, hit a park feet away from the s entrance of the build	ident, there was no evide ided adequate supervision of other residents who were of in the non-smoking arrived thair, rolling through the sed car (approximately 40 loped sidewalk at the ing), fell out of her ained a hematoma to the	e in ea.				
	assessed the seating	as no evidence that facilit g device (wheelchair) use ermine if it was personal fi dent to use.	d by				
	Resident #56 is a sm as a smoker and the	facility staff states that noker, she was not identif re was no smoking plan in place to address t					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						С
		HFD02-0017	B. WING		04	4/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE		
DEANIMO	OD DELIABILITATION AN	JD WELLNESS CEN. 5000	NANNIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	WAS	SHINGTON, DC 2001	9		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page	e 51	L 052			8/24/22
	#30 (Director of Reha 04/13/22, at 2:20 PM assessment was not and provided docume wheelchair referral w During a face-to-face on 04/20/22 at 10:28 incident, Resident #5 wheelchair. Prior to the didn't know she was staff said they didn't I The resident is free to	interview with Employee abilitation Department) on , she confirmed a wheelchair completed for Resident #56 entation to show that a as initiated on 04/10/22. Interview with Employee #7 AM, he stated, "Prior to this 6 was not assessed for a his there was no escort. I going outside and the facility know she was going outside. To go outside. So we put so this doesn't happen				
	(Director of Nursing) she stated, "She [Resherself to smoke. He to wheel her to go smaround to go back she wheelchair. He [Empminutes later and characteristics] 3. Facility staff failed supervision as specification plan resulting in the redocumented, "Writer PM) by the reception resident is observed entrance of the facility writer that "I hit the wall against a surface and	oloyee #22] saw her two ased after her." to provide adequate ied in Resident #61's care esident having multiple falls.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				_			:	
		HFD02-0017		B. WING			0/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
DEANNAG	OD DELIA DII ITATIONI AN	ID WELL NEGO OFN	5000 NANN	IE HELEN BU	RROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN	WASHINGT	ON, DC 2001	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
L 052	abrasion with no bleethis time transfer regall for further assess Resident #61 was ad multiple diagnoses in Chronic Obstructive Management of the perfect of the assistance of one the unit (how the result of the asside for dining, active of the section of the unit (how the returns from off unit least of the side for dining, active of the section of the unit (how the result of the assistance of one of the unit (how the result of the same floor. If it is self-sufficiency once off the unit (how the returns from off unit least of the section of the unit (how the returns from off unit least of the unit (how the returns f	eding/swelling observed sident to the nearest EF sment" mitted on 11/06/20 with cluding Diabetes Melliture Pulmonary Disease, And Kidney failure, Systemic ises Syndrome and Anxiet 161's medical record g: Data Set (MDS), with a ce dated 09/09/21 that wing: We Patterns), a Brief Status (BIMS) summary ng moderate cognitive or), no indicators of of care, or wandering. In al Status), supervision of the person for locomotion of the chair, and an adjacent corn a wheelchair, in the chair) and locomore sesident moves to and ocations (e.g. areas set ities, or treatments). Conditions), one (1) fall of the chair in the chair) and conditions), one (1) fall of the chair in the chair).	R via US, emia, cety. an rridor otion with ; or at to	L 052			8/24/22	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C / 20/2022	
					04	12012022	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT				
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	INIE HELEN BUR STON, DC 20019	RROUGHS AVE. NE			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE	
L 052	Continued From page	e 53	L 052			8/24/22	
	"At risk for fall" due to gait, cognitive impairs condition, pain, poor processand impair will remain free of injunext review date. Interisk on admission quain low position." 10/17/21 at 7:11 PM notified at 1405 (2:05 the front desk that res	art date of 11/07/20 showed, o history of falls, unsteady ment, unstable health coordination, Diseased ed balance. Goal: Resident ury from falls through the erventions: Assess for fall arterly and as needed. Bed [Progress Note] "Writer was in PM) by the receptionist at sident is observed lying face					
	outside and observe Resident is alert and Resident reported to my wheelchair agains wheelchair and hit my my head hurts". Resident distress at this time his head on a scale or right side of his foren- with no bleeding/swe	writer that 'I hit the wheel of st a surface and fell off my y head on the ground and dent denies any otherresident verbalized pain on of (1-10) 9/10 resident's ead noted with an abrasion					
	to the nearest ER (en further assessment	nergency room) via 911 for ." // [Nurses Note] "At about a loud noise at the hall in then staff went to check, they the floor in laying position					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED	
		HFD02-0017	B. WING		I	C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE. ZIP CODE	•		
		5000 NA	, ,	RROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	IGTON, DC 2001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 052	Continued From page	e 54	L 052			8/24/22	
	11/27/21 (Revision da area] "Actual fall on 1 forehead abrasion, 1 11/27/21 fall with no i Goal: Resident will no around in his wheeled date. Interventions: S rounds to resident's r resident to use the ca assistance. Increase intensity based on replace. PT (physical thand mobility. Provide exercise and strength Provide 1:1 activities 11/27/21 at 1:55 PM alert and verbally res ER at 1:35pm (1:3	ate) [Care Plan with focus 10/17/21 with a right 1/24/21 fall with no injury, injury at the front lobby." To speed when moving thair through the next review staff will make frequent from to constantly remind all button to call staff for d staff supervision with sidents' needs. Bed alarm in the nerapy) consult for strength activities that promote in building where possible. If bed-bound" [Nurses Note] "Resident ponsive. He returned from 5PM) in stable condition					
	Resident denied pain tomography) scan of no acute fracture"	the head and face indicated					
	Review of Resident # 10/17/21, through 11/documented evidenc "increase in staff sup on residents' needs a (created dated 10/18)	ervision with intensity" based as directed in the care plan					
	04/19/21 at 9:30 AM, Floor Unit Manager) and stated, "He [Res or monitored. He [Re	interview conducted on with Employee #8 (2nd acknowledged the finding ident #61] is not supervised sident #61] goes off the unit s returned with no problem."					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C 4 /20/2022	
	ROVIDER OR SUPPLIER	ND WELLNESS CEN	T ADDRESS, CITY, STATE NANNIE HELEN BURI IINGTON, DC 20019	,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 052	4. Facility staff failed supervision and more location, resulting in altercation with Resiler Review of a facility of 03/30/22 documents of Charge nurse on the two of the reside other, [Resident #72] his face with his right [Resident #188] fell noted" Resident Background A. Resident #72 was 10/25/18 with the fol Non-Alzheimer's De Tachycardia, Chronic Depression, and Ged A review of the Qual (MDS) for Resident that facility staff cod In Section C (Cognit Interview for Mental Score was "99," indiseverely impaired of In Section E (Behaver 1) in Section E (Behave	It to provide adequate nitoring of Resident #72's a resident-to-resident ident #188. It ident #188] in ident got close to each ident #188] in ident ident ident #188] in ident ident ident #188] in ident id	L 052			8/24/22	
	this type occurred 4 daily." B. Resident #188 was 01/21/22 with the following the second sec	Staff answered, "Behavior of to 6 days, but less than as admitted to the facility on llowing diagnoses: mentia, Altered Mental					

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	N OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING			C 4/20/2022	
		111 502-0017	1			+/20/2022	
NAME O	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
DEANV	OOD REHABILITATION AN	ND WELLNESS CEN	NNIE HELEN BURI IGTON, DC 20019	ROUGHS AVE. NE			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
L 09	Status, Visual Halluci Agitation. A review of the Quart (MDS) for Resident # revealed that facility s for Mental Status (BII "99," indicating that the impaired cognition and aily. During a tour conduct approximately 9:52 Adocument was obsert the nurses station that 08/10/2021 4 South Les Behavior Documenta #72] Common behave elopement, med., tes Resident-to-resident 02/24/22 [Physician's seen because of alter Patient not injured. Hesparated from the oredirection as the oth used to occupy" Resident-to-resident 03/30/22 at 6:13 PM Assessment and Rec Communication Tool punched Resident #1 symptom started: 03/and initiate behavior Comments. [Resident Communication Tool]	inations, Restlessness and derly Minimum Data Set 188 dated 03/03/22 staff coded a Brief Interview MS) Summary Score was the resident had severely and wandering that occurred atted on 04/11/22 at and of unit 4 south, a facility atted taged to a partition at that stated, " Updated on a list of Residents for Daily tion. Room #430 [Resident atterioral traits, wondering, attercation #1 a Progress Note]: "Patient arcation with another resident. attercation with another resident. attercation is in a room he altercation #2 [Situational, Background,	L 052	DEFICIENCY)		8/24/22	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
							С	
		HFD02-0017		B. WING			4/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN			RROUGHS AVE. NE			
	OUNAMA DV OT	CATEMENT OF DEFINITION	WASHING	TON, DC 2001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUR SEC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
L 052	Continued From page	e 57		L 052			8/24/22	
	#72] then punched R his right hand, to the Subsequently, [Reside a result of the punch. incident and then we immediately. [Resided 1 on 1 monitoring at a center was updated at the residentMD awhas been updated tomade aware of the 03/03/22 to 03/31/22 Documentation] show documented, "Reside Going through other Wandering Behavior problems led to issue Resident #72's medic 03/30/22 [Physician's consult secondary to altercation." 03/30/22 [Physician's with 1 on 1 sitter until Prior to 03/30/22, the active care plan to ac physically aggressive to revise Resident #7 his aggressive behave altercation with Residinjury. During a face-to-face	esident #188 in his face left side of face. Itent #188] fell to the floor. The charge nurse saw int to separate the resident #72] has been place this time. The mobile or and will be out to evaluate Resident's care preflect the incident. Resident as well." [Daily Behavior wed that facility staff ent exhibits the following people. Elopement atteors are constant. Behaves with care" 16 times in cal record. [S Order]: "Psych (Psych resident-to-resident as well as we	or as the ents d on isis ate blan g: mpts. ior n iatric) ent an failed ess r				0/24/22	
	The evidence showe to revise Resident #7 his aggressive behave altercation with Residenty.	e behavior. d that the facility's staff 2's plan of care to addr viors resulting in anothe dent #188 resulting in m interview 04/14/22 at M, Employee #7	ess r					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			•	
		HFD02-0017	B. WING			C 20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	INIE HELEN BU STON, DC 2001	RROUGHS AVE. NE 9			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLÉTE DATE	
L 052	Continued From page	e 58	L 052			8/24/22	
	Resident #72 was no	longer a wanderer.					
		ent #151 to protect and s (Residents' #71 and #67) ggressive behavior					
	" At 0730AM, the se [Resident #151] assa	ted 12/09/21 documented, ecurity officer observed ulting another resident front of the building"					
	At 2030 on 12/29/2	ted 01/02/22 documented, " (12/29/21), [Resident #67] onist that [Resident #151] hit n the lobby"					
	Resident Background	Information					
	10/22/20 with multiple	s admitted to the facility on e diagnoses that included: is, Epileptic Syndrome and erplasia.					
	Review of Resident # revealed:	151's medical record					
	_	MDS], facility staff coded a e of "07", indicting severe					
	In Section E (Behavio	or):					
	E0100. Potential Indi- Delusions (misconce firmly held, contrary t	ptions or beliefs that are					
	E0200. Behavioral Sybehavioral symptoms	mptoms: Physical directed towards others					

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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN' STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	C 04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN' STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019	
DEANWOOD REHABILITATION AND WELLNESS CEN 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	
DEANWOOD REHABILITATION AND WELLNESS CEN' WASHINGTON, DC 20019	
WASHINGTON, DC 20019	
CHAMADY CTATEMENT OF DEFICIENCIES	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - "Behavior of this type occurred 1 to 3 days", verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - "Behavior of this type occurred 4 to 6 days", Impact on Resident Put the resident at significant risk for physical illness or injury? "yes"; impact on others put others at significant risk of physical injury? "yes"; significantly intrude on the privacy or activity of others? "yes"; significantly disrupt care or living environment? "yes"	
In Section G (Functional Status): Activities of Daily Living (ADL) Assistance - bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, Resident #151 required "supervision" and "one person physical assist" Review of the Care Plan revealed:	
07/27/21 (Revision date) "As evidenced by a positive PASARR (Preadmission Screening and Resident Review) Level I screen and Level II evaluation, it was determined that the resident needs Specialized Services while in the Nursing Facility. Related to: schizophreniaInform the MD (medical doctor) if the Individual has a serious health decline and services previously agreed to may need to be modified or deleted. Inform the MD of any significant changes may require additional evaluation to add, modify or remove services"	
for changes in behavior problems related to: agitation" 10/18/21 (Revision date) "[Resident #151] has	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPI	
						C
		HFD02-0017	B. WING		l l	20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	to treatment/care relation (Dementia, Schizoph taking medications, non compliant with Scompliant with Wader and hitting" 10/20/21 (Revision daimpaired cognitive fur processes r/t (related 10/20/21 (Revision daimpaired cognitive fur processes r/t (related 10/20/21 (Revision daimpaired cognitive fur processes r/t (related 10/20/21 (Revision daimpaired cognitive medicated management, Parance Monitor/record occurs symptoms violence staff/others) and doct 10/22/21 (Revision daimpaired cognitive floor, dis Non-compliant letting moving chair into another stop Combative, as members, trying to be Administration area as staff monitoring for sa sitter is available" B. Resident #71 was 08/20/18 with multiple Schizoaffective Disorwithout Behavioral Di Hypertension. Review of Resident #	n which resident acts propriate behavior; resistive sted to: Cognitive Impairment renia). Non compliant with on compliant with vital signs, naving and showers. Non guard placement kicking ate) "[Resident #151] has notion or impaired thought to) Dementia" ate) "[Resident #151] uses ions r/t behavior bid Schizophrenia rence of for target behavior elaggression towards ument per facility protocol" ate) "Resident #151] has (Combative, Spilling water strobing) r/t Schizophrenia. roommate into the room, other room and refusing to gitation, hitting multiple staff reak down doors in the end rolling on the floor 1:1 afety until seen by psych or admitted to the facility on the diagnoses that included der, Unspecified Dementia sturbance and	L 052			8/24/22
	_	10/23/21where facility staff				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		
		HFD02-0017	B. WING		C 04/20/2022
NAME OF D		CTDEET AS	DDRESS, CITY, STA	TE ZID CODE	•
NAME OF P	ROVIDER OR SUPPLIER			,	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	STON, DC 2001	RROUGHS AVE. NE	
	OUR MARK OF				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
L 052	Continued From page	e 61	L 052		8/24/22
	moderate cognitive in indicators of psychos behavioral symptoms person physical assis range of motion and r. C. Resident #67 was 09/29/08 with multiple Unspecified Intellecture Disorder with Hallucin Dementia without Bel Review of Resident # Quarterly MDS dated coded a BIMS summinatat cognitive respoof psychosis, no physical assistance of person physical assistance.	is and no physical or verbal, limited assistance with one of the for ADLs, no limitations in the skin conditions. admitted to the facility on ediagnoses that included hal Disabilities, Psychotic nations, and Unspecified the navioral Disturbance. 67's medical revealed, a 11/06/21 where facility staff ary score of "14", indicating has, no potential indicators sical or verbal behavioral extensive assistance with assist for ADLs and no			0/24/22
	limitations in range of Resident -to-Residen				
	[Receptionist's Name assaulting another refront of the building. Treceptionist ran to the both residents [Res He said, 'the man jumbuilding for no reason him. I don't know whe asked [Resident #15' [Resident #71]. He saw The MPD (Metropowas called took [Reaggressive behavior a [Hospital Name] at 08	y Officer's Name] and the] observed resident [#151] sident [Resident #71] at the The security officer and the e residents and separated ident #71] was interviewed. Inped on me in front of the In I have never spoken to ere this came from today'			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMP	LETED
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
DEANIMO	OD DELIABILITATION A	SOOO NAM	NNIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN WASHING	GTON, DC 2001	9		
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L 052	Continued From page	e 62	L 052			8/24/22
	mark observed on the	e back of his left hand"				
	Resident-to-Residen	t Altercation #2:				
	12/30/21 at 11:30 AM	// [Nurses Note] " At 2030				
		2 (12/29/21), Resident #67]				
	_	ionist that [Resident #151] hit				
		in the lobby; the receptionist or; the supervisor assessed				
		e denied any pain At 2040				
	(8:40 PM) [Resident #151] was observed at the					
	gate trying to exit. He was redirected back to the					
		he building entrance trying to				
		ting the building will not let building. The DC Police				
		ed and notified at 2340				
		responded at 2345 (11:45				
		w with [Resident #151], he				
		he made attempts to hit one				
		. [Resident #151] was taken				
		dent #67] was assessed e alleged being hit on the				
		r his previous surgical site.				
		ation or open area observed				
	during assessment. I	He denied pain"				
	Review of Resident #	#151's medical record				
	showed documented	aggressive behaviors and a				
		altercation on 12/08/21.				
		nented evidence that facility				
		nt #151's plan of care to ts and then on 12/29/21,				
	•	ked another resident at the				
	facility.					
	During a face to face	e interview conducted on				
	_	#7 (Clinical Coordinator)				
		ndings and stated that				
	_	een on 1:1 since he was				
	admitted back to the	facility in 01/2022 and has				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADDRESS, (CITY, STAT	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'			RROUGHS AVE. NE		
	T	V	VASHINGTON, D	C 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX AG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
L 052	Continued From page	e 63	L 05	52			8/24/22
	not had any resident-	to-resident altercations.					
	6. Facility staff failed #183's wheelchair du resulting in the reside		ent				
	"At 6:33PM on 10/1 escort reported to to was on the van going	ted 10/19/21 documented 9/21, [Resident #183] he nurse that when reside to this appointment reside at] belt slit out of his whee held the brake"	ent lent				
	Resident #183 was admitted to the facility on 03/20/14 with multiple diagnoses including, Acquired Absence of Left Leg Below Knee, Diabetes Mellitus Type 2 and End Stage Renal Disease.		I				
	Review of Resident # revealed the following						
		MDS dated 10/01/21, taff coded the following:					
	In Section C (Cognitive Patterns), a BIMS summary score of "15", that indicated intact cognition.						
	assistance requiring	nal Status), extensive one-person physical assis neelchair for mobility devic s in range motion.					
	on LOA (leave of abs While in the van his v and he slipped out of well as not hurting. H	[Nurses Note] "Resident vence) for appointment. wheelchair tilted backward his chair. He denied pain e was assisted back to a e van proceeded to his	l,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	00 NANNIE HELEN BI ASHINGTON, DC 200 ⁰			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 052	appointment. [Reside facility after the appoireported to his unit. Hone with range of mequal strength. He rewith bilateral ling (sp) shortness of breath nevidence of rednessResident is wheeld [below knee amputati Representative) and 10/14/21 at 3:42 PM "Resident's wheeld the bus at all times wfor safety reasons." 10/14/21 (Initiation da "[Resident #183] is at gait/balance problemsIn service the van dis properly strapped of Alter/remove any pote Educate resident/fam (interdisciplinary team 10/21/21 [Physician's program" During a face-to-face 04/07/22 at 3:05 PM, remember the time I is bumped my head a limy wheelchair." During a face-to-face 04/08/22 at approxim #34 (Van Driver), he is property when it happ	ent #183] returned to the intment and the incident lead to toe assessment otion to extremities with mains alert and oriented X3 fields clear. No evidence of oted at this time no nor bruising noted nair bound with a left BKA fon]. RP (Resident MD made aware." [Care Plan Note] hair should be strapped to hen ridding (sp) on the bus at a trisk for falls r/t (related to) is. Actual fall on 10/14/21 liver to make sure resident on the van before driving off ential causes if possible. illy/caregivers/IDT	f I d			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HFD02-0017	B. WING		04	C I/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION	AND WELLNESS CEN	DDRESS, CITY, STATE NNIE HELEN BUR			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
(Employee #34 and #183] wasn't injure scheduled appointr During a face-to-far 04/08/22 at 3:15 Pl Nurse Aide) stated back, still in the whard." The evidence show properly secure Rethe facility van prious 7. Facility staff faile with adequate supercaution to preven she had left hip sur Review of an intake by the State agencular after having hip suppressed two days positioned like the sent to the hospital surgery. Resident #409 was 07/08/21 with diagr for Orthopedic Afte Artificial Hip Joint, Au (Unspecified), Repure (Generalized), and and Mobility. Review of Residen revealed the follow	the straps weren't secured. We did #35) saw that [Resident did and took him to [his ment]." The ce interview conducted on the conducted that facility staff failed to conducted that facility staff failed to conducted the conducted that facility staff failed to conducted the conducted that facility staff failed to conducted that facility staff failed to conducted the conducted that facility staff failed to conducted the conducted that facility on the conducted that facility of the conducted that facility on the conduct	L 052			8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		RED.	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING _		04	C / /20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CEN	STREET ADDRESS, CITY 5000 NANNIE HELEN WASHINGTON, DC 2	BURROUGHS AVE. NE		
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L 052	Resident #409 dated facility staff coded the facility staff coded the In Section C (Cognit Interview for Mental Score was "99," indicognition. In Section G (Functi for transfers, toilet un resident was totally or more person's phomore staff. For bed limited physical assimember. For dressin extensive physical assimember. In Section H (Bowel incontinent" for bladdown in Section J (Health resident have a fall aprior to admission /effracture related to a to admission /entry of major surgery during admission; resident procedure during the that requires active of the section O (Special and Programs), star Physical Therapy "0007/08/21 at 12:10 Physical Therapy"0007/08/21 at 12:10 Physical Therapy "0007/08/21 at 12:10 Physical Therapy"00007/08/21 at 12:10 Physical Therapy "000000000000000000000000000000000000	d 07/11/21 revealed that he following: live Patterns), the Brief Status (BIMS) Summary cating severe impaired onal Status), ADL assist se, and personal hygien dependent and required ysical assistance from to mobility, the resident redistance from one staffing, the resident required issistance from one staffing, the resident required issistance from one staffing and Bladder) - "Always der and bowel Conditions), "Yes" to: any time in the last montentry or reentry; resident fall in the last 6 months or reentry; resident have go the 100 days prior to have a major surgical exprior inpatient hospital care during the SNF states at Treatments, Procedure that date for Occupational at 7/09/2021." M [Hospital Discharge at Course Patient presents status post Arthroplasty	tance: te, the two wo or quired th have prior stay y. es, and			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				_			С
		HFD02-0017		B. WING		(4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'			RROUGHS AVE. NE		
	0.000		WASHINGT	ON, DC 2001		- 00DD-0710N	
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L 052	Continued From page	e 67		L 052			
	LeftRestrictions as precautions"	Tolerated (WBAT); Later follows: Posterior hip	ally;				8/24/22
	Hospital] for rehabilita ArthroplastyReside pillow and WBAT. Fa initiated: resident loca	nitted from [Name of Local ation post left hip ent has hip abduction wit Il and safety precautions ation close to nurses' sta , call light and commonly	h tion				
	07/08/21 (3:00 PM-11:00 PM) [CNA Documentation], facility staff documented that Resident #409 was given a bath, assisted with bed mobility and provided incontinent care for bowel and bladder.		h				
	07/09/21 [Physician's hip for inflammation,	order] "Left hip: monito pain, and drainage."	r left				
	and Plan of Treatmer therapy after having a hemiarthroplasty that Precautions (no fle	[Physical Therapy Evalunt Note] "referred to skila L (left)) hip resulted from a fall exion past 90 degrees, le, or internal rotation,					
	Resident #409 receiv	100 PM) [CNA lity staff documented that red a bath/shower and sing, assistance with bed d incontinent care for bo					
		11:00 PM) [CNA lity staff documented tha red assistance with bed	t				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		:D:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ND WELLNESS CEN	STREET ADDRES 5000 NANNIE H WASHINGTON	HELEN BUF	RROUGHS AVE. NE		
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L 052	mobility, and provide and bladder. 07/09/21 (11:00 PM-Documentation], fac Resident #409 receir mobility, and provide and bladder. 07/10/21 [Physician's between lower extre reposition when resident when resident with appropriately after case [the] resident is in between Resident #4 care, and wedged reand repositioning when the state of summander of the state of the state of summander of the state of the	ed incontinent care for book and incontinent care for book alility staff documented that wed assistance with bed and incontinent care for book as Order] "Place a pillow mities after care, turn and dent is in bed." Is Order] "Wedge resident are, turn and reposition wed." Is Order] "Wedge resident are, turn and reposition wed." Is OPM) [Treatment are (TAR)], showed that far they placed a pillow 409's lower extremities at they placed a pillow 409's lower extremities at the resident was in beautiful that Resident #409 wer and assistance with	t wel d d t //hen cility fter ing ed. n], ote] er cing ient en n"	052			8/24/22

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PRINTED: 07/27/2022 FORM APPROVED

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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CEN	STREET ADDRESS, CITY, ST. 5000 NANNIE HELEN BU WASHINGTON, DC 2004	IRROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUI LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 052	responsive, no appar change in mental state Person contacted: [Nepresentative] was in person. Notes: She her mom to be trans 07/10/21 at 6:20 PM at bedside visiting to was seen by the me At about 4 PM daugi (Resident #409) need because she want[eleg was not dislocated daughter that [the] redoctor in her presenthere was any concentre was the felt leg was any concentre was the felt leg was any concentre was taken out from the hospital via nonfurther evaluation per was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was taken out from the left leg was any concentre was the left leg was an	esident is alert and verbal rent distress noted. No atus notedR-Request - lame of Resident at bedside. Communica e [Representative] requester[ed] to the Hospital" [Nurses Note] "Family day from 11:45 AM Residical director at 12:30 Photer requested that she ded an X-ray to be done do to make sure her mothed. Writer explains[ed] to esident has been seen by the sent to the hospital eray. She insisted that she be sent to the hospital eray. She insisted that she be sent to the hospital eray. Writer told her the from the doctor, but it will also hours for the X-ray to Name] was notified and the will take about 4-6 hours fent should be transfer[referency transport for the facility at 5:50 [PM] to the facility at 5:50 [PM] to go the facility at 5:50 [PM] to do something is going wroted the something is	was ident A, hers' the y the o. If uld e to be at an II be the sto did to did ated.			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						С
		HFD02-0017	B. WING		04/	/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
55411140		5000 NA	NNIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN WASHIN	GTON, DC 2001	9		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1		COMPLETE DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCED TO TO		DATE
			 			8/24/22
L 052	Continued From page	je 70	L 052			0/2-1/22
	requested transporta	ation to the hospital ED				
	(Emergency Departn	nent) Course/Critical Care				
		ent's hip was reduced [explain				
	_	olerated the procedure well				
		PM plan to discharge back				
		. 03:51 PM cleared for				
	discharge. Request k	knee immobilizer for				
	discharge"					
	A review of the Resident #409's medical record lacked documented evidence that the facility staff					
		ent #409 from 07/08/21 to				
		er with adequate supervision,				
		recautions to ensure that				
	Resident #490's hip	was not dislocated.				
	During a talanhana ir	ntarview conducted on				
		nterview conducted on mately 12:30 PM, Resident				
		resentative stated, "On				
		nat my mother looked out of it				
		pulled back the cover to see				
	what was wrong. I di	dn't see the knee immobilizer				
	on her leg. Her leg w	as positioned like the letter				
	-	unit manager and told her l				
	wanted to see the do	octor. They finally brought in				
	'	he wasn't my mother's				
		he ordered oxycodone for				
		ny mother get an X-ray for				
		e X-ray would take a long I asked the nurse to call 911.				
	'	not have a doctor's order,				
		o I did. 911 showed up and				
		cal emergency, so they [911]				
		ency vehicle, and my mother				
	was transported to [H					
	During a face to fee	n interview on 04/40/00 -t				
	_	e interview on 04/19/22, at				
		PM, Employee #4 (Educator) ughter how long it would take				
	(x-ray). She insisted					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _			
		HFD02-0017	B. WING		l l	C 20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN. 5000 NAN	INIE HELEN BU	RROUGHS AVE. NE		
DLANVO	OD KENABIENATION A	WASHING	STON, DC 2001	9		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page	e 71	L 052			8/24/22
	the hospital. Per the doctor's permission, ambulance was calle	X-rayed and evaluated at daughter's request, with the a non-emergency d. The resident [was ospital Name]. I did an SBAR				
	approximately 4:00 F Unit Manager) stated with hip precautions therapy or by the universident is admitted. Employee #8 stated, in the resident's room and two (2) nurses wevening shifts on this the pillow/wedge bets to put the hip immobil how to roll the reside from crossing midline the bed in the lowest light near the residen able to provide a cop					
	applying her denture					
	asked if she liked the resident reported that okay, but she wanted she eats. The writer with her in the facility					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		0,	C 4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		ROUGHS AVE. NE		
	T	WASHIN	GTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 052	08/22/18 with diagnos Vascular Accident (CV Immuno-Deficiency V Mellitus, and Cognitiv A review of the Quarte (MDS) for Resident # that facility staff coder following manner: In Section C (Cognitiv Interview for Mental S Score was "03," indicaseverely impaired cognises of the company of th	ses including Cerebral (A), Human irus (HIV), Diabetes e Communication Deficit. erly Minimum Data Set 81 dated 03/06/22 revealed d the resident in the (A) Patterns), the Brief Status (BIMS) Summary ating that the resident had gnition. Inal Status), ADL assistance: the resident was totally ed physical assistance from eating/meals, the resident tance from one staff person. #81's medical record ed) [Care Plan focus area]: for ADL Self-care deficit as eas to right side related to cluded: Assist with daily ressing, oral care, and incourage to participate in [1] at risk for dental or oral related to health condition [1] is edentulous. Interventions ral hygiene as needed"	L 052			8/24/22
		nt is satisfied with fit, 2) h esthetics, 3) Name is in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING			C 04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	202 0011	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		0-1/L0/L0LL
DEANWO	OD DEHABII ITATION A	ND WELL NESS CEN.			RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES THE MUST BE PRECEDED BY FULL THE STATE OF THE		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	52 Continued From page 73			L 052			8/24/22
	the denture, 4) Dentu	ıre kit given"					
	09/02/2021 [Dentist New With fit and esthetics.	Note]: "Patient satisfied "	d				
	10/29/21 at 8:00 AM [Physician's Order]: "ST (Speech Therapy) Strategies sit upright, alternate small bites/sips at slow rate, reduce distractions, check for pocketing, assist with cutting up meat, clear to cough/throat clear." 02/06/22 at 7:52 PM [Physician's Order]: "CHO (Consistent Carbohydrate Diet) regular texture, thin liquid consistency." During a second observation on 04/01/22 at 1:45 PM, Resident #81 was seen with her lunch tray. The resident was not wearing her dentures. When asked about the dentures, Resident #81 stated, "No one put them in for me."		rnate ons,				
			ay.				
		d that facility staff filed to ssistance with putting in es.					
	1:51 PM, Employee # acknowledged that R comprehensive care the resident with putt	e interview on 04/01/22 a #2 (Director of Nursing/D tesident #81's plan did not include ass ing in her dentures at he would update the cal	OON)				
		to ensure Resident #82 address his ability to he with others.					
	03/29/2022 at approx	interview conducted on kimately 10:00 AM, Resi ear. You have to come					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017		B. WING		0.	C 4/20/2022
NAME OF P	ROVIDER OR SUPPLIER	111 502 0017	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		- //20/2022
		ND WELLNESS SEN			RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHINGT	TON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	observed on the resi Resident #82 was ac 09/15/2021 with mult Sensorineural Hearir End Stage Renal Dis Review of Resident # revealed: A Quarterly MDS dat facility staff coded a	dmitted to the facility on tiple diagnoses that include Loss, Schizophrenia sease. #82's medical record ted 01/31/22 that showe BIMS summary score, "	and ed				
	Audiology consult 2/2 (patient) reports of bi impacting communic days" 09/21/21 (Created days)	s Orders] "Referral for 2 (secondary to) to pt illateral hearing loss ation and quality of life 3 ate) [Care Plan] "[Reside earing function Arrange	ent				
	health record lacked the facility staff ever his audiology consult communication and of During a face-to-face 04/05/22 at 2:59 PM Coordinator) acknow that Resident #82 was audiology consult ap Based on record revistaff interview, for on	quality of life. e interview conducted or , Employee #7 (Clinical rledged the finding and s as never scheduled for t	that for n stated he				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
			-			С
		HFD02-0017	B. WING		04	/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NNIE HELEN BU GTON, DC 2001	RROUGHS AVE. NE 9		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 052	Continued From page 75		L 052			8/24/22
	Resident #113 showe	ers.				
	10. Facility staff failed received showers.	I to ensure Resident #113				
	bed and a certified nu finished providing am asked, how often doe	AM, Resident #113 was in urse aide (CNA) had just care. The resident was she receive showers, I just				
	Resident #113 was admitted to the facility on 06/19/14. The resident has a history of General Muscle Weakness, Generalized Arthritis, Difficulty Walking, and Osteoporosis.					
	Review of a Quarterly 02/09/22 showed the	/ Minimum Date Set dated following:				
	a Brief Interview for M	re Pattern) - the resident had Mental Status Summary ing the resident had intact				
	was coded as needin assistance with bathir to stabilize with staff a	nal Status) - Resident #113 g supervision and set-up ng, not steady and only able assistance during nnsfers and using a mobility				
	coded for Generalized	agnoses) the resident was d Muscle Weakness, and Chronic Obstructive				
	Review of a care plar	n with a revision date of following:				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		` ′	CONSTRUCTION		E SURVEY PLETED
ANDILAN	SI GORREGION	IDENTIFICATION NOMBER	ν.	A. BUILDING: _		CON	
		HFD02-0017		B. WING		04	C 1/20/2022
NAME OF P	ROVIDER OR SUPPLIER	8	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		IIE HELEN BU ON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page 76			L 052			8/24/22
	of Daily Living) self-or (related to) disease p Vascular Accident). I [Resident #113] with to promote independ supervision personal Review of the showe	ent #113] has an ADL (Act care performance deficit r/ process CVA (Cerebral interventions: provide basin and bathing supplie dence, [Resident #113] I hygiene and oral care. er schedule revealed the I shower days were on ys on evening shift.	t				
	Review of Skin Swee revealed the following	ep Observation Sheets ng:					
	04/01/22 (Friday) - the bath	ne resident provided a bed	d				
	04/05/22 (Tuesday) shower	- the resident provided a					
	04/07/22 (Friday) - th shower	ne resident provided a					
	approximately 3:00 F she was recently rele has not had a showe year". When asked in 04/05/22 and not know was located. When a 04/05/22 or 04/07/22 observation sheets? that is lying bring the they are lying. I have resident stated, "I wo	e interview 04/12/22 at PM, Resident #113 stated ocated to the unit, and sheer since her relocation "last she had a shower on ow where the shower room asked if she had a shower 2 as document on skin sweet the shower said!" Whoever to me so I can tell them to me to had a shower." The bould love a shower."	e t n on eep ver				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C 1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CEN 5000 I	T ADDRESS, CITY, STATE NANNIE HELEN BURI IINGTON, 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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	Nursing Assistant - C with Resident #113 a year and she had shower. The employ resident supplies up own bed bath. During a face-to-face approximately 3:30 I stated that she work months on the evening "She (Resident #113 employee was then scheduled showers? hot water in a bowl" 11. Facility staff faile medication to Resident #118 was a 01/28/22 with diagnoral Alcohol Dependence Intertorchanteric Frause and History of Faccording to the Quidated 04/11/22, Under Score showed Resident #15" indicating that sunder Section E Belicoded as no behavior Under Section J Heavas coded for Pain a medication; Under Section J Heavas coded for Pain a medication; Under Section of the physical pain intensity was 05 According to the physical pain intensity was	cNA) stated that she worked on the evening shift for about never given the resident aree said that she set the for the resident to give her experience interview on 04/12/22 at PM, Employee #57 (CNA) and the resident for about 8 mg shift. The employee said, 30 doesn't take shower." The asked how does get her asked how does get her are the employee said, "I put for her. I have a fact that included, Insomnia, and the moses that included, Insomnia, and the moses that included, Insomnia, and the mose that included, Insomnia, and the mose that included in the control of the section C0500 BIMS and the was cognitively intact. The mose that included in the complex section C0500 BIMS and the mose cognitively intact. The mose exhibited.	L 052			8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER	JD WELLNESS CEN 5000 NAI	DDRESS, CITY, STAT NNIE HELEN BUR GTON, DC 20019	RROUGHS AVE. NE		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 052	(medication is used to severe pain) 1 tab (ta as needed for moder.) Review of the Februar Administration Recorpain level when he womedication on the following to the following the foll	co help relieve moderate to blet) by mouth every 4 hours ate to serve pain (4-10). Try 2022 Medication d showed Resident #118's as administered the lowing dates: The lam Level = 1; The lam Level = 2; The lam Level = 3; The lam Level = 3; The lam Level = 0; The lam Level = 0; The lam Level = 2; The lam Level = 3; The lam Level = 0; Th	L 052			8/24/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017		B. WING		04	C 1/20/2022
NAME OF F		111 202-0017	CTDEET ADD		TE ZID CODE	0-	1/20/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		ON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From pag	e 79		L 052			8/24/22
	on 04/11/22 at approstated, "I believe the the effectiveness of the forgot to document the same before administration before adminis	d to assess Resident #2 ering Tylenol (pain relie assess Resident # 236 ering Tylenol.	ting 236's ver). t's n ne, ther				
	Review of the Quarte (MDS) dated 03/16/2	erly Minimum Data Set 22 revealed:					
	In section C (Cognitive Patterns) Brief Interview for Mental Status Summary Score of "15" was coded by facility staff and indicates intact cognition.						
	Management "At any the resident?" "Rece	Conditions): J0100 Pain	has				
		medication or was offe ity staff coded "0" No."	red				
	J0200 "Should a pair conducted?" Facility	n assessment interview staff coded "1" Yes.	be				
	J0300 "Pain Presence	ceHave you had pair	ı or				

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							С
		HFD02-0017		B. WING			4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN			RROUGHS AVE. NE		
	OLIMAN DV OT	CATEMENT OF DEFICIENCIES	WASHING	TON, DC 2001		000000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FL LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page	e 80		L 052			8/24/22
	hurting at anytime in the last 5 days?" Facility staff coded "0" No.		у				
	potential for alteration immobility, neck and revised on 10/05/21, pain medication as proders and note the experience of pain on patient successions, sleep, apprelationships with oth concentrate etc. Eval signs/symptoms i.e. experity, contributing characteristics intensively factor. Give	lan with a focus area of: in in comfort/pain related bilateral shoulder pain" " interventions: "Admi er MD (medical doctor) effectiveness. Assess et ch as accompanying petite, physical activity, iers, emotion's ability to luate for and report pain exact location, characte factors Evaluate pain et PRN medications for s per MD orders and not	d to inister ffects n r, n				
	Review of the physic following:	ian's orders revealed th	е				
		blet 325 mg Give 2 tabl urs as needed for mild p					
	4% Lidocaine Apply t	maximum strength pate o left deltoid topically in 15 days and remove afte	the				
	at approximately 12:2 (Registered Nurse) w medications to Resid Employee for someth administered the Ace	ent #236 when he aske ning for pain. Employee taminophen but did not pain level (such as mile	ed the e #37				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7 50.25 10			C	
		HFD02-0017		B. WING		0.	4/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN			RROUGHS AVE. NE			
	Г		WASHINGT	ON, DC 2001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
L 052	Continued From page	e 81		L 052			8/24/22	
	Employee #37 why si resident's pain level. acknowledged that sh #236's pain level and 13. The facility's staff practice by not provid #3 from 12/01/2021 to Review of an intake for the DC Departmer Regulation and Licen 01/26/22 showed the [granddaughter] alleg Resident #3 she and responsible party) has stomano one at the cleaning." The complephotos of my grandfa	ne did not assess the The Employee ne did nto assess Reside stated, "No, I didn't ask failed to follow standard ling stoma care for Reside 0 02/06/2022. form for a complaint recent of Health, Health Care sing Administration on	ds of dent eived eth				0/24/22	
	mucus and the rubbin can irritate the skin and around the stoma shot twice a day to preven infection. If the area as smells badly, stoma of performed more frequently https://www.hopkinsnving/stoma.html Resident #3 was adm 12/01/2021 with multi	appears red, tender or cleaning should be uently" medicine.org/tracheostor nitted to the facility on ple diagnoses including of Larynx, Carcinoma of ence of Larynx, and	ube .in my/li					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		HFD02-0017	B. WING		C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD DELIADII ITATION AN	SOUD WELLNESS CEN. 5000 NA	NNIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	WASHIN	GTON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 052	Continued From page 82		L 052			8/24/22
	Review of Resident #3's medical record revealed the following:					0, _ ,
	12/01/2022 - 02/06/2022 [nursing progress notes]- lacked documented evidence nursing staff provided stoma site care.					
	12/01/2022 - 02/06/2022 [medication administration records] - lacked documented evidence nursing staff provided stoma site care. 12/01/2022 - 02/06/2022 [treatment administration record] - lacked documented evidence nursing staff provided stoma site care.					
	12/02/2022 [physicial lari (lary)-tube daily o	n order] instructed, cleanse on day shift.				
	02/07/2022 [physician order] instructed, please clean, and remove crusting from in and around the stoma BID (two-times-a day) with moist gauze and sterile					
	12/03/21 revealed that Summary Score sect the resident was code Tracheostomy care a Continued review sho	ion Minimum Data Set dated at the Brief Interview Mental ion was blank. Additionally, ed for receiving and speech therapy services. by bwed that Resident #3 was ng respiratory therapy				
	initial date of 12/04/2 Focus Area-[resident' (related to) laryngeal Goal-[resident's name drainage around trace	ehensive care plan with an 1 showed the following: 's name] has lary tube r/t cancer. e] will have no abnormal hea site through the review ex (signs/symptoms) of				

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			A. BUILDING		
		HFD02-0017	B. WING		C 04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		5000 NAI		RROUGHS AVE. NE	
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN' WASHIN	GTON, DC 2001	9	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
L 052	052 Continued From page 83		L 052		
	infection through the Interventions- lari-tub daily, assist with coug Further review of Recare plans lacked doc	review date. e care daily, change HME			8/24/22
	12/01/22 to 02/06/22	•			
	During a telephone interview on 04/12/22 at 11:35 AM, the resident's emergency contact (granddaughter) stated that when she visited Resident #3 at the facility, she would often notice his stoma with crusty secretions. She also stated that when she would visit him at the radiation/chemotherapy infusion site Resident #3 stoma site and lary-tube were dirty frequently. She said a few times that the radiation/chemotherapy infusion center had to clean the stoma site and lary-tube before they could render care. The granddaughter then stated that she had multiple pictures as evidence of her concerns.				
	2:25 PM, Employee # stated that when staff lary-tube daily they postoma site. Employee	interview on 04/13/22 at 47 (Clinical Coordinator) f cleaned Resident #3's rovided care to the resident's e #7 then said, "I have care e care plan. I just didn't add			
	#181's Tiotropium Bro Aerosol Inhaler as ordered and per st	dmitted to the facility on			
	· ·	Pulmonary Disease, Asthma,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
							С	
		HFD02-0017		B. WING			04/20/2022	
NAME OF PROVIDER OR SUP	PLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWOOD REHABILIT	ATION AN	ND WELLNESS CEN		IIE HELEN BU FON, DC 2001	RROUGHS AVE. NE 9			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
A. During a ron 03/29/22 (RN) was ob Resident #18 administer the Aerosol Inha waiting for the come and she to administed (RN-Unit Mainstructed Eninhaler for Resident receptable presence of Review of a instructed, The Aerosol Soluinhaler orally Obstructive Inhaler	e, and Ennedications and Ennedications at a served and B1. Where e reside a ler. The e unit may be a served that type and the unit resident # sived the unit resident # sived the unit resident and th	on administration obsertat 11:24 AM, Employee administering medication asked why she did not asked why she did	vation e #45 ns to of e) to w how e #43 the d the the chat d it pium aler	L 052	DEFICIE	:NCT)	8/24/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
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		HFD02-0017	B. WING		04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
L 052	Review of Treatment. Vital Summary sheet #181's oxygen satura 96-98% on room air frand respiration rate raper minute from 03/18 During a face-to-face approximately 11:45 // that 03/29/22 was the Tiotropium Bromide Nobecause she did not Note that 03/29/22 was the Tiotropium Bromide Nobecause she did not Note and error." The employ make anyone aware administer that type of Employee #45 failed Tiotropium Bromide Note as ordered from 03/18 B. During a medication on 03/29/22 starting a (RN) was observed a Symbicort inhaler two inhaler two spays inheresident rinse her moon According to the man cause serious side effinfection in your mouth your mouth with water that the start of the start o	Administration Record and documented that Resident tion rate ranged from rom 03/18/22 to 03/21/22 anged from 17 to 20 breaths 8/22 to 03/24/22. Interview on 03/29/22 at AM, Employee #45 stated of first time she administered fonohydrate Aerosol inhaler know how to administer it. The initial that she 03/29/22? She said, "It was see also said that she did not she did not know how to if inhaler. Ito administer Resident #181 fonohydrate Aerosol inhaler 8/22 to 03/24/22. In administration observation at 11:24 AM, Employee #45 dministering Resident #181	L 052	DEFICIENCY)	8/24/22
	getting thrush" https://www.mysymbi	cort.com/asthma/side-effect			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
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		HFD02-0017	B. WING		04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9	
(X4) ID		ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
L 052	Continued From page 86		L 052		8/24/22
	rinse your mouth with	, " after using your inhaler, water, gargle, and spit. Do r. This helps reduce side dicine"			
	https://medlineplus.gov/ency/patientinstructions/0 00041.htm				
	Review of a physiciar following:	n orders revealed the			
	03/18/22 - Budesonide-Formoterol Fumarate (Symbicort)Aerosol 160-4.5 mg/ACT 2 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disorder) 03/18/22 - Tiotropium Bromide Monohydrate (Spiriva) Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease).				
	approximately 11:45	interview on 03/29/22 at AM, Employee #45 stated e the resident rinse her ch inhaler.			
	Employee #45 failed to follow standards of practice when administering metered dose inhalers for Resident #181.			ORRECTIVE ACTION FO	OR THE
L 056	3211.5 Nursing Facility	ties	L 056	AFFECTED RESIDENT: No resident was affected	by this
	provide a minimum da tenth (4.1) hours of di resident per day, of w hours shall be provide	practice a minimum daily average of four and one 4.1) hours of direct nursing care per at per day, of which at least six tenths (0.6) shall be provided by an advanced practice red nurse or registered nurse, which shall practice IDENTIFICATION OF OTHER WITH THE POTENTIAL TO B AFFECTED: None			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
	HFD02-0017	B. WING		C 04/20/2022	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION A	AND WELLNESS CEN 5000 NA	ADDRESS, CITY, STA ANNIE HELEN BU NGTON, DC 2001	JRROUGHS AVE. NE		
PREFIX (EACH DEFICIENT	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE	
This Statute is not Based on record reduring a review of sadvanced practiced Resident per day he the facility failed to average of four and direct care per day accordance with Tit Nursing Personnel The findings include According to the Di Regulations for Nur Beginning January provide a minimum one-tenth (4.1) hour resident per day' A review of the Nur 04/20/2022, at approvide a minimum one-tenth (4.1) hour per day. Hours of Direct Car Saturday, 07/10/20	met as evidenced by: view and staff interview, staffing [direct care and d registered nurse per ours], it was determined that provide a minimum daily d one-tenth (4.1) hours of for 31 of 31 days in the 22 DCMR Section 3211, and Required Staffing Levels. ed: strict of Columbia Municipal rsing Facilities: 3211.5 1, 2012, each facility shall daily average of four and rs of direct nursing care per	L 056	MEASURES TO PREVENT RECURRENCE: In -service will be provided by staff educator/Designee to the staffing coordinator to alwensure that the total number of hours worked per oby the nursing staff who are providing direct patient can accurately recorded. Also, that all staffing records maintained per facility's policy. Human Resources Manager's assistant will audit staffing records weekly to ensure the staffing coordinator is recording the actual number nursing staff directly responsible for residents' car Findings will be corrected by 8/24/22.	vays day are is are /	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STA	ATE, ZIP CODE		v=
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	IANNIE HELEN BU INGTON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
L 056	Tuesday, 07/20/2021 provided direct nursin of 3.6 hours. Saturday, 08/14/2021 provided direct nursin of 3.4 hours. Wednesday, 08/18/20 provided direct nursin of 3.5 hours. Tuesday, July 6, 202 provided direct nursin of 3.47 hours. Friday 08/27/2021, sh provided direct nursin of 3.3 hours. Monday, 08/30/2021, provided direct nursin of 3.5 hours. Tuesday, 10/19/2021 provided direct nursin of 3.6 hours. Sunday, 02/20/2022, provided direct nursin of 3.6 hours. Sunday, 02/21/2022, provided direct nursin of 3.06 hours. Monday, 02/21/2022, provided direct nursin of 3.45 hours. Tuesday, 02/22/2022	showed that the facility g care per resident at a rate showed that the facility g care per resident at a rate of the facility g care per resident at a rate of the facility g care per resident at a rate of the facility g care per resident at a rate of the facility g care per resident at a rate of the facility g care per resident at a rate	L 056	MONITORING CORRECTIVACTION: Human Resources Director Designee will ensure the state coordinator is posting a reproductive responsible to correctly. The will be conducted weekly a monthly x3. Findings will be corrected immediately and to QAPI committee.	/ affing ort of asible for is audit 4, then	8/24/22

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		p.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	E	3. WING		04	C 1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CEN	STREET ADDRE 5000 NANNIE WASHINGTOI	HELEN BUI	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 056	Wednesday, 02/23/2 provided direct nursin of 3.23 hours. Thursday, 02/24/202 provided direct nursin of 3.42 hours. Friday, 02/25/2022, sprovided direct nursin of 3.59 hours. Saturday, 02/26/2022 provided direct nursin of 3.33 hours. Sunday, 02/27/2022, provided direct nursin of 3.1 hours. Monday, 02/28/2022 provided direct nursin of 3.12 hours. Wednesday, 03/03/2 provided direct nursin of 3.28 hours. Sunday, 03/13/2022,	e 89 2022, showed that the facing care per resident at a 22, showed that the facilitying care per resident at a 23, showed that the facilitying care per resident at a 24, showed that the facilitying care per resident at a 3, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a 4, showed that the facilitying care per resident at a	rate y rate rate rate rate rate rate rate rate	L 056	DEFICIENCY		8/24/22
	provided direct nursing of 2.8 hours. Tuesday, 03/15/2022	, showed that the facility ng care per resident at a 2, showed that the facility ng care per resident at a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ARED.	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
	HFD02-0017		B. WING		C 04/20/2022
NAME OF PROVIDER OR SUP	PLIER ATION AND WELLNESS CEN	STREET ADDRE 5000 NANNIE WASHINGTO	HELEN BUI	RROUGHS AVE. NE	
PREFIX (EACH I	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
provided dire of 3.3 hours. Thursday, 03 provided dire of 3.1 hours. Monday, 03/2 provided dire of 3.08 hours. Tuesday, 03/2 provided dire of 3.13 hours. Wednesday, provided dire of 3.31 hours. Thursday, 03 provided dire of 3.31 hours. Thursday, 03/2 provided dire of 3.54 hours. Friday, 04/01 provided dire of 3.37 hours. Sunday, 04/0 provided dire of 2.9 hours. Monday, 04/0 provided dire of 2.9 hours. A face-to-face Employee #2	03/16/2022, showed that the act nursing care per resident at //17/2022, showed that the fact ct nursing care per resident at 28/2022, showed that the facility ct nursing care per resident at 29/2022, showed that the facility ct nursing care per resident at 03/30/2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at //2022, showed that the facility ct nursing care per resident at	facility t a rate cility t a rate ity t a rate lity t a rate facility t a rate facility t a rate / t a rate ity t a rate / t a rate ity t a rate	L 056		8/24

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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CIN SUBMANY STATEMENT OF DEPOCRACIS PRETTY MAY STATE. JIP CODE SOO NANNE HELLER BURROUGHS AVE. NE WASHINGTON, DC. 20019 PROVIDERS PLAN OF CORRECTION CONTROL PROVIDERS PLAN OF CORRECTION CONTROL SIGNAL OR COMPACT. PREDLATORY OR LSC IDENTIFYING INFORMATION) L 088 217.3 Nursing Facilities The Infection Control Committee shall establish written infection control policies and procedures for at least the followling: (a)Investigating, controllling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statule is not met as evidenced by: Based on observation and staff intenview, facility staff failed for (1) ensure Resident H132 surine collection bags is not a privacy bag and that the bag is not on the floor. Also, to ensure that residents will urine collection bag is not approach to the protection and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statule is not met as evidenced by: Based on observation and staff intenview, facility staff failed for (1) ensure resident H132 surine collection bags have a privacy bag and that the bag is not on the floor. Also, to ensure that all employees are using their PPE'S are correctly while in patient care area, Any issues found will be corrected by issues found will be corrected by	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CIN WASHINGTON, DC 20019 PREFIX PROVIDER OR SUPPLIER SITERET ADDRESS, CITY, STATE, JIP CODE SOON MANNE HELLER BURROUGHS AVE. NE WASHINGTON, DC 20019 L 088 L 088 L 088 L 088 L 088 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections, and theatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statule is not met as evidenced by: Based on observation and staff intenview, facility staff failed to: (1) ensure Resident #132 surine collection bag is in a privacy bag, strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Residents with Foley residing in the facility have the potential to be affected by this practice. House wide audit will be conducted by nursing staff to ensure that residents will urine collection bag is not not the floor. Also, to ensure that all employees are using their PPE'S are correctly while in patient care area. Any issues found will be corrected by issue found will be corrected by issue found will be corrected by issue found will be corrected by issues found will be corrected by	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES DEPICE NOT NOT SET INTERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEPICE NOT NOT SET INTERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEPICE NOT NOT HEAPPROPRIATE DATE OF THE APPROPRIATE DATE	HFD02-0017			B. WING			
DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
L 088 L 088 L 088 L 088 L 088 L 088 CORRECTIVE ACTION FOR THE APPROPRIATE DATE The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infections; and (h)Nondiscrimination in admission, retention, and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to: (f) ensure Resident #132's urine collection bag was not resting on the floor and (2) maintain infections. The census on the first day of survey EREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) L 088 L 088 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #132 was assessed on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident urine collection bag is in a privacy bag, strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Residents with Foley residing in the facility have the potential to be affected by this practice. House wide audit will be conducted by nursing staff to ensure that residents will urine collection bag was not resting on the floor and (2) maintain infection control and prevention practices to help prevent the development and transmission of communicable diseases and infections. The census on the first day of survey	DEANWO	OD REHABILITATION AN	D WELLNESS CEN				
The Infection Control Committee shall establish written infection control policies and procedures for at least the following: (a)Investigating, controlling, and preventing infections in the facility; (b)Handling food; (c)Processing laundry; (d)Disposing of environmental and human wastes; (e)Controlling pests and vermin; (f)The prevention of spread of infection; (g)Recording incidents and corrective actions related to infections; and treatment of persons who are infected with the HIV virus or who have a diagnosis of AIDS. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to: (1) ensure Resident #132's urine collection bag was not resting on the floor and (2) maintain infection control and prevention practices to help prevent the development and infections. The census on the first day of survey CORRECTIVE ACTION FOR THE AFFECTED Resident witage and explained to affected to affect suffered no negative outcome. MD/RP notified on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident urine collection bag is in a privacy bag, strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Resident #132 was assessed on 4/26/22. Resident urine collection bag is in a privacy bag. Strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Resident #132 was assessed on 4/26/22. Resident urine collection bag is na privacy bag. Strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Resident #132 was assessed on 4/26/22. Resident urine collection bag is na privacy bag. Strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. Resident #132 was assessed on 4/26/22. Resident withe collection bag is na privacy bag. Strapped loosely to his bed. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
was 255. The findings include:	L 088	The Infection Control written infection control of at least the following (a) Investigating, continued infections in the facility (b) Handling food; (c) Processing laundry (d) Disposing of environments (e) Controlling pests at (f) The prevention of some states (g) Recording incident related to infections; at (h) Nondiscrimination treatment of persons (HIV virus or who have the state of the st	Committee shall establish of policies and procedures and: rolling, and preventing y; rommental and human and vermin; pread of infection; s and corrective actions and in admission, retention, and who are infected with the e a diagnosis of AIDS. et as evidenced by: and staff interview, facility are Resident #132's urine t resting on the floor and (2) atrol and prevention ent the development and nunicable diseases and	L 088	CORRECTIVE ACTION FOR THE AFFECTED RESIDEN Resident #132 was assessed 4/26/22, resident suffered in negative outcome. MD/RP in on 4/26/22. Resident urine collection bag is in a privacy strapped loosely to his bed. IDENTIFICATION OF OTHE WITH THE POTENTIAL TO AFFECTED. Residents with Foley residing the facility have the potential affected by this practice. House wide audit will be conducted by nursing staff the ensure that residents will un collection bags have a private bag and that the bag is not of floor. Also, to ensure that all employees are using their Pare correctly while in patient area. Any issues found will be corrected.	ed on o otified bag, ERS BE Ing in all to be o ine acy on the I PPE'S t care	8/24/22

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S			
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COWIFE	00 22.25	
		HFD02-0017	B. WING		04/2	0/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE. ZIP CODE			
		5000 NA		IRROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN' WASHIN	IGTON, DC 2001	9			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
L 088	1. Facility staff failed #132's urine collection floor. According to the Cen (CDC) guidelines for associated urinary traincludes: " Keep the level of the bladder a bag on the floor." (https://www.cdc.gov.deline2009final.pdf) On 04/07/22 at approfution approximate collection bag in the collection bag in the collection bag in the collection approximate the collection, Alzhe and Muscle Weakness A review of the Quart (MDS) for dated 02/1 staff coded the follow In Section C (Cognitive Interview for Mental Score of "99," indicate cognition. During a face-to-face 3:48 PM, Employee # Nurse/LPN), acknowledge was on the floor and is in its lowest position morning. I will explain.	to provide ensure Resident n bag was not resting on the ter for Disease Control prevention of catheter act infections (CAUTI) e collecting bag below the t all times. Do not rest the hicpac/pdf/CAUTI/CAUTIgui eximately 3: 45 PM, Resident esident lying in bed with his esting lying on the floor. eadmitted to the facility on sees that included: Urinary timer's, Dementia, Epilepsy ss (Generalized).	L 088	MEASURES TO PREVENT RECURRENCE Training will be provided to all facility by staff educator/ Desig importance to ensure that staff PPE's correctly In- service will be provided by educator/ designee to all licent to always ensure that urine co is not on the floor. Unit managers/ Supervisors wrounds on their units to ensure are wearing their PPE's correct Will be corrected by 8/24/22. Charge nurses will conduct round their shift to ensure urine collenot on the floor. Findings will be by 8/24/22. QA nurse / Designee will condon the unit during their shift to staff members are wearing the correctly and that infection corpractices are implemented by Findings will be corrected by 8 Supervisors will conduct round their shift to ensure infection or practices are implemented per policies. Findings will be corrected by 8/24/22 Unit managers/ Designee will residents #132 urinary collection the floor, and that it is in the bag. Findings will be corrected.	gnee on the f put on their staff sed nurses llection bag fill conduct that staff ctly. Findings for corrected luct rounds ensure the sir PPE's notrol the staff. 13/24/22 ds during ontrol fracility's cted by ensure that on bag is not e privacy	8/24/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	HFD02-0017			B. WING		C 04/20/2022	
		HFD02-0017	070557.400		T. J. 2005	04/2	.0/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		ON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 088	Continued From page	e 93		L 088	MONITORING CORRECTIVE ACTION:		8/24/22
	2. Facility staff failed to wear the required PPE while in a resident care area on three (3) of three occurences.			DON/ Designee will conduct how wide audit to ensure that emplorate wearing their PPE's correct ensure that the bag for urine contents.	oyees tly and		
	A. During tour of unit 4 south on 04/06/22 at 6:16 AM, Employee #29 (CNA) was observed less than 6 feet apart from a resident, providing ADL care and did not have on a face shield.				is not on the floor. This audit winglace weekly x3, then monthly Findings will be addressed immediately, and report present QAPI committee.	x4.	
	During a face-to-face interview conducted at the time of the observation, Employee #29 acknowledged the finding and stated that she was aware of the facility's policy to wear face shields at all times in the facility. 32. Facility staff failed to wear PPE while in a resident care area. B. During a tour of unit 4 north on 04/06/22 at 6:21 AM, Employee #49 (CNA) was observed coming out of a resident's room wearing a face mask but did not have on a face shield. During a face-to-face interview conducted at the time of the observation, Employee #49 acknowledged that she knew the facility's PPE policy and stated, "I just took it off, and I needed a little air." C. Facility staff failed to wear a face shield when providing for Resident #55.			QAFI commuee.			
			ed				
			when				
	Nursing Assistant) wa	AM, Employee #26 (Cer as observed providing a esident #55 without wea	am				
	6:20 AM, Employee #	interview on 04/06/22 a \$26 stated that the facili wear a face shield. She	ity's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVI		
			A. BUILDING.			
		HFD02-0017	B. WING		C 04/20/20	022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		OMPLETE DATE
L 088	Continued From page	94	L 088		8,	/24/22
	forgot to put it (face s	hield) on.				
L 099	from spoilage, safe for served in accordance forth in Title 23, Subtin Regulations (DCMR), This Statute is not measured and the statement of the statement of the serve are accordance with profession of the serve are accordance for food servition of the server of the s	be clean, wholesome, free or human consumption, and with the requirements set the B, D. C. Municipal Chapter 24 through 40. He as evidenced by: In and staff interview, facility and distribute foods in the essional standards of	L 099	L099 No Resident was affected by this deficient practice. IDENTIFICATION OF OTHERS OTHE POTENTIAL TO BE AFFECTED All residents residing in the facilit the potential to be affected by this practice. Food services director will condurounds to in the kitchen to ensure food is distributed in accordance	WITH TED: y has s	
	Hot foods temperatures were inconsistent during food tray assessments on April 4, 2022, and on April 12, 2022. On April 4, 2022, hot foods temperatures (regular diet) were normal, and pureed foods temperatures tested at less than 140° F. Spaghetti with meatballs (regular diet) = 149° F Green Beans (regular diet) = 147° F Spaghetti with Meatballs (puree) = 136° F Green Beans (puree) = 138° F On April 12, 2022, hot foods from the regular diet, such as fried fish (pollock), green beans, rice, and mechanical mixed vegetables tested under 140 degrees Fahrenheit, while pureed foods tested normal.			professional standards of practice the residents get their food within standards temperature. Findings addressed immediately but not la 8/24/22	e, that the will be	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### SUPPLIER ### STREET ADDRESS, CITY, STATE, ZIP CODE ### SUBMARY STATEMENT OF DESCISIONOSS (### CACH EMPICIARY MUST BE PRECEDED BY PULL TAG ### TAG ### CONTINUED FROM JOS (### COMPRECED BY PULL TAG ### CONTINUED FROM JOS (### COMPRECED BY PURP) ### CONTINUED FROM JOS (### COMPRECED BY JOS	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREET, 2IP CODE SOON NANNEH HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 LOSS CONTINUED TO PREVENT STREET AND OF CORRECTION FREETY OR SUMMANY STREMENT OF DEPOCIENCES FREETY OR SUMMANY STREMENT OR DEPOCIENCES FREETY OR SUMMANY STREMENT OF DEPOCIENCES FREETY OR SUMMANY STREMENT OR DEPOCIENCES FREETY OR SUMMAN	ANDILAN	or connection	IDENTIFICATION NOWE	JLIV.	A. BUILDING: _		COMIL	-160	
DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY PLLL RECOULTIVE ACTION SHOULD BE PRECEDED BY PLLL TAG TAG Continued From page 95 L099 Continued From page 95 Fried Fish (regular diet) = 132° F White Rice (regular diet) = 132° F White Rice (regular diet) = 132° F White Rice (regular diet) = 132° F Mixed Vegetables (mechanical) = 147° F White ine (mechanical) = 148° F Ride Fish (puree) = 150° F Mixed Vegetables (puree) = 148° F Mixed Postatoes = 150° F Mashed Potatoes = 150° F Mashed Potatoes = 150° F These findings were acknowledged by Employee #15. during a face-to-face interview on April 12, 2022, at 3:45 PM. L128 Mixed Vegetables (puree) = 148° F Mixed Vegetables (puree) = 150° F Mixed Vegetables (puree			HFD02-0017		B. WING		_		
CALL	NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
L 099 Continued From page 95 Fried Fish (regular diet) = 132° F White Rice (regular diet) = 147° F Fried Fish (purce) = 150° F Mixed Vegetables (purce) = 148° F Mixed Vege	DEANWO	OD REHABILITATION AN	ND WELLNESS CEN						
Fried Fish (regular diet) = 132° F White Rice (regular diet) = 132° F Green Beans (regular diet) = 129° F Mixed Vegetables (mechanical) = 148° F Fried Fish (mechanical) = 147° F White rice (mechanical) = 142° F Fried Fish (mechanical) = 142° F Fried Fish (puree) = 150° F Mixed Vegetables (puree) = 148° F Mashed Potatoes = 150° F These findings were acknowledged by Employee #15, during a face-to-face interview on April 12, 2022, at 3.45 PM. L 128 C 128 L 128 L 128 C 129 MEASURES TO PREVENT RECURRENCE. In-service will be provided by Staff Educator/ Designe to the diary staff on the importance to ensure that food is served and distributed in accordance with professional standards. Completed by 8/24/22. Food Services Director will ensure that his staff members serve and distribute dod in accordance with professional standards of practice for food services. Any issues found will be corrected by 8/24/22. Dietician and Nutritionist will ensure that the food served to the residents are in accordance with professional standards of practice for food services. Any issues found will be corrected by 8/24/22. Food services director will ensure that the food service day 8/24/22. Food services director will ensure that the food services and stamp to the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the ensure that the pallets temperature is up to standard to ensure the food stays warm. Any issues found will be corrected by 8/24/22. Food services director will ensure that the food services	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERT	D BE	COMPLETE	
		Fried Fish (regular di White Rice (regular di White Rice (regular di Green Beans (regular di Mixed Vegetables (maried Fish (mechanic White rice (mechanic Fried Fish (puree) = Mixed Vegetables (puree) = Mixed Ve	et) = 132° F liet) = 132° F r diet)) = 129° F rechanical) = 138° F lechanical) = 138° F lechanical) = 142° F lal) = 142° F las) = 142° F las) = 148° F lasor F lacknowledged by Emplerace interview on April lities	t at the ector tor on ad		L099 MEASURES TO PREVENT RECL In-service will be provided by Staff Designee to the dietary staff on the importance to ensure that food is s distributed in accordance with prof standards. completed by 8/24/22. Food Services Director will ensure staff members serve and distribute accordance with professional stan- practice for food services. Any isst will be corrected by 8/24/22. Dietician and Nutritionist will ensure food served to the residents are in accordance with professional stan- practice for food services. Any isst will be corrected by 8/25/22. Food service director will ensure th pallets temperature is up to standa ensure the food stays warm. Any is found will be corrected by 8/24/22. Food services director will conduct temperature test on the units to co the food temperature of hot food is degrees per food service standard issues found will be corrected by 8 MONITORING CORRECTIVE AC Director of food services will monit ensure that food is served and dist accordance with food standards. T will take place weekly x4, then mo Findings will be corrected and repo	that his e food in dards of ues found the that the dards of ues found the the the the the that the dards of ues found the	8/24/22	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED C	
		HFD02-0017	B. WING		l l	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CEN	T ADDRESS, CITY, STANANNIE HELEN BU HINGTON, DC 2001	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 128	that an account of al maintained and period This Statute is not in Based on record rev (6) of 105 sampled in to: (1) show docume attending physician of monthly medication acted upon the pharmand (2) ensure that the reconciliation of confollowed. Residents' and #238. The findings included Review of the facility Regimen Review", dum. Recommendation documented by the four The prescriber accepted recommendation for disagnated and document recontending or designated and document recontending of the facility's policy astorage of controlled 08/2020 stated: Policy: "Medications Enforcement Administrations are subjustances are subjustances are subjustorage, disposal, ar facility in accordance other applicable laws Procedures: Unlease of the substances and the substances are subjustances are subjustorage, disposal, ar facility in accordance other applicable laws Procedures: Unlease the substances are subjustances are su	ug records are in order and a controlled substances is odically reconciled. net as evidenced by: iew and staff interview, for six esidents, facility staff failed inted evidence that the or designee reviewed the regimen review and that they macists' recommendations he system used for the rolled medications was 16, #22, #61, #167, #190 d: policy entitled, "Medication ated 08/2020 documented, is are acted upon and acility staff and/or prescriber. It is and acts upon rejects provides an preeing The Director of its dicensed nurse address mendations that do not intervention, e.g., monitor and procedures for the substances revised on the classified by the Drug stration (DEA) as controlled ect to special handling, and recordkeeping in the evith federal, state, and	L 128	L 128 CORRECTIVE ACTIONS AFFECTED RESIDENTS: No resident was affected I IDENTIFICATION OF OTI POTENTIAL TO BE AFFE All residents residing in th potential to be affected	: by this practice. HERS WITH THE ECTED:	8/24/22

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
	HFD02-0017		B. WING		04/2	20/2022
(EACH DEFICIENC	ID WELLNESS CEN' ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU	5000 NANN WASHINGT	RESS, CITY, STA	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	N D BE	(X5) COMPLETE
Continued From page change, or when keys inventory of all control refrigerated items, is personnel and is door substance inventory in Medication Administration documented on a Coform) or in accordance. 1. Facility staff failed recommendation to "I GDR (gradual dose reflection of the GDR (gradual dose reflection of the GDR) and Dementia in Othe Elsewhere Without Border Without Border Gognitive Patterns) of Interview for Mental Stacility staff coded "On Section N (Medicar	y MUST BE PRECEDED BY FUSC IDENTIFYING INFORMATION OF STATE OF STA	sical ing sed the distribution of the distribu	ID	PROVIDER'S PLAN OF CORRECTIO	a new ble cing of all ound clinical ow vo vials 3/24/22. Les are nes found cits e conduct urses heets corrected harmacy a timely as off on	
during the last 7 days reentry if less than 7 Resident #16 as rece	sification, not how it is used or since admission/endays." Facility staff codiving Antipsychotic, oagulant and Diuretic co	try or ed				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0017		B. WING		C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CEN	5000 NANN	RESS, CITY, STA	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ΤE
L 128	N0450 "Did the resid medications since ad the prior OBRA asserecent? Facility staff." "Has a gradual dose attempted?" Facility s "Physician document contraindicated" Facility of the physic following: 05/21/20, Escitalopragive 1 tablet orally or 06/23/21, "Risperdal give 1 tablet by mout psychotic disorder." Review of Resident #Record revealed a preview was conducte 02/14/22, 03/15/22. Oval was marked that given to the IDT (Interesident of the IDT) (Interesident of the IDT) (Interesident of the IDT) (Interesident of the IDT) (Interesident of IDT) (IDT) (Interesident of IDT) (IDT) (I	ent receive antipsychot Imission/entry or reentry syment whichever is more coded "1" No reduction (GDR) been staff coded "0" No. red GDR as clinically litty staff coded "0" No. rent Review" This section ian's orders revealed the moxalate Tablet 20 Mare time a day for depress tablet 1 MG (risperidon h two times a day for two times a day for the seassessments at stated "Recommenda redisciplinary team). The segimen review dated dations are "Please evaluations are "Please evaluations" are "Please evaluatio	y or ore ore ore ore ore ore ore ore ore	L 128	MONITORING CORRECTIVE ACTION: DON/Designee will conduct at on all the units to ensure that nurses are using the controlle medication sheet accurately a all control substances are alwaccounted for. This audit will be conducted weekly x4, then money as a counted to conducted and reported to committee.	udits the d nd that ays ee	H/22

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION		ATE SURVEY MPLETED
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		HFD02-0017		B. WING			04/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN			RROUGHS AVE. NE		
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	WASHING	ON, DC 2001	PROVIDER'S PLAN OF COR	PRECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 128	Continued From page	99		L 128			8/24/22
	respond."						
	During a face-to-face interview conducted on 04/19/22 at 1:11 PM, with Employee #2 (Director of Nursing) stated, "I didn't see a note."						
		rledged there was no e that a physician review harmacist recommenda					
	the attending physicia monthly medication re	to show documentation and or designee reviewed egimen review and act of for Residents' #22, #61	the n				
	11/09/15 with multiple	s admitted to the facility diagnoses that included a and Hyperlipidemia.					
	Review of Resident # revealed:	22's medical record					
	03/23/22 showed that Interview for Mental S	Data Set (MDS) dated t facility staff coded a Br Status (BIMS) summary ng moderate cognitive	ief				
	#22] is, at risk for adv polypharmacy Rev	ate) [Care Plan] "[Reside erse reaction r/t (related iew Pharmacy consult d follow up as indicated.	I to)				
	#22] receives 9 or mo	ate) [Care Plan] "[Reside ore different medications drug interactions Clini n review monthly and pre- ecommendations"	and cal				

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AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HFD02-0017	B. WING		04	C I/20/2022
	PROVIDER OR SUPPLIER	ND WELLNESS CEN	DDRESS, CITY, STATE NNIE HELEN BURI			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 12	MRR form for Decen (3) months labs over that the physician or medication review for reviewed. MRR form for Janua month) Keppra (antist no evidence that the signed the medication it was reviewed. 2B. Resident #61 was 11/06/20 with multipl Diabetes Mellitus, Cl Disease, Chronic Vir Hypertension, Periph Kidney failure, Systesyndrome, and Anxieta A review of Resident showed that from Jumonthly MRR's lacked the attending physicial monthly medication in the recommendation response box [agree the physician's signaresponse area, were not reviewed. 2C. Resident #167 was 10/25/19 with multiple end-stage Renal Dis Hyperlipidemia, Hyporobstructive Pulmona Depressive Disorder	nber 2021 read, "Every three due". There was no evidence designee signed the rm to indicate that it was ry 2022 read, "month (every seizure) overdue". There was physician or designee on review form to indicate that as admitted to the facility on e diagnoses including pronic Obstructive Pulmonary all Hepatitis C, Anemia, peral Vascular Disease, Acute mic Inflammatory response ety. ##61's medical record by 2021 to February 2022, the end documented evidence that an or designee reviewed the regimen review and acted on s. The Physician/Prescriber /disagree/other], allotted for atture and the date and left blank, indicating it was was admitted to the facility on e diagnoses including ease, Anemia, ertension, Chronic ary Disease, Major	L 128			8/24/22

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, ,	E SURVEY PLETED
		HFD02-0017		B. WING		04	C 1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN		5000 NANN		RROUGHS AVE. NE	, ,	#120/2022
			WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 120	128 Continued From page 101 the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted		L 128			8/24/22	
	on the recommendation Physician/Prescriber [agree/disagree/other	ions. The response box r], allotted for the physic te and response area, w	ian's				
	2D. Resident #190 w 11/27/21 diagnoses t Renal Disease, Hype Pressure Induced De	as admitted to the facilit hat included: End Stage	ne				
	Review of Resident # revealed:	190's medical record					
	80mg (milligram) Ato reducer) be reduced? that the physician or	?" There was no evidenc	ce				
	Darbopoetin (antiplat (hemodialysis) clinic. that the physician or	ary 2022, read " sugge elet) state 'give at HD " There was no evidence designee signed the rm to indicate that it was	e				
	(evaluate) Buspar (ar effects" There was physician or designed review form to indicar	2022 read, "Please evantianxiety) for serotons no evidence that the e signed the medication te that it was reviewed. as admitted to the facilit	in				
		owing diagnoses: Diabe					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HFD02-0017	B. WING		04	C 1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CEN 5000 NA	DDRESS, CITY, STATE NNIE HELEN BURI GTON, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 128	Mellitus, Hypertensio Hyperlipidemia, Gast Disease, Chronic He and Dysphagia, Dem A review of Resident showed that from Octhe monthly MRR's lathat the attending phythe monthly medication the recommendati Physician/Prescriber [agree/disagree/othe signature and the dat left blank, indicating in During a telephone in 04/19/22 at 10:55 AM Pharmacist) was ask of the aforementione stated, "The MRR repthe Administrator, Dirthe Unit Managers. Tappropriate physician Once a response is pother) it goes into the their permanent recounting a face-to-face 04/19/22 at 1:11 PM, acknowledged the fin #167's, #190's and #1 reviewed. Employee	n, Cirrhosis of the Liver, ro-esophageal Reflux patitis, Cerebral Infarction entia with behavioral. #238's medical record tober 2021 to March 2022, acked documented evidence visician or designee reviewed on regimen review and acted ons. The response box of all of the physician's are and response area, were towas not reviewed. Interview conducted on the MRRs for each documented to which she coort forms are submitted to the nor Nurse Practitioner (NP). In or Nu	L 128			8/24/22
	the MD (medical doc Practitioner). Sometin don't require any acti review and sign the M	I Unit Manager who notify tor) or NP (Nurse mes the recommendations on. Once they (MD/NP) MRR form, it is filed." When ff failed to document agree,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		, , ,	E SURVEY PLETED	
		HFD02-0017	B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER	ID WELLNESS CEN 5000 NAM	DORESS, CITY, STATI INIE HELEN BUR BTON, DC 20019	ROUGHS AVE. NE	•	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 128	disagree, or other and physician or designed medication review for reviewed, Employee specific time frame for but we try to get them 3. Facility staff failed medication records the reconciliation and accommedications. During an observation Medication Cart 2 on (2) residents (Reside ordered "Diazepam (a (milligram) rectal gel" observed with two (2) however, the narcotic received 1". On 03/31/22, starting medication cart #1 (not residents with Diazepant contained two (2) gel milligrams each. How the two syringes as on Drug Administration For During a face-to-face 11:44 AM, Employee stated that the syring and the 2nd syringes. Further review of the Administration Recontained for seizure as needed for seizure as needed for seizure as needed for seizure and the syring and the seizure as needed for seizur	d why there was no e signature on the m to indicated that it was #2 stated, "There is no or the reviews to be done, in done as soon as possible." It to have a system of nat enables accurate counting for all controlled on on 03/31/22 at 11:02 AM of unit 4 South, there was two ints' #151 and #188) with antianxiety) 10 MG. The package was indoses (20 MG in total) is book showed, "amount is book showed, "amount is syringes of Diazepam 10 prever, the staff reconciled ine (1) kit on the Controlled Record. Interview on 03/31/22 at #61 (Registerd Nurse) is are counted as one (1) is destroyed if not used. Controlled Drug direvealed a physician order 10 mg (milligrams) rectally in 4 hrs. (hours) once call	L 128			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			/		,	С
		HFD02-0017	B. WING		l l	20/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 128	Continued From page 104		L 128			8/24/22
	During a face-to-face 03/31/22 at 12:02 PM she stated, "I spoke t about the Diazepam, just the kit as 1 not th asked how the facility once one dose is adristated that she wasn' During a telephone in contracted pharmacis stated that the two sy are counted as one b "denotes the kit as or 4. The facility staff fai system used for the medications was follo occurences. 4A. During a tour on on 03/29/22 at approof the narcotic card c Cart #1 revealed the On 02/26/22, 03/05/2 03/17/22, and 03/19/2 licensed nurse signed #2, instead of two diff the narcotic card course to sign (Nurse On 03/07/22, only on signed off. The space nurse to sign (Nurse On 03/07/22, only on	interview conducted on M with Employee #2 (DON), to the pharmacist and asked she stated they are counting the number of doses." When we accounts for the other dose ministered, Employee #2 to sure. Interview, the facility's set on 03/31/22 at 3:18 PM wringes in the Diazepam kit recause the manufacturer the (1)." Iled to ensure that the econciliation of controlled to wed on three (3) Ithe 2 South unit of the facility eximately 12:00 PM, a review ount sheets for Medication				

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CEN	5000 NANN	RESS, CITY, STA	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	JLL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 128	(DON) on 03/29/22 a when the nurses worn nurse signed as Nurs narcotic card count si form (narcotic card si following: Medication Cart #1: 0 03/18/22, and 03/19/2 signed the controlled record for two shifts 7 PM-11:30 PM. Medication Cart #2: 0 03/12/22,03/19/22, 03/12/22,	interview with Employed 12:30 AM, she stated ked a double shift, the stee #1 and Nurse #2 on the heets. "I can see how thount document) is confount document) is confount document) is confount document) is confount changes to that." the 5 North unit on 03/3/20 AM, a review of the to-shift count record found #2 revealed the 20 03/05/22, 03/06/22, 22, one licensed nurse drugs shift-to-shift count record for 3/20 AM-3:30 PM and 3/20 On 03/06/22, and 03/27/22, do the controlled drugs cord for two shifts 7:00	that same the he using. 31/22 or at the he using. 31/22 or at the he using. at the he using.	L 128			8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0017	B. WING		04	C I/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CEN 5000 NA	ADDRESS, CITY, STATE ANNIE HELEN BUR IGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 128	Unit 2 North was comapproximately 10:00 that on April 1 - 12, 20 sheet had one nurse's the spaces allotted for and one nurse comin. Narcotics together for shift, and 3 PM - 11:3 *A review of the Shift Unit 2 South was comapproximately 10:10 on April 1, 2022, 3p-1 and on April 4, 2022, Narcotic sheet had or spaces allotted to the coming on duty to rectogether. A review of the Shift Controlled Drug Reconciliation Verification Form] directogether. A review of the Shift Controlled Drug Reconciliation Verification Form] directogether. The evidence showed was found signing off north on April 1 -12, 200 April 1, 2022, and April 1, 2022	count Narcotic records on upleted on 04/12/22, at AM. The review showed 022, the Shift count Narcotic is signature was placed in in one nurse going off duty in one of the other of the oth	L 128			8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD02-0017	B. WING		C 04/20/2022
DEANWO	(EACH DEFICIENC	STREET AD ND WELLNESS CEN TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) E COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
L 128	Employee #8 on 04/1 AM. After a review of acknowledged the fin 3227.12 Nursing Fac	2/22, at approximately 11:10 the documentation, he adings.	L 128	L 161 starts here: CORRECTIVE ACTION FOR THAFFECTED RESIDENTS: No Resident was affected by this practice.	
	usage. This Statute is not m Based on observation facility staff failed to e biologicals were prop medication carts. The findings include: The facility's policy an medications revised o "Medications and b securely, and properl recommendations or expired medications or expired medications or active supply and des facility policy, regardl" 1. Facility staff failed medications. 1A. During an observ AM on Unit 4 South, following was noted: stored for use that ha "2/22/22, 2/27/2022 a During a face-to-face time of the observation	and staff interviews, ensure that medications and perly stored for two (2) of 16 and procedures for storage of on 08/2020 stated, iologicals are stored safely, by following manufacturer's those of the supplierAll will be removed from the stroyed in accordance with ess of the amount remaining to properly store ation on 03/30/22 at 11:11 Medication Cart #1, the three (3) vials of Insulined expiration dates of and 3/25/22". Interview conducted at the on, Employee #47 (LPN) adings and stated, "This isn't		IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFECT All residents residing in the facility potential to be affected. DON/ Designee will conduct audicates to ensure that all medication correctly labeled an stored properissues found will be corrected by 8/21/22. MEASURES TO PREVENT RECURRENCE: In service will be provided by Stan Development team/ Designee to licensed nursing staff to always ethat medications are labeled and correctly completed by 8/24/22. MDS team has been assigned to that medications are labeled and correctly for safety purposes. This exercise will be done during grounds daily. Any issues found we corrected by 8/24/22.	cted: ity have dit on all ons are erly. Any ff all ensure stored ensure stored s und

Health Regulation & Licensing Administration

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE	/2022
5000 NANNIE HELEN BURROUGHS AVE. NE	
5000 NANNIE HELEN BURROUGHS AVE. NE	
DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161 Continued From page 108 18. During an observation on 03/31/22 at 10:18 AM on Unit 4 North, Medication Cart 1, the following was noted: three (3) vials of Insulin stored for use that had expiration dates of "2/210/22, 2/10/2022 and 2/22/22". During a face-to-face interview at the time of the observation. Employee #48 (LPN) acknowledged the findings and stated that licensed staff are provided education on putting dates when they open a new Insulin vial or pen. L 162 3227.13 Nursing Facilities Each medication that is no longer in use shall be destroyed or returned to the in-house pharmacy. This Statute is not met as evidenced by: Based on observations and staff interviews, facility staff failed to ensure that medications are stored correctly on a weekly basis. Any issues found will be corrected by 8/24/22. Licensed Nurses who are found to be non-compliant will be provided coaching and counseling and will be sent to staff developers for re in-service completed by 8/24/22. MONITORING CORRECTIVE ACTIONS: During a face-to-face interview conducted at the time of the observation, Employee #47 (LPN) acknowledged the findings and stated, "This isn't my usual floor. I work upstairs." During a face-to-face interview conducted on 04/19/22 at 10:55 AM, Employee #23 (Consultant)	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING		C 04/20	0/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	D WELLNESS CEN	5000 NANN	RESS, CITY, STA	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 168	have been discontinu discharged, have to b or be destroyed by 2 to be stored in the me storage room."	Narcotic medications the dor if the patient is e returned to the pharm licensed staff. They are edication cart or medical	nacy e not ation	L 168	L162 CORRECTIVE ACTION FOR T AFFECTED RESIDENT: No resident was affected by this practice. IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE All residents residing in the facil the potential to be affected.	s deficient S WITH CTED	8/24/22 t
	accordance with curre principles, and include and cautionary instruct date. This Statute is not me Based on observation facility staff failed to e biologicals were proper 16 medication carts. The findings include: The facility's policy are medications revised or "Medications and bis securely, and properly recommendations or Procedures: III. Expired Dating) When the communification and recommendation	as and staff interviews, insure that medications erly labeled for three (3 and procedures for storage on 08/2020 stated, ologicals are stored say following manufactur those of the supplier ation Dating (Beyond-Uoriginal seal of a ner or vial is initially brovill be dated The nurse ened" sticker on the did the date opened, and in. The expiration date of e 30 days from opening rer recommends anoth tainer is found without	onal ssory cion and c) of ge of fely, er's Jse oken, e the of the g er a		House wide audit will be conduct Unit managers on all carts to en medications that are not in use off the cart. Any issues found w corrected by 8/24/22. MEASURES TO PREVENT RECURRENCE In service will be provided to all nursing staff on the importance destroying narcotics and send be medication when the resident is longer in the facility completed 8/24/22. Unit managers will ensure that resident is discharged, his/her medication will be reconciled and back to the pharmacy. Any issue will be corrected by 8/24/22. Charge nurses will ensure that medications are taken off the caresident is no longer in the facilities uses found will be corrected by ADON/Designee will conduct rochecking all carts to ensure that medications that are no longer in taken off the cart. Any issues for be corrected by 8/24/22.	licensed of back and sent es found art once a ty Any y 8/24/22 bunds, t all n use are	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY ETED		
		HED02 0047		B. WING		04/2	
		HFD02-0017				04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		ON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
L 168	Continued From page	e 110		L 168	L 162		8/24/22
	the expiration date will be calculated accordingly" 1. Facility staff failed to accurately label medications.				MONITORING CORRECTIVE ACTION DON/Designee will conduct h wide audit to ensure that all medications that are not in us	ouse	0/2-1/22
				taken off the cart and are eith back to the pharmacy or dest two RN's if its narcotics. This will be conducted weekly x4, monthly x3. Findings will be cand reported to QAPI Commi	er sent royed by audit then orrected		
			:hat				
	B. During an observation on 03/30/22 at 11:11 AM on Unit 4 South, Medication Cart #1, the following was noted three (3) open vials of Insulin with no date opened or expiration date.						
	During a face-to-face interview conducted at the time of the observation, Employee #47 (LPN) acknowledged the findings and stated, "This isn't my usual floor. I work upstairs."						
	AM on Unit 4 North, following was noted:	ntion on 03/31/22 at 10:18 Medication Cart 1, the three (3) Insulin pens and ate opened or expiration	d				
		interview at the time of t ee #48 (LPN) acknowled					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1		(X3) DATE S COMPLI	TE SURVEY MPLETED	
				A. BUILDING:			
		HFD02-0017		B. WING) 20/2022
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 168	Continued From page 111 the findings and stated that licensed staff are provided education on putting dates when they			L 168	L168 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:)	8/24/22
					No Resident was affected by this practice.		
	open a new Insulin vial or pen.				IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.:		
L 191	L 191 3231.2 Nursing Facilities A designated employee of the facility shall be assigned the responsibility for implementing and maintaining the medical records service. This Statute is not met as evidenced by:			L 191	All residents residing in the facility have potent be affected. DON/ Designee will conduct audit on all carts ensure that all medications are correctly labele	to ed and	
					stored properly. Any issues found will be corre 8/2122. MEASURES TO PREVENT RECURF	,	
	Based on record review and staff interview, for 2 (two) of 105 sampled residents, the facility's staff failed to ensure that Resident #181's and #188's Quarterly Minimum Data Sets (MDS) were completed 14 days after the assessment		staff		In service will be provided by Staff Development team/ Designee to all lic nursing staff to always ensure that	censed	
			88'S		medications are labeled and stored of to be completed by 8/24/22	orrectly	
	reference date. The findings include:				MDS team has been assigned to ens medications are labeled and stored or for safety purposes. This exercise wil	orrectly	
	_	s admitted to the facility	on		during ground rounds daily. Any issue will be corrected by 8/24/22.	s found	
	Chronic Obstructive F	Pulmonary Disease, Asi d Stage Renal Disease			Charge nurses will ensure that they a carts on a weekly basis to ensure tha medications are labeled and stored appropriately. Any issues found will b	t	
	Review of the resident's Quarterly MDS dated 03/01/22 showed Resident #181 had an assessment reference date of 03/01/22, which made the MDS required completion date 03/15/22. Sections G (Functional Status), GG (Functional Abilities and Goals) and Z (Assessment Administration) showed that Employee #19 (Regional MDS Coordinator)			corrected by 8/21/22. ADON/Designee will conduct random on a weekly basis to ensure that med are labeled and stored correctly. Any found will be corrected by 8/24/22. Supervisors will ensure that medications are clean and that the medications are correctly on a weekly basis. Any issue will be corrected by 8/24/22.	lications issues on carts e stored		
	Coordinator's Signatu completion" was left b	Z0500, "RN Assessmer ire and Date to verify olank.			Licensed Nurses who are found to be compliant will be provided coaching a counseling and will be sent to staff de for re in-service.	and	
		s admitted to the facility owing diagnoses: Diabe					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
	HFD02-0017		B. WING		04/20/2022	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'		RROUGHS AVE. NE		
		WASHING	TON, DC 2001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE		i) LETE E
L 191	Status, Visual Halluci Agitation, Syncope a	cular Accident (CVA), nentia, Altered Mental inations, Restlessness and	L 191	MONITORING CORRECTIVE ACTION DON / designee will ensure that medic are labeled and stored correctly in all the carts. on a weekly basis. This audit will done weekly x4 then monthly x 3. Find be corrected and reorted to QAPI com	ation ne be ings will	24/22
L 200	Data Set (MDS) date assessment reference on the MDS assessment required completion of 03/17/22. Section ZO: Coordinator's Signatus completion" was left to the evidence showed complete the MDS with (03/17/22). During a face-to-face 12:49 PM, Employee Coordinator) acknow stated that she did not dates for Residents # 3231.11 Nursing Facility and discipling This Statute is not measurement, in black ink, asignature and discipling This Statute is not measurement, in 100 of 105 samplifailed to ensure that the records included current Residents' #3, #50, # #183, #404, #408 and measurement in the status i	d 03/03/22 revealed an e date of 03/05/22. Based hent reference date, the date for the MDS was 500, "RN Assessment ure and Date to verify blank. d that facility staff failed to ithin the required 14 days interview on 04/11/22 at #19 (Regional MDS ledged the findings and bt sign the MDS completion #181 and #188 dical record shall be legible, dated and signed with full ne identification. let as evidenced by: ew and staff interview, for led residents, facility staff the resident's medical ent assessment information. 126, #155, #160, #164,	L 200	L191 STARTS HERE: CORRECTIVE ACTION FOR AFFE RESIDENTS: Resident #181 was assessed from h toe by Unit Manager on 4/26/2022, suffered no negative outcome. MD/n notified on 4/26/22. This deficiency of be retroactively corrected Resident #188 was assessed from h toe by Unit Manager on 4/26/2022, suffered no negative outcome. MD/n notified on 4/26/22 This deficiency of be retroactively corrected. IDENTIFICATION OF OTHERS WIT POTENTIAL TO BE AFFECTED: All residents residing in the facility h potential to be affected by this pract MDS Coordinators will conduct hous audit to ensure that quarterly assess are completed within the required 14 the assessment reference date and RN has signed to verify completion of assessment. Any issues found will b corrected by 8/24/22.	nead to resident RP cannot nead to resident RP annot TH THE ave the rice. See wide sments I days of that an of	
	The findings include:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		JRVEY ETED	
			B. WING		С	
		HFD02-0017	B. WING		04/2	0/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	5000 NAN	DRESS, CITY, STA	NTE, ZIP CODE RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	WASHING	STON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 200	1. The facility staff fai Treatment Administra 02/07/22 contained a Resident #3 was adm 12/01/21 with multiple Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status Review of a physiciar [physician order] instraction "Change HME (Heat Day shift." Review of Treatment from 01/08/22 to 02/0 facility's nurses initial Resident #3's HME during a telephone in PM, Employee #31 (Fithat Resident #3 did in his lary-tube from 01/asked why it took so HMEs, Employee #3' size of the resident's had in house was not lary-tube his family proceed to reflect the need of assist. Resident #50 was ad 06/26/14 with multiple in the sident #50 was ad 06/26/14 with	led to ensure Resident #3's tion Record for 01/08/22 to occurate information. Initted to the facility on a diagnoses including of Larynx, Carcinoma of ence of Larynx, and It's order dated 12/02/21 mucted stated staff to, Moisture Exchanger) daily Administration Records 7/22 showed that the ed that they changed aily on dayshift. However, terview on 04/14/22 at 2:35 Respiratory Therapist) stated not have HMEs to connect to 08/22 to 02/07/22. When long for Resident #3 to get a said, "I did not know the lary-tube. And the HMEs we compatible with the ovided on 01/08/22." It to code Resident #50's MDS having 2 person's physical mitted to the facility on a diagnoses that included: ety Disorder, Mood Affective epressive Disorder. 50's medical record	L 200	L191 MEASURES TO PREVENT RECURRENCE: Training will be provided by Regional MDS coordinator to MDS team members to always ensure that the quarterly assessments are completed the required 14 days after the Any issues found will be corby 8/24/22. The Director of Quality Assumill validate that all quarterly assessments are completed timely manner and that an Find signed to verify completion. issues found will be corrected 8/24/22. MONITORING CORRECTIVACTION: The MDS Lead staff members are completed by the MDS correctly and that an RN signed to the assessment to verify completion. This audit will be weekly x4, then monthly x4. Findings will be corrected immediately and reported to committee.	o the ays I within he ARD. Trected I in a RN has Any hed by I will sments team and fy he done	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
HFD02-0017			B. WING		04/20	0/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CEN	5000 NANN	RESS, CITY, STA IIE HELEN BU TON, DC 2001	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
L 200	Continued From page 01/30/20 (Revision da #50] has an ADL (act self-care performance limited ROM (range of morbid obesity the participation to repos resident requires total hygiene care" 11/16/20 (Creation Da abuse 2 CNAs (Ceprovide ADL care all shift" Review of Resident #09/24/21 showed that person physical assist personal hygiene. During a face-to-face 04/19/22 at 12:26 PM (Regional MDS Coorthe finding and made 3. Facility staff failed	e 114 ate) [Care Plan] "[Residitivities of daily living) e deficit r/t (related to) of motion), limited mobile resident requires 2 statition and turn in bed, that assistance with personate) [Care Plan] "Allege ertified Nurse Aides) to shift" s Order] "2 CNAs to prosent the content of	dent lity, iff e nal vide vide ted ne vith dged	L 200		FOR ENT: the not return ssed on parent now where Right arm	8/24/22
	dated 12/27/21 docur from wheelchair to be suddenly sway her rig against the 1/4 side r laceration on the upp scratched her right le	acility Reported Incident mented "During a tranged by two staff, resident ght leg and the leg scrawall; resident sustained aper lateral right leg; resident at the edge of the 1/4 aware of the incident; "	nsfer t tched a dent I side				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			.
		HFD02-0017	B. WING		04/2	, 0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	INIE HELEN BU STON, DC 2001	JRROUGHS AVE. NE 19		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
L 200	Resident #126 was a 11/16/21 with multiple Failure Unspecified, I Knee Joint, Chronic March (Severe), and Other I Review of the Admiss (MDS) dated 11/17/2 staff coded the follow In section C (Cognitive for Mental Status (BII indicating moderately In section G (Function "Extensive assistance physical assist" Review of the Facility submitted to the Deput 12/23/21 at 6:47 PM transfer from wheelch residents suddenly swagainst the 1/4 side rate of incident; writer assisted incident; writer assisted and the suddenly swagainst the suddenly swagainst the suddenly swagainst the suddenly swagainst sudden	dmitted to the facility on e diagnoses including Heart Presence of Right Artificial Kidney Disease, Stage 4 Lack of Coordination. Sion Minimum Data Set 1, revealed that the facility ring: We Patterns): Brief Interview MS) Summary Score "11", impaired cognition. Inal Status): Transfer e" requiring "Two-person We Reported Incident that was artment of Health on showed, " During a nair to bed by two staff way her leg scratched il writer was made aware sessed the wound" In progress note dated AM documented, " During a nair to bed by two staff, ay her right leg and the leg	L 200	Resident # 50 was assessed by Managers on 4/26/2022, resides suffered no negative outcome. Updated. Coding for MDS is two persons assist for ADL. Resident # 155 was assessed Manager on 4/26/22, resident in no negative outcome. MD/RP updated. MDS coding his desire to go home. Resident # 183 was assessed 4/26/22 by Unit Manager, reside suffered no negative outcome. Updated MDS coding reflects in falls. Resident #502 discharge home. Resident #502 discharge home. Resident #502 discharge home. Resident #502 discharge home. All residents residing in the facility potential to be affected by this prace. MDS coordinators will conduct how audit to ensure that MDS staff are correctly for residents with two persphysical assist with ADL resident with the desire to return to community, residents rejecting care residents with history of fall and reswith diagnosis of dialysis are accur coded. Any issues found will be conby 8/24/22.	by Unit suffered reflects on lent MD/RP nultiple e 6/2/22 226/22, ome. ejection ITH THE have the stice. se wide coding sons the es, sidents ately	8/24/22

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SI	
74101 2741	or contraction	IDEITH IOMINET NOMBER	A. BUILDING:		33 22.23	
		HFD02-0017	B. WING	B. WING		0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		5000 NA	NNIE HELEN BU	JRROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN WASHIN	GTON, DC 2001	9		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	COMPLETE DATE
L 200	Continued From page	e 116	L 200	MEASURES TO PREVENT RECURR	ENCE:	
	the leg was bleeding. When I got her on the bed, I called the nurse to come and have a look at it." The handwritten nurse's statement which was signed and dated 12/22/21 was reviewed and it lacked any mention of any additional staff being interviewed regarding the incident. During a face-to-face interview conducted on 04/20/2022 at 10:45 AM with Employee #58 (Certified Nurse Aide) stated "It was just me who transferred her [Resident #126] to the bed. Nobody was there only me." Employee # 58 was responding to questions about the incident with Resident #126 that documented on 12/23/2021 in which staff was transferring resident from the wheelchair to the bed. During a face-to-face interview conducted on 04/20/2022 at 1:38 PM with Employee #7 (Clinical Coordinator) Employee #7 acknowledged the findings.			Training will be provided by Staff Educ Regional MDS coordinator to the MDS on the importance of proper coding.		8/24/22
				MDS coordinators will conduct a chec coding to ensure that they are coding correctly for residents who are two pe assist, those on dialysis and those wis return to the community. Any issues for be corrected by 8/24/22.	rsons shing to	
				Unit Manager and Supervisors will enter that C N A 's are documenting accurat a resident is two persons assist so that can be on the same page with MDS documentation and coding. Any issue will be corrected by 8/25/22. ADON/Designee will conduct audits to that the residents who are non-compli	tely that at they s found o ensure ant with	
				care are documented and that MDS is capturing and coding this aspect corre Any issues found will be corrected by Training will be provided by Staff Educ Regional MDS coordinator to the MDS on the importance of proper coding co	ectly. 8/24/22. cator/ S staff	
	#155's MDS to reflec community. Resident #155 was a 11/18/19, with multipl	to accurately code Resident of this desire to return to the admitted to the facility on le diagnoses that included:		by 8/24/22. MDS coordinators will conduct a chec coding to ensure that they are coding correctly for residents who are two pe assist, those on dialysis and those wis return to the community. Any issues for be corrected by 8/24/22.	rsons shing to	
	Lack of Coordination Hemiparesis Followir Cerebrovascular Dise Side.	, Hemiplegia and ng Unspecified ease Affecting Left Dominant		Unit Manager and Supervisors will entithat C N A 's are documenting accurate a resident is two persons assist so the can be on the same page with MDS documentation and coding. Any issue will be corrected by 8/24/22.	tely that at they	
	(MDS) dated 02/18/2 coded a (Brief Intervi	erly Minimum Data Set 22, showed that facility staff ew for Mental Status (BIMS) 4, indicating severe cognitive		ADON/Designee will conduct audits to that the residents who are non-complicare are documented and that MDS is capturing and coding this aspect corrected by issues found will be corrected by	ant with ectly.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY ETED	
				A. BUILDING: _			
		HFD02-0017		B. WING		04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELL NESS CEN.	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
L 200	In Section Q (Particip Goal Setting), "Reside assessment "1" mean Q0400 (Discharge Plaplanning already occureturn to the community of this question be asked assessments? "No" Q0500 (Return to Coal talk to someone about this facility and return services in the community of the community of the community on all assessments? "No" Q0500 (Resident's prasked question Q0500 (Resident's prasked question Q0500 (Referral), Hasten In the local contact agerous of Care Plan 12:13 PM showed, "Lead today 3/4/2020 (representative) was [social worker] reported tong-term care status [Name] to locate apprountil that time he will review of the Social Review of the Socia	e 117 ation in Assessment and ent participated in hing yes an): Is active discharge arring for the resident to lity? "No". Does the lord document a request of donly on comprehensive mmunity), Do you want to the possibility of leaving to live and receive unity? "No" reference to Avoid being OB again) Does the residual returning to the leasements? "Yes" as a referral been made to heavy? "No" meeting note on 03/04/2care plan meeting was [Resident #155] and his present at the meeting. Seed that he is a full code at the SW is working with the remain in long term care. Work Progress Notes	that re to ag dent coRP SW and th but	L 200		ON uct audit done reekly x4	8/24/22
	revealed the following: 06/16/21 at 7:18 AM, "Information sent to the Office on aging for [Resident #155] to be considered for transition back to the community.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING		04	C // 20/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 07	HEGI EGEE
DEANWO	OD REHABILITATION AN	5000 NAN		RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	WASHING	TON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	e 118	L 200			8/24/22
	The social worker will	follow up with the family"				
	for [Resident #155]. I soon to be Power of A child was present a 07/23/21 at 2:50 PM, Representative] call of She stated that he calleave here because here because here because here SW and the Supe [Resident's sister] felt transition worker were	n) meeting was held today His new RP [Representative] Attorney and mother of his at meeting" "The SW return [Resident concerning [Resident #155] Illed her and was asking to be was tired of being here" " the Ombudsman called rvisory SW stated that as if the SW and the be holding up the process 55] going into [Name of				
	The evidence showed expressed a wish to be community, however, accurately code the M	pe discharged to the				
	04/18/22 at 1:30 PM,	interview conducted on with Employee #18 (MDS ed, "The social services fills ion Q)."				
	04/18/22 at 3:00 PM v Floor Social Worker), MDS for Resident #19 coded and stated, "I f what the team has ag issue."	ill out the section based on reed. This is a systemic				
	to reflect Resident #1	to accurately code the MDS 60's rejection of care				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			TE SURVEY MPLETED		
		HFD02-0017		B. WING			C 4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		REET ADDI	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		IE HELEN BUI ON, DC 20019	RROUGHS AVE. NE 9		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	e 119		L 200			0/24/22
	Resident #160 was at 02/20/12, with multipl Morbid Obesity, Diabone Depressive Disorder	e diagnoses that included: etes Mellitus, Major					8/24/22
	Review of Resident #160's medical record revealed the following: 02/25/22 at 12:08 PM [Daily Behavior Documentation] "Resident exhibits the following Refuses Medications. Refuses ADL Care. Refuses Treatment. Refuses Therapeutic Activities. Behaviors are constant. Behavior problems leads to issues with care."						
	Note] "Care conferen	PM [Care Plan Meeting ce with resident's daughter she is noncompliant with					
	02/26/22 at 2:44 PM [Daily Behavior Documentation] "Resident exhibits the following Refuses Treatment. Refuses Therapeutic Activities. Behaviors are constant. Behavior problems leads to issues with care."						
	coded a BIMS summa severe cognitive impa	12/26/22 showed facility staf ary score "06", indicating airment and in Section E ection of care behaviors	ff				
	04/11/22 at 10:03 AM Coordinator) acknowl	interview conducted on I, Employee #18 (MDS edged the finding and ehavior) is completed by					
	6. Facility staff failed	to accurately document the					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						С
		HFD02-0017	B. WING		04/	/20/2022
NAME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
DEANWOO	D REHABILITATION A	ND WELLNESS CEN'	NNIE HELEN BUF NGTON, DC 20019	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	pressure. Resident #164 was a 07/26/2016 with multical Stage Renal Dis Mellitus, and Hyperlij Review of Resident # revealed the followin 03/04/2022 [Quarterl BIMS summary scorcognitive response a O (Special Treatmen Programs). 04/07/2022 [Physicia AV (arteriovenous) g bleeding, redness, te every shift, (No B/P (blood draws on this a 03/18/2022 (Revision "[Resident #164] has dialysisDo not take specimens from left a Review of the vital si 03/18/22 to 04/10/22 documented: 03/18/22 at 8:05 PM of mercury) Lying I/a 03/22/22 at 9:39 PM 03/25/22 at 11:11 PM 03/26/22 at 8:40 PM 03/27/22 at 11:29 AM 03/27/22 at 10:41 PM 03/27/22 at 10:41 PM	admitted to the facility on tiple diagnoses that included: sease, Type 2 Diabetes pidemia. #164's medical record g: If MDS], facility staff coded a e of "15", indicating intact and "yes" to dialysis in Section ats, Procedures, and An's Order] "Assess dialysis araft site on left upper arm for enderness, and swelling (blood pressure) and no arm) every shift" In date) [Care Plan] as Left arm site used for the blood pressure or blood arm" Igns documentation from the showed that facility 136/87 mmHg (millimeters)	L 200	DEFICIEN	CY)	8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BUILDING:	
HFD02-0017	B. WING	C 04/20/2022
NAME OF PROVIDER OR SUPPLIER STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
DEANWOOD REHABILITATION AND WELLNESS CEN	NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT TAG CROSS-REFERENC	PLAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLETE EED TO THE APPROPRIATE DATE FICIENCY)
Continued From page 121 03/31/22 at 6:41 PM 128/74 mmHg Lying I/arm 04/09/22 at 1:51 PM 138/76 mmHg Lying I/arm 04/09/22 at 7:35 PM 128/72 mmHg Lying I/arm 04/10/22 at 11:50 AM 120/71 mmHg Lying I/arm 04/10/22 at 11:50 AM 120/71 mmHg Lying I/arm The evidence showed that facility staff failed to accurately document the site where they were obtaining Resident #164's blood pressure. During a face-to-face interview conducted on 04/20/22 at 10:36 AM, Employee #2 (Director of Nursing) acknowledged the finding ad stated, "This is an identified issue and a PIP (performance improvement plan) is in place to address the issues of documentation." 7. Facility staff failed to ensure Resident #183's MDS was accurately coded to reflect the resident's history of falls. Review of a Facility Reported Incident dated 10/14/21 documented, " fall was in the facility van" Resident 183 was admitted to the facility on 03/20/14 with diagnoses that included Diabetes Mellitus Type 2, End Stage Renal Disease, and Acquired Absence of Left Leg Below Knee. Review of the physician's orders showed the following: 10/21/21 "Yellow star fall program (yellow star indicates resident is a high risk for falls)" Review of the care plan revised on 10/19/2021 with a focus area of, "[Resident #183] had an actual fall with no injury unsteady gait on 4/1/2019, 6/4/2019 had a fall without injury, fel	L 200	8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С
		HFD02-0017	B. WING		04/	20/2022
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	TATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	NANNIE HELEN B SHINGTON, DC 200	URROUGHS AVE. NE 119		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	÷ 122	L 200			8/24/22
		rly MDS dated 11/22/21, (Health Conditions) facility ing:				
	J1700 - "Fall History of Reentry" was left blar	on Admission/Entry or nk				
		rly MDS) dated 02/22/22, (Health Conditions), facility				
	last month prior to ad facility staff coded "0" resident have a fall ar	sion/entry or reentry?,				
	admission/entry or re-	ver is most recent?, facility				
	The evidence showed accurately code Residual 11/22/21 and on 02/2					
	04/08/22 at 12:35 PM Coordinator) acknowl	interview conducted on , Employee #18 (MDS edged the finding and erstand the questions being				
	Resident #404 while I					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CEN 5000 NAI	ODRESS, CITY, STAT NNIE HELEN BUI GTON, DC 20019	RROUGHS AVE. NE	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETE
L 200	dated 02/23/22, docunurse observed [Resibesides his roommate nurse noticed blood of and mouth. The nurse #404's] left ear and mear or abrasion inclu #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he fe Resident #404 was a 12/06/16 with diagnost Unspecified Dementia Disturbances, Vascul Behavioral Disturbances and Ischemic Attack. Review of Resident #showed the following 09/29/21 [Physician's elopement/wandering every hour" 02/21/22 [Treatment revealed a check man for the evening shift (sections, "Nurse to conceive and behind ear and ea	y Reported Incident (FRI) mented, "The charge ident 404] sitting on the floor le's bed #420A; the charge on [Resident #404's] left ear le assessed [Resident louth and there was no skin ding his face [Resident lhe said, "that man keeps led side and when I asked side of the bed, he punched lind chest and I punched him li" dmitted to the facility on lises that included: la without Behavioral lar Dementia without ces and Transient Cerebral 404's medical record lind monitoring and location. Administration Record link and licensed staff initials licensed staff init	L 200		8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY MPLETED		
							С
		HFD02-0017		B. WING		0	4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN			RROUGHS AVE. NE		
	T		WASHINGT	ON, DC 2001	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	e 124		L 200			8/24/22
		aled that facility staff rature of "97.7" (degree /22 for the evening shift					
	4:00 PM to 02/26/22 documented 14 times room (IRM)" in the se	owed that from 02/21/22 at 3:00 AM, facility staff s that Resident #404 wa ection, "Hourly g monitoring and location	s "In				
	02/21/22 at 4:57 AM [Nursing Supervisor Progress Note] " The Ambulance left with the Resident at 3:15 AM to [Hospital Name]. They were handed over the Resident's face sheet, order summary, Code status, Recent Physical, labs, and order to transfer."		ey '				
	call was paced to [Ho the status of the resident nurse [Registered Nu resident is critically ill	[Nurse's Progress Note] ospital Name] to know aldent in the ER, spoke will urse's Name] who stated , he has been intubated ed to ICU (intensive care tive) made aware"	bout ith I I and				
	04/18/22 at approxim	interview conducted on ately 1:00 PM, Employe acknowledged the findi comments.	ee #7				
	an "Incident/Accident	ltercation resulting in	y of				
	03/30/22 at 12:15 PM	interview conducted on I, Employee #1 ded the survey team with					

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PRINTED: 07/27/2022 FORM APPROVED

Health Regulation & Licensing Administration

B. WING	
HFD02-0017 B. WING 04/20/	/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
5000 NANNIE HELEN BURROUGHS AVE. NE	
DEANWOOD REHABILITATION AND WELLNESS CEN WASHINGTON, DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
L 200 Continued From page 125 L 200	8/24/22
copy of the facility's investigation documents of	
the resident-to-resident altercation. The	
documents revealed an "Incident/Accident	
Report" with Resident #404's name dated	
"2/22/22" that showed the following: An	
anatomical depiction with no markings to reflect	
that Resident #404 had no injuries, for "type of	
injury", "swelling" was checked and the words "left face" written next to it, "no" in the section	
asking if person taken to the hospital, name and	
signature of Employee #7 (Clinical Coordinator)	
as the "person preparing report", name and	
signature of Employee #6 (Administrator in	
Training) in the section, "Director of Nursing", the	
name and signature of Employee #1 in the	
section "Administrator". The documents also	
revealed written statements from Employee's #25	
(Registered Nurse), #26 (CNA), #27 (CNA), #28	
(Nursing Supervisor) and #29 (CNA).	
An email correspondence was received by the	
survey team from Employee #1 on 03/30/22 at	
8:53 PM. This correspondence revealed a	
second copy of the facility's investigation	
documents of the resident-to-resident altercation.	
This document was an "Incident/Accident Report"	
with Resident #404's name on it dated "2/21/22"	
that revealed the following: An anatomical	
depiction with markings to showed areas of injury	
on the right side of the face, for "type of injury",	
"Other (specify)" had "bleeding from the mouth	
and left ear" written next to it, "yes" in the section	
asking if person taken to the hospital and	
[Hospital's Name] next to it, the name and	
signature of Employee #7 (Clinical Coordinator)	
as the "person preparing report", name and	
signature of "Director of Nursing" was blank, the	
name and signature of Employee #1 in the section "Administrator". The documents also	
revealed written statements from Employee's #25	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7. BOILBING. <u>-</u>			С
		HFD02-0017	B. WING		l l	20/2022
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN. 5000	NANNIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	WAS	SHINGTON, DC 2001	9		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	e 126	L 200			8/24/22
	(Registered Nurse), # #29 (CNA) and a type	#28 (Nursing Supervisor), ed statement with the name ident #82, absent of date				0/24/22
	03/31/22 at 3:30 PM, why there are two verinvestigation report. So (the original) on Satureport and had the erstatements." Employed completed the incider dated 02/22/22, wrote #7's name and signathe was out of the cour #1 continued to say, in Training) found the 2/21/22) in the shred documents that were During a face-to -face 04/04/22 at 12:48 PM	interview conducted on Employee #1, was asked rsions of the facility's She stated, "I couldn't find it rday (03/26/22). I redid the imployees rewrite their ee #1 also stated that she intraccident report form with e in and signed Employee ture on the report because antry at the time. Employee "Employee #6 (Administrator original documents (dated box and those were the emailed [on 03/30/22]." e interview conducted on I, Employee #7 (Clinical ee #7 was asked about the				
	survey team on 03/30 investigation docume he completed the incisubmitted it to Emplo 02/21/22. When show "Incident/Accident Re 02/22/22 with his nan #7 stated, "That is no incident report that I f Administrator." During a face-to-face 04/11/22 at 5:49 PM stated, "I was not par	ort that was provided to the 0/22 as part of the facility's ints. Employee #7 stated that ident/accident form and yee #1 (Administrator) on wed a copy of the eport" document dated ne and signature, Employee it my writing. This is not the filled out and provided to the interview conducted on with Employee #6, she t of the original incident in the part of the process at	t			

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		C	
		HFD02-0017	B. WING		1	0/2022
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWOO	D REHABILITATION AN	ID WELLNESS CEN	IIE HELEN BU	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
	report was done by [E couldn't find it, I filled report forms [to include name on the signature handwriting. She [Em form on the administration of the adm	uldn't find it (original nts). The original incident Employee #7]. When we out the incident/accident de writing in Employee #7's e line]. That's my ployee #1] just signed it [the ator signature line]." interview conducted on Employee #6 (Administrator dged and admitted to nt/Accident Report" related to altercation resulting in dent #404. Irrately documented to doing dent #408 who has ted 02/22/22 documented, ed of right knee pain d she was assessed by NP. X-ray report received this ion of Acute fracture of the en hairline fracture of the en hairline fracture of the ondyle All staff who from 2/9/22 to 2/16/22 all yed to determine if resident in anyone" dmitted to the facility on ediagnoses that included: iparesis, Hypocalcemia, d Lack of Coordination. 408's medical record	L 200	DEFICIENCY)		8/24/22

Health Regulation & Licensing Administration STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		TE SURVEY MPLETED		
							С
		HFD02-0017		B. WING			04/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEAMIO	OD REHABILITATION AF	TO WELLINEOU OLIV	WASHINGT	TON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SECTION TO THE SECTION OF TH		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 200	Continued From page	e 128		L 200			8/24/22
	01/04/22 [Quarterly Note that following: a BIMS sure severe cognitive imparts of the control of	MDS], facility staff coded mmary score "04", indica airment.	ating				
	02/17/22 at 11:29 AM [Social Work Progress Note] "[Resident #408] was transferred to [Hospital Name]"						
	complained of right k and she was assesse X-rays of bilateral kno this morning with imp the left distal femur, a right lateral femoral c Name] notified and sl	I [Nurses Note] " Res nee pain yesterday 2/16 ed by NP NP ordered ees. X-ray report receive pression of acute fracture acute hairline fracture of condyle [Physician's the gave order to send mergency room) for 2nd	6/22 ed e of the				
		M [Social Work Progres sent to the hospital. The d and forwarded to					
	Review of Resident #408's electronic medical record revealed that despite the resident being hospitalized, facility documented to completing the following resident assessments:		ng				
	02/27/2022 at 9:14 A 02/27/2022 at 10:20 / 02/28/2022 at 12:17 I 02/28/2022 at 12:18 I 02/28/2022 at 12:19 I	AM Dental/Oral PM Elopement Risk PM Use of Side Rail(s)					
	04/18/22 at approxim (Clinical Coordinator) and stated, "The asse	interview conducted on nately 1:00 PM, Employe acknowledged the findi essments automatically he system even though	ee #7 ings pop				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I `	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP		
				_			C
		HFD02-0017	E	B. WING			20/2022
NAME OF PI	ROVIDER OR SUPPLIER	STRE	EET ADDRE	ESS, CITY, STAT	ΓE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		HELEN BUI	RROUGHS AVE. NE		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	COMPLETE DATE
L 200	Continued From page	2 129		L 200			8/24/22
	resident maybe out of	f the facility."					
	10. Facility staff failed Resident #502's MDS						
	03/17/22 with multiple End-Stage Renal Disc Pancreatitis, Chronic	ease, Anemia, Chronic					
	Review of Resident # revealed the following						
	03/17/22 [Physician's Thursday, Saturday	Order] "Dialysis: Tuesday, "					
	03/17/22 [Quarterly M staff coded the following	IDS], showed that facilitying:					
	In Section C (Cognitive Interview for Mental Secore of "15", indicating	Status (BIMS) summary					
	and Programs), O010	, Treatments Procedures 10 under other Dialysis, indicating not on Dialysis	s.				
		I that facility staff failed to dent #502's MDS to reflect as on Dialysis.					
	04/19/22 at 1:40 PM, Coordinator) acknowled						

Health N	egulation & Licensing P	Aummistration				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		HFD02-0017	B. WING		1	0/2022
			1		1 0-1/2	0/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN 5000 NAN	NIE HELEN BU	IRROUGHS AVE. NE		
		WASHING	TON, DC 2001	9		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGOLATORI ORE	100 IDENTIFY THE INTONIATION)	TAG	DEFICIENCY)	WAIL	
				1.004		
L 201	Continued From page	e 130	L 201	L201		8/24/22
L 201	3231.12 Nursing Faci	ilities	L 201	CORRECTIVE ACTION FOR THE AFI	FECTED	0/24/22
	ozo i. iz italollig i dol			RESIDENTS:		
	Each medical record	shall include the following		Desident # 400	/00 ht	
	information:	Ç		Resident # 182 was assessed on 4/26/ manager, resident in no apparent distre		
				MD/RP updated. Resident refused to ta	ake the	
	(a)The resident's nam	ne,age, sex, date of birth,		pneumococcal vaccine. Risk versus be		
	race, martial status ho	ome address, telephone		explained.		
	number, and religion;			Resident #603 was assessed by unit m	nanger on	
				4/26/22, resident suffered no negative		
		ses and telephone numbers		Responsible party accepted that pneur	nococcal	
	of the personal physician, dentist and interested			vaccine should be administered to the	resident. It	
	family member or spo	onsor;		will be administered 6/15/22.		
	/ \\A P			House wide audit in progress for pneur	mococcal	
	• •	e and health insurance		vaccine administration. Any issues four		
	numbers;			corrected by 8/25/22.		
	(d)Social security and	dother entitlement numbers;		IDENTIFICATION OF OTHERS WITH	THE	
	(d)Coolai Scoulity and	outer chatternent numbers,		POTENTIAL TO BE AFFECTED.		
	(e)Date of admission.	results of pre-admission				
	screening, admitting of			All resident eligible for to receive pneur vaccine have the potential to be affected	mococcal	
	diagnoses;	3 ,		practice	ed by this	
	J ,			House wide audit is ongoing to identify	resident	
	(f)Date of discharge,	and condition on discharge;		that the facility staff did not ensure they	y have take	n
				or at least offered to administer the pne		ļ.
	(g)Hospital discharge	summaries or a transfer		vaccine. Any issues found will be corre 8/24/22	ected by	
	form from the attendir	ng physician;		0/2 1/22		
	(h)Medical history and	d allergies;				
	(i)December					
		sical examination, diagnosis				
	and prognosis;					
	(j)Rehabilitation poter	ntial:				
	U)i teriabilitation potei	iuai,				
	(k)Vaccine history, if a	applicable, and other				
		about immune status in				
	relation to vaccine pre					
		-,				
	(I)Current status of re	sident's condition;				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLE	
		HED02 0047		B. WING		04/2	
		HFD02-0017				04/2	0/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		ON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
L 201	Continued From page	e 131		L 201	MEASURES TO PREVENT RECURRENCE.		8/24/22
	written at the time of significant changes in when medication or the changed or renewed condition remains state condition; (n)The resident's medischarge, which shate attending physician adiagnoses, course of essential information discharge and location discharge and location discharged; (o)Nurse's notes which accordance with the assessment and the service; (p)A record of the resongoing reports of physician physician and the services; (q)The plan of care; (r)Consent forms and	dical experience upon II be summarized by the and shall include final treatment in the facility, of illness, medications on to which the resident ch shall be kept in resident's medical policies of the nursing sident's assessment and aysical therapy, occupating, podiatry, dental, and, dietary, and social I advance directives; and of the resident's person of the resident	n, quo e , on was d		In- service will be provided to a nursing staff to ensure that the to administer pneumococcal vat no cost to them. Licensed clinical staff will ensure they re-offer to administer pneumococcal vaccine to reside who refused and ensure proper documentation is in place. Any found will be corrected by 8/24 Review will be conducted by supervisors to ensure that the consent for pneumococcal vaccined upon admission and the contents of the consent is implemented. Any issues found be corrected by 8/24/22. The pneumococcal consent for been added to the admission package so assist responsible to determine if they want their ones to take the vaccine or no issues found will be corrected 8/24/22.	ey offer accine ure that dents er y issues 4/22. ccine is at the d will erm has e party loved bt. Any	
		et as evidenced by: ew and staff interview, ed residents, facility staf					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
7442 1 2744 01 00141420	1011	IBERTIN IO/RITOR HOM	DEIX.	A. BUILDING: _			
		HFD02-0017		B. WING		04/2	20/2022
NAME OF PROVIDER OF	SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
DEANWOOD REHAE	BILITATION AI	ND WELLNESS CEN		NIE HELEN BU FON, DC 2001	RROUGHS AVE. NE 9		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
failed to the residinformation benefits administ contrained #182 and The find Review of Policy are "It is the residents administ recomme Control (1). Residing 105/07/21 Hyperter Mellitus According (MDS) of Resident Status (Ecognitive Review of health refacility stresident benefits pneumon vaccine (2). Residing 103/14/22	ent's medical on/education and risks of ration or the dications to the dications to the dications include: of the policy of facts of the policy of facts of the policy of the policy of facts of the policy of facts of the policy o	chere was documentated record of the provided regarding the immunization, the refusal of or medical he vaccine(s). Resider entitled, "Pneumococce" (not dated) documentation and with the the Centers of Disease facility Medical Directs admitted to the facilities that included Failure, Type 1 Diabett in Chronic Kidney Disects and provided and provided and provided and provided and the content of the facility staff coded and provided	nts' cal nted, all nd ector" cy on resease. chall to the ne of the cy on	L 201	MONITORING CORRECTIVE ACT DON/Designee will conduct house wide to ensure that pneumococcal statu each resident is documented. This a will take place week then monthly. Findin be addressed and reported to QAPI Committee	e audit us for udit kly x3,	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			-			c
		HFD02-0017	B. WING		04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN'	TON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 201	Continued From page	e 133	L 201			8/24/22
	End of Right Humeru	ıs, Seizures and Anemia.				
	in Section C (Cogniti	sion MDS dated 03/20/2022, ve Status), facility staff 3 as "resident is rarely/never				
	Review of Resident #603's electronic and paper health record lacked documented evidence that facility staff provided information/education to the resident or their representative(s) regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). During a face-to-face interview conducted on 04/13/22 at 10:03 AM, Employee #5 (Infection Preventionist) acknowledged the findings for Resident #182 and #603 and stated, "Vaccine administration consent or refusal is documented in Point Click Care (PCC). I will look and see if I can find it."					
	provide the survey te	at Employee #5 was not able cam with any documentation or #603 vaccine(s) education,				
L 204	3232.2 Nursing Facil	ities	L 204			
	A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following:					
	(a)The date, time, an	d description of the incident;				
	(b)The name of the v	vitnesses;				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING		C 04/20/2022
NAME OF D	ROVIDER OR SUPPLIER	111 202 0011	STREET AND	RESS, CITY, STA	TE ZID CODE	1 04/20/2022
NAME OF P	ROVIDER OR SUPPLIER					
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		TON, DC 2001	RROUGHS AVE. NE	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		1	PROVIDER'S PLAN OF CORRECTION	IN (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
L 204	L 204 Continued From page 134 (c)The statement of the victim;			L 204	L 204	8/24/
					CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS:	
	(d)A statement indicating whether there is a pattern of occurrence; and				Resident # 3 was discharged 3/29/2 deficient practice cannot be retroac corrected.	
	(e)A description of the corrective action taken. This Statute is not met as evidenced by: Based on record review and staff interview, for nine (9) of 105 sampled residents, facility staff failed to implement its policies and procedures for investigating allegations of abuse, neglect and injuries of unknown source. Residents' #3, #11, #50, #67, #71, #151, #221, #408 and #409. The findings include: Review of the facility policy entitled, "Prohibition of Abuse" (not dated), documented, " Reports on abuse are reviewed and investigation conducted by the director of nursing within 24 hours following the incidentIf suspected abuse/inappropriate behavior are between two residents, residents will be immediately separated		Resident # 409 was discharged hor 9/28/20 this deficient practice cannot retroactively corrected.			
			aff es for nd		Resident #71 was assessed from h toe on 4/26/22, resident suffered no negative outcome from the incident occurred between him and another resident. MD/RP notified on 4/26/22	that
					Resident #67 was assessed from h toe by Unit Manager from head to to 4/26/22, resident suffered no negatioutcome. MD/RP notified on 4/26/2	pe on ve 2
			cted wo arated		Resident #151 was assessed from to toe by Unit Manager on 4/26/22, resident suffered no negative outco from the incident that happened bet him and another resident. MD/RP u 4/26/22.	me ween
	interventions are implicing a memo attesting compliance to abuse facility's policy also sidefined as "the failure employees or service and services to a resiavoid physical harm, emotional distress"	providers to provide go dent that are necessary pain, mental anguish, o The policy revealed tha an incident/accident for	es will and f the cods y to or at m for		Resident #221 discharged this defice practice cannot be retroactively confidence and did not come back. Resident # 408 was sent to ER on 2 and did not come back. Resident #11was assessed from he toe by Unit 4/26/22 resident suffer negative outcome. MD/RP notified 64/20/22. Resident #50 was assessed from head-to-toe Unit manager on 4/26/2 suffered no Issues.	rected. 2/12/22 ead to ed no on
	staff are to complete an incident/accident form for any unusual occurrences and submit it to the Director of Nursing or designee A final report of the investigation will be reported and signed by the Administrator."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					;
	HFD02-0017	B. WING		04/2	0/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DEANWOOD REHABILITATION	AND WELLNESS CEN	INIE HELEN BU STON, DC 2001	IRROUGHS AVE. NE 9		
PREFIX (EACH DEFICIENT	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
Process" dated 02/will ensure thoroug incident or occurrer residents, employed interview and/or ob victim/resident in statements from all and or obtain stated [Facility Name] we components to elimassociated with restraining, prevention reporting response. 1. The facility's staff investigation for Rebeing occluded by subsequently, caustransferred to the edislodgment. According to Johns (https://www.hopkiresources/glossary.) HME is a humidifying the trach tube and sizes. It is also know including Thermal hose, Artificial nose Thermovent T. Resident #3 was as as 12/01/2021 with mumiding mant Neoplass Larynx, Acquired A Tracheostomy States.	cy policy entitled, "Investigation 2022 showed, " The facility in investigation during an inces that may involve our es, volunteers, and visitors tain statement from terview and/or obtain eged perpetrators, interview ments from potential witnesses will use the following initiate and/or minimize the risk ident abuse: screening, identification, protection, and " failed to conduct an sident #3's airway (stoma) a medical device HME ing the resident to be mergency room (ER) for Hopkins Medicine is medicine.org/tracheostomy/r intml#Tracheotomy) and filter that fits onto the end of comes in several shapes and with by several other terms in the facility on altiple diagnoses including in of Larynx, Carcinoma of beence of Larynx, and	L 204	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFECT All residents residing in the facility the potential to be affected by the deficient practice. Clinical care coordinator/Designation conduct house wide audit to ensure all resident-to-resident altercation fully investigated, and that all stappesent provided statements. And found will be corrected by 8/24/2 Unit Managers/ Supervisors will house wide audit to ensure that alleged threat of violence is invested and reported. Any issues found to corrected by 8/24/22.	ee will ure that n are off ey issues 12. conduct all stigated	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED		
HFD02-0017			B. WING		C 04/20/2022		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		ON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 204	(MDS) assessment dathe Brief Interview Mesection was blank, included for receiving Transpeech therapy service showed that Resident receiving respiratory to the following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 19:54 [active following: -12/01/21 at 10:29 [pt progress note]- Pt. (pt appears alert and state tracheostomy and doit (blood pressure), 86 (temperature), 95% Roon room air)12/02/21 [physician of day shift12/02/21 at 13:15 [reassessment]- Type- in was alert and oriented place with an HME. Letholder changed. HME assessment respirator room air, lung sounds assessment respirator	ated 12/03/21 revealed ental Summary Score dicating the resident hationally, the resident was racheostomy care and ces. A continued review that was not coded for therapy services. It's medical record revealed mission nursing progression and biopsy on 10/21 resident alert and orient Resident has a lary tubice In the services of	d not as v valed ess omy 7/27 ted to e ician 97.6 ate aily dent der in ont [on] ot	L 204	MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed nurses by Staff Educathe importance of completing accident/incident report accurator report their findings to DOH whours if the incident resulted in injury and within 72 hours for inwithout injury. Unit Managers will ensure that members provide written staten on resident incidents/ accidents situations. Any issues found will corrected by 8/24/22. Supervisors will ensure all incident/accident reports are conaccurately. Any issues found we corrected by 8/24/22. Charge nurses will ensure that collect statements from staff ab incident/accident that occurred their shifts and ensure that incidented are reported. Any issues found corrected by 8/24/22.	tor on tely and within 8 an icidents all staff ments the beautiful be they out during dents	8/24/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		HFD02-0017	B. WING	B. WING		; 0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'	NNIE HELEN BU GTON, DC 2001	IRROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY 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	(X5) COMPLETE DATE
L 204	the nearest ER (emerovaluation related to -12/03/21 at 14:42 [In respiratory therapist has an HME stuck in Resident has a lari-tuand no respiratory didenied pain. No blee (saturation) checked RA (room air). [Doctoinstruction to transfer (emergency room) for Resident's granddauk now what happened explainedwhen shough there was an HME sitherapist explained to maybe the HME initial (airway) and the resimal explained to ma	order] - transfer resident to ergency room) for further stuck HME in stoma. Jursing progress note] - The notified writer that resident the stoma (airway). Jube. Resident was assessed stress noted. Resident ding noted. O2 (oxygen) Sat immediately and was 99% or's name] notified. He gave resident to nearest ER or further evaluation. Ighter notified and wanted to d. The respiratory therapist e did care for lari-tube and sterday 12/2/21, the stoma at today she observed that tuck in the stoma. The to the granddaughter that ally stuck down in stoma dent coughed it up the coughed it up	L 204	Unit Managers will validate duri grand rounds daily that incident occurred in the facility have been reported to DOH and that the responsible party has been notified .Any issues found will be corrected by 8/24/22. Final check will be conducted be Supervisors, ADON/ Designee, ensure that incidents are investigated ,that the incident for completed accurately and that if are reported in a timely manner Department of Health. Any issues found will be corrected by 8/24/ MONITORING CORRECTIVE ACTION: DON/Designee will audit all incident report to ensure that the are fully investigated upon and each incident report has employees' statements. This are will be conducted weekly x4, the monthly x3. Findings will be corrected immediately and reported to the QAPI committee.	ts that en e e e e e e e e e e e e e e e e e e	8/24/22

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
						;
		HFD02-0017	B. WING		1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	ATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(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	(X5) COMPLETE DATE
L 204	204 Continued From page 138		L 204	L 204 STARTS HERE:		8/24/22
	"How to Clean a Tracheostomy Tube, Adult." -12/04/21 at 07:54 [nursing progress note] -		I	CORRECTIVE ACTION FOR TH AFFECTED RESIDENTS:		
	Resident came back from the hospitalon arrival 129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air.			Resident # 3 was discharged 3/2 deficient practice cannot be retro corrected.		
	-12/04/21 [physician order] - Do not occlude stoma in neck. The [patient] is an obligate neck breather. -12/06/21 at 16:13 [physician assistant progress note] - Re-admission follow-up, pt (patient) was hospitalized for tracheostomy malfunction. Pt. seen at the bedside appears alert and stablevitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations), 97% RA (oxygen saturation rate on room air)resp (respiration): lung CTA (Clear to auscultate), BL (bilaterally). However, further review of progress notes lacked documented evidence that Employee #31 (Respiratory Therapist) assessed or provided care for Resident #3 from 12/03/21 to 12/06/21 (post being sent to the emergency room).			Resident # 409 was discharged h 9/28/20 this deficient practice car retroactively corrected.		
				Resident #71 was assessed from toe on 4/26/22, resident suffered negative outcome from the incide occurred between him and anoth resident. MD/RP updated on 4/26 Resident #67 was assessed by L Manager from head to toe on 4/2	no ent that er 5/22 Jnit	
				resident suffered no negative out MD/RP update on 4/26/22 Resident #151 was assessed by Manager on 4/26/22, resident sufnegative outcome from the incide	come. Unit ffered no	
	Change HME daily da The facility's nurse in	ober 2021 Treatment d showed the following: ay shift (start date 12/03/21). itialed on 12/03/21 indicating sident #3's HME on dayshift		happened between him and anot resident. MD/RP updated on 4/26 Resident #221 discharged this de practice cannot be retroactively of	her 5/22 eficient	
	initial date of 12/04/2 Focus Area- [resident (related to) laryngeal Goal- [resident's nam drainage around track	le] will have no abnormal hea site through the review ox (signs/symptoms) of		Resident # 408 was sent to ER o and did not come back	n 2/12/22	2

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 20.12310.		C	
		HFD02-0017	B. WING		1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	NNIE HELEN BU GTON, DC 200 [,]	JRROUGHS AVE. NE 19		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES BY 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 RIATE	(X5) COMPLETE DATE
L 204	Further review of Rescare plans lacked docinterventions to addreuse of a lary-tube and 12/03/22. Review of a complair Department of Health that Resident #3 was 12/03/21, because th (Resident #3) neck standard resident #3 was unatime of the survey be the hospital on 03/29. During a telephone in AM, the resident's rescordinator and the reher informing her that grandfather's stoma. Informed her what han either one of them of clinical coordinator] is things that happened. During a face-to-face approximately 5:00 P stated, I cleaned som a shift. Respiratory settime. I had training for remember when." The don't remember the real HME."	be care daily, change HME gh as needed sident#3's comprehensive cumented evidence of less care for Resident #3's defined HME from 12/01/22 to the received by the DC in on 01/26/22 from alleged is rushed to the ER on lere was an HME put into his stoma (airway)." able to be interviewed at the recause he was discharged to 1/2022. Interview on 04/12/22 at 11:35 is sponsible party led that the clinical espiratory therapist called it the HME was stuck in her	L 204	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFECT All residents residing in the facility the potential to be affected by the deficient practice. Clinical care coordinator/Designate conduct house wide audit to ensuall resident-to-resident altercation fully investigated, and that all stappesent provided statements. An found will be corrected by 8/24/2 Unit Managers/ Supervisors will house wide audit to ensure that a alleged threat of violence is investand reported. Any issues found we corrected by 8/24/22.	ee will ure that a are ff y issues 2. conduct all stigated	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	CONSTRUCTION	(X3) DATE S COMPLE		
		7.1. 20.22.110.			С	
	HFD02-0017	B. WING		04/2	0/2022	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND	WELLNESS CEN 5000 NAN	ORESS, CITY, STA NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
The employee then sha not in any distress whe his stoma (airway). Wh investigation was condithe incident of the HME #3's stoma (airway) has stated, "No." The employerespiratory therapist was the resident's HME. During a telephone into PM, Employee #31 (Resthat she informed the shades HME was "stuck in his sure how the HME got (Resident #3) did not go stoma it would have be employee stated that she informed that she informed the shades a week, and on the facility nursing staff was Resident #3's lary-tube Also, Employee #31 sanursing staff education Resident #3's lary-tube documented the training office. The employee a nursing staff to do a retensure competency. During a face-to-face in approximately 3:00 PM stated that respiratory to training on tracheostom	(Clinical Coordinator) respiratory therapist ME was stuck in the respiratory therapist ME was stuck in the respiratory therapist ME was stuck in the responsible for evaluation. The stuck in the HME was lodged in ren asked if an ren ucted to determine how responsible for changing The strong of the stuck in the store of the HME out of his ren detrimental." The ren detrimental in the ren detrim	L 204	MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed nurses by Staff Educate the importance of completing accident/incident report accurate to report their findings to DOH whours if the incident resulted in a and within 72 hours for incidents injury. Unit Managers will ensure that a members provide written statem resident incidents/ accidents situations. Any issues found will corrected by 8/24/22 Supervisors will ensure all incident/accident reports are cor accurately; Any issues found will corrected by 8/24/22. Charge nurses will ensure that the collect statements from staff abounded incident/accident that occurred of their shifts and ensure that incident reported. Any issues found will be corrected by 8/24/22.	ely and vithin 8 an injury s without all staff sents on be mpleted ll be hey out during ents are	8/24/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'	NNIE HELEN BU GTON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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)	JLD BE	(X5) COMPLETE DATE
L 204	resided, she could not him. A review of in-service documented evidence education on the lary During a face-to-face approximately 3:30 F stated that the respirates for provious and the state of the transfer of education therapist." There was no evident developed a personfor and provide neces #3 who had a larynge Resident #3's airway medical device HME transferred to the ER device. 2. Facility staff failed statements from all s #11's care in an allege Resident #11 was ad 04/22/15 with diagnor Disorder, Anxiety Dis Disorder and Convuls Review of Resident #1 revealed:	the floor where Resident #3 of remember working with the training documents lacked that staff was provided thubes or HMEs. Interview on 04/14/22 at 19M, Employee #4 (Educator) atory therapist was ding staff education on the The employee said that the was to provide her with nof education provided to raid, "I don't have any provided by the respiratory ce that facility staff centered approach to care sarry services to Resident fectomy. Subsequently, (stoma) was occluded by a causing him to be for dislodgment of the to interview and/or obtain taff involved in Resident lation of neglect. mitted to the facility on ses that included: Bipolar forder, Major Depressive sions.	L 204	Unit Managers will validate grand rounds daily that inci occurred in the facility have reported to DOH and that the responsible party has been notified. Any issues found corrected by 8/24/22. Final check will be conduct Nurse Supervisors, ADON/Designee, to ensure that in are investigated, that the informs are completed accurate that incidents are reported manner to Department of HAny issues found will be co 8/24/22.	dents that been ne vill be ed by cidents cident ately and n a timely ealth.	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			
		HFD02-0017	B. WING		04/2	; 0/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	STREE 5000 N	TADDRESS, CITY, STA IANNIE HELEN BU INGTON, DC 2001	IRROUGHS AVE. NE		···
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDE DEFICIENCY)	D BE	(X5) COMPLETE DATE
L 204	Status (BIMS) summa severe cognitive impawith "one person physhygiene and "frequen and bowel continence Review of Facility Re 03/18/22 showed," wrote a grievance on father had not been of during the night shift PM). She stated that urine and had feces were received to the writer the facility staff failed investigating allegation failure to interview an all staff that took care PM on 03/12/22 to 11 During a face-to-face 04/12/22 at 2:39 PM, Nursing) acknowledge was not able to get even 3. Facility staff failed of resident-to-resident Residents' #71, #67 at Review of the FRI dat " At 0730AM, the set [Resident #151] assat [Resident #71] at the Review of the FRI dat At 2030 on 12/29/2	Brief Interview for Mental ary score of "03", indicating airment, "total dependence" sical assist" for personal tly incontinent" for urinary e. ported Incident (FRI) dated [Resident #11's] daughter 03/14/22 stating that her hanged since 03/12/22 until 03/13/22 at 18:30 (6:30 her father was soaked in when she came in to visit" s investigation documents on 04/12/22 revealed that to follow its policy for ms of neglect evidenced by d/or obtain statements from of Resident #11 from 11:00 :00 PM on 03/13/22. interview conducted on Employee #2 (Director of ed the finding and stated, "I veryone's statements."	L 204	MONITORING CORRECT ACTION: DON/Designee will audit incident report to ensure they are fully investigate and that each incident reemployees statements. audit will be conducted vx4, then monthly x3. Find be corrected immediately reported to the QAPI corrected to the QAPI corrected in the part of the part o	all that d upon port has This veekly dings will y and	8/24/22

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			CONSTRUCTION		TE SURVEY MPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER		A. BUILDING: _				
		HFD02-0017		B. WING			C)4/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'		IIE HELEN BU FON, DC 2001	RROUGHS AVE. NE 9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 204	Continued From page	e 143		L 204			8/24/22	
	him on his chest x 2	in the lobby"					0/2 1/22	
	Resident Background	d Information						
	A. Resident #151 was admitted to the facility on 10/22/20 with multiple diagnoses that included: Unspecified Psychosis, Epileptic Syndrome and Benign Prostatic Hyperplasia.							
	Review of Resident #151's medical record revealed: 12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.							
			а					
	In Section E (Behavio	or):						
		cators of Psychosis - ptions or beliefs that are to reality) - "yes"						
	(e.g., hitting, kicking, grabbing, abusing oth this type occurred 1 t symptoms directed to threatening others, so at others) - "Behavior days", Impact on Ressignificant risk for phyimpact on others physical injury? "yes' privacy or activity of disrupt care or living	s directed towards others pushing, scratching, hers sexually) - "Behavior to 3 days", verbal behavior to 3 days", verbal behavior to 3 days, verbal behavior towards others (e.g., creaming at others, cursing of this type occurred 4 to sident Put the resident ysical illness or injury? "yes out others at significant risl "; significantly intrude on the others? "yes"; significantly	ral g 66 at es"; k of he					
		ssistance - bed mobility,						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		HFD02-0017	B. WING		04	C 4/20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CEN. 500	EET ADDRESS, CITY, STA 0 NANNIE HELEN BU SHINGTON, DC 2001	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 204	locomotion on unit, I #151 required "super physical assist" Review of the Care II 07/27/21 (Revision of positive PASARR (PResident Review) Leevaluation, it was deneeds Specialized SFacility. Related to: MD (medical doctor) serious health declina agreed to may need Inform the MD of any require additional everemove services" 07/27/21 (Revision of for changes in behaving agitation" 10/18/21 (Revision of problematic manner characterized by inate to treatment/care relevant (Dementia, Schizophtaking medications, in non compliant with scompliant with Wade and hitting" 10/20/21 (Revision of impaired cognitive for processes r/t (related 10/20/21 (Revision of psychotropic medical system)	Plan revealed: Plan revealed:	e it			8/24/22

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HFD02-0017	B. WING		04	C / 20/2022
	PROVIDER OR SUPPLIER	ID WELLNESS CEN 5000 NAI	DDRESS, CITY, STATE NNIE HELEN BURI GTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 204	Monitor/record occurr symptoms violence staff/others) and doct 10/22/21 (Revision day behavior problem r/t (on the entire floor, dis Non-compliant letting moving chair into and stop Combative, as members, trying to be Administration area a staff monitoring for sa sitter is available" B. Resident #71 was 08/20/18 with multiple Schizoaffective Disor without Behavioral Di Hypertension. Review of Resident # Quarterly MDS dated coded a BIMS summ moderate cognitive in indicators of psychos behavioral symptoms person physical assis range of motion and in C. Resident #67 was 09/29/08 with multiple Unspecified Intellecture Disorder with Hallucin Dementia without Bel Review of Resident # Quarterly MDS dated coded a BIMS summintact cognitive responsible.	rence of for target behavior e/aggression towards ument per facility protocol" ate) "Resident #151] has (Combative, Spilling water crobing) r/t Schizophrenia. roommate into the room, other room and refusing to gitation, hitting multiple staff eak down doors in the nd rolling on the floor 1:1 afety until seen by psych or admitted to the facility on e diagnoses that included der, Unspecified Dementia sturbance and 71's medical revealed, a 10/23/21 where facility staff ary score of "09", indicating is and no physical or verbal, limited assistance with one of the facility on ediagnoses that included and Disabilities, Psychotic nations, and Unspecified	L 204			8/24/22

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PRINTED: 07/27/2022 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		HFD02-0017		B. WING		04	C 1/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	·	
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		IIE HELEN BU FON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 204	one person physical a limitations in range of Altercation #1 involving 12/08/21 at 11:18 AM 0730AM, the [Securit [Receptionist's Name assaulting another refront of the building. The receptionist ran to the both residents [Resident #15] [Resident #71]. He saway as called took [Resident #71]. He saway as called took [Resident #71] was a mark observed on the Altercation #2 involving 12/30/21 at 11:30 AM (8:30 PM) on 12/29/2 alleged to the reception him on his chest x 2 in notified the supervisor [Resident #67] and he (8:40 PM) [extensive assistance wassist for ADLs and no formation. Ing Residents #151 and Ing Residents #151 and Ing Residents Was and the security officer and the resident [Resident #71] at Ingel and the resident was interviewed on me in front of the security officer and the resident was interviewed on me in front of the security officer and the resident was interviewed on the security officer and the resident was interviewed on the security of the se	#71: he 51] t the the ed wed. ne to y' ater' t) of his atch " #67: #67] fi] hit onist sed 2040 the ing to oot let e	L 204			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE	SURVEY	
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
DEANWO	OOD REHABILITATION AN	ID WELLNESS CEN'	ANNIE HELEN BUR			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 204	PM). During interview was not cooperating; of the Police Officers. into custody [Resident Harmonic Programment of the Police Officers. into custody [Resident Harmonic Programment of the Police Officers. into custody [Resident Harmonic Programment of the Police Programment of the Pr	with [Resident #151], he he made attempts to hit one . [Resident #151] was taken lent #67] was assessed a alleged being hit on the his previous surgical site. Ation or open area observed le denied pain" #151's medical record aggressive behaviors and a litercation on 12/08/21. Lented evidence that facility to #151's plan of care to so .On 12/29/21, Resident for resident at the facility. Interview conducted on #7 (Clinical Coordinator) dings and stated that the en on 1:1 since he was facility in 01/2022 and has to-resident altercations. Ito thoroughly investigate an sident threat of violence by acility Reported Incident) mented "resident ge nurse that he did not like mate. He stated that if he in that room that one day mate hurt" Peradmitted to the facility on the diagnoses including, ation Deficit, Hemiplegia and any Cerebral Infarction ominant Side, Paraplegia	L 204	DE. HOLLIN	,	8/24/23

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE S		
7.1.12 1 27.1.1	A. BUILDING:					
		HFD02-0017	B. WING _			20/2022
NAME OF P	ROVIDER OR SUPPLIER	STR	REET ADDRESS, CITY,	STATE, ZIP CODE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'	0 NANNIE HELEN SHINGTON, DC 20	BURROUGHS AVE. NE 0019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETE DATE
L 204	Continued From pag	e 148	L 204			8/24/22
	revealed that the fac In section C (Cognitive Summary Score "15" Review of the docume Background Assessing Recommendation)-peractitioner)/PA (Phy Communication Tool PM, showed "Todacharge nurse that he roommate. He stated to be in that room that roommate in a pool of the resident's side untransferred to another transferred to the rooms.	hysician /NP (Nurse visician Assistant) " dated 03/28/22 at 12:27 y, resident explained to the did not like rooming with his that if he were to continue at one day, we will find the of blood. A nurse stayed by ntil the resident could be ar room. Prior to being om he was introduced to the nate and stated that the				
	documentation that vide of the constraint of the	e statements, a copy of a a form titled port", a form titled "Quality ormance Improvement investigation for cognitively				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY IPLETED	
		UED02 0047		B. WING			C
		HFD02-0017				<u> </u>	4/20/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		IIE HELEN BU TON, DC 2001:	RROUGHS AVE. NE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	***************************************	ID ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETE DATE
L 204	Continued From pag	e 149		L 204			8/24/22
	04/18/22 at approxim	e interview conducted or nately 1:00 PM, Employe acknowledged the findi	ee #2				
	statements from all s	to interview and/or obta staff involved in Residen an injury of unknown ori	t				
	"Resident complair yesterday 2/16/22 ar (Nurse Practitioner) morning with impress left distal femur, Acuright lateral femoral completes worked with resident		NP this the				
	05/25/2021 with mult Hemiplegia and Hem Muscle Weakness at	admitted to the facility or tiple diagnoses that incluniparesis, Hypocalcemiand Lack of Coordination #408's medical record	uded:				
	revealed the followin						
	following: a BIMS su severe cognitive imp assistance to total de persons physical ass and personal hygier motion.	ependence with two plus sist" for transfers , mobil ne, no impairment in ran	ating s ity ge of				
		[Nurse Practitioner (NP essment and f/u knee pa					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		C
		HFD02-0017	B. WING		04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN. 5000 NAN	NIE HELEN BU	RROUGHS AVE. NE	
	Г	WASHING	TON, DC 2001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
L 204	Continued From page	÷ 150	L 204		8/24/22
	both knees. She adm knees, dull and affect on both knees" 02/17/22 at 7:38 AM [X-ray of the both knee	sment due to c/o pain on its to moderate pain in her ing her sleep Plan [x-ray] 'Nurses Note] "Resident's es (Positive) for LT (left)			9,2 ,,2
	displacement RT (r	ure of the distal femur with ight) Knee: There is tion and a cortical hairline			
		ateral femoral metaphysis			
	which is impacted A	call placed to the NP"			
	complained of right kr and she was assesse X-rays of bilateral kne this morning with imp the left distal femur, a right lateral femoral or alignment All staff w from 2/9/22 to 2/16/22 to determine if resided had reported fallen to	who worked with resident 2 all shifts will be interviewed nt had a fall or if resident anyone. [Physician's Name] order to send resident to			
	provided to the survey revealed that facility so obtain a statement from	#408 on 02/16/22 during			
	04/18/22 at approximate Employee #43 (3rd Fl	interview conducted on ately 1:30 PM with loor Unit Manager), she ding and made no further			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. B	BUILDING:	COMPLETED
HFD02-0017 B. W	WING	C 04/20/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS,	S, CITY, STATE, ZIP CODE	
DEANWOOD REHABILITATION AND WELLNESS CEN 5000 NANNIE HI WASHINGTON,	HELEN BURROUGHS AVE. NE , DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
L 204 Continued From page 151 6. Facility staff failed to implement its written policies and procedures for abuse and neglect evidenced by failure to identify and investigate the unusual occurrence of Residents #409's dislocated hip. Review of an intake form for a complaint received by the State agency on 12/06/21 documented "after having hip surgery on 07/08/21, was observed two days later on 07/10/21 with "leg positioned like the letter 'K'" Resident #409 was sent to the hospital for a dislocated hip and hip surgery. Resident #409 was admitted to the facility on 07/08/21 with diagnoses that included: Encounter for Orthopedic Aftercare, Presence of Left Artificial Hip Joint, Alzheimer's Disease (Unspecified), Repeated Falls, Muscle Weakness (Generalized), and Other Abnormalities of Gait and Mobility. A review of the Quarterly MDS for Resident #409 dated 07/11/21 revealed that facility staff coded the following: In Section C (Cognitive Patterns), a BIMS summary score of "99", indicating that the resident had severely impaired cognition. In Section G (Functional Status), ADL assistance: for transfers, toilet use, and personal hygiene, the resident was totally dependent and required two or more person's physical assistance from two or more staff. For bed mobility, the resident required limited physical assistance from one staff member. For dressing the resident required extensive physical assistance from one staff member	204	8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	CONSTRUCTION	(X3) DATE	SURVEY LETED	
ANDILAN	or dorace more	IDENTIFICATION NOMBE	.13.	A. BUILDING: _		COM	
		HFD02-0017		B. WING			C 20/2022
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		IIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 204	prior to admissionh in the last 6 months p major surgery during admission In Section O (Special and Programs), start Physical Therapy "07 Review of Resident # revealed the following 07/08/21 at 8:29 PM "Resident was adm Hospital] for rehabilita ArthroplastyReside pillow and WBAT (we Fall and safety precal location close to nurs monitoring, call light a within close reach' 07/10/21 at 3:29 PM "Patient seen at the r and the family. Patien pain at the site of suradded oxycodone ((as needed) for 14 da 07/10/21 at 5:40 PM to [Hospital's Name] started: 07/10/2021 . post) left hip Arthropla A-Assessment Res responsive, no appar change in mental sta	Conditions), "Yes" to: ny time in the last month had a fracture related to a prior to admission and the 100 days prior to I Treatments, Procedure date for Occupational ar 7/09/2021." #409's medical record g: [Admission Note] hitted from [Name of Loca ation post left hip ent has hip abduction wit eight bearing as tolerated utions initiated: resident hes' station with close and commonly used item [Physician's Progress Note and commonly used item [Physician's Progress Note and commonly used item [Sequest of Nurse Manage on reportedly has increas gery, worse with movem (narcotic pain reliever) pr ays for breakthrough pain [SBAR] "Resident tran Date problem or symp Background S/P (sta asty done on 7/5/2021 sident is alert and verbal rent distress noted. No tus notedR-Request -	a fall had s, and al ch d). al ch d). as ote] er ch	L 204	DEFICIEN		8/24/22
	responsive, no appar change in mental sta Person contacted: [N	ent distress noted. No tus notedR-Request -					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL) STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE COMPLETE
DEANWOOD REHABILITATION AND WELLNESS CEN' (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE COMPLE
DEANWOOD REHABILITATION AND WELLNESS CEN' (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE
DEANWOOD REHABILITATION AND WELLNESS CEN' WASHINGTON, DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE
DECLUATION COLLOCURENTIES (NO INFORMATION)
DEFICIENCY)
DEI ICIENCI)
L 204 Continued From page 153 L 204
in parson. Notice She requested her man to be
in person. Notes: She requested her mom to be transfer[ed] to the Hospital"
transfer[ed] to the riospital
07/10/21 at 6:20 PM [Nurses Note-Late Entry]
"Family was at bedside visiting today from 11:45
AM Resident was seen by the medical director at
12:30 PM, At about 4 PM [the] daughter
requested that she needed an X-ray to be done
because she want[ed] to make sure her mothers'
leg was not dislocated. Writer explains[ed] to the
daughter that [the] resident has been seen by the
doctor in her presen[ce] just a few hours ago. If
there was any concern note[d] the doctor would have order[ed] an X-ray. She insisted that she
want[ed] her mom to be sent to the hospital
immediately because she need[ed] an X-ray to be
done and read right [away]. Writer told her that an
X-ray can be gotten from the doctor, but it will
take b/n (between) 2-4 hours for the X-ray to be
done[Physician's Name] was notified and the
doctor said an X-ray will take about 4-6 hours to
be done so the resident should be transfer[red] to
the hospital via non-emergency transport for
further evaluation per family requestResident
was taken out from the facility at 5:50 [PM] to
[Hospital's Name]."
07/12/21 at 6:34 PM [Hospital Discharge
Summary] "The patient presents from [Name of
Facility], where she has been staying for the past
few days Her daughter and son-in-law went to
visit her looked under her covers and found
that her left leg was significantly inwardly rotated.
They were concerned something is going wrong
with the surgery at the left hip, and they
requested transportation to the hospital
Procedure -joint reduction: closed joint reduction
(procedure for treating a hip dislocation without
surgery, using manipulation of thigh bone (femur) to put the hip back in place) ED (Emergency

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WINO		С	
		HFD02-0017	B. WING		04/20/2022	2
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	TON, DC 2001:	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(5) PLETE ATE
L 204	patient's hip was reduprocedure well howevhip inNarratives: 0 back to [Name of Factor discharge. Requestischarge" A review of Resident revealed no documer staff identified or inve (dislocated hip) as an During a face-to-face approximately 4:00 P Manager), stated, "The weekend, when I was the facility did not investigation of the state of the stat	Critical Care2:30 AM: The ucedshe tolerated the ver did take 4 tries to get the 2:27 PM plan to discharge cility]. 03:51 PM cleared st knee immobilizer for #409's medical record the devidence that facility stigated the resident's injury	L 204		8/2	4/22
L 206	agency within forty-ei occurrence, except the that result in harm to to the licensing agency occurrence. This Statute is not m Based on record reviet two (2) of 105 sample failed to report the un Residents #3 and #40. The findings include:	e documented in the reported to the licensing ght (48) hours of lat incidents and accidents a resident shall be reported by within eight (8) hours of let as evidenced by: ew and staff interview, for led residents, facility staff lusual occurrences for	L 206			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI		, ,	CONSTRUCTION	(X3) DATE S	
7.1.12 1 2.1.1	5. GOTH (2011)		.	A. BUILDING: _			
		HFD02-0017		B. WING		04/2	; 0/2022
NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'		E HELEN BUI ON, DC 20019	RROUGHS AVE. NE		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 206	Abuse" with a revision neglect was defined a its employees or services to necessary to avoid planguish, or emotionarevealed that staff are incident/accident for occurrences and sub Nursing or designee. investigation will be read Administrator."	n date of 02/22, showed as the failure of the facility rice providers to provide to a resident that are hysical harm, pain, menta I distress. The policy e to, "complete an in for any unusual mit it to the Director of	al e	L 206	L206 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #3 was discharge 3/29/22, this deficient practice cannot be retroactively corrected. Resident #409 was discharge 9/28/2021, this deficiency of be retroactively corrected. Resident #408 was sent to 2/12/22, this deficiency carretroactively corrected.	ed ice rected rged cannot	8/24/22
	to be transferred to the dislodgment to the standislodgment to the standislodgment to the standislodgment to the standislodgment to the standislogment to the standislogment to the and comes in sealso known by severa Thermal Humidifying Artificial nose, Filter, (https://www.hopkins.esources/glossary.html Resident #3 was adm 12/01/2021 with mult Malignant Neoplasm Larynx, Acquired Abstracheostomy Status Review of an Admiss (MDS) assessment dithe Brief Interview Mesection was blank, in	ne emergency room (ER) ate agency. Hopkins Medicine a HME fits onto the end of the traceveral shapes and sizes. It all other terms including Filters, Swedish nose, Thermovent T. In medicine.org/tracheostom ml#Tracheotomy) nitted to the facility on it iple diagnoses including of Larynx, Carcinoma of sence of Larynx, and	is a ach t is		DENTIFICATION OF OTH WITH THE POTENTIAL TO AFFECTED: No resident residing in the has and HME stoma. Unit Manager / Designee we conduct audit on their units ensure that injuries of unknorigin were investigated an reported. Any issues found corrected by 8/25/22	D BE facility vill to own d	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04/20	0/2022
NAME OF PROVIDER OR S DEANWOOD REHABI		ND WELLNESS CEN	DDRESS, CITY, STA	RROUGHS AVE. NE		
	CH 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
coded for speech the showed the receiving. Review of the following street on the following speech the following speech the following speech and with direct support on the following speech sp	erapy servinat Resident respiratory If the resider ing: at 19:54 [ausident under it laryngosod sessment, and place HME] in plate at 20:29 [plate and state and sessure), 86 aure), 95% Fair) [physician at 13:15 [resent] - Type - it land oriente and HME. Leanged. HME and oriente and HME. Leanged. HME and sent respirator and sent resp	racheostomy care and ces. A continued review t #3 was not coded for therapy services. It's medical record revealed dmission nursing progress rwent awake tracheostomy opy and biopsy on 10/27/27 resident alert and oriented to Resident has a lary tube	L 206	MEASURES TO PREVENT RECURRENCE: Supervisors will conduct da rounds to ensure that resid with stoma site that aids wi respiration present with cle stoma sites. Any issues for will be corrected by 8/25/22 In- service will be provided Staff Educator /Designee to Licensed nursing staff (LP RN) on how to assess resid with a stoma and to report findings completed by 8/25. Charge nurses /Designee versure to investigate and reinjuries of unknown origins immediately they are noted issues found will be correct 8/25/22. Respiratory therapist will enthat residents with respirators issues are in no form of respiratory distress every so Any issues found will be corrected by 8/25/22.	aily lents th an und 2. by by c all N/ dent their /22. will eport d. Any ted by nsure bry	8/24/22

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C	;
		HFD02-0017	B. WING		04/2	0/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CEN	DRESS, CITY, STA NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
L 206	Continued From page -12/03/21 at 14:42 [In respiratory therapist has an HME stuck in Resident has a lari-tu and no respiratory didenied pain. No blee (saturation) checked RA (room air). [Docto instruction to transfer (emergency room) for Resident's granddauk know what happened explainedwhen she changed HME on yee (airway) was clear but there was an HME st therapist explained to maybe the HME initia (airway) and the resident's daughter Respiratory Therapis resident was alive, inhow she determine non-verbal 911 cal at 1400 v/s (vital spressure), 63 (pulse) (temperature), 02 Sa air). -12/04/21 [hospital did Diagnosis-tracheostores.]	ursing progress note] - The notified writer that resident the stoma (airway). abe. Resident was assessed stress noted. Resident ding noted. O2 (oxygen) Sat immediately and was 99% or's name] notified. He gave resident to nearest ER or further evaluation. In the respiratory therapist and did care for lari-tube and sterday 12/2/21, the stoma at today she observed that suck in the stoma. The or the granddaughter that ally stuck down in stoma dent coughed it up forcalled and spoke with thewanted to find out if distress or pain and asked that since resident is led at 1345 and they arrived igns): 121/80 (blood of the the stoma), 97.8 at (saturation) 99% RA (room secharge summary]- somy malfunction. Diagnostic	L 206		IVE at audits a stuck and f This ekly x4, vill be	8/24/22
	radiology XR (x-ray) PA (posterior-anterior Call for follow-up app within 2 to 4 days [pr "How to Clean a Trace -12/04/21 at 07:54 [n	neck soft tissue, XR chest and LAT (lateral) 2 view. cointment with physician ovided education tool] for cheostomy Tube, Adult." ursing progress note] - from the hospitalon arrival				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		HFD02-0017		B. WING		0	4/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLINESS CEIN	WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 206	Continued From page	= 158		L 206			8/24/22
	129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air. -12/04/21 [physician order] - Do not occlude					0/24/22	
	stoma in neck. The [patient] is an obligate neck breather.						
	-12/06/21 at 16:13 [physician assistant progress note] - Re-admission follow-up, pt (patient) was hospitalized for tracheostomy malfunction. Pt. seen at the bedside appears alert and stablevitals: 130/67 (blood pressure), 71 (pulse), 17 (respirations), 97% RA (oxygen saturation rate on room air)resp (respiration): lung CTA (Clear to auscultate), BL (bilaterally). However, further review of progress notes lacked documented evidence that Employee #31 (Respiratory Therapist) assessed or provided care for Resident #3 from 12/03/21 to 12/06/21 (post being sent to the emergency room). Review of the December 2021 Treatment Administration Record showed the following: Change HME daily day shift (start date 12/03/21). The facility's nurse initialed on 12/03/21 indicating that she changed Resident #3's HME on dayshift						
			d				
			3/21). cating				
	initial date of 12/04/2 Focus Area- [resident (related to) laryngeal Goal- [resident's nam drainage around track date. Will have no s/s infection through the Interventions- lari-tub	ne] will have no abnormathea site through the revex (signs/symptoms) of review date. The care daily, change HI	r/t al ⁄iew				
	daily, assist with coug	gh as needed sident#3's comprehensi	ve				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	s	STREET ADDRESS, CITY, STA	TE, ZIP CODE	·	
DEANWO	OD REHABILITATION A	JD WELLNESS CEN. 5	000 NANNIE HELEN BU	RROUGHS AVE. NE		
DLANVO	OD KENABIENATION A	V VELENESS CEN V	VASHINGTON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 206	interventions to addreuse of a lary-tube and 12/03/22. Review of a complair Department of Health that Resident #3 was 12/03/21, because the (Resident #3) neck is Resident #3 was unatime of the survey be the hospital on 03/29. During a telephone in AM, the resident's resecond in a tone of the resident's resecond in a tone of them of the informing her that grandfather's stomal informed her what has informed her what has informed her what has resident in the resident in the resident's stomal informed her what has resident in the resident	cumented evidence of ess care for Resident #3's d HME from 12/01/22 to at received by the DC on 01/26/22 from alleged rushed to the ER on ere was an HME put into toma (airway)." ble to be interviewed at the cause he was discharged /2022. Interview on 04/12/22 at 11 sponsible party ed that the clinical espiratory therapist called the HME was stuck in he When asked if they appened, she said, "No, could explain, but [name of aid sometimes there are that we can't explain." Interview on 04/12/22 at 11 sponsible party espiratory therapist called the HME was stuck in he when asked if they appened, she said, "No, could explain, but [name of aid sometimes there are that we can't explain." Interview on 04/12/22 at 11 sponsible party espiratory, but I don't espiratory, but I don't employee also stated, "esident (Resident #3) using the interview on 04/13/22 at 11 spiratory explains."	his ne to 1:35 rer f			8/24/22
	reported that when the informed him that an	#7 (Clinical Coordinator) ne respiratory therapist HME was stuck in the vay), he had Resident #3				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED		
		HFD02-0017		B. WING		I	C 20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
BEARTO	OB REHABIEHATION AL	- THE THE COURT OF	WASHINGT	ON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TO DEFICIENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 206	transferred to the emittee employee then so not in any distress whis stoma (airway). We investigation was conthe incident of the HM #3's stoma (airway) his stated, "No." The emittee resident's HME. During a telephone in PM, Employee #31 (Fithat she informed the HME was "stuck in his sure how the HME go (Resident #3) did not stoma it would have be employee stated that days a week, and on facility nursing staff was employee #31 so nursing staff education Resident #3's lary-tube documented the train office. The employee nursing staff to do an ensure competency. During a face-to-face approximately 3:00 Pistated that respiratory training on tracheostory provide education on or HMEs. The employregularly worked on the stoma is not in the store in the sto	ergency room for evaluation hared that Resident #3 hen the HME was lodger/hen asked if an aducted to determine how the being lodged in Resident properties and the was responsible for characteristics of the	was d in w dent nging 2:35 stated s ot ne ur n the ning ME.	L 206			8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING		٠,	C 4/20/2022	
NAME OF F		HFD02-0017	CTDEET ADD		TE 7/D CODE		+/20/2022	
NAME OF P	PROVIDER OR SUPPLIER			RESS, CITY, STAT	RROUGHS AVE. NE			
DEANWO	OOD REHABILITATION A	ND WELLNESS CEN		ON, DC 2001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 206	A review of in-service documented evidence education on the lary. During a face-to-face approximately 3:30 F stated that the respir responsible for provider to the state of the transfer of the respiratory therapist written documentation staff. However, she is records of education therapist." There was no evident developed a personfor and provide nece #3 who had a laryng Resident #3's airway medical device HME transferred to the ER device.B. Review of complaint received by 12/06/21 documente on 07/08/21, was obsort/10/21 with "leg por Resident #409 was a dislocated hip and him state agency. Resident #409 was a 07/08/21 with diagnor for Orthopedic After of Artificial Hip Joint, Al	e training documents lace that staff was provided at the true of true of the true of the true of the true of the true of true of true of the true of true	d at ator) the the to tory are ent by a rgery c'"	L 206			8/24/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
		HFD02-0017	B. WING		04/2	20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
			INIE HELEN BU	IRROUGHS AVE. NE			
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN WASHING	STON, DC 2001	9			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO		COMPLETE DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PROPRIATE	DATE	
			1				
L 206	Continued From page	e 162	L 206			8/24/22	
	and Mobility.					0/24/22	
	-						
		terly MDS for Resident #409					
		aled that facility staff coded					
	the following:						
	In Section C (Cogniti	ve Patterns), a BIMS					
		9", indicating that the					
	resident had severely						
	•	, ,					
	07/08/21 at 8:29 PM	[Admission Note]					
		nitted from [Name of Local					
	Hospital] for rehabilit	•					
		ent has hip abduction with					
		eight bearing as tolerated).					
		utions initiated: resident ses' station with close					
		and commonly used items					
	within close reach"	and definitionly adda terms					
	07/10/21 at 3:29 PM	[Physician's Progress Note]					
		equest of Nurse Manager					
	,	nt reportedly has increasing					
	•	gery, worse with movement					
		(narcotic pain reliever) prn					
	(as needed) for 14 da	ays for breakthrough pain"					
	07/10/21 at 5:40 PM	[Situational, Background					
		t (SBAR) Communication					
		insfer to [Hospital Name]					
	_	ptom started: 07/10/2021					
	Background S/P (s						
		7/5/2021 A-Assessment					
		nd verbally responsive, no					
		ted. No change in mental					
		quest - Person contacted: depresentative] was at					
	=	ated in person. Notes: She					
		to be transfer[ed] to the					
	Hospital"						

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PRINTED: 07/27/2022 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN (OF CORRECTION	IDENTIFICATION NUME	SEK:	A. BUILDING: _		COM	PLETED
							С
		HFD02-0017		B. WING		04	/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			5000 NANN	NE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHING	TON, DC 2001	9		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FL		PREFIX	(EACH CORRECTIVE AC	CTION SHOULD BE	COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATI	ION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
L 206	Continued From page	e 163		L 206			8/24/22
	07/10/21 at 6:20 PM	[Nurses Note-Late Entr	vl				
		Iside visiting today from					
		en by the medical direc					
	12:30 PM At about	,	tor at				
		eeded an X-ray to be d	one				
		d] to make sure her mot					
	_	ed. Writer explains[ed] to					
		sident has been seen b					
	doctor in her presen[ce] just a few hours ago	o. If				
	there was any conce	rn note[d] the doctor wo	ould				
	have order[ed] an X-	ray. She insisted that sl	he				
		be sent to the hospital					
	_	e she need[ed] an X-ray					
		[away]. Writer told her tl					
		from the doctor, but it w					
	, , , , , , , , , , , , , , , , , , , ,	-4 hours for the X-ray to					
		Name] was notified and					
		will take about 4-6 hour					
		ent should be transfer[r	_				
	· · · · · · · · · · · · · · · · · · ·	emergency transport for					
		r family requestResion he facility at 5:50 [PM] t					
	[Hospital's Name]."	ne lacility at 3.30 [FIVI] t	U				
	[1103pitar3 Name].						
	07/12/21 at 6:34 PM	[Hospital Discharge					
		ent presents from [Name	e of				
		nas been staying for the					
		ghter and son-in-law we					
	visit her looked un	der her covers and four	nd				
	that her left leg was s	significantly inwardly rot	tated.				
	They were concerned	d something is going wi	rong				
	with the surgery at th						
		tion to the hospital					
		uction: closed joint redu					
		ng a hip dislocation with					
		oulation of thigh bone (fe	•				
		place) ED (Emergency					
		/Critical Care2:30 AM					
	patient's hip was red	ucedshe tolerated the	е				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				_			<u> </u>
		HFD02-0017		B. WING		1	20/2022
NAME OF PI	ROVIDER OR SUPPLIER	S	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'		IE HELEN BU ON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	, , , , , , , , , , , , , , , , , , ,	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
L 206	Continued From page	e 164		L 206			8/24/22
	hip inNarratives: 0 back to [Name of Fac	ver did take 4 tries to get to 2:27 PM plan to discha cility]. 03:51 PM cleared st knee immobilizer for	rge				
	revealed no documer	#409's medical record need evidence that facility usual occurence to the					
	During a face-to-face interview with Employee #8 (Unit Manager/Registered Nurse) on 04/20/22 at approximately 4:00 PM, he stated, "The incident happened on a weekend, when I was not here. I am not sure why the facility did not investigate or file a report. The incident was documented in the progress notes and in an SBAR."		at nt . I or				
L 339	3247.16 Nursing Faci	ilities		L 339			
	front and each of the adequate room for oth as needed. This Statute is not m Based on observation interview, for one (1) the facility's staff faile access to the bathroom	n and resident and staff of 105 sampled residents d to provide Resident #17 om and an elevated toilet dent to be dependent on	l as nt, s,				
	The findings include:						

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HFD02-0017	B. WING		04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	-
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	Έ
L 339	Continued From page		L 339	L339: STARTS HERE:	8/24/22	2
	was also observed that the bathroom did not have an elevated toilet seat. Resident #113 was admitted to the facility on			CORRECTIVE ACTION FOR T AFFECTED RESIDENT:	HE	
	06/19/14. The resided Muscle Weakness, G Walking, and Osteopo Review of a Quarterly 02/09/22 showed Resummary score of "15 had intact cognition. I revealed Resident #1 supervision and required of one person for tolk the toilet during this a steady and requiring during surface-to-surwheelchair. Additional	ant has a history of General Generalized Arthritis, Difficulty orosis. If Minimum Date Set dated sident #113 had a BIMs 5," indicating the resident Further review of the MDS 13 was coded for needing iring the physical assistance et use, not moving on and off assessment period, not being staff assistance for stability face transfers, and using a ally, the resident was coded or incontinence and frequent		Resident #113 was assessed of 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP updated. Rehab team will provide an elevatorilet seat in the resident's bath. Unit Manager explained to resident mext room to residents #113 room to always leave the bath. door unlock when not in use. Resident verbalized understand be corrected immediately but not than 8/24/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE	vated room. Jent in its poom. Jing to plater	
	04/12/22 lacked docu order for an elevated			AFFECTED: All residents with shared bathro have the potential to be affected	om	
	Focus Area- [residen urinary incontinence muscle tone (revision Interventions: -Brief use: the resider Change when wet an -Check for incontinent incontinent care as no Focus Area -[residen (Activity of Daily Livin	nt uses disposable briefs. Id prn (as needed). Id provide eceded. It's name] has an ADL Id provide eceded. It's name] has an ADL Id provide eceded.		House wide audit will be conduct by DON/Designee to identify rewho need elevated toilet seats. issues found will be corrected by 8/24/22. House wide audit will be conduct by Unit Managers and the maintenance team to ensure shouthroom can easily be accessithe residents. Any issues found be corrected by 8/24/22.	sident Any y cted ared ble by	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
741012141	or correction.	IDEIVIII IO/WIOWWOODE	-1 V.	A. BUILDING: _		CONTRACT	-125
						c	;
		HFD02-0017		B. WING		04/2	0/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHINGT	ON, DC 2001	9		
(V4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		· ·	PROVIDER'S PLAN OF CORRECTIO	ıN.	(YE)
(X4) ID PREFIX	_	CY MUST BE PRECEDED BY FUL	_L	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATIC	DN)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
L 339	Continued From page	e 166		L 339	MEASURES TO PREVEN	T	8/24/22
			_		RECURRENCE:		
		ne] will improve current le	evel				
		r and personal hygiene.			In service will be provided	hy Staff	
		sident upon arising, after			Educator to all	by Clair	
	meals and at bedtime	e.					
					CNA's on the importance t		
		dated 11/11/21 showed	that		the charge nurse if a resid		
		Bariatric Commode [an			having difficulties using the	Э	
	elevated tollet seat tr	nat's placed over a toilet]			bathroom because the toil	et seat is	6
	During a face to face	intomious on 02/20/22 o	4		too low completed by 8/24	122	
	_	e interview on 03/29/22 a				, 	
		PM, Resident #113 stated or, who she shares a	ıııaı		Charge pures will notify th	_	
		s the bathroom door lock	rod		Charge nurse will notify the		
		s the bathroom. The resi			therapy team when they g		
		ving access to the bathro			that a resident is having di		
		e toilet is too low, and sh			using the toilet so the resid	dent can	
		ly transfer from the toilet			be assessed for the use of	an	
	-	n asked how she uses th			elevated toilet seat. Any is	sues	
		#113 said that she uses t			found will be corrected by		
	· · · · · · · · · · · · · · · · · · ·	d), cleans herself up, and			lound will be corrected by	0/27/22.	
	calls staff to remove				The second secon		_
					Therapy team will ensure		5
	During a face-to-face	e interview on 04/12/22 a	t		who need elevated toilet s	eat are	
		#59 (Restorative Aide) st			assessed and provided on	e as	
		ked with the resident on			soon as possible so that the	ne	
	transferring from the	toilet to the wheelchair			resident will not depend or		r
	because the resident	t needed an elevated toil	et		toileting. Any issues found		
	seat.				corrected by 8/24/22.	Will DC	
	Deminer of 6				001100104 54 012-1122.		
	_	e interview on 04/12/22 a			Nurse aides are encourag	od to	
		#55 (Occupational Thera					
		her an elevated toilet sea			frequently check the bathr		
	made her supervisor	The employee said that	sne		door between room 315 ar		
		aware the resident's ad not been delivered.			316 to ensure the bathroom	m door	
	erevated tollet seat n	au not been delivered.			is unlocked. Any issues fo	und will	
	During a face to face	interview on 04/12/22 a	t		be corrected by 8/24/22.		
		#56 (Certified Nursing	L				
		t she had worked with the	e				
	′	ear, and the resident do					

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				_		C	
		HFD02-0017		B. WING		1	0/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		IIE HELEN BU	RROUGHS AVE. NE		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	***************************************	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
L 339	not call for assistance employee stated that herself" when she soi then said that when R	e for the bathroom. The the resident "changes Is her brief. Employee a Resident #113 changes it in a trash bag and ca	#56 her	L 339	MONITORING CORRECT ACTIONS: The DON/ Designee will conduct rounds to ensure residents who need an ele	all evated	8/24/22
L 410	3256.1 Nursing Facili	-		L 410	toilet seat are assessed by therapist and assign one if applicable.		
	maintenance services exterior and the interior sanitary, orderly, commanner. This Statute is not meased on observation failed to provide hous necessary to maintain environment as evide curtains in six (6) of 7 bathroom vents in five a foul, offensive odor and malfunctioning paconditioner (PTAC) unresident rooms.	ns and interview, facility ekeeping services in a safe, clean, comfort inced by damaged priva 6 resident's rooms, soil in (5) of 76 resident's rockaged terminal air	the fe, staff able acy led oms,		Maintenance team will cor frequent rounds on all unit ensure that shared bathrouseasily accessible by all pa Findings will be corrected immediately and reported QAPI Director /committee weekly x4 and monthly x 3 L 410 STARS HERE: CORRECTIVE ACTION FOR THE AFFECT RESIDENT: All rooms will be assessed, to ensure that the clean and free from odor, and that the envir clean and homelike .Findings were corrected.	s to om is rties. to 3. TED ney are onment is	
	facility on March 30, 2 PM, and on April 4, 20 3:45 PM, the following 1. Privacy curtains we the rails in six (6) of 7 rooms #211, #308, #309, #310,	ere torn and separated 6 resident's rooms incl	1 and from uding		IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All rooms in the facility have the potential to by this deficient practice. Damaged privacy curtains in rooms #211, # #309,#310, #311 NA #329 are clean and un Room #420, #428, #502, #516, #524 are cleaned with no smell of urine noted. Bathroom vents in rooms # 401, #405,#428 #529 are clean. Air conditioners in rooms 329,#508, #524 we checked. Findings will be corrected by 8/24.	be affected 308, idamaged. , #420,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPLI		
		HFD02-0017	B. WING	B. WING	
	ROVIDER OR SUPPLIER	D WELLNESS CEN 5000 N	ADDRESS, CITY, STA ANNIE HELEN BU NGTON, DC 2001	RROUGHS AVE. NE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 410	#405, #428, #420, and #529. 3. A strong urine odor room #420, #428, #50 of 76 resident's rooms st. 4. PTAC (Packaged Tunits did not function reach set temperatures in thr (#209, #508 and #524) These findings were a #16, and/or Employee	was evident in resident 02, #516, and #524, five (5) urveyed. Ferminal Air Conditioner) as intended and failed to ee (3) of 76 resident rooms	L 410	MONITORING CORRECT ACTIONS: Director of Maintenance an Housekeeping director will validate that all privacy curtains, bathroom vents, condition units are function properly and that the rooms free from odor weekly x4 th monthly x3. Findings will be corrected immediately and reported to QAPI committee	air ing s are nen
L 521	assured privacy durin receiving personal ca This Statute is not m Based on record revie one (1) of 105 sample failed to ensure that F with respect and dign provide an environme resident's quality of lift individuality and mediand the findings include: Resident #64 was additional calculations as a surface of the sample of	respect and dignity and g treatment and when re; et as evidenced by: ews and staff interviews, for ed residents, facility staff Resident #64 was treated ity evidenced by failure to ent that enhances the fe, was based on his	L 521	L521 CORRECTIVE ACTION FO AFFECTED RESIDENTS: Resident #180 was assess head to toe by Unit Manage 4/26/2022, resident suffere negative outcome. MD/ RP on 4/26/22. Comprehensive plan to address behavior of urinating on the bathroom f smearing bathroom with fee be updated.	ed from er on d no notified e care f

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:).	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		I	C 20/2022	
DEANWO	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CEN	NASHINGTON, DC 20	BURROUGHS AVE. NE	DECTION.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	11111111	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
L 521	Encounter for Fractur (Generalized), Spinal According to the quart dated 01/22/22, the runder Section C0500 he is cognitively intact Under Section G0110 resident was coded a extensive assistance one-person physical actensive actensiv	led Leg below Knee, e, Unspecified Femur, Initiate, Muscle Weakness Stenosis, Site Unspecified Interly Minimum Data Set esident was coded as "15 BIMS Score indicating the st. District Functional Status, the as "3", indicating he require for toilet use, with assist. District Functional Status, the assist. Functional Status, the assist. District Functional Stat	ed. grant ed ed ed ed ed ed ed ed th	IDENTIFICATION OF WITH THE POTENTI. AFFECTED;' All residents residing facility have the potent affected. Licensed clinical team (LPN/RN) conducted audit on 4/22/2022 to no other resident is strees on the floor. Any found will be corrected 8/24/22.	in the intial to the members house wide ensure that mearing y issues	8/24/22	

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING.			
		HFD02-0017	B. WING		1	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	INIE HELEN BU STON, DC 2001	RROUGHS AVE. NE 9		
(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	(X5) COMPLETE DATE
L 521	Continued From page with feces. He said the use the toilet, he doed This, he said, has be #180, in room #515, year. Resident #64 said, as embarrassed to have his diaper, but he has Staff is aware he said Resident #180 urinate he would like to move not moving because and he was told a lor who complains is the Face-to-face interview 04/07/22, between 1: Employee #51 (RN or Resident #180 often room and in the bath his hand and under he these behaviors and regularly. Employee #51 said the sometimes ask for he mostly uses diapers. Employee #52 (CNA) sometimes urinates of in the bathroom, and every time he goes to gets feces on his har #180 behavior, and he will be the said the sa	e 170 nat although he would like to s not, because of the smell. en going on since Resident moved in sometime last s a grown man, he is staff clean him and change is no choice. d, and staff has even seen e on the floor. When asked if e. Resident #64 said he was of Resident #180's behavior, ag time ago that the resident one who should move. ws were conducted on 15 PM and 2:00 PM: n 5 North) confirmed that turinates on the floor, in his room. He also gets feces on his nails. Staff is aware of clean his hands and nails nat Resident #64 will elp to go to the bathroom but a) said that Resident #180 on the floor in his room and his hands must be cleaned on the bathroom because he and. Staff is aware of Resident the documents it. r stated, Resident #64 uses	L 521		to all bers, by staff vays th feces visors to mearing ssues 8/24/22. to mearing ssues 8/24/22. ts are ces	8/24/22
	Employee #50 (CNA)) said that Resident #180				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		' '	(X3) DATE SURVEY COMPLETED			
		HFD02-0017		B. WING		_	C 04/20/2022	
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L 521	messes up the bathrouses the diapers. Employee #53 (CNA) years. She also said the floor and gets fectries to wipe himself. she documents it. Employee #53 stated go to the toilet but " because it 's always A review of Resident 04/08/22 at approxim care plan for Bowel Ir interventions to "encotoilet to evacuate bow through resident and no indications that Reto use the toilet. Employee #54 alterna North and 5 South. D	is poop on his hands and form. Resident #64, she so has worked on 5 North that Resident #180 pees es on his fingers when h Nursing staff is aware, at that Resident #180 used stopped using the toiled messy". #64's medical records on a tely 10:00 AM on show regularity with specific burage resident to sit on wels if possible". However staff interviews, there we staff interviews, there we staff interviews, there we staff interviews as a RN between 5 turing a face-to-face 2, at 10:35 AM, he reveal es diapers only and	said, for 5 s on lie lind d to t n er, ere staff	L 521	Unit Managers will ensure residents with behavior of urinating on the bathroom is smearing the bathroom wit feces have a care plan for behavior in place. Such reswill be assessed for toiletin program. Any issues found be corrected by 8/24/22. MONITORING CORRECT ACTIONS: DON/Designee will audit residents' chart to ensure the resident centered care plan revised, updated and implemented as indicated. audit will take place weekly then monthly x3, findings we corrected immediately and reported to QAPI committee.	floor, h such sident ig I will IVE	8/24/22	
L 529	3269.1l Nursing Facil	ities ental or physical abuse;		L 529				
	and staff interviews, f residents, facility staff	et as evidenced by: n, record review, residen for seven (7) of 105 sam f failed to ensure residen e (willful infliction of injury	pled nts					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(3) DATE SURVEY
AND FLAN OF CORRECTION IDENTIFICATION NOMBER. A BIJLI DING-	COMPLETED
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WASHINGTON, DC 20019	
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L 529 Continued From page 172 L 529 L 529	8/24/22
	0,,
and neglect as evidenced by: failure to prevent	
THE WIND INDICTOR OF SCHOOL HIDLY OF DESIGED	`
#404 by Resident #82; failure to implement AFFECTED RESIDENTS:	
person center care measures for Resident #151	
who had incidences of aggressive behavior Resident # 404 was sent to the	he
Trestastic in the state of the	
to Posident #67: failure to ensure staff received	101
training to provide person-centered care to	
Resident #409 post hip replacement,	
subsequently the resident sustained a dislocated	
hip; failure to ensure Resident #3's airway IDENTIFICATION OF OTHER	DC
	-
(stoma) was not occluded by a medical device WITH THE POTENTIAL TO E	BE
Heat Moisture Exchanger (HME) subsequently, AFFECTED:	
the resident to be transferred to the Emergency	
Room (ER) for dislodgment; and failure to have	vo the
available lary-tube and HME (medical equipment) All residents in the facility have	
for treatment and care of Resident #3's stoma potential to be affected by this	is
subsequently, the resident was transferred to the practice.	
ER a second time for replacement of the	
Lary-tube. DON/ Designed will conduct	
DON/ Designee will conduct	
Actual harm was determined to be present for house wide audit to ensure the	nat
Residents #404, #71, #67, #409, and #3. the nurses are monitoring and	id
providing ongoing assessmer	
The findings include: and interventions for resident	
Review of the facility policy entitled, "Prohibition of supply will be corrected by 8/2	
	24/22.
Abuse" [not dated], documented, "Abuse is the	
willful infliction of injury resulting in physical	
harm, pain or mental anguish Willful, as used	
in this definition of abuse, means the individual	
must have acted deliberately, not that the	
individual must have intended to inflict injury or	
harm Neglect, is failure of the facility, its	
employees or service providers to provide goods	
and services to a resident that are necessary to	
avoid physical harm, pain, mental anguish or	
emotional distress"	
Review the facility policy entitled,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING: COMPLE				
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L 529	L 529 Continued From page 173 "Resident-to-Resident Altercation/Incidents"			L 529	MEASURES TO PREVENT RECURRENCE:		8/24/22
	revised in 01/2022 do resident is observed of aggressive to having the potential for abus assessment of strates	ocumented, " When a or identified as being aggressive behavior or ing other residents, an gies to prevent such ing will be provided by	r has		In- service will be provided by 8 Educator/ Designee to License on the importance to ensure th residents with behavior are mo and supervised during their shi completed by 8/24/22.	d Nurses at nitored	
	Review the facility policy entitled, "Your Rights and Protections as a Nursing Home Resident" revised on 03/2022 documented,"You have the right to be free from verbal, sexual, physical, and mental abuse" 1. Facility staff failed to prevent the willful infliction of serious injury of Resident #404 by Resident #82 evidenced by failure to adjust Resident #404's plan of care resulting in a resident-to-resident altercation. Review of a Facility Reported Incident (FRI) dated 02/23/22, documented, "The charge nurse observed [Resident 404] sitting on the floor besides his roommate's bed #420A; the charge nurse noticed blood on [Resident #404's] left ear and mouth. The nurse assessed [Resident #404's] left ear and mouth and there was no skin tear or abrasion including his face [Resident #82] was interviewed he said, "that man keeps coming over to my bed side and when I asked		nt" e the		Competency check list will be completed by Licensed nurses indicate that they understand h work with residents with aggres behavior. Any issues found will	ow to ssive	
			ent		corrected by 8/24/22. ADON/Designee will ensure the are monitoring and supervising residents with aggressive behaduring their shift. Any issues fo be corrected by 8/24/22.	l avior	
				Unit Mangers will validate that with behavior problems are mo and supervised every shift, and there is documentation to justif supervision. Any issues found corrected by 8/24/22.	onitored d that y		
	him to go back to his me on my stomach at on the chin and he fe Review of a Complair documented, "famil they say their father v	side of the bed, he pur nd chest and I punched II" nt dated 03/26/22 y is hoping for answers was brutally beaten at a	nched d him s after		Charge nurses will conduct rou ensure that residents with aggressed behavior are being supervised shift. Any issues found will be a by 8/24/22.	essive every	
		District. [Representative ew that his father [Res					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S COMPLI	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIDER.		A. BUILDING:		COMPLETED	
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L 529	Name]. [Resident #40 March 20 (2022)" Review of a Complain documented, " Avoid Patient assaulted in right was assaulted 02/22/ facility by another resident trauma with ble and mouth. He was the hospital and later died. Resident Background A. Resident #82 was 09/15/21 with multiple Schizophrenia, End Schizophrenia, Interview and Schizophrenia (ADLs), used a received antipsychoti	while living at the [Facility 24] died from his injuries of the dated 03/31/22 dable death. Comments: nursing home. Beneficiary 2022 in skilled nursing sident. He sustained blunt eding noted on his left ear ransferred to an acute d" If Information: admitted to the facility on diagnoses that included: Stage Renal Disease and g Loss. Berly Minimum Data Set 2 showed that facility staffew for Mental Status (BIMS 4", indicating intact cognitival or behavior symptoms ers, required supervision was sist for activities of daily walker for mobility and c medications. Is admitted to the facility or ses that included: a without Behavioral ar Dementia without ces and Transient Cerebra 4404's medical record	S) ve vith	L 529	Unit Managers will assess resident determine if they qualify for one-on-one supervision second aggressive behavior, if they qualify that services will be provided until seen by psych do unit Managers will ensure that intervention in the care plan for intrusive behavior is being implemented. Any issues found be corrected by 8/24/22. Education will be provided to residents with a BIMS score of and above to report any reside is intrusive to the charge nurse CAN'S. Frequent rounds will be conducted by Licensed nurses N A during their shift to monitor residents who and nonverbal or unable to identify an intruder. A identified intruder will be redire out of the room and supervised completed by 8/24/22 Family members will be updated their loved one is exhibiting introbehavior either through mail or telephone or during interdisciple meetings. Documentation of intrusive behavill be documented, plan of caupdated, and implementations carried out as indicated. Any is found will be corrected by 8/24.	r dary to alify, octor. every d will 12 nt who s or eand C rany cted I rusive inary eavior re sues	8/24/22

Health Regulation & Licensing Administration STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
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L 529	coded a BIMS summsevere cognitive imparage in Section E (Behavior psychosis, no physical directed towards other pushing, scratching, gsexually), verbal behavior towards others (e.g., screaming at others, "1 to 3 days", wander daily" In Section G (Function (how resident walks by room), "Supervision wassist" and no function motion In Section P (Restrain wander/elopement also wander/elopement also wander/elopement also wander/elopement also wandering to the adjacent unit on 5 adjacent unit on 7/3/2 Wandering to the adjace	IDS] showed facility staff ary score of "03", indicating airment. or), no potential indicators of all behavioral symptoms ares (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred ing behaviors "occurred ing behaviors "occurred in all Status), walk in room between locations in his/her with one person physical anal limitation in range of ints and Alarms), arm, "Used daily" (Revision date) "[Resident openent: cognitive a Observed wondering at 6/28/2021. Wandering to the end and the end of the adjacent unit in adjacent unit irected Avoid leaving erved for long periods of ant/wandering monitoring and behavior Documentation	L 529	MONITORING CORRECTIVACTION: DON/Designee will conduct to ensure that residents are accounted for, monitored, a supervised every shift. This will be conducted weekly x4 monthly x3. Findings will be addressed immediately and reported to QAPI committee	audits nd audit audit	
	02/02/22 at 2:12 PM	" Elopement attempts.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
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L 529	Continued From page 176		L 529		8/24/22
	Wanderingsleeping in other people's bed Behaviors are constant."				
	02/03/22 at 1:12 PM bed. Behaviors are co	" sleeping in other people onstant."			
	02/07/22 at 1:52 PM " sleeping in other people's bed. Behaviors are constant."				
	02/09/22 at 1:47 PM "sleeping in other peoples bed. Behaviors are constant."				
	02/10/22 at 12:17 PM "sleeping in other peoples bedBehaviors are constant."				
	02/11/22 at 11:16 AM bed. Behaviors are co	" sleeping in other people onstant."			
	02/13/22 at 12:32 PM peoples bedBehavi				
	02/14/22 at 2:10 PM bedBehaviors are c	"sleeping on other peoples constant."			
	02/16/22 at 1:28 PM bedBehaviors are c	"sleeping on other peoples constant."			
	02/18/22 at 2:19 PM bedBehaviors are c	"sleeping on other people's constant."			
	02/19/22 at 1:18 PM bedBehaviors are c	"sleeping on other peoples onstant."			
	02/20/22 at 12:23 PM peoples bedBehavi				
	documented, "Observ	ol dated 02/21/22 at 2:40 AM vations face Blood was th, we managed to stop it by uss and ice"			

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Health Regulation & Licensing Administration

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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DEANWO	OD REHABILITATION AN	WASHING	TON, DC 2001	9	
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTION	J (V5)
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				DEFICIENCY)	
L 529	Continued From page	e 177	L 529		0/04/00
					8/24/22
	o:: ::				
	•	Assessment Request			
	` ,	22 at 4:00 AM showed,			
	"Situation The resid	ent got hit by his			
	roommate Backgrou	und: Altered mental status			
	Resident Reports Pai	n? 'No'. Non-verbal			
	-	lent? 'No'. Functional Status			
		ound Status- (area was left			
		t (area was left blank)			
	,	,			
		At approximately 02:30			
		erved [Resident #404] sitting			
		nmate's bed (420 bed A)			
	with blood coming out	t of his left ear, face. The			
	writer immediately no	tify the supervisor and called			
	911. DC (District of Co	olumbia) police. I saw			
	·	tting on his walker facing			
		writer asked [Resident #82]			
	_	ent stated 'I hit him because			
		DC fire department arrived			
		and left with [Resident			
	#404] in a stretcher a	•			
	ambulance attendants	s to [Hospital Name].			
	[Physician Name] and	d RP (representative) was			
	made aware."	, ,			
	02/21/22 at 4:16 AM [Nursing Supervisor			
		Charge Nurse reported that			
	•	rounds, Resident [#404]			
		on the floor beside Room			
		noted with some blood on			
		e, a quick assessment was			
		ed for pain and discomfort.			
	Resident could not de	escribe what happened. This			
	is his base line. A qui	ck assessment was done,			
	Range of motion exer	cise was done, ice was			
	•	e of the face, vital signs was			
		ature) 96.5, P. (pulse) 82, R.			
	, -	. (blood pressure) 140/90,			
	opoe (sp) (oxygen sa	turation) 97% on Room Air."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETI						
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L 529	02/21/22 at 1:43 PM placed to [Hospital Na status of the resident nurse [Registered Nu Resident (#404) is cri intubated and about t (intensive care unit). During a tour conduct approximately 3:00 P document was observed the nurses station tha 08/10/2021 4 South L Behavior Documentat #404] Common behave wondering, elopemented" Review of this evidenthad knowledge of and #404's intrusive behave resident's rooms and beds. a. Although the facility address Resident #40 resident units; there we care plan was update residents intrusive be resident rooms and side sident #404's behave resident such as put for physical injury, into the resident such as put for physical injury, into the resident place in the resident such as put for physical injury, into the resident place is the resident place is the resident place in the resident place is the resident place is the resident place is the resident place in the resident place is the	[Nurses Note] "A call warme] to know about the [#404] in the ER, spokerse's Name] who stated tically ill, he has been to be transferred to ICU RP made aware." Ited on 03/28/22 at M of unit 4 south, a factoried taped to a partition at stated, " Updated consist of Residents for Daition. Room #420D [Residents for Daition. Room #420D [Residents for Daition. The stated of t	e with d ility at on ily sident oples staff t ent's ce to her e e other e e t risk or	L 529			8/24/22	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) CC 04/20/2022 STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019 SUMMON ANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PREFIX TAG			WASHING	TON, DC 20019	9		
c. Although the staff record that Resident #404 was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to manage the residents behavior. During a face-to-face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) stated. "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed. "When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's beds. Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] are plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation" that stated Resident #404's behavior, Employee #7 stated, "I didn't see it." 2. Facility staff failed to provide adequate supervision and implement the plan of care interventions for Resident #151 to protect and prevent Residents #71 and #67 from incidences of aggressive behavior (resident-to-resident altercations) and willful infliction on injury. Review of Facility Reported Incidences showed the following altercations involving Resident #151:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETE
was being monitored hourly, he was still found wandering into other resident rooms and sleeping in their beds. There is no evidence that monitoring the resident was readjusted to manage the residents behavior. During a face-to-face interview conducted on 04/04/22 at 12-48 PM, Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in other resident's rooms and sleeping in other resident's beds, Employee #7 stated, "I was never made aware by the nurses on the unit. I knew him (Resident #404) as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation" that stated Resident #404's behavior, Employee #7 stated, "I didn't see it." 2. Facility staff failed to provide adequate supervision and implement the plan of care interventions for Resident #151 to protect and prevent Residents #71 and #67 from incidences of aggressive behavior (resident-to-resident altercations) and willful infliction on injury. Review of Facility Reported Incidences showed the following altercations involving Resident #151:	L 529	Continued From page	e 179	L 529			8/24/22
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2. Facility staff failed to provide adequate supervision and implement the plan of care interventions for Resident #151 to protect and prevent Residents #71 and #67 from incidences of aggressive behavior (resident-to-resident altercations) and willful infliction on injury. Review of Facility Reported Incidences showed the following altercations involving Resident #151:		into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation" that stated Resident					
At 0730AM, the security officer observed		see it." 2. Facility staff failed supervision and impleinterventions for Resiprevent Residents #7 of aggressive behavioral altercations) and willf Review of Facility Rethe following altercations Review of the FRI da	to provide adequate ement the plan of care ident #151 to protect and r1 and #67 from incidences or (resident-to-resident iul infliction on injury. ported Incidences showed ons involving Resident #151:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ED.	PLE CONSTRUCTION G:	(X3) DATE COMF	SURVEY PLETED	
		HFD02-0017	B. WING _		04	C / 20/2022
NAME OF F	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY,	STATE ZIP CODE	, , ,	
TO THE OT 1	TO VIDEN ON OUT FIEN			BURROUGHS AVE. NE		
DEANWO	OOD REHABILITATION A	ND WELLNESS CEN	WASHINGTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	1	(EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
L 529	[Resident #151] assa [Resident #71] at the Review of the FRI daAt 2030 on 12/29/2 alleged to the recept him on his chest x 2 Resident Background A.Resident #151 was 10/22/20 with multipl Unspecified Psychos Benign Prostatic Hype Review of Resident # revealed: 12/08/21 [Admission BIMS summary score cognitive impairment In Section E (Behavioral Summary score cognitive impairment In Section E (Behavioral Summary score firmly held, contrary to behavioral symptoms (e.g., hitting, kicking, grabbing, abusing of this type occurred 1 symptoms directed to threatening others, sat others) - "Behavioral symptoms directed to threatening others, sat others) - "Behavioral symptoms directed to threatening others, sat others) - "Behavioral symptoms directed to the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on others primary for the significant risk for phimpact on the significant risk f	aulting another resident a front of the building" ated 01/02/22 document 2 (12/29/21), [Resident #15 in the lobby" d Information for Resident #15 in the lobby d Information for Resident #15 in the lobby	ents' on ed: and ed a re s or of rioral sing to 6 ent at r/yes"; risk of			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING			20/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	NNIE HELEN BU GTON, DC 2001!	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG			Y FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETE DATE
L 529	In Section G (Function Daily Living (ADL) Astransfer, walk in room locomotion on unit, low #151 required "super physical assist" Review of the Care Proceed to 7/27/21 (Revision day positive PASARR (Procedure Pasarrange) Leveraluation, it was det needs Specialized Sefacility. Related to: som MD (medical doctor) serious health decline agreed to may need a linform the MD of any require additional evaremove services" 07/27/21 (Revision day for changes in behave agitation" 10/18/21 (Revision day redure additional evaremove services" 10/18/21 (Revision day redure additional evaremove services"	others? "yes"; significantly environment? "yes" anal Status): Activities of sistance - bed mobility, h, walk in corridor, ocomotion off unit, Resident vision" and "one person Plan revealed: ate) "As evidenced by a readmission Screening and vel I screen and Level II ermined that the resident revices while in the Nursing chizophreniaInform the rif the Individual has a read services previously to be modified or deleted. Significant changes may aluation to add, modify or ate) "[Resident #151] at risk for problems related to: ate) "[Resident #151] has n which resident acts oppopriate behavior; resistive ated to: Cognitive Impairment renia). Non compliant with on compliant with vital signs, having and showers. Non reguard placement kicking	L 529			8/24/22
	taking medications, non compliant with vital signs, non compliant with shaving and showers. Non compliant with Wader guard placement kicking and hitting" 10/20/21 (Revision date) "[Resident #151] has					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING			
		HFD02-0017		B. WING			20/2022
NAME OF P	ROVIDER OR SUPPLIER	S	TREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
		5	000 NANN	IE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	/ASHINGT	ON, DC 2001	9		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION))	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
L 529	Continued From page	e 182		L 529			8/24/22
	impaired cognitive function or impaired thought processes r/t (related to) Dementia"						
	,	ate) "[Resident #151] uses	5				
	psychotropic medicat						
	management, Parano Monitor/record occur	rence of for target behavio	r				
	symptoms violence	_					
	staff/others) and document per facility protocol" 10/22/21 (Revision date) "Resident #151] has						
	behavior problem r/t (Combative, Spilling water						
		srobing) r/t Schizophrenia.					
		roommate into the room,					
	_	other room and refusing to gitation, hitting multiple sta					
		reak down doors in the	ali				
		and rolling on the floor 1	:1				
	staff monitoring for sa sitter is available"	afety until seen by psych o	r				
	B. Resident #71 was	admitted to the facility on					
		e diagnoses that included					
	without Behavioral Di	der, Unspecified Dementia isturbance and	a				
	Hypertension.	71's medical revealed, a					
		1713 medical revealed, a 110/23/21where facility sta	aff				
	1	ary score of "09", indicatin					
		npairment, no potential	J				
		is and no physical or verb					
	• •	s, limited assistance with o					
	range of motion and i	st for ADLs, no limitations i no skin conditions.	ın				
	C. Resident #67 was	admitted to the facility on					
		e diagnoses that included					
	Unspecified Intellectu	ıal Disabilities, Psychotic					
	Disorder with Hallucir Dementia without Bel	nations, and Unspecified havioral Disturbance.					

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NAME OF PROVIDER OR SUPPLIER HFD02-0017 STREET ADDRESS, CITY, STATE, ZIP CODE C 04/20/202	22
111 502-0011	22
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	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) DMPLETE DATE
L 529 Continued From page 183 L 529 8/2	24/22
Review of Resident #67's medical revealed, a Quarterly MDS dated 11/06/21 where facility staff coded a BIMS summary score of "14", indicating intact cognitive response, no potential indicators of psychosis, no physical or verbal behavioral symptoms, limited to extensive assistance with one person physical assist for ADLs and no limitations in range of motion. Altercation #1 involving Residents #151 and #71: 12/08/21 at 11:18 AM [Nurses Note] " At 0730AM, the [Security Officer's Name] and the [Receptionist's Name] observed resident [#151] assaulting another resident [Resident #71] at the front of the building. The security officer and the receptionist ran to the residents and separated both residents. "Resident #71] was interviewed. He said, 'the man jumped on me in front of the building for no reason. I have never spoken to him. I don't know where this came from today' asked [Resident #151] why he assaulted [Resident #71]. He said, he raped my daughter' The MPD (Metropolitan Police Department) was called took [Resident #151] because of his aggressive behavior and transported him to [Hospital Name] at 0809 (AM) for evaluation. [Resident #71] was assessed and small scratch mark observed on the back of his left hand" Altercation #2 involving Residents #151 and #67: 12/30/21 at 11:30 AM [Nurses Note] " At 2030 (8:30 PM) on 12/29/2 (12/29/21) Resident #71] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby; the receptionist notified the supervisor; the supervisor assessed [Resident #71] and the denied any pain At 2040	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		_			
	HFD02-0017	B. WING		04/20/2022	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	FE, ZIP CODE		
DEANWOOD REHABILITATION AND	WELLNESS CEN'	NIE HELEN BUF TON, DC 20019	RROUGHS AVE. NE		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE	
building stood by the grab and hit staff exiting staff exit or enter the bud pepartment was called (11:50 PM). 2 MPD rPM). During interview was not cooperating; he of the Police Officers. [Finto custody [Resider this AM (morning). He alateral abdomen over hin No swelling, discolorating during assessment. He Review of Resident #15 showed documented agresident-to-resident alter There was no document staff revised Resident # protect other residents; Resident #151 attacked facility. In both instance removed from the facility behaviors towards othe During a face-to-face in 04/14/22, Employee #7 acknowledged the finding Resident #151 has bee admitted back to the facinot had any resident-to-3. Facility staff failed to training to provide person to hip precautions) for Findal left hip surgery.	vas redirected back to the building entrance trying to g the building will not let uilding. The DC Police and notified at 2340 responded at 2345 (11:45 with [Resident #151], he e made attempts to hit one Resident #151] was taken in t #67] was assessed alleged being hit on the is previous surgical site. on or open area observed denied pain" 51's medical record ggressive behaviors and a ercation on 12/08/21. Inted evidence that facility #151's plan of care to and then on 12/29/21, dianother resident at the es the resident was ty due to his aggressive er residents. Interview conducted on (Clinical Coordinator) ings and stated that en on 1:1 since he was cility in 01/2022 and has resident altercations.	L 529		8/24/2	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HFD02-0017		B. WING		04	C 1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A		5000 NAN	PRESS, CITY, STANIE HELEN BU	RROUGHS AVE. NE	,	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 529	observed two days la positioned like the le sent to the hospital for surgery. Resident #409 was a 07/08/21 with diagnor for Orthopedic Afterdartificial Hip Joint, Al (Unspecified), Repeat (Generalized), and Coand Mobility. Review of Resident are revealed the following A Quarterly Minimum Resident #409 dated facility staff coded the In Section C (Cognition Interview for Mental Score was "99," indicated in Section G (Function for transfers, toilet us resident was totally or more person's phymore staff. For bed relimited physical assist member. For dressing extensive physical assist member. In Section H (Bowel incontinent" for bladding in the section of the	rgery on 07/08/21, was ater on 07/10/21 with "letter 'K'" Resident #40 or a dislocated hip and admitted to the facility of oses that included: Encorare, Presence of Left tzheimer's Disease ated Falls, Muscle Weal Other Abnormalities of Grand (MDS) for a 107/11/21 revealed that e following: live Patterns), the Brief Status (BIMS) Summar cating severe impaired onal Status), ADL assiste, and personal hygien dependent and required sysical assistance from the mobility, the resident recistance from one staffing, the resident required sesistance from one staffing and Bladder) - "Always der and bowel"	eg 19 was hip n bunter kness Gait t y tance: ne, the I two wo or quired d f	L 529			8/24/22
	In Section J (Health	Conditions), "Yes" to:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED		
		HFD02-0017	B. WING			C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE	, , , , ,		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	IANNIE HELEN BU INGTON, DC 2001	RROUGHS AVE. NE 9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 529	prior to admission /en fracture related to a fa to admission /entry or major surgery during admission; resident h procedure during the that requires active can ln Section O (Special and Programs), start Physical Therapy "07 07/08/21 at 12:10 PM Summary] "Hospital with left hip fracture; replacement). With no complicationsDischWeight Bearing as LeftRestrictions as precautions" 07/08/21 at 8:29 PM "Resident was adm Hospital] for rehabilital ArthroplastyReside pillow and WBAT. Fal initiated: resident local with close monitoring used items within close 07/08/21 (3:00 PM-11 Documentation], facil Resident #409 was gibed mobility and proviousle and bladder.	iny time in the last month outry or reentry; resident have all in the last 6 months prior or reentry; resident have the 100 days prior to ave a major surgical prior inpatient hospital stay are during the SNF stay. Treatments, Procedures, date for Occupational and //09/2021." I [Hospital Discharge I Course Patient presented status post Arthroplasty (hip or postoperative harge Procedure Orders Tolerated (WBAT); Laterally; follows: Posterior hip station post left hip ent has hip abduction with I and safety precautions attion close to nurses' station, call light and commonly see reach" 1:00 PM) [CNA ity staff documented that ityen a bath, assisted with ided incontinent care for Order] "Left hip: monitor left over the past of the process of the process of the process of the past of the	L 529			8/24/22	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
		HFD02-0017		B. WING			C 4/20/2022
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		ON, DC 2001	RROUGHS AVE. NE 9		
(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 529	07/09/21 at 2:18 PM and Plan of Treatmer therapy after having a that resulted from a fallexion past 90 degre or internal rotation, W 07/09/21 (7:00 AM-3: Documentation], facil Resident #409 receiv assistance with dress mobility, and provider and bladder. 07/09/21 (3:00 PM - Documentation], facil Resident #409 receiv mobility, and provider and bladder. 07/09/21 (11:00 PM-7 Documentation), facil Resident #409 receiv mobility, and provider and bladder. 07/09/21 (11:00 PM-7 Documentation), facil Resident #409 receiv mobility, and provider and bladder. 07/10/21 [Physician's between lower extrer reposition when resident #409 receiv mobility and provider and bladder.	[Physical Therapy Eval at Note] "referred to set a L (left) hip hemiarthrocall Precautions (notes, abduction past midle //BAT" 100 PM) [CNA lity staff documented the red a bath/shower and sing, assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for both dity staff documented the red assistance with bed d incontinent care for	skilled plasty ine, at d owel at owel at owel at at owel	L 529			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:			
						С	
		HFD02-0017	B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE			
TO AVIC OF T	NOVIDER OR OUT FIER			RROUGHS AVE. NE			
DEANWO	OD REHABILITATION A	ND WELLNESS CEN'	GTON, DC 2001				
0.40.15	CLIMMADY C	TATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CO	DDECTION	0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
1 520	Continued From non	400	L 529			8/24/22	
L 529	Continued From pag	e 188	L 529				
		PM) [CNA Documentation],					
	facility staff documer	nted that Resident #409					
		ver and assistance with					
	dressing and bed mo	obility.					
	07/40/24 at 2:20 DM	[Dhysisian's Dragrass Note]					
		[Physician's Progress Note]					
		request of Nurse Manager					
	and the family. Patient reportedly has increasing pain at the site of surgery, worse with movementadded oxycodone (narcotic pain reliever) prn						
		ays for breakthrough pain"					
		ayo lor broakin ough pulli					
	07/10/21 at 5:40 PM	[SBAR] "Resident transfer					
	to [Hospital Name]	. Date problem or symptom					
	started: 07/10/2021 .	Background S/P (status					
	post) left hip Arthrop	lasty done on 7/5/2021					
	A-Assessment Re	sident is alert and verbally					
	I	rent distress noted. No					
	-	itus notedR-Request -					
	Person contacted: [N						
		at bedside. Communicated					
		e [Representative] requested					
	ner mom to be trans	fer[ed] to the Hospital"					
	07/10/21 at 6·20 PM	[Nurses Note] "Family was					
		day from 11:45 AM Resident					
	_	dical director at 12:30 PM,					
		nter requested that she					
	_	ded an X-ray to be done					
		d] to make sure her mothers'					
		ed. Writer explains[ed] to the					
		esident has been seen by the					
		t (sp) just a few hours ago. If					
	_	ern note[d] the doctor would					
		ray. She insisted that she					
	_ = =	be sent to the hospital					
		e she need[ed] an X-ray to be					
	_	[away]. Writer told her that an					
	X-ray can be gotten	from the doctor, but it will					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
				A. BUILDING:				
		HFD02-0017		B. WING			C / 20/2022	
NAME OF PROVIDER	OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DEANWOOD REF	IABILITATION AN	ND WELLNESS CEN		IIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9			
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take be done doctor be do the hot further was ta [Hosp 07/12]. Summ Facilitifies day visit he that he They with the reque (Emer2:30 processurgeNarrito [Nadischard	[Physician's Nor said an X-ray of the resided pospital via non-ear evaluation per aken out from the ital Name]." /21 at 6:34 PM hary] "The patienty, where she hays Her daugher looked under left leg was so were concerned by the sted transportation of the patienty) tolerated for treating the concerned by the patienty of the Resided documented for the Resided documented for Resided documented for Resided documented for Resided (21, provided heance and hip prent #490's hip with the patient with the patient for the Resided (21, provided heance and hip prent #490's hip with the patient for Resided (21, provided heance and hip prent #490's hip with the patient for the patient for Resided (21, provided heance and hip prent #490's hip with the patient for the patient for the patient for the patient for Resided (21, provided heance and hip prent #490's hip with the patient for the patient f	e 189 4 hours for the X-ray to dame] was notified and will take about 4-6 hour ent should be transfer[remergency transport for family requestReside facility at 5:50 [PM] to the facility	the rs to ed] to det] to dent o ee of spast ent to nd deated. deated out oack r ord ort otstaff to vision, at ent ut of it see	L 529			8/24/22	

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PRINTED: 07/27/2022 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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		HFD02-0017		B. WING		04/2	0/2022	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
DEANNAG	OD DELLADU ITATION AN	ID WELL NESS SEN!	5000 NANNII	E HELEN BU	RROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN	WASHINGTO	ON, DC 20019	9			
(X4) ID PREFIX TAG			I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
L 529	on her leg. Her leg w 'K'. I spoke with the u wanted to see the do the doctor, who said primary doctor, and h pain. I insisted that m her hip. I was told the time (4-6 hours), so I She told me she did n and I can call 911, so said it wasn't a medic called a non-emerger was transported to [H During a face-to-face approximately 3:30 P stated, "I told the dau (x-ray). She insisted to [Resident #409's] hip the hospital. Per the doctor's permission, a ambulance was calle transferred out to [Ho of the incident." During a face-to-face approximately 4:00 P Unit Manager) stated with hip precautions of the resident is admitted. Employee #8 stated, in the resident's room and two (2) nurses w evening shifts on this the pillow/wedge bets to put the hip immobi how to roll the reside	as positioned like the lett nit manager and told her ctor. They finally brought he wasn't my mother's he ordered oxycodone for mother get an X-ray for X-ray would take a long asked the nurse to call shot have a doctor's ordered I did. 911 showed up and lemergency, so they [State of the call of	r I t in r r g 911. r g 911. r her st ttor) take at the BAR t oor ss ical ning put how d her	L 529			8/24/22	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		HFD02-0017		B. WING			C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE RROUGHS AVE. NE		.20.2022	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN		ON, DC 2001				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
L 529	able to provide a cop sign in sheet or the h provided to the staff. There was no eviden the necessary staff tr to meet Resident #40 surgery. 4. The facility's staff #3's airway (stoma) v medical device Heat subsequently, causin transferred to the Emdislodgment, keep a equipment in the facilicare for and treat Resistoma subsequently, transferred to the ER obtain/provide Resided. These failures resulted #3. 4A. The facility's staff #3's airway (stoma) v medical device HME resident to be transfer (ER) for dislodgment. According to Johns Hottps://www.hopkinsiesources/glossary.html HME is a humidifying the trach tube and cosizes. It is also known	t." Employee #8 was not y of the "impromptu trais andouts that he said we ce that facility staff provaining and staff supervi 19's needs status post he failed to ensure Reside was not occluded by a Moisture Exchanger (H g the resident to be ergency Room (ER) for supply of respiratory melity that was necessary sident #3's laryngectom the resident had to be for a replacement; and ent #3's with HMEs. The failed to ensure Reside was not occluded by a subsequently, causing a subsequently, causing the remedicine.org/tracheostem of the emergency of the failed to the f	ning" ere rided sion iip ent ME) edical to y and sident ent the room omy/r end of and s	L 529			8/24/22	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	` '	E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN			RROUGHS AVE. NE		
	T		WASHINGT	ON, DC 20019			
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L 529	L 529 Continued From page 192			L 529			8/24/22
	Resident #3 was admitted to the facility on 12/01/2021 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status.						
	Review of an Admission Minimum Data Set (MDS) assessment dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank, indicating the resident had not been assessed. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services. A continued review showed that Resident #3 was not coded for receiving respiratory therapy services.						
	Review of the resider the following:	nt's medical record reve	aled				
	-12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27upon assessment, resident alert and oriented to person and placeResident has a lary tube with cap [HME] in place		omy 7/27 ted to				
	progress note]- Pt. (p appears alert and sta tracheostomy and do (blood pressure), 86	hysician assistant physicatient) seen at bedside blePt. also has ing wellvitals: 126/81 (pulse, 18 (respiration), RA (oxygen saturation ra	97.6				
	-12/02/21 [physician day shift.	order]- Change HME da	aily				
		espiratory therapy nitial assessment, Resid d with lary tube and hol					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			CONSTRUCTION		TE SURVEY MPLETED
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DEANWO	OD REHABILITATION A	ND WELLNESS CEN'		IE HELEN BU ON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 529	holder changed. HM assessment respirat room air, lung sound assessment respirat capillary oxygen satulung sounds clear -12/03/21 [physician the nearest ER (emercy aluation related to evaluation related to evaluation related to evaluation related to respiratory therapist has an HME stuck in Resident has a laritiand no respiratory didenied pain. No blee (saturation) checked RA (room air). [Doctoinstruction to transfe (emergency room) for Resident's granddauknow what happene explainedwhen she changed HME on ye (airway) was clear by there was an HME sterapist explained to maybe the HME initi (airway) and the resimplement was alive, inhow she determine non-verbal 911 ca at 1400 v/s (vital spressure), 63 (pulse)	Lary tube cleaned, tube E changed. Pre-treatment ory rate 18, SPO2 98% [or is clear Post-treatment ory rate 18, SPO2 (peripheration) 99% on room air, order] - transfer resident to gency room) for further stuck HME in stoma. The stoma (airway). The resident was assess stress noted. Resident adding noted. O2 (oxygen) stress in the stoma was 99% or's name] notified. He gave resident to nearest ER or further evaluation. The respiratory therapise did care for lari-tube and sterday 12/2/21, the stoma at today she observed that tuck in the stoma. The or the granddaughter that ally stuck down in stoma dent coughed it up the stress or pain and asked that since resident is lied at 1345 and they arrive stress or pain and asked that since resident is lied at 1345 and they arrive.	n] eral o ne tt sed st d a tt	L 529			8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN			RROUGHS AVE. NE		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	WASHING	ON, DC 20019	PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 529	9 Continued From page 194			L 529			8/24/22
	radiology XR (x-ray) r PA (posterior-anterior Call for follow-up approvithin 2 to 4 days [pro "How to Clean a Trac -12/04/21 at 07:54 [nt Resident came back 129/89 (blood pressur 98% (oxygen saturation -12/04/21 [physician of stoma in neck. The [physician of stoma	my malfunction. Diagnostick soft tissue, XR chest of tissue, XR chest of the Art (lateral) 2 view of progress note] - from the hospitalon arre), 18 (respiratory rate) on rate) on room air. Order] - Do not occlude the patient] is an obligate new prostomy malfunction. Pt. ppears alert and stable dipressure), 71 (pulse), A (oxygen saturation rate or progress notes lace that Employee #31 et has employe	st w. r rival ck ess as . 17 e on r to cked				
	Review of the compre	ehensive care plan with a	an				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		p.	LE CONSTRUCTION S:		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CEN	STREET ADDRESS, CITY, S 5000 NANNIE HELEN E WASHINGTON, DC 20	BURROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
L 529	Focus Area- [residen (related to) laryngeal Goal- [resident's nandrainage around tracedate. Will have no shinfection through the Interventions- lari-tut daily, assist with course of a lary-tube and 12/03/22. Review of a complain Department of Health that Resident #3 was 12/03/21, because the (Resident #3) neck is Resident #3 was unatime of the survey be the hospital on 03/25. During a telephone in AM, the resident's recordinator and the inher informing her that grandfather's stomal informed her what he neither one of them of clinical coordinator] is things that happened.	21 showed the following: at's name] has lary tube r/l cancer. ane] will have no abnormathea site through the reviews (signs/symptoms) of review date. be care daily, change HM gh as needed sident#3's comprehensive cumented evidence of ess care for Resident #3'd HME from 12/01/22 to an	lew IE e s ed o his the d to I1:35 d ner of			8/24/22
		PM, Employee #32 (LPN) nething in his neck two tir				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING			C / 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	JD WELLNESS CEN. 5000 N	ADDRESS, CITY, STA ANNIE HELEN BU NGTON, DC 2001	RROUGHS AVE. NE		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 529	time. I had training for remember when." The don't remember the real HME." During a face-to-face 2:25 PM, Employee # reported that when the informed him that an resident's stoma (airwayseried to the em The employee then so not in any distress whis stoma (airway). We investigation was conthe incident of the HM #3's stoma (airway) investigation was conthe incident of the HM #3's stoma (airway) is stated, "No." The emprespiratory therapist with the resident's HME. During a telephone in PM, Employee #31 (If that she informed the HME was "stuck in his sure how the HME go (Resident #3) did not stoma it would have be employee stated that days a week, and on facility nursing staff we Resident #3's lary-tuk Also, Employee #31 soursing staff education Resident #3's lary-tuk documented the train office. The employee	ees him (Resident #3) all the om respiratory, but I don't e employee also stated, "I esident (Resident #3) using interview on 04/13/22 at #7 (Clinical Coordinator) erespiratory therapist HME was stuck in the way), he had Resident #3 ergency room for evaluation. hared that Resident #3 was nen the HME was lodged in when asked if an inducted to determine how ME being lodged in Resident appened, Employee #7 ployee also said the was responsible for changing enterview on 04/14/22 at 2:35 Respiratory Therapist) stated staff that Resident #3's sestoma (airway). I'm not be stuck in his stoma. If he get the HME out of his peen detrimental." The she worked three to four the days, she was not in the ras responsible for cleaning the and changing the HME. Seaid that she provided on on how to care for	L 529			8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	E SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER	L	STREET AND	LRESS, CITY, STA	TE ZIP CODE		4/20/2022
TVAIVIL OF T	NOVIDEN ON OUT FIELD				RROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CEN		ON, DC 2001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 529	9 Continued From page 197			L 529			8/24/22
	approximately 3:00 F stated that respirator training on tracheost provide education on or HMEs. The emplo regularly worked on tresided, she could no him. A review of in-service	e interview on 04/14/22 at PM, Employee #33 (RN) y therapy provided her womy care, but they did not laryngectomy's, lary-tub yee said that although shithe floor where Resident of remember working with	ith ot es, ne #3				
	documented evidence that staff was provided education on the lary-tubes or HMEs. During a face-to-face interview on 04/14/22 at approximately 3:30 PM, Employee #4 (Educator) stated that the respiratory therapist was responsible for providing staff education on the lary tube and HME. The employee said that the respiratory therapist was to provide her with written documentation of education provided to staff. However, she said, "I don't have any records of education provided by the respiratory therapist."						
			tor) ne ne				
	for and provide nece #3 who had a laryngo Resident #3's airway medical device HME	centered approach to car ssary services to Resider ectomy. Subsequently, (stoma) was occluded by	nt				
	respiratory medical e was necessary to cal laryngectomy (lary-tu	ed to keep a supply of equipment in the facility the re for and treat Resident labe) and stoma (airway). sident had to be transferi	#3's				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	NIE HELEN BU STON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
L 529	Medical Science, a latube designed to main the laryngectomy surmaintain the airway a laryngectomy. (https://patientslearn.ds/sites/95/2018/03/LReview of Employee Therapist) signed and description, showed the providing necessary resident (sp) to perform Resident #3 was adn 12/01/2021 with multion Malignant Neoplasm Larynx, Acquired Abstracheostomy Status Review of an Admiss 12/03/21 revealed the Summary Score sect resident was not asseresident was coded for care and speech there. Review of the resider a physician's order desirevealed the following 10/1/07/22 at 4:51 PM	versity of Arkansas for ary tube is a flexible silicone intain the stoma right after gery. A lary tube is used to and can be following a uams.edu/wp-content/uploa.ary_Tube_Care.pdf) #31's (Respiratory didated 06/03/19 job that she was responsible for material and equipment for rm required therapy. Initted to the facility on iple diagnoses including of Larynx, Carcinoma of sence of Larynx, and is. Ion MDS assessment dated at the Brief Interview Mental ion was blank, indicating the essed. Additionally, the or receiving Tracheostomy rapy services. Int's medical record revealed ated 12/02/21that stated, aily on day shift." Sident #3's medical record go nursing progress notes: "It was observed today that	L 529	DEFICIEN	NO.1)	8/24/22
		tube is out. He was assessed				

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			SURVEY PLETED
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	HFD02-0017	B. WING		04	/20/2022
ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
OD REHABILITATION AN	ID WELLNESS CEN				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
send resident out to the replacement. 911 arrival control of the replacement of t	the ER for laryn [lary] tube wedleft at 4:40 PM. " "Image: "Image: Image:	L 529			8/24/22
therapist assessed or	provided care for Resident				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE REGULATORY OR LE SEGULATORY	TIDENTIFICATION NUMBER: HFD02-0017 ROVIDER OR SUPPLIER STREIF OD REHABILITATION AND WELLNESS CEN: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 199 send resident out to the ER for laryn [lary] tube replacement. 911 arrivedleft at 4:40 PM. " -01/07/22 at 6:10 PM: "[MD's Name] called from [Name of Hospital] need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission." -01/08/22 at 6:32 AM: "Resident returned from [Name of Hospital] at 2:30 AM in stable condition O2 SAT (oxygen saturation) 95% RA (room air)."; and -01/08/22 at 4:02 PM: "Resident alert and orientedResident observed with difficult breathing with the new lary tube placed from hospital 1/7/22. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary tuberesident O2 sat (oxygen	ROVIDER OR SUPPLIER TOD REHABILITATION AND WELLNESS CEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 199 send resident out to the ER for laryn [lary] tube replacement. 911 arrivedleft at 4:40 PM. " -01/07/22 at 6:10 PM: "[MD's Name] called from [Name of Hospital] need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission." -01/08/22 at 6:32 AM: "Resident returned from [Name of Hospital] at 2:30 AM in stable condition O2 SAT (oxygen saturation) 95% RA (room air)."; and -01/08/22 at 4:02 PM: "Resident alert and orientedResident observed with difficult breathing with the new lary tube placed from hospital 1/1/22. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary tuberesident O2 sat (oxygen saturation) 98." Review of the comprehensive care plan with an initial date of 12/04/21 and revision date of 1/7/22 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube replacement. Goal- [resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed Review of a respiratory therapy assessment/infection screener progress note lacked documented evidence the respiratory therapist assessed or provided care for Resident	ROVIDER OR SUPPLIER BY STREET ADDRESS, CITY, STATE, ZIP CODE SOON MANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OF LSC (DENTIFYING INFORMATION) COntinued From page 199 Send resident out to the ER for laryn [lary] tube replacement. 911 arrivedleft at 4:40 PM.* -01/07/22 at 6:10 PM: "(IMD's Name) called from [Name of Hospital] need to know the size laryngectomy tube. RT (respiratory therapy) note said size was gathered at admission." -01/08/22 at 6:32 AM: "Resident returned from [Name of Hospital] at 2:30 AM in stable condition O2 SAT (oxygen saturation) 95% RA (room air)."; and -01/08/22 at 4:02 PM: "Resident alert and orientedResident observed with difficult breathing with the new lary tube placed from hospital 1/7/22. Resident's family took him to [Name of Hospital] of 100-up and possible change of lary tuberesident O2 sat (oxygen saturation) 98." Review of the comprehensive care plan with an initial date of 12/04/21 and revision date of 1/7/22 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube replacement. Goal- [resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (sign/symptoms) of infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed Review of a respiratory therapy assessment/infection screener progress note lacked documented evidence the respiratory therapist assessed or provided care for Resident	TODRECTION IDENTIFICATION NUMBER HFD02-0017 BY WING DO REHABILITATION AND WELLNESS CEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATION ON LIST DIENTIFINE INFORMATION) Continued From page 199 Continued From page 199 Continued From page 199 L 529 Continued From Page 199 C 529 C 52

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NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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DEANWO	OD REHABILITATION A	ND WELLNESS CEN	WASHING	TON, DC 20019	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 529	Continued From page 200			L 529			8/24/22
	complainant alleged the ER on 01/07/22 due to facility throwin had.	#DC00010525 showed that Resident #3 was sofor a lary tube replaceming out the one (lary-tube interview on 04/12/22 at randdaughter stated that	ent to ent e) he				
	AM, the resident's granddaughter stated that the facility made her aware of the lary-tube missing. She stated, "I told them that my grandfather's lary tube was missing when I visited him 5 days prior. I asked them why it took them so long to get his lary-tube replaced."		sing. 's lary prior.				
	PM, Employee #31 (that when the reside (01/07/22) she had t for replacement. The while Resident #3 was the emergency room about the size of the could not give the ph did not know the size When asked if it was respiratory supplies, but she could not or because she "did no asked if she made th medical director awa I don't talk the doctor	nterview on 04/14/22 at Respiratory Therapist): nt's lary tube was misple he resident sent out the employee then reported as in the emergency rocal staff called her to inquiresident's lary-tube, but yesician the size because of the resident's lary-tube as her responsibility to order Resident #3's lary-tube to the resident physician of the resident physician of the resident physician of the resident's physician of the resident's physician of the employee stated are, the employee stated or in the physician of the	stated acced ER ed that om ire t she se she cube. der es" ube or d, "No,				
	no evidence that fac Resident #3's Lary T therefore, none were	ith Employee #31 there ility staff knew the size of ube to order replaceme e available in the facility Resident #3 was sent to	of ents, for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING		04	C / 20/2022
	PROVIDER OR SUPPLIER	AND WELLNESS CEN 5000	EET ADDRESS, CITY, STA D NANNIE HELEN BUI SHINGTON, DC 20019	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
L 529	emergency room for 4C.Facility staff fails #3 with HMEs that we mucus production a and filtering the air I from 01/08/22 to 03 According to Oxforce important to keep ye easy to cough up [n wear a stoma proteth Moisture Exchange cassette). These are and will moisten much https://www.ouh.nhs/11587Pstoma.pdf Review of complain allegations that the and HMEs for Resident the following Physical Physician Day shift." 12/02/21 [Physician Day shift." The medical record nursing notes: 01/07/22 at 4:51 Physical was observed today out. He was assess and recommended	r replacement of the lary tube. red to obtain/provide Resident were necessary to help reduce and coughing by humidifying breathed through his stoma //02/22. I University Hospital, it is bur mucus thin so that it is nucous]. You should always ctor such as aHeat (HME: baseplate and e available on prescription acous s.uk/patient-guide/leaflets/files t #DC00010525 revealed facility did not have lary-tubes dent #3. #3's medical record showed				8/24/22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CEN 5000 NA	ADDRESS, CITY, STATE ANNIE HELEN BUR IGTON, DC 20019	E, ZIP CODE ROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 529	lacked documented of therapist assessed of #3 from 01/05/22 to 0. -01/07/22 at 6:10 PM [MD's Name] called four University Hospital) roll laryngectomy tube. For said size was gathered as a size was gathered	espiratory therapy on screener progress notes evidence the respiratory reprovided care for Resident 01/12/2022. I [nursing progress note] - from HUH (Howard need to know the size RT (respiratory therapy) note ed at admission. I [nursing progress note] - from HUH at 2:30 AM in stable signs): 144/75 (blood ation), 70 (pulse), 96.8 AT (oxygen saturation) 95% I [nursing progress note] - friented. Resident tolerated ications. Resident tolerated ications. Resident observed g with the new lary tube 1/7/21. Resident's family for follow-up and ary [laryngectomy] tube oxygen saturation) 98. Administration Records 02/22 showed that the led they changed Resident ayshift. However, it should be respiratory therapist the could not be changed 02/22 because the facility did patible to connect with	L 529			8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBI		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED
							С
		HFD02-0017		B. WING		04	/20/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN	WASHINGT	TON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 529	Continued From page 203			L 529			8/24/22
	Focus Area- [resident (related to) laryngeal for laryn (sp) tube replace Goal- [resident's name drainage around trace date. Will have no s/s infection through the Interventions- lari-tub daily, assist with cough the care plans lacked docinterventions to address.	t's name] has lary tube in cancer, 01/07/22 sent of cement, taken to ER for the cement. The sent of the calculation of the calculation of the calculation of the calculation of the calculation. The calculation of the calc	out r al riew ME ve				0/24/22
	Review of the of an invoice dated 03/02/22 showed the facility ordered one box of 30 cassette HMEs and 1 laryngectomy (Lary) tube. Further review of the invoice showed handwritten entry "received [on] 03/03/22". Review of emails from Resident #3's responsible party to Employee #11 (Social Worker) showed the following:						
	February 8th, I emaile respiratory therapist] name lary-tubes and prior conversation sh that she needed to kr she (Employee #31) supplies. I gave her t (02/07/22). Checked Monday 02/14/22) an belonging (Lary-tubes (Employee #31) has	-"On February 7th and ed [Employee #31's nan in reference to Residen HME's being ordered. It is (Employee #31) state now the size of tube so to could order his (Resider he information on the 7th back with her the followed she stated she order is and HMEs)She the information and the HMEs) need to ordered	t #3's n d that nt #3) h ing the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HFD02-0017	B. WING		04/20/2022
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DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'		RROUGHS AVE. NE	
240.15	CLIMMADV CT		FON, DC 2001		ON OUT
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
L 529	Continued From page	e 204	L 529		8/24/22
	ASAP."				
	his (Resident #3) lary ordered. I gave the ne still hasn't received the #31's name- respirate February 7th of 2022 get back with me and are important necess in." 03/25/22 at 12:47 PM HME's and lary-tubes #3's name] back in February 1 back i	I- Has anyone looked into tubes and HMEs being eeded information, and he lose supplies that [Employee bry therapist] ordered on She stated that she would rever did. Theses supplies ities to his current state he is I -It was told to me that the swere ordered for [Resident ebruary. Medicaid is es for said ordersCan you documentation in reference			
	AM, the resident's em (granddaughter) state lari-tube several times be replaced by the tre center) center. She fu [Employee #31; respi and 02/08/22 size for and straps) but she n (Employee #31) a we said [Employee #7-Cl the supplies and she them." During a face-to-face 2:25 PM, Employee #	ed, "He was without a s and they (lari-tube) had to eatment (chemo infusion urther stated, "I emailed ratory therapist] on 02/07/22 supplies (lari-tube, collar, ever responded. I called her lek later (02/14/22) and she linical Coordinator] approved (Employee #31) ordered interview on 04/13/22 at f7 (Clinical Coordinator) oblem with supplies one spiratory therapist			
	,	interview on 04/14/22 at			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED
7.1.5 . 2 . 1. 6 . 66 . 1		A. BUILDING: _		
	HFD02-0017	B. WING		C 04/20/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
DEANWOOD REHABILITATION AND WI	ELLNESS CEN'	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9	
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
approximately 2:00 PM, E Worker) stated that Reside emailed him on 02/22/22, inquiring about order for s Lary-tubes). During a telephone intervity PM, Employee #31 (Resp that Resident # 3 did not at to his lary-tube from "01/0 ordered and received by the When asked why it took so to get the HME, Employee know the size of the reside HMEs we had in house was the lary-tube his family promame of the lary-tube so see HME, but the granddaught told me (granddaughter) the important", and she did not the lary-tube until 02/07/22 that she did call the reside get the size of his lary-tube call her back. However, she (Administrator) and Emplot Coordinator) aware multip #3 did not have HMEs. It should be noted that num in Treatment Administration changed the resident's HM dates: 01/09/22 to 01/25/22 01/27/22 to 02/02/22, 02/04/22 to 02/08/22, 02/11/22 to 02/14/22, 02/18/22 to 02/22/22, and 02/24/22 to 03/01/22.	employee #11 (Social ent #3's granddaughter 03/22, and 03/29/22 applies (HMEs and ew on 04/14/22 at 2:35 airatory Therapist) stated a have HME to connect 8/22 to until they were he facility [03/03/22]". o long for Resident #3 e #31 said "I did not ent's lary-tube. And the as not compatible with evided on 01/08/22." whe reached out to the 22 or 01/13/22 to get the she could order an atter said, "The doctor hat the HME is not et send me the size of 2." Employee #31 said ent's physician once to be once, but he did not not made Employee #1 eyee #7 (Clinical olle times that Resident ersing staff documented on Records that they ME on the following	L 529		8/2422

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED
		HFD02-0017	B. WING			C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AI	ND WELLNESS CEN	NNIE HELEN BU GTON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 529	Continued From page	e 206	L 529			8/24/22
	by the facility with an showed the facility di 03/03/22, at which tir During a face-to-face approximately 2:00 F (Admission Director) residents' medical su facility before the res asked if Resident #3' ordered and in the fa (12/01/22), she state was not in the facility admitted. It should be invoice the facility prodate of 03/02/22, while	e interview on 04/20/22 at				
L 535	of each resident with admission and twice discharge assessme This Statute is not massed on record revi (6) of 105 sampled reto: (1) have a dischar record/document inforesident's discharge clinical record;(3) ensureds were adequate	duct a discharge assessment in fourteen (14) days after annually thereafter. The nt shall include: net as evidenced by: iew and staff interview, for six esidents, facility staff failed rge plan for one resident; (2) formation related to the plan to the community in the sure the residents discharge ely identified and the results charge plan. Residents' #155,	L 535			

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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN SITECT ADDRESS, CITY, STATE, ZIP CODE 500 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 PREERIX (#ACH DEPGENON Must be PRECEDED BY PLUL TAG CONTINUE OF PROVIDER SHAN OF CORRECTION BOULD BE (#ACH DEPGENON Must be PRECEDED BY PLUL TAG CONTINUE OF PROVIDER SHAN OF CORRECTION BOULD BE (#ACH DEPGENON Must be PRECEDED BY PLUL TAG CONTINUE OF THE GROWN OF CORRECTION BOULD BE (#ACH DEPGENON Must be PRECEDED BY PLUL TAG CONTINUE OF TAG CORRECTIVE ACTION FOOLUD BE (#ACH CORRECTION BOULD BE (#ACH CORRECTION BOU		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEN SUMMARY STATEMENT OF DEPICIENCIES (XA) ID PREPRY (EACH DEPICIENCY MUST BE PRECEDED BY FULL) PREPRY (EACH DEPICIENCY) THO findings include: 1. Facility staff failed to update Resident #155's discharge plan and avoid unnecessary delays in the discharge process. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses including. Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded the following: In section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment. In section Q (Participation in Assessment and Goal Setting), yes Resident participated in the assessment and that no family or representative participated Q0400 (Discharge Plan): "Is active discharge planning already occurring for the resident to return to the community? - No" Q0500 (Return to Community): "Ask the resident to return to the community? - No" Review of the care plan meeting notes revealed			HFD02-0017	B. WING		1	
L535 Continued From page 207 The findings include: 1. Facility staff failed to update Resident #155's discharge plan and avoid unnecessary delays in the discharge process. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses including, Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded the following: In section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment. In section Q (Participation in Assessment and Goal Setting), yes Resident participated in the assessment and that no family or representative participated Q0400 (Discharge Plan): "Is active discharge planning already occurring for the resident to return to the community? - No" Q0500 (Return to Community) "Ask the residentDo you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? - No" Review of the care plan meeting notes revealed	DEANWO	OD REHABILITATION AN	STREET ADD STREET ADD 5000 NANI WASHING ATEMENT OF DEFICIENCIES	FON, DC 2001	RROUGHS AVE. NE 9 PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETE
The findings include: 1. Facility staff failed to update Resident #155's discharge plan and avoid unnecessary delays in the discharge process. Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses including, Dysphagia, Oropharyngeal Phase, Unspecified Lack of Coordination, Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Left Dominant Side. Review of the Quarterly Minimum Data Set (MDS) dated 02/18/22, showed that facility staff coded the following: In section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment Goal Setting), yes Resident participated in the assessment and Goal Settingy, yes Resident participated of Q0400 (Discharge Plan): "Is active discharge planning already occurring for the resident to return to the community? - No" Q0500 (Return to Community) "Ask the residentDo you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? - No" Review of the care plan meeting notes revealed	TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		RIATE	DATE
l l l	L 535	The findings include: 1. Facility staff failed discharge plan and at the discharge process. Resident #155 was at 11/18/19, with multiple Dysphagia, Orophary Lack of Coordination, Hemiparesis Followin Cerebrovascular Disc Side. Review of the Quarte (MDS) dated 02/18/22 coded the following: In section C (Cognitive Interview for Mental Standicating severe cognology of the Control of the Community of the Commun	to update Resident #155's void unnecessary delays in s. dmitted to the facility on e diagnoses including, ngeal Phase, Unspecified Hemiplegia and g Unspecified ease Affecting Left Dominant rly Minimum Data Set 2, showed that facility staff The Patterns BIMS (Brief Status) Summary Score "05" nitive impairment. The action in Assessment and sident participated in the no family or representative an): "Is active discharge arring for the resident to ity? - No" The months of the resident to someone about the his facility and returning to ces in the community? - No"	L 535	AFFEDTED RESIDENTS: Resident #155 was assessed to manager on 4/26/22, resident if apparent distress. MD/RP updates Discharge planning in progress. Resident # 170 was assessed 4/26/22, resident in no apparent distress. MD updated. discharge planning in progress. Resident #227 was discharged 4/1/22 Resident #237 was assessed 4/26/22, resident suffered no noutcome. Discharge plan in progress. Resident #406 was sent to the 2/10/22 and did not return to the Resident #412 was discharged.	oy Unit n no ated. s. on nt ed I home on egative ogress. hospital ne facility.	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		HFD02-0017	B. WING		04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER	Sī	REET ADDRESS, CITY, S	TATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	000 NANNIE HELEN E ASHINGTON, DC 200	BURROUGHS AVE. NE 019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 535	talked about things the SW were not doing the care at [facility] at (Resident) moved to revealed the following 11/29/21 at 4:17 PM informed the social whim into assisted lineeded certain docur facility The SW (So requested for the social statement. They were were some problems also requested they r SW will meet her at the Motor Vehicles) for [F (identification)" 12/29/21 at 5:11 PM, ombudsman office] the SW (Social Worker) at [name] stated that [R SW and the transition process towards [Resigname] stated Living Facil 01/06/22 at 3:18 PM, Living SW] [and] she do to assist with [Resident #155] into 03/29/22 at 1:05 PM, (Aging and Disability email out to the family I was able to contain facility] regarding the	rey felt like the facility and agThey are not happy what they wanted him another facility" Work progress notes I'[Resident Representative] Orker that she is trying to giving. She stated that she ments to get him into the pocial Worker) has called arial security income as supposed to fax it but the control of the supposed to fax it but the pocial worker) has called it In addition, the ment of the DMV (Department of the DMV (Department of the DMV (Department of the Supervisory SW the sident #155] to get his ID " [name of staff in the Ombudsman called the land the Supervisory SW the sident #155] going into sity]" "The SW called [Assisted She asked him what could	get and sere	IDENTIFICATION OF OT WITH THE POTENTIAL TAFFECTED: Resident who are due for have the potential to be a this practice. House wide conducted by social service members to determine the no delays in the discharge Will ensure that documenthe discharge process in irresidents' record and ensidents discharge needs are in plaissues found will be corre 8/24/22.	discharge ffected by audit will be ces team at there are e process. tation about in the ure that ace. Any	8/24/22

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HFD02-0017	B. WING		C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	INIE HELEN BU STON, DC 2001	RROUGHS AVE. NE 9		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	E
L 535	SW] is currently looki to me. In the event he assessment he is will come out and re-do to the documented evidence. Resident #155. During a face-to -face 04/14/2022 at 3:44 P Worker) acknowledge "We started talking al man from [assisted lirout to do another assisystemic issue." 2. Facility staff failed information related to plan to the communit Residents #170 and at 2A. Resident #170 wo 08/16/18, with diagnor Diabetes Mellitus with Disease, Cirrhosis of Pulmonary Disease, Muscle Weakness, Dialysis, and Hemipa According to the Qua Dated 02/14/22, Under Score showed Reside indicating that she was Section E Behavior, to behaviors exhibited. Under Section G (Furwas coded as requiring the side of the policy of the plant of th	ng into and will be sending it e cannot access the ing to have another nurse he assessment." medical record lacked e of a discharge plan for e interview conducted on M, Employee #13 (Social ed the finding and stated, bout other placements. The ving facility] is coming back essment this is a to record/document the resident's discharge y in the clinical record for #227. as admitted to the facility on bees which included, Type 2 in Diabetic Chronic Kidney Liver, Chronic Obstructive Congestive Heart Failure, ependence on Renal	L 535	MEASURES TO PREVENT RECURRENCE: Licensed Social workers will e that the discharge plan for res who are due for discharged is out in a timely manner. Any ist found will be corrected by 8/24 Licensed Social services team ensure that documentation ab resident's discharge plan to the community is placed in the residentical records. Any issues for be corrected by 8/24/22. Licensed Social services team ensure that residents discharge needs are identified and ensure these needs are developed in discharge care plan. Any issue found will be corrected by 8/24 In service will be provided by seducator/ designee on the importance of carrying out discontinuous in a timely manner completed by 8/24/22	idents carried sues l/22. will out e ident und will e e o a es l/22.	22

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		HFD02-0017		B. WING		04/2	0/2022
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	5000 NANN	IIE HELEN BU	RROUGHS AVE. NE		
DEANNO	OD REHADIEHAHON AF	ID WEELINEOO OEN	WASHINGT	TON, DC 2001	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 535	35 Continued From page 210 L 535 MONITORING CORRECTIVE ACTION		ACTION:	8/24/22			
	transferring, dressing, toilet use, and personal hygiene. Under Section G0400 Functional Limitation in range of motion, the resident was coded as having no impairment of upper and lower extremity.			Social services Director will audit residents' chart to ensure that there are no delays in discharge planning, that			
					there is adequate documentation resident's discharge plans. This will be conducted weekly x4, the monthly x3. Findings will be con	audit en	
l	Under G0600 Mobility Devices the resident was coded as not using mobility devices.				and report presented to QAPI		
	Under Section Q, the resident was coded as participating in the discharge plan, having "An active discharge plan is already occurring for the resident to return to the community"; and has been referred to the local contact agency. Care Plan last updated on 04/07/21, Focus area, "Goal and Expectation for discharge is to go home"Interventions, "Assess future placement setting to determine if resident's needs can be metreview progress toward discharge during discharge meetings."		n the				
			ment e				
	7:02 AM, read, "The ERESIDENT FOR THE TOTAL TOTA	s Note dated 03/11/22 a SW (social worker) sat wassisted her in filling out of Assisted Living-LS], e of Transition Worker] sage in the presence of will attempt to call her accompletion of the packet ed with the proper (as soon as possible)."	with t the gain s so				
	#13 (Social Worker) of stated, "We transition	ne of Organization]. We	she				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
		A. BOILDING			С
	HFD02-0017	B. WING		l l	20/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWOOD REHABILITATION AND WE	LLNESS CEN'	INIE HELEN BUI STON, DC 20019	RROUGHS AVE. NE 9		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Manager], we are now work Organization] and [Name of get her (Resident #170) into Living We will try [Name of again to see if they are taking again, because that was morganization] is based of motion have no openings for place have the application for [Naturing]. We are still in the pland the resident has to have the application for Resident has to have the application for Resident has to have the application of the status of the application of the applicat	of Case Manager] to on another Assisted of Assisted Living] ing dialysis patients onths ago. [Name of mental health and they ement at this time] ame of Assisted process of submitting it are an interview." ployee #13 it was at taken toward ident #170 have not betive clinical record. It is in the ement at the facility on the included, Deficit, Cerebral tive Pulmonary pertension, Multiple Pressure Chronic with Necrosis of Muscle. In Minimum Data Set at a cognitively intact. In the resident was ibited. In the resident was ibited. In the resident pervision with	L 535			8/24/22

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.		A. BUILDING: _	NG:		LETED
		HFD02-0017		B. WING		I	C 20/2022
NAME OF D	ROVIDER OR SUPPLIER			DECC CITY CTA	TE 710 000E	1 04/	ZOIZOZZ
NAIVIE OF P	ROVIDER OR SUPPLIER			RESS, CITY, STAT	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'		ON, DC 20019			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE
L 535	Continued From page	e 212		L 535			8/24/22
	limited assistance wit	nd off unit; He required th one-person physical erring, dressing, toilet use, e.					
	range of motion, the r), Functional Limitation in resident was coded as none side of upper and					
		der G0600, Mobility Devices the resident was ded as using a walker.					
	Under Section Q, the resident was coded as, "Expects to be discharged to the community"; "An active discharge plan is already occurring for the resident to return to the community."						
	potential for discharge representative exprese home"Interventions family will transport [F	care plan "Resident shows e and resident, relative, or sees wish for discharge s: Arrange transportation Resident #227]. Assess ing to determine if resident' home."	's				
	04/01/22 at 12:42 PM D/C (discharged) hon writer contact APS (A file an APS report. [R puzzled upon dischar provided the son with and informationSon	Work Progress Note dated I showed, "[Resident #227 ne. Upon discharge this adult Protective Services) to esident #227] seemed rege however this writer I his care navigator number in stated that he will contact I follow up with her"					
	#12 on 04/07/22 at 4: told that he had a cas	interview with Employee 45 PM he stated, "We were seworker in the community eHe has an assessment	e				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP			
			A. BOILDING.			C
		HFD02-0017	B. WING			20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN'	NIE HELEN BU	RROUGHS AVE. NE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L 535	Continued From page	e 213	L 535			8/24/22
	from Liberty in the want to wait to be dis be here. He wanted him to go AMA (agair the case worker and provided the number about the resident be That's why I call APS He was adamant aboresident told me that came (to the facility) was going to care for comfortable about hir resident was adaman During a face-to-face #43 on 04/07/22 at 5 resident was suppose 04/05/22. His son did [Resident #227] was home with someone Friday and got him. and picked him up. I workers door saying had a lot of anxiety." There was no eviden updated Resident #2 status of the liberty at Employee #12 failed time that he left a me community case work transitioning back into	system. The resident didn't charged. He was irritated to to go homeI did not want lest medical advice). I called left several messages and to the family. I was worried cause he was not calm. adult protective services. But leaving. The son and the had an aid. The son with someone who said she him. I didn't feel m leaving with her. The strate about leaving the facility." Interview with Employee and to leave on Tuesday. He angry and wanted to go else. The son came on The son was off on Friday the kept going to the social the wanted to go home. He ce that Employee #12 27's clinical record with the sessesment and outcome. To document the date and ssage for the resident's cert o discuss the resident's to the community safely.				O/Z-1/ZZ
	regarding the resident related to being discharge community.	entation in the clinical record it's anxiety and behavior harged from the facility to the wledged the findings on and Employee # 43				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		SURVEY PLETED
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	•	
DEANWO	OD REHABILITATION AN	ND WELLNESS CEN		RROUGHS AVE. NE		
	T	WASH	NGTON, DC 2001			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
L 535	Continued From page	e 214	L 535			8/24/22
	acknowledged the fin PM.	dings on 04/05/2022 at 5:11				
	#237's, #406's and #	to ensure that Resident 412's discharge needs were and the results developed				
	3A. Resident #237 was admitted to the facility on 07/19/19, with multiple diagnoses including Gout unspecified, Unspecified Atrial Fibrillation and Essential Hypertension. Review of the Quarterly Minimum Data Set (MDS) dated 03/17/22 showed that facility staff coded the following:					
	In section Q (Particip Goal Setting) Reside assessment "Yes"	ation in Assessment and nt participated in				
	Q0300 Residents ove not coded	erall expectation Section was				
		n: Is active discharge urring for the resident to nity? "Yes"				
	Review of the care pl following:	an notes revealed the				
	interested in obtainin returning to the comm working with him tow	I, "[Resident #237] is g his own housing and nunity the social worker is ards that goal. He doesn't uments and the SW will g them"				
	Review of the social revealed the following					

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HFD02-0017	B. WING		04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN	TON, DC 2001	RROUGHS AVE. NE 9		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	LETE
L 535	Continued From page	e 215	L 535		8/24	1/22
	will be going to pick ut [Resident #237] and a the process of dischar Further review of the	medical record lacked				
	documented evidence of a discharge plan for Resident #237.					
	During a face-to-face interview conducted on 04/07/22 at 1:10 PM, with Employee #13 (Social Worker) acknowledged the finding and stated, "It's been difficult for him, he's not disabled, and his income isn't enough where he can get an apartment. The plan is for discharge."					
	3B. Resident #406 was admitted to the facility on 01/28/22 with multiple diagnoses including, End Stage Renal Disease, Alcohol Abuse Uncomplicated and Hemiplegia and Hemiparesis Following Cerebral Infarction.					
		sion Minimum Data Set 2 showed facility staff coded				
		ve Patterns): Brief Interview MS) Summary Score "15", ition				
	In section G (Function "Supervision" requiring	nal Status): Bed Mobility ng "Setup"				
	Transfer "Limited ass "One-person physical	· · ·				
	Dressing "Limited ass "One-person physical					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С
		HFD02-0017	B. WING		04/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	NIE HELEN BUI TON, DC 20019	RROUGHS AVE. NE 9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
L 535	Continued From page	216	L 535		8/24/22
	Toilet use "Extensive "One-person physical				
	Mobility Devices "Car	ne/Crutch" "Wheelchair"			
	In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes"				
	Q0300, resident's overemain in this facility"	erall goal "Expects to			
	Q0400 Is active disch occurring for the resid community? "No"	arge planning already dent to return to the			
	Q0600 Has a referral been made to the local contact agency? "No-referral not needed"				
	Review of the social vertexealed the following				
	#406] in reference his stated that he does not time. Prior to his hos shelter. Housing reso explored and the apprecommendations will Identification is a issuin order to apply for h				
	Review of the nursing following:	progress notes showed the			
	the lobby with some of	' He was observed on in of his belongings. His ay to visited him, and he			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _				
		HFD02-0017	B. WING		04/2	0/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DEANNO	OD REHABILITATION AN	5000 NAN	NIE HELEN BU	RROUGHS AVE. NE		
DEANWO	OD REHABILITATION AP	WASHING	TON, DC 2001	9		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
L 535	Continued From page	e 217	L 535			8/24/22
L 535	met resident at the from his belonging and as home. A meeting was Relative], SW, admis Resident attests he doneeds to sign a pape Medical Advice). We #406] to stay until Frinave a proper discharoutside with his [Relative and the care of the care of the consult, and elopement of the care of the	ont entrance with some of king his nephew to take him is held with [Resident #406's sion and the unit manager. iid mot (SP) know that he is to leave AMA (Against convivence (sp) [Resdient day coming when he will riged (sp). However, he went stive] and all of a sudden he is e worker car. Resident was read brought inside the el. He agreed to wait until to be discharge. Psych. Ent risk initiated for the refused wander guard" "[Resident #406] was all name]" an initiated on 02/07/22, with and appropriate discharge." Interventions "on inity, encourageto discuss is with impending discharge. Eass episodes of anxiety fear, team along with [Resident ident representative) will arge plan with specific needs addressed prior to sident #406's medical record evidence of any updates, is for the resident to safely cility.	L 535			8/24/22
	04/11/22 at 4:00 PM	interview conducted on with Employee #10 (Director byledged the finding and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ` ′	(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING			C 20/2022	
	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE RROUGHS AVE. NE	, , , , , , , , , , , , , , , , , , , ,		
DEANWO	OD REHABILITATION AN	WASHING	TON, DC 2001	9			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 535	to leave AMA, it was provided no explanati documented in the dis #406 wanting to leave advice. 3C. Resident #412 w: 02/26/21 with multiple Hemiplegia Unspecifi Nondominant Side, C Myelopathy Cervicoth Abnormalities of Gait Review of the Admiss (MDS) dated 03/07/2 coded the following: In section C (Cognitive for Mental Status (BIN indicating intact cogn In section Q (Particip: Goal Setting): Q0100 assessment "Yes" Q0300, resident's oved discharged to the con Indicated the informa "Resident"	here a short time he wanted not safe for him" and ion why there was nothing scharge plan about Resident e the facility against medical as admitted to the facility on e diagnoses including, ed Affecting Left servical Disc Disorder With noracic Region, and Other and Mobility. Sion Minimum Data Set 1, showed that facility staff are Patterns): Brief Interview MS) Summery Score "15" ition. ation in Assessment and Resident participated in erall goal, "Expects to be namunity" tion source for Q0300 A arge planning already dent to return to the	L 535			8/24/22	
	03/01/21 at 12·52 PM	L "This is an initial care					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HFD02-0017	B. WING		04	C / 20/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, ,	
DEANWO	OD REHABILITATION AN	ID WELLNESS CEN'	NIE HELEN BU TON, DC 2001	RROUGHS AVE. NE 9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 535	team) and resident home" 04/28/21 at 8:46 AM, with [Resident #412's today to begin the disinterested in participar referral for the Waiver the Clinical Team will discharge plkanning (05/10/21 at 1:48 PM, assessed for services [Agency name], 5/14/assigned Nurse will the his room if there are a questions sthe (sp) N Worker" 05/25/21 at 5:52 PM, further benefit from on however he has reque [Resident #412] and he put in place a plan of until the HHA (Home identified and put in ple discharged from [Fine Review of the care plarevealed a focus area resident to have a saf home." Goal "The resident wiverbal needs and requeeds prior to discharged from to discharged prior to disch	with the IDT (Interdisciplinaryplans are to discharge "The Social [Worker] met] POA (Power of Attorney) charge process. Family is ting in [agency name] The Program was completed meet again to continue sp)" "[Resident #412] will be in the community by 21 at 11:00 AM. The elephone [Resident #412] in any additional information or urse will consult this Social " [Resident #412] cou (sp) ur skilled service program ested to be discharged his Responsible party have care for the family to follow Health Agency) have been lace[Resident # 412] will facility]. an initiated on 03/01/21 are in initiated on 03/01/21 are an appropriate discharge. Il be able to communicate uired services to meet age." Interventions meeting will be held with hilly"	L 535			8/24/22

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PRINTED: 07/27/2022 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HFD02-0017	B. WING		04	C / 20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CEN 5000	EET ADDRESS, CITY, STA D NANNIE HELEN BU BHINGTON, DC 2001:	RROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 535	05/26/21 "Discharge musing (sp) PT (phy (occupational therap (prescriptions) on 5/2 Further review of Re lacked documented modifications or plan discharge from the fa During a face-to-face 04/11/22 at 3:51 PM Social services) ackir	resident home with skilled sical therapy)/OT y)/HHA and scripts 26/21." sident #412's medical record evidence of any updates, as for the resident to safely acility. e interview conducted on personal properties in the properties of the finding and me there was no way he	L 535			8/25/22

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