Health Regulation & Licensing Administration

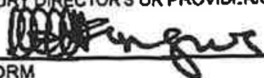
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments 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 sampled residents. The facility's census during the survey was 255. The following complaints were investigated during this survey: DC00010689, DC00010640, DC00010663, DC00010638, DC00010532, DC00010531, DC00010525, DC00010503, DC00010493, DC00010435, and DC00010365. The following facility reported incidents were investigated during this survey: DC00010721, DC00010720, DC00010719, DC00010717, DC00010694, DC00010656, DC00010651, DC00010645, DC00010644, DC00010636, DC00010634, DC00010618, DC00010584, DC00010575, DC00010576, DC00010565, 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,	L 000	Deanwood Rehabilitation and wellness center Disclaimer: The facility submits this plan of correction under procedures established by the department of Health in order to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of alleged deficiencies or any admission of any wrongdoing.	8/24/22

Health Regulation & Licensing Administration

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



TITLE LNHA

(X6) DATE 8/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ________ B. WING ________	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 1	L 000		8/24/22

Continued From page 1

DC00010336, DC00010334, DC00010330, DC00010314,

This survey did identify substandard quality of care at 42 CFR 483(c)(2)(3)(4) F610 and 42 CFR 483.25(d)(2) F689. The extended survey was conducted on April 20, 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:

AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
cm - Centimeters
CFR- Code of Federal Regulations
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CRF - Community Residential Facility
CRNP- Certified Registered Nurse Practitioner
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C- Discontinue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 2 Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight N/C- nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POS - physician ' s order sheet	L 000		8/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Continued From page 3 Prn - As needed Pt - Patient Q- Every RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		8/24/22
L 015	3203.5 Nursing Facilities Each facility shall maintain the following administrative records: (a)Payroll records; (b)Reports of fire inspections; (c)Compliance reports required to be maintained pursuant to the 1996 BOCA National Building Code, construction and permit regulations; (d)Reports of inspections of the fire alarm system and fire drills; (e)Reports of elevator inspections; (f)Disaster plan and procedures; (g)Certification of flame spread ratings of carpets, curtains and wall coverings; (h)Each contract for professional and facility	L 015	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #404 went to the hospital on 2/21/22 and later expired. Resident #82 was assessed on 4/26/22 by clinical coordinator, resident suffered no negative outcome.MD/RP notified on 4/26/22. Resident placed on 1:1 for monitoring for aggressive behavior until evaluated by psychiatrist , Resident taken by DC police into custody on 7/20/22, currently not in the facility. Resident # 151 was assessed on 4/26/22, resident suffered no negative outcome. Resident is currently on 1:1 monitoring for aggressive behavior Resident #408 was sent to the ER on 2/17/22 and did not return to the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 015	Continued From page 4 services; (i)Radiation survey reports of x-ray equipment, if applicable; (j)Summaries and analyses of each incident involving residents, staff and visitors; and (k)Policies and procedures governing the operation of the facility. This Statute is not met as evidenced by: Based on observation, record review and staff interview, Governing body failed to ensure that established and implemented policies regarding the management and operation of the facility were followed and action plans were developed and implemented to: prevent resident-to-resident abuse and altercations for six (6) residents; ensure adequate supervision was provided to one (1) resident who sustain a dislocated hip of unknown origin; adequately supervise one (1) resident who sustained a fall with injury; ensure the appropriate respiratory medical supplies were on hand for care and treatment; ensure staff were trained on how to care for two (2) residents with a laryngectomies; and to ensure the administrative staff maintained the integrity of an Incident/Accident Report (investigative report) for one (1) resident. The census on the first day of survey was 255. The findings include: 1. In the area of Freedom from Abuse, Neglect, and Exploitation, Administration failed to ensure residents were free from abuse (willful infliction of injury) and neglect as evidenced by: failure to prevent the willful infliction of serious injury of Resident #404 by Resident #82; failure to	L 015	Resident # 3 was discharge home on 3/29/2022 Resident # 126 was assessed on 4/26/2022,by Unit Manager, resident suffered no negative outcome. MD/RP notified on Resident # 164 was assessed on 4/26/2022,by Unit Manager, resident suffered no negative outcome. MD/RP notified 4/26/22 Resident # 183 was assessed by Unit Manager 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 on the left forehead on 4/7/22. RP/MD notified on 4/7/22 Resident #304 was assessed on 4/26/22, for respiratory distress, resident suffered no negative outcome. MD/RP notified on 4/26/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED;' All residents residing in the facility have the potential to the affected. Licensed clinical team members (LPN/RN) conducted house wide audit on 4/22/2022 to ensure that the residents have a person-centered comprehensive care plan, that residents with dentures have them and if need be, assistance with wearing the dentures, that residents with non-compliant behavior have documentation on the implementations and that residents are supervised and monitor. That resident with respiratory diagnosis has their equipment handy. Findings will be corrected by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 015	Continued From page 5	L 015	MEASURES TO PREVENT RECURRENCE:	8/24/22

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 failed to ensure staff received training to provide person centered care 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 accidents as evidenced by: resident-to-resident altercation resulting in serious injury to one (1) resident; resident-to-resident altercation resulting in harm to one (1) resident; failure to supervise one (1) resident while seated in a wheelchair outside in front of the facility and subsequently sustained a fall resulting in harm; failed to implement resident-centered interventions (assistive devices) for one (1) resident status post left hip replacement, who subsequently sustained a dislocated hip of unknown origin; failed to secure one (1) residents wheelchair during a van transport; failed to implement care plan interventions to help prevent one (1) resident with a history of falls.

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.

3. In the area of Respiratory Care, the Administration failed to ensure Resident #3's

Provider's Plan of Correction (L 015):

In-service will be provided to all licensed clinical staff members, Rehab staff and C N A 's by staff educator / Designee to ensure that a person-centered care plan for a resident is implemented as indicated by 8/24/22

In- service will be provided to the clinical team, housekeeping team, environmental team, activities team on how to provide care for residents with aggressive behavior.

ADON/Designee will audit residents clinical record weekly to ensure that the nurses are revising and updating resident's person-centered care plans. Any issues found will be corrected by 8/24/22
Charge nurses, supervisors / designee will ensure that residents 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 resident with respiratory diagnosis always have their equipment handy.

Facility's van driver has been provided in service by staff educator on resident's safety while riding the van.

Respiratory therapist will ensure weekly that residents with respiratory diagnosis are provided care per physicians' order. Findings will be addressed by 8/24/22.

DON/ Designee will ensure that residents records always maintain their integrity. Weekly audits will be conducted. Findings will be addressed by 8/24/22

Respiratory therapist will ensure that residents with respiratory problems are assessed during their shift to ensure that they are in no form of respiratory distress. Findings will be addressed by 8/24/22
Governing body will ensure the DON is auditing charts for accuracy weekly. Findings will be addressed by 8/24/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 015	Continued From page 6 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' #3 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 resident ...the governing body failed to ensure a resident's record contained 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 #2 were made aware of the findings.	L 015	In-services will be provided by staff educator / Designee to licensed nurses, C N A's, restorative team and Rehab staff on how to provide care to residents with hip replacement Charge nurses and respiratory therapist will assess residents with respiratory diagnosis during their shift to ensure the stoma is not occluded. Findings will be corrected by 8/24/22. MONITORING CORRECTIVE ACTIONS: DON/Designee will audit residents' chart on a weekly basis to ensure that there is a person centered care plan in place that addresses the residents medical needs. They will also ensure that residents are monitored and supervised to avoid resident to resident altercation and that residents with respiratory diagnosis have their respiratory equipment handy. This audit will take place weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 017	3203.7 Nursing Facilities Each administrative record shall be retained for at least five (5) years from the date of creation. This Statute is not met as evidenced by: Based on record review and staff interview, the facility staff failed to retain administrative record of posted nurse staffing data for at least five (5) years from the date of creation. The findings include: During a review of the "Report of Nursing Staff Directly Responsible for Resident Care" forms on 04/14/22, the writer asked the facility staff to show proof that it maintained 18 months of the posted nurse staffing data. During a face-to-face interview conducted on 04/14/22 at approximately 3:43 PM, Employee #20 (Regional Director of Human Resources) stated the facility was unable to provide proof that they maintained 18 months of "Report of Nursing Staff Directly Responsible for Resident Care" forms.	L 017	L017 starts here: CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this practice IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: REVENT RECURRENCE: In-service will be provided by Staff Educator /Designee to the Staffing coordinator to always ensure that the total number of hours worked per day for the nursing staff who are providing direct patient care is recorded. Also , that all staffing records must be maintained by 8/24/2022. Human Resources Manager assistant will audit staffing records to ensure the staffing coordinator is recording the actual number of nursing staff directly responsible for resident's care. Any negative findings will be corrected no later than 8/24/22 . MONITORING CORRECTIVE ACTIONS: Human Resources Director will conduct audit to ensure that the staffing coordinator is posting a report of nursing staff directly responsible for residents care correctly. Findings will be corrected no later than 8/24/22. Human Resource Manager will ensure that staffing records are preserved monthly. Any issues found will be corrected by 8/24/22. The Administrator will ensure staffing records are retained every three months	8/24/22
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;	L 051		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 8 (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for 14 of 105 sampled residents, facility staff failed to: (1) implement nursing care plan interventions; (2) revise resident's care plans with appropriate goals and approaches; (3) follow facility policy to make changes in a resident's active clinical record; and (4) ensure a licensed nurse was competent on how to administer Tiotropium Bromide Aerosol Inhaler. Residents' #3, #27, #50, #56, #81, #82, #126, #132, #151, #155, #180, #181, #403 and #404. The findings include: Review the facility's policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... It is the policy of [Facility Name] to develop and implement person-centered care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care..." Policy Title: "Correction in Resident Medical Records" revised 03/2022 documented,	L 051	L 051 STARTS HERE: Resident # 3 was discharged on 3/29/22 Resident #27 was assessed from head to toe on 4/26/22 by Unit manager, resident suffered no negative outcome. MD/RP notified on 4/26/22. Residents dental need will be addressed. Resident # 50 was assessed from head to toe on 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/2022.care plan indicate two person assist with ADL Resident # 56 was assessed from head to toe on 4/7/22, resident suffered A hematoma on the left forehead. MD/RP notified on 4/722. Resident #81 was assessed from head to toe by Unit Manager on 4/26/22, resident suffered no negative outcome. MD/RP updated on 4/26/22. Resident # 82 was assessed from head to toe on 4/26/22 by Unit manager, resident suffered no negative outcome.MD/RP notified on 4/26/22.Resident taken by DC police on 7/20/22, currently not in the facility. Resident # 126 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident #132 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22 Care plan updated to indicate indwelling catheter use.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 9 "...Procedure and Implementation- Whenever there is an error or multiple errors observed in resident(s) medical records or clinical chart. The facility will proceed as follows: The medical staff or clinical staff that made error in the resident electronic medical record must strike the error in documentation, and then document the reason why the documentation in being strike and sign and save. After striking the error in the electronic medical record of the resident, the medical staff or clinical staff will right an addendum for correct documentation if it is needed or appropriate. If the error in documentation occurred in resident(s) paper medical chart, the medical staff or clinical staff who made error will draw a line across the error, the staff will add his/her initial to the correction and add the date the error is crossed out. After the paper error has been corrected as above, the medical staff or clinical staff will write an addendum for correct documentation if it is needed or appropriate." 1. Facility staff failed to include interventions to implement care of Resident #3's stoma site. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. An Admission Minimum Data Set (MDS) dated 12/03/21 showed that facility staff coded the following: In Section I (Active Diagnoses), cancer, malignant neoplasm of laynx (sp), surgical aftercare following surgery of respiratory system, tracheostomy status and malignant neoplasm of	L 051	Resident #151 was assessed on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/2022. Resident # 155 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident # 180 was assessed from head to toe on 4/26/22 by Unit manager, resident suffered no negative outcome. MD/RP notified on 4/26/22 Resident #404 was sent to the hospital on 2/21/22 and later expired. Resident #403 expired 3/18/22 Resident # 181 was assessed by Unit manager on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 10 supraglottis. In Section O (Special Treatment, Procedures, and Programs) - the resident was coded for receiving tracheostomy care and speech therapy services. The resident was not coded for respiratory therapy services. Review of Resident #3's medical record revealed the following: 11/30/21 [Hospital Discharge Summary] documented, "laryngeal cancer s/p (status post) total laryngectomy, laryngectomy tube 10/27/21...Do not occlude stoma in neck, the patient is a neck breather..." 12/02/21 at 3:31 PM [physician progress note] documented, "He was recently hospitalized secondary to laryngeal cancer with tracheostomy requirement ...Past medical history ...large laryngeal mass, status post total laryngectomies ..." 12/04/21 [Physician's order] instructed, "Do not occlude stoma in neck. The [patient] is neck breather." 02/07/22 [Physician's order] instructed, "Please clean and remove crusting from in and around to stoma BID (two-times-a day) with moist gauze and sterile (stoma should not be covered). Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area-[Resident's name] has lary tube r/t (related to) laryngeal cancer. Goal-[Resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of	L 051	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit conducted by DON/ Designee, to ensure residents with dental needs are addressed, that care plan interventions are implemented as indicated, that residents active records are updated as indicated, that residents are assisted with wearing dentures at mealtimes, that resident's aggressive behavior interventions are implemented, that comprehensive care plans are accurate, that residents with speech deficit issues are addressed, and that staff members are competent in administering medications to the residents. Any issues will be addressed by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 11 infection through the review date. Interventions- lari-tube care daily, change HME daily, assist with cough as needed... Further review of Resident #3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22. During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated that he included interventions to address Resident #3's use of a lary-tube, but he did not include interventions to address the resident's stoma site care. 2. Facility staff failed to revise the care plans to address Resident #27's dental needs. Resident #27 was admitted to the facility on 05/06/20 with the following diagnoses: Diabetes and End-stage Renal Failure. Review of a progress note dated 03/16/22 showed, "Resident was seen by [Dentist name] during the shift and had tooth extraction ...Has been advised not to suck on candies or through a straw, not to drink hot or carbonated drinks to avoid spicy foods..." Review of Resident #27's comprehensive care plan showed a focus area, "[Resident Name] has potential for Dental or oral cavity health problem related carious teeth, poor oral hygiene" initiated on 05/06/20 ... Assist with oral hygiene as needed. Observe for report any changes in the oral cavity, chewing ability, signs, and symptoms of oral pain ... treatment as ordered. Refer to the dentist for evaluation and recommendation..."	L 051	MEASURES TO PREVENT RECURRENCE: In service will be provided by staff educator/ designee to the nursing staff on the importance of revising residents care plans to reflect person center care . In service will be provided by staff educator to licensed nursing staff on the importance of making changes to a resident's active record as indicated and to ensure that the information in the records is accurate. In - service will be provided to all Licensed nursing staff on the importance of ensuring that residents with dentures have them on, and that C N A's assist residents in wearing dentures during meals. Unit managers, supervisors / Designee will ensure weekly that residents are free from abuse and neglect and that the residents are supervised and monitored for safety. Findings will be addressed by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 12 The evidence showed that facility staff failed to revise Resident #27's care plan to include the resident's tooth extraction (on 03/16/22) and aftercare. During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), he acknowledged the findings. 3. Facility staff failed to implement the care plan intervention of having two (2) CNAs (Certified Nurse Aides) for activities of daily living assistance (ADL) for Resident #50. Review of a Facility Reported Incident (FRI) received on 11/22/21, documented, "...allegation made by [Resident #50] on 11/15/21 that at 11:30 AM, a CNA ... hit her 6 times on her left knee with a bar of soap wrapped in a towel ..." The CNA ...was interviewed; she said she went to resident's room at 9:20PM and asked her if she was ready to be changed and Ms. Lambright said yes. The CNA said she called the nurse to come and assist her because resident is two persons assist, but resident refused two persons to provide care to her; the CNA then said she proceeded to provide incontinent care to resident..." Resident #50 was admitted to the facility on 06/26/14 with multiple diagnoses that included: Morbid Obesity, Anxiety Disorder, Mood Affective Disorder and Major Depressive Disorder. Review of Resident #50's medical record revealed the following: A Quarterly MDS dated 09/24/21 showed that	L 051	In service will be provided by staff educator/Designee to all licensed staff on the need to develop a comprehensive care plan for all residents and ensure they are updated as required by 8/24/22. In service will be provided to all licensed nursing staff by staff educator / Designee on the importance of ensuring that respiratory medical equipment is clean and always available weekly. In service will be provided by staff educator/Designee to all licensed staff on the importance of addressing residents' intrusive behavior completely and to maintain the integrity of all incident/accident reports. In-services will be provided by respiratory therapist/ designee to all licensed nurses on how to assess residents with respiratory diagnosis and to ensure their documentation reflects their findings,	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 13 facility staff coded the following: a Brief Interview for Mental Status (BIMS) summary score of "13", indicating intact cognition. 01/30/20 (Revision date) [Care Plan] "[Resident #50] has an ADL self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity ... the resident requires 2 staff participation to reposition and turn in bed, the resident requires total assistance with personal hygiene care ..." 11/16/20 (Creation Date) [Care Plan] "Alleged abuse ... 2 CNAs to provide ADL care all shift..." 11/17/20 [Physician's Order] "2 CNAs to provide ADL care all shift" 11/16/21 at 9:40 AM [Nurses Note] "At around 9.30 PM (11/15/21), the CNA ... called the writer to room 229 B because [Resident #50] was refusing her to finishing cleaning her. Upon entering the room, the writer found [Resident #50] shouting, cursing the CNA alleging that the CNA hit her on the thigh. The writer assessed the resident and there were no signs of hitting nor was she in any pain or distress ...The writer released the CNA and called CNA ... to help finish cleaning the resident..." The evidence showed that facility staff failed to implement the care plan intervention of having two CNAs perform for ADL care of Resident #50 on 11/15/21 during the evening shift (3:00 PM to 11:00 PM). During a face-to-face interview conducted on 04/12/22 at 10:00 AM, Employee #7 (Clinical Coordinator) acknowledged the finding and made no further comment.	L 051	Unit Manager will ensure weekly that residents with dental needs are addressed. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that C N A 's are providing care(ADL) according to the resident's care plan. Two persons to assist with ADL must be implemented. Any issues found will be corrected by 8/24/22. Unit managers will ensure that charge nurses follow the facility policy to make changes in residents active record weekly. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that residents with dentures have them on and that C N A 's are assisted residents with wearing dentures during meals . Any issues found will be corrected by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 14 4. Facility staff failed to follow facility policy to make changes in the Resident #56's active clinical record. During a review of the chart on 04/07/22 at approximately 5:35 PM, the nursing progress notes dated 04/06/22 at 18:37 recorded "Resident was observed outside, in the parking lot, and on the floor. Upon the initial assessment, resident was observed with a hematoma to the left side of her forehead. When asked what occurred, she informed the staff that she was attempting to get something off the floor and slid out of her wheelchair..." However, upon review of the nursing progress notes on 04/08/22 at 9:56 AM the following information related to the resident's incident was recorded, "On 4/6/2022 at 18:37 read, "...The Security [Employee #46] was coming from the patio when she observed resident's wheelchair suddenly rolling into the parking lot. The Security chased after the wheelchair and resident, but resident ran into a car and fell. Resident said during interview, 'My wheelchair suddenly started rolling from the building into the parking lot, I was unable to stop it and into a car and hit my head." During a face-to-face interview with Employee #7 on 04/20/22 at 10:28 AM, he stated, with the documentation, "I was trying to document what actually happened. I was trying to document the actual occurrence." There was no evidence that when facility staff changed/altered the documentation in Resident #56's active clinical record that it was done in accordance with the facility policy.	L 051	Unit managers will audit charts weekly to ensure that residents comprehensive care plans capture aggressive behavior where applicable. Any issues found will be corrected by 8/24/22. Unit managers / Designee will ensure weekly that residents have comprehensive care plans and that they are reviewed and revised as needed. Any issues found will be corrected by 8/24/22. DON/Designee will conduct rounds weekly to ensure that licensed nurses are administering medication via inhaler correctly. Any issues found will be corrected by 8/24/22. Supervisors will conduct rounds on a weekly basis to ensure that nurses are administering medication via inhaler correctly to the residents. Any issues found will be corrected by 8/25/22. Charge nurses will ensure during their shift that C N A 's are assisting residents with transfer correctly. Findings will be addressed by 8/24/22 Unit manager will audit charts weekly to ensure care plan for residents with indwelling catheter is revised and updated. Findings will be addressed by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 15	L 051		

L 051

5. Facility staff failed to develop a care plan to address Resident #81's include assisting Resident #81 with applying her dentures at mealtimes.

During an observation on 03/30/22 at approximately 1:30 PM, Resident #81 the resident was observed with her lunch tray. When asked if she liked the food at the facility, the resident reported that the food in the facility was okay, but she wanted to wear her dentures when she eats. The writer asked if her dentures were with her in the facility and she stated, "Yes."

Resident #81 was admitted to the facility on 08/22/18 with diagnoses including Cerebral Vascular Accident (CVA), Human Immuno-Deficiency Virus (HIV), Diabetes Mellitus, and Cognitive Communication Deficit.

A review of the Quarterly Minimum Data Set (MDS) for Resident #81 dated 03/06/22 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 "03," indicating that the resident had severely impaired cognition.

In Section G (Functional Status), ADL assistance: for personal hygiene, the resident was totally dependent and required physical assistance from one staff person. For eating/meals, the resident required limited assistance from one staff person.

A review of Resident #81's medical record revealed:

08/23/18 (Date initiated) [Care Plan focus area]:

L 051 — Provider's Plan of Correction (Complete date: 8/24/22)

Unit managers will ensure that residents with intrusive behavior are monitored and supervised every shift. Any issues found will be corrected by 8/24/22.

Unit managers will ensure that residents with speech deficit are assessed by speech therapist and followed up as indicated. Any issues found will be corrected by 8/24/22.

Charge nurses will ensure that they document on residents' refusal of care during their shift and notify the R/P. Any issues found will be corrected by 8/24/22.

Unit manager will ensure there is a comprehensive care plan in place to address resident's behavior of smearing bathroom with feces and urinating on the floor is revised/ updated weekly. Findings will be addressed by 8/24/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 16	L 051		8/24/22

[Resident #81] at risk for ADL Self-care deficit as evidenced by weakness to right side related to CVA. Interventions included: Assist with daily hygiene, grooming, dressing, oral care, and eating as needed ...Encourage to participate in self-care..."

"Focus: [Resident #81] at risk for dental or oral cavity health problem related to health condition (CVA). [Resident #81] is edentulous. Interventions included assist with oral hygiene as needed..."
09/02/21[Denture Quality Assurance Checklist] documented: 1) Patient is satisfied with fit, 2) Patient is satisfied with esthetics, 3) Name is in the denture, 4) Denture kit given ... "signed by Unit Nurse and Dentist."

09/02/2021 [Dentist Note]: "...Patient satisfied with fit and esthetics..."

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."

Review of the comprehensive care plan lacked documented evidence that facility staff included an intervention to assist Resident #81 with putting in her dentures including at mealtimes.

Provider's Plan of Correction (L 051):

DON/Designee will conduct rounds weekly to ensure licensed nurses were competent with the administration of medications via inhaler. Findings will be addressed by 8/24/22

Staff educator/ Designee will ensure that competency check list is accurate and that licensed nurses can accurately carry out return demonstration on how to administer medications especially medications administered via inhaler.

Charge nurses will ensure during their shift that implementation of the refusal of care is implemented and documented. Findings will be addressed by 8/24/22.

DON/ADON/Designee will ensure weekly that the care plan for residents with aggressive behavior are revised/ updated. Findings will be addressed by 8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 17	L 051		8/24/22

Continued From page 17

During a face-to-face interview on 04/01/22 at 1:51 PM, Employee #2 (Director of Nursing/DON) acknowledged that Resident #81's comprehensive care plan did not include assisting the resident with putting in her dentures at mealtimes and that she would update the care plan.

6. Facility failed to revise the comprehensive care plans to address Resident #82's physically aggressive behavior towards another resident (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 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..."

Resident #82 was admitted to the facility on 09/15/21with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss.

Review of Resident #82's medical record revealed:

A Quarterly MDS dated 01/31/22 that showed facility staff coded, a BIMS summary score, "14", indicating intact cognitive response. In section E (behavior), the resident was coded for not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 18	L 051		8/24/22

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 04/05/22 lacked documented evidence that facility staff revised Resident #82's behavior care plan to include his physically aggressive behavior towards another resident (Resident #404) after a resident-to-resident altercation (on 02/21/22).

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.

7. Facility staff failed to develop a care plan to address Resident #126's needing 2 person physical assist with transfers.

Review of the FRI (Facility Reported Incident) dated 12/27/21 documented "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched

MONITORING CORRECTIVE ACTIONS:

DON/Designee will ensure that residents dental and speech need are addressed, that necessary changes are made in the resident's clinical 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051		L 051		8/24/22

Continued From page 19

against the 1/4 side rail; resident sustained a laceration on the upper lateral right leg; resident scratched her right leg at the edge of the 1/4 side rail. Writer was made aware of the incident; writer assessed the wound..."

Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure, Presence of Right Artificial Knee Joint, and Other Lack of Coordination.

Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following:

In Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11", indicating moderately impaired cognition.

In Section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist"

Review of the nursing progress note dated 12/23/21 at 11:50 AM documented, "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the ¼ side rail ..."

Review of Resident #126's care plan revealed that facility staff failed to develop a comprehensive care plan to address the resident ' s need for two-person physical assist with transfers.

During a face-to-face interview conducted on 04/20/22 at 10:45 AM, Employee #58 (Certified Nurse Aide) stated, "It was just me who transferred her [Resident #126] to the bed (on 12/23/21). Nobody was there, only me."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 20	L 051		8/24/22

8. Facility staff failed to develop a comprehensive care plan to address Resident #132's use of an indwelling urinary catheter.

During an observation on 04/07/22 at approximately 3:45 PM, Resident #132 was observed with an indwelling urinary catheter with a urine collection bag.

Resident #132 was readmitted to the facility on 02/11/22 with diagnoses that included: Urinary Tract Infection, Alzheimer's, Dementia, Epilepsy and Muscle Weakness (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 and Bladder) H0100 Appliances: Indwelling catheter

A review of Resident #132's medical record revealed:

01/06/22 (Date initiated) [Care Plan focus area]: "[Resident #132] has urinary incontinence related to dementia, impaired mobility ...."
02/11/22 at 11:11 PM [Nurses Note - Late Entry]: "...resident, readmitted in evening.. Head-to-toe assessment done: Skin is warm to touch, and patient noted with Foley catheter ...Resident is stable."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 21	L 051		8/24/22

04/04/22 at 2:48 PM [Nurses Note]: "...Foley catheter intact and draining clear urine."

Further review of Resident #132's medical record lacked documented evidence that facility staff developed a comprehensive care plan to address the resident's use of an indwelling urinary catheter.

During a face-to-face interview on 04/07/22 at 3:48 PM with Employee #47 (Licensed Practicing Nurse/LPN), she acknowledged that Resident #132's comprehensive patient-centered plan did not include the resident's indwelling urinary catheter care, and she would make sure the care plan was updated.

9. Facility failed to revise the comprehensive care plans to address Resident #151's physically aggressive behaviors towards other resident (resident-to-resident altercations).

Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Resident #151 was re-admitted to the facility on 12/02/21 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.

In Section E (Behavior):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 22	L 051		8/24/22

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (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"

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 ... [Resident #71] was assessed and small scratch mark observed on the back of his left hand..."

Review of the Care Plan revealed:

07/27/21 (Revision date) Focus area, "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) Focus area, "[Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 23	L 051		8/24/22

Continued From page 23

#151] has problematic manner in which resident acts characterized by inappropriate behavior ... kicking and hitting ..."

10/20/21 (Revision date) Focus area, "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) Focus area, "Resident #151] has behavior problem... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor... 1:1 staff monitoring for safety until seen by psych or sitter is available..."

Further of Resident #151's comprehensive care plans lacked documented evidence that facility staff revised the care plans to include interventions to address the resident's physically aggressive behavior towards another resident (Resident #71) after a resident-to-resident altercation (on 12/08/21).

During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 acknowledged the finding and stated, "[Resident #151] was put on 1:1 in January of 2022 and has not had any further incidences of resident-to-resident altercations.

10. Facility staff failed to develop a comprehensive person-centered care plan that addressed Resident #155's speech deficit and the resident's complaint of chest pains which resulted in an emergency room visit.

Resident #155 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 24	L 051		8/24/22

11/18/19, with multiple diagnoses that included: 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 B (Hearing, Speech, and Vision), Speech Clarity "1" "Unclear Speech"

Makes self-understood "1-Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time."

Ability to understand others "1- Usually understands"

In Section C (Cognitive Patterns) BIMS (Brief Interview for Mental Status) Summary Score "05" indicating severe cognitive impairment.

A.Review of the document titled "Speech Therapy SLP Evaluation and Plan of Treatment" dated 11/02/21 and signed by the residents' providers, revealed the following: In the section titled "Diagnoses" "Cognitive communication deficit, Dysphagia, Oropharyngeal phase"

In the section titled "Receptive/Expressive Language & Communication Abilities" "Verbal Expression =50% ...making needs known= 50%, Conversation = 50%, Functional speech characteristics = Non-Fluent"

Review of Residents #155's care plan lacked any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 25	L 051		8/24/22

Continued From page 25

documented evidence that the facility staff developed a comprehensive person-centered care plan that addressed the resident's communication deficit.

During a face-to-face interview conducted on 04/14/22 at approximately 1:00 PM, Employee #2 (Director of Nursing) stated, "He has slurred speech and he gets frustrated quickly." Employee #2 reviewed the care plan and acknowledged the findings.

B. Review of the document titled "Situation, Background, Assessment and Request (SBAR) ... communication tool" dated 03/30/22 at 6:40 PM, "Resident is alert and verbally responsive Resident complaint of chest pain radiating to the abdomen. NP (Nurse Practitioner) ... ordered to be transferred to the hospital for further evaluation. Writer called 911 at 3:15 PM, arrived at 3:23 PM and left with resident at 4:04 PM to [Hospital name]."

Review of a Discharge Summary dated 03/31/22 showed, "Resident was admitted on 03/30/22 and discharged on 3/31/22. He [Resident #155] is being discharged hemodynamically stable to follow up with a cardiologist as outpatient. He will also need an echo outpatient."

Resident #155's care plan lacked documented evidence that the facility's staff developed a comprehensive person-centered care plan that addressed the resident's complaint of chest pains and the follow up care required.

During a face-to-face interview conducted on 04/18/22 at 11:43 AM, with Employee #2 (Director of Nursing) stated, "The care plan was not updated, we will have to educate everyone."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD02-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 26	L 051		8/24/22

Continued From page 26

11. Facility staff failed to develop a comprehensive care plan to address Resident #180's behavior of frequently urinating on the bathroom floor, smearing the bathroom with feces.

Resident #180 was admitted to the facility on 11/16/17 with the following diagnoses: Unspecified Dementia Without Behavioral Disturbance, Parkinson's Disease and Anxiety Disorder.

According to the Quarterly Minimum Data Set dated 03/03/22, the resident was coded "15" under Section C (Cognitive Patterns), a BIMS Score, indicating that he was cognitively intact.

Under Section E0200 (Behavior), the resident was coded as "0" indicating that no behavior symptoms were exhibited.

Under Section G0110 Functional Status, the resident was coded as "1", indicating he required supervision for toilet use, with one-person physical assist.

Under Section H (Bladder and Bowel) the resident was coded as such:

H0200 (Urinary Toileting Program) = No

H0300 (Urinary Incontinence) = 2, indicating he was frequently incontinent

H0400 (Bowel Continence) = 2, indicating he was frequently incontinent

H0500 (Bowel Toileting Program) = No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 27	L 051		8/24/22

During an environmental tour of the facility on 03/30/22 at approximately 4:00 PM, a urine odor was noted in the bathroom that services the resident in room #515 and #516 on unit 5 North. Resident #64, in room #516, complained that Resident #180 in room #515, frequently urinates on the bathroom floor, and smears the bathroom with feces. This, he said, has been going on since the resident moved in sometime last year. Resident #64 also stated that staff are aware and have even seen Resident #180 urinate on the bathroom floor.

Face-to-face interviews were conducted on 04/07/22, between 1:15 PM and 2:00 PM with the following employees:

Employee #51 (Registered Nurse) confirmed that Resident #180 often urinates on the floor, in his room and in the bathroom.

Employee #52 (CNA) said that Resident #180 sometimes urinates on the floor in his room and in the bathroom, and his hands must be cleaned every time he goes to the bathroom because he gets feces on his hand. Staff are aware of Resident #180's behavior and it is documented.

Employee #50 (CNA) said that Resident #180 urinates on the floor, gets feces on his hands and messes up the bathroom.

Employee #53 (CNA) has worked on 5 North for 5 years. She stated that Resident #180 urinates on the floor and gets feces on his fingers when he tries to wipe himself. Nursing staff is aware, and it is documented.

During a review of Resident #180's clinical records on 04/11/2022 at 10:25 AM with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 28	L 051		8/24/22

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 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 how to administer the inhaler for Resident #181. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor.

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).

Review of the Medication Administration Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 29	L 051		8/24/22

for March 2022 revealed that the following: Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day (9:00 AM) for COPD (Chronic Obstructive Pulmonary Disease) start date 03/18/2022.

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.

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.

During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that 03/29/22 was the first time she administered Tiotropium Bromide Monohydrate Aerosol inhaler because she did not know how to administer it. When ask why did she initial that she administered prior to 03/29/22? She said, "It was an error." The employee also stated that she did not make anyone aware she did not know how to administer that type of inhaler.

13. Facility staff failed to implement Resident #403's refusal care plan.

Review of the FRI (Facility Reported Incident) dated 03/21/22, documented " ...At 10:45 AM resident was observed in her room bathroom sitting the commode and was unresponsive. Large amount of BM (Bowel Movement) was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 30	L 051		8/24/22

observed on floor. On assessment, resident has no vital signs. She was transferred to her bed and CPR initiated."

Resident #403 was re-admitted to the facility on 02/10/22, with multiple diagnoses including Respiratory Failure with Hypercapnia, Chronic Obstructive Pulmonary Disease, Unspecified, Tracheostomy Status and Right Heart Failure Due to Left Heart Failure.

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"

In Section G (Functional Status): Bed mobility "Limited assistance" requiring "Two-person physical assist"; "Transfer "Extensive assistance" requiring "Two-person physical assist"; "Walk in room "Limited assistance" requiring "One-person physical assist"; "Toilet use "Extensive assistance" requiring "One-person physical assist"; "Personal hygiene "Limited assistance" requiring "One-person physical assist"

In Section O (Special Treatments, Procedures, and Programs) O0100 Respiratory Treatments "Oxygen Therapy, Suctioning and Tracheostomy care" was coded by facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 31	L 051		8/24/22

Review of the physician's orders revealed the following:

02/11/22 "NPO (Nothing by mouth) diet NPO texture NPO for Bolus via PEG (percutaneous endoscopic gastrostomy) tube"

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 disease ...Resident 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 ..."

Review of the nursing progress notes revealed the following:

03/09/22 at 11:24 PM "Resident refused all medications..."

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"

03/18/22 at 9:15 AM "...sitting on the bed refused oxygen via trach (Tracheostomy) mask no sign of resp (respiratory) distress noted ...Resident refused trach care, suction and neb (nebulizer) Tx (treatment)..."

There was no documented evidence in the medical record showing that facility staff followed the refusal of care plan to leave and return later when care is refused and provide education to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 32	L 051		8/24/22

the resident and family.

During a face-to-face interview conducted on 04/13/22 at 11:20 AM, Employee #9 (Registered Nurse) acknowledged the finding and stated, "When she (Resident #403) first came, we did trach care and then she started refusing ...Sometimes I would teach."

14. Facility staff failed to demonstrate competent nursing skills sets to assure resident safety as evidenced by failure to address Resident #404's intrusive behavior which led to an altercation that resulted in serious injury to Resident #404.

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 ..."

Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name] ... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..."

Review of a Complaint dated 03/31/22 documented, "...Avoidable death. Comments:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 33	L 051		8/24/22

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 #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.

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 ..."

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.

In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 34	L 051		8/24/22

Continued From page 34

In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion

In Section P (Restraints and Alarms), 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 Behavior Documentation showed the following:

02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant."

02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 35	L 051		8/24/22

peoples bed...Behaviors are constant."

02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant."

02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant."

02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant."

02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant."

02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant."

02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant."

02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant."

Situation Background Assessment Request (SBAR): 02/21/22 at 4:00 AM "Situation... The resident got hit by his roommate...The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face ...The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware."

This evidence showed:

a. Although the facility had a care plan in place to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051		L 051		8/24/22

Continued From page 36

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 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 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] 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 37 #404's behavior, Employee #7 stated, "I didn't see it."	L 051	L 052 STARTS HERE: CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS. Resident # 404 was sent to the hospital on 2/21/22, did not return to the facility.	8/24/22
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she	L 052	Resident # 82 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/ RP update. Resident is on 1;1 monitoring and supervision until seen by psychiatrist. Resident taken by DC police into custody on 7/20/22. Currently not in the facility, Resident # 56 was assessed from head to toe on 4/7/22, resident suffered a hematoma to the left forehead MD/RP updated. An employee has been assigned to monitor residents in front of the building. Resident #61 was assessed head to toe on 4/26/22, resident suffered no negative outcome. MD/PR updated. Resident will be taken to the day room A for monitoring. Resident # 72 was assessed from head to toe on 4/26/24,resident suffered no negative outcome. Resident will be taken daily to the day room B for monitoring. Resident # 118 was assessed from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22.Medication is administered according to physician order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 38 requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on observation, record review, resident and staff interview, facility staff failed to ensure 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 was assessed before administering Tylenol (pain reliever); (13) Resident #3 was provided with	L 052	Resident # 151 was assessed on 4/26/22, in no negative . MD/RP updated. Resident is on 1;1 monitoring and supervision until assessed by psych doctor. Resident # 183 was assessed on 4/26/22, in no negative outcome MD/ RP updated. Bus driver has been trained on how to keep resident safe in the van while transporting them to the hospital. Resident#133 was offered shower, resident continue to refused. Care plan updated and documentation is in place. Resident #236 was assessed on 4/26/22 from head to toe by Unit manager, resident suffered no negative outcome. MD/RP notified on 4/26/22. Resident assessed for pain prior to administration of pain medication.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 39 stoma site care; and (14) Resident #181's nebulizer inhaler was administered as ordered by the physician. The findings include: Review of the facility policy entitled, "Resident-to-Resident Altercation/Incidents" revised in 01/2022 documented, " ... When a resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT) ... These immediate actions may include ... monitor and adjust care to reduce negative outcomes ... aggressor placed on 1:1 monitoring ... the care plan will be updated with the interventions in place to prevent and deescalate behaviors by the licensed nurses/manager..." Review of the facilities policy titled "Pain Management" revised March 2022, showed: "...The relief of pain in resident becomes a priority. It is also our duty to monitor and assess for signs and symptoms of pain, advocate for pain management and meet our goal of keeping resident as comfortable as possible. ...Meeting resident need for pain management; nursing staff will proceed as follows: -Assess for signs and symptoms of pain which include verbal and nonverbal gestures. - Vital signs if appropriate -note the type of pain -Location of pain -Characteristics of the pain (sharp, stabbing and throbbing etc.) -Rating of Pin numerically on a scale od 0-10 or use of facial expression chart to determine pain	L 052	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected: DON/ ADON/Unit managers conducted house wide audit to ensure residents are adequately monitored and supervised in house and out of the facility, that residents with aggressive behavior are supervised, that licensed nurses know how to provide care to residents with hip dislocation, that the C N A 's are assisting residents with dentures to wear it during meals, that residents are taking shower on their assigned shower day and that non compliance with care plan is documented and care updated., that licensed nurses are assessing residents for pain prior to administration of pain medication, and that medication administered via inhaler is done corrected. Findings will be corrected immediately and not later than 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 40 severity. -Provide non pharmacologic approach as needed or as requested by resident. -Medicate for pain -Monitor the effectiveness of pain medication through reassessment. -Document nursing assessment, nursing intervention, behavior of resident during pain assessment; and resident response to interventions." 1. Facility staff failed to ensure Resident #404 received adequate supervision to prevent an altercation with Resident #82, resulting in serious injury. 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 ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name]... in an interview that his father [Resident #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..."	L 052	In service will be provided to all CNA's/ escorts by staff educators on the importance of ensuring that the residents are safe while riding the van by 8/24/22. In-service will be provided by staff educator/ designee to clinical staff, activities staff, housekeeping, and environmental staff on the importance of ensuring that residents are supervised / monitored always for safety reasons. In -service will be provided by staff educator/ designee will provide in service to all licensed team members on the importance of assessing resident pre and post administration of pain medication and ensure to documents pain level. In- service will be provided by staff educator / designee on the importance to ensure that residents with dentures have them on during meals. In service will be provided by staff educator / designee to all charge nurses and C N A 's to ensure that residents take shower on their assigned days and that documentation is in place if resident	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 41 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 staff coded: a Brief Interview for Mental Status (BIMS) 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 antipsychotic 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.	L 052	charge nurse and C N A's will ensure during their shift that residents are monitored and supervised for safety. Findings will be corrected by 8/24/22 Lobby supervisor will ensure that residents in front of the building are supervised and monitored during his shift. Findings will be addressed immediately but no later than 8/24/22. Charge nurse will make rounds during their shift to ensure residents with a history of frequent falls are supervised and monitored. Findings will be addressed by 8/24/22 Unit manager / Designee will ensure that residents who have had altercations with another resident are placed on a different unit and supervised.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 42 In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily" In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion In Section P (Restraints and Alarms), 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 Behavior Documentation showed the following: 02/02/22 at 2:12 PM "... Elopement attempts. Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people	L 052	Charge nurses /supervisor will ensure during their shift that C N A 's , restorative aides and rehab team are providing care to residents with hip replacement correctly. Findings will be corrected by 8/24/22 In-service will be provided by staff educator/ designee on the importance of assessing resident for hearing needs and schedule appointment for the resident to see the audiologist as soon as possible. Charge nurses/ designee will ensure they interact with the resident during their shift to ensure they are not having difficulty to hear; Findings will be addressed by 8/24/22 Unit manager/ Supervisors will ensure during their shift that charge nurses are assessing residents prior to and post administration of pain medication, that documentation of pain score is in place. Findings will be corrected by 8/24/22 Respiratory therapist / designee will ensure that residents with respiratory diagnosis are assessed for respiratory distress every shift, ensure their stoma are not occluded and that they have enough supply to meet their respiratory needs. Findings will be corrected by 8/24/22. Charge nurses/ supervisors will ensure during their shift that residents who wander are redirected, supervised, and monitored, Findings will be corrected by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 43	L 052		

bed. Behaviors are constant."

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 bed...Behaviors are constant."

02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant."

02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant."

02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant."

02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant."

02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant."

02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant."

02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant."

Skin Observation Tool dated 02/21/22 at 2:40 AM documented, "Observations... face... Blood was coming from his mouth, we managed to stop it by applying cold compress and ice..."

Situation Background Assessment Request (SBAR) dated 02/21/22 at 4:00 AM showed, "Situation... The resident got hit by his

Provider's Plan of Correction (L 052) — Complete date: 8/24/22

Resident with a BIMS score of 12 and above will be notified to inform the charge nurse or C N A if a resident is intruding into their rooms. Such resident will be redirected and monitored. Rounds will also be made by charge nurses, unit managers and CNA 's to ensure no one is intruding into the rooms of residents who are sleeping. Findings will be addressed by 8/24/22.

Unit manager / supervisor will conduct rounds during their shift to ensure charge nurses are administering medication via inhaler correctly. Findings will be corrected by 8/24//22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 44 roommate... Background: Altered mental status... Resident Reports Pain? 'No'. Non-verbal indicators of pain evident? 'No'. Functional Status unchanged... Skin/Wound Status- (area was left blank) ... Assessment ... (area was left blank) ... Additional comments ... At approximately 02:30 am ... The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face. The writer immediately notify the supervisor and called 911. DC (District of Columbia) police. I saw [Resident #82] also sitting on his walker facing [Resident #404]. The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware." 02/21/22 at 4:16 AM [Nursing Supervisor Progress Note] "The Charge Nurse reported that While making routine rounds, Resident [#404] was observed sitting on the floor beside Room 420 A. Resident was noted with some blood on the left side of his face, a quick assessment was made, he was assessed for pain and discomfort. Resident could not describe what happened. This is his base line. A quick assessment was done, Range of motion exercise was done, ice was applied to the left side of the face, vital signs was monitored T. (temperature) 96.5, P. (pulse) 82, R. (respirations) 18, B.P. (blood pressure) 140/90, Spoe (sp) (oxygen saturation) 97% on Room Air." 02/21/22 at 1:43 PM [Nurses Note] "A call was placed to [Hospital Name] to know about the status of the resident [#404] in the ER, spoke with nurse [Registered Nurse's Name] who stated	L 052	MONITORING CORRECTIVE ACTIONS: DON/ Designee will conduct house wide audit to ensure that nurses are assessing residents before and after administering pain medication , that the medications are administered according to the physician's order, that charge nurses are assessing residents for hearing deficit, monitoring and supervising residents for safety inside and in front of the building, that residents are assisted with wearing their dentures during meals, that residents are given their showers on their assigned days. This audit will be conducted weekly x4, then monthly x3, findings will be addressed immediately and reported to QAPI Committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 45	L 052		8/24/22

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 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 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 monitoring the resident was readjusted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 46	L 052		8/24/22

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] 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 for Resident #56 while in the front of the building in the non-smoking area, resulting in injury.

Review of the facility incident report submitted to DC Department of Health dated 04/07/22 read as follows: "[Resident Name] ...with a BIMS score of 15 who presents with COPD, Diabetes, Heart Failure, [Hypertension], and [End Stage Renal Disease]. On April 6, 2022, around 17:15, resident was observed outside, in the parking lot, and on the floor. Upon the initial assessment, resident was observed with a hematoma to the left side of her forehead. When asked what occurred, she informed the staff that she was attempting to get something off the floor and slid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 47 out of her wheelchair. She was assessed and did not have any complaints of pain. She was then assisted back into the wheelchair and taken up to her room for further interventions and assessments. Neuro check was conducted, and everything was within normal limits ...CRNP (Certified Registered Nurse Practitioner) was made aware of the fall and an order was obtained to transfer the resident to the hospital for further evaluation. 911 was called ...arrived at the facility ...to take the resident to the hospital. Resident was transferred to [Name of Hospital] ...Care plan updated for resident to seek assistance with retrieving items from the floor while in the wheelchair and she was educated on the importance of not bending over while in the chair for safety ..." Resident #56 was admitted to the facility on 11/20/19 with diagnoses which included End Stage Renal Disease, Hypertension, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Acquired Absence of Right and Left Leg Below the Knee. The Quarterly MDS dated 01/22/22 under section C0500 BIMS Score showed Resident #56 was coded as a "15" indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited. Under Section G Functional Status, the resident was coded as requiring extensive assistance with one-person physical assist under bed mobility, locomotion on and off unit, dressing and personal hygiene. Under Section G0400 Functional Limitation in range of motion, the resident was coded as having impairment on both sides of lower extremities. Under G0600 Mobility Devices, the resident was coded as using a wheelchair.	L 052		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 48	L 052		8/24/22

Review of the nursing progress notes read as follows:

04/06/22 at 12:19 PM "... [Employee #22 (Activities Aide)] was coming from the patio when she observed resident's wheelchair suddenly rolling into the parking lot. The Security chased after the wheelchair and resident, but resident ran into a car and fell. Resident said during interview, 'My wheelchair suddenly started rolling from the building into the parking lot, I was unable to stop it and into a car and hit my head." Head to toe assessment done; A hematoma was observed on the left forehead. No skin tear, no bleeding, no discoloration observed. Denied pain ...NP (Nurse Practitioner) ...was notified and she gave an order to transfer to the nearest ER ..."

04/07/22 at 11:04 AM [Nurse Practitioner Progress Note] "...seen today for assessment s/p fall and f/u (follow up) ER visit ...While in the ER, she had a negative head scan and negative right knee X-R (Xray), and she was sent back to the facility this morning to continue rehab and acute care."

04/07/22 at 11:40 AM "Resident returned from [Hospital Name] at 10:15 AM in stable condition S/P (status post) fall. On assessment, swelling remains on left forehead with discoloration noted. Nose bleeding observed. Resident is alert and responsive. Denied pain. Able to communicate. Per hospital transfer records, a head CAT (computed tomography) Scan was don which demonstrated no evidence of brain injury."

A face-to-face interview with Resident #56 was conducted on 04/08/22, at approximately 10:30 AM. She stated that someone from Activities Department was helping her outside (pushing her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 49	L 052		8/24/22

Continued From page 49

wheelchair). The staff member did not put the brakes on the wheelchair. The wheelchair rolled down and she hit her head on the concrete after the wheelchair hit a car and she fell over.

During a face-to-face interview with Employee #22 (Activities Aide) on 04/08/22, at approximately 2:15 PM. He stated, "I am the staff member who helped [Resident #56] with her wheelchair on 04/05/2022 (date of the incident). Employee #22 and I (writer) proceeded outside the facility, and he showed me where he left [Resident #56], on the day of the incident (04/06/2022). Employee #22 and I turned left at the front door of the facility and walked a few steps past the guardrails, towards the smoking area. He stopped between the fourth and fifth guardrail and pointed to an area with a yellow arrow on the ground and identified it as the spot where le left the resident. He said that the resident told him she had it from there. He left and went inside and within minutes, he turned around and saw [Resident #56's] wheelchair rolling down the parking lot. He ran to try to catch her and her wheelchair, but it was too late. [Resident #56's] wheelchair hit a car that was parked at the far-right corner (third row of the parking lot), and she fell out of the chair onto the concrete.

During an interview with Resident #56 on 04/11/22 at 11:30 AM, she stated, "I can lock and unlock the wheelchair. I can roll myself outside. I was coming from Bingo. I asked to go outside. They pushed me outside in front of the building. He (Employee #22) did not put the locks on the wheelchair, and he took his hands off the wheelchair. He did not push me when he let go of the wheelchair. I know how to put the locks on the wheelchair. I was outside when the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 50	L 052		8/24/22

happened."

During an interview with Resident #56 on 04/13/22 at 11:40 AM, she stated, "I did not turn the wheelchair around after the staff member left."

During an interview on 04/13/22 at 12:20 PM, Employee #22 said that he normally locks the wheelchair before he leaves a resident but did not lock [Resident #56's] wheelchair on 04/06/22, because she was heading to the smoking area, they had not gotten to that area when she told him ... "I got it from here". He said that he thinks [Resident #56] turned her wheelchair around after he left her to head to the other side of the building where her friend [Resident #80] was.

At the time of the incident, there was no evidence that facility staff provided adequate supervision for Resident #56 and other residents who were in the front of the building in the non-smoking area. Subsequently, Resident #56 was observed seated in her wheelchair, rolling through the parking lot, hit a parked car (approximately 40 feet away from the sloped sidewalk at the entrance of the building), fell out of her wheelchair and sustained a hematoma to the left side of her head.

Additionally, there was no evidence that facility assessed the seating device (wheelchair) used by Resident #56 to determine if it was personal fit and safe for the resident to use.

Lastly, although the facility staff states that Resident #56 is a smoker, she was not identified as a smoker and there was no smoking assessment or care plan in place to address the resident smoking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052		L 052		8/24/22

Continued From page 51

During a face-to-face interview with Employee #30 (Director of Rehabilitation Department) on 04/13/22, at 2:20 PM, she confirmed a wheelchair assessment was not completed for Resident #56 and provided documentation to show that a wheelchair referral was initiated on 04/10/22.

During a face-to-face interview with Employee #7 on 04/20/22 at 10:28 AM, he stated, "Prior to this incident, Resident #56 was not assessed for a wheelchair. Prior to this there was no escort. I didn't know she was going outside and the facility staff said they didn't know she was going outside. The resident is free to go outside. So we put interventions in place so this doesn't happen again."

During a face-to-face interview with Employee #2 (Director of Nursing) on 04/20/22 at 10:28 AM, she stated, "She [Resident #56] was wheeling herself to smoke. He [Employee #22] was trying to wheel her to go smoke. When she turned around to go back she loss control of her wheelchair. He [Employee #22] saw her two minutes later and chased after her."

3. Facility staff failed to provide adequate supervision as specified in Resident #61's care plan resulting in the resident having multiple falls.

Review of the FRI received on 10/21/22 documented, "Writer was notified at 1405 (2:05 PM) by the receptionist at the front desk that resident is observed lying face down at the entrance of the facility ... Resident reported to writer that 'I hit the wheel of my wheelchair against a surface and fell off my wheelchair and hit my head on the ground and my head hurts". ...right side of his forehead noted with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 52	L 052		8/24/22

abrasion with no bleeding/swelling observed at this time... transfer resident to the nearest ER via 911 for further assessment ..."
Resident #61 was admitted on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Anemia, Hypertension, Acute Kidney failure, Systemic Inflammatory Response Syndrome and Anxiety.

Review of Resident #61's medical record revealed the following:

A Quarterly Minimum Data Set (MDS), with an Assessment Reference dated 09/09/21 that documented the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "09", indicating moderate cognitive impairment.

In Section E (Behavior), no indicators of psychosis, rejection of care, or wandering.

In Section G (Functional Status), supervision with the assistance of one person for locomotion on the unit (how the resident moves, between locations in his/her room and an adjacent corridor on the same floor. If in a wheelchair, self-sufficiency once in the chair) and locomotion off the unit (how the resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments).

In Section J (Health Conditions), one (1) fall with injury (skin tears, abrasions, lacerations. Superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain) since admission/entry/reentry (11/06/2020).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 53	L 052		8/24/22

A care plan with a start date of 11/07/20 showed, "At risk for fall" due to history of falls, unsteady gait, cognitive impairment, unstable health condition, pain, poor coordination, Diseased process ...and impaired balance. Goal: Resident will remain free of injury from falls through the next review date. Interventions: Assess for fall risk on admission quarterly and as needed. Bed in low position."

10/17/21 at 7:11 PM [Progress Note] "Writer was notified at 1405 (2:05 PM) by the receptionist at the front desk that resident is observed lying face down at the entrance of the facility. Writer rushed outside and observe resident lying face down. Resident is alert and verbally responsive. Resident reported to writer that 'I hit the wheel of my wheelchair against a surface and fell off my wheelchair and hit my head on the ground and my head hurts". Resident denies any other distress at this time ...resident verbalized pain on his head on a scale of (1-10) 9/10 ... resident's right side of his forehead noted with an abrasion with no bleeding/swelling observed ... MD (medical doctor) made aware ... transfer resident to the nearest ER (emergency room) via 911 for further assessment. .."

11/26/21 at 11:36 PM [Nurses Note] "At about 10:10 pm staff heard a loud noise at the hall in front of room 204. When staff went to check, they observed resident on the floor in laying position on his left side in front of his wheelchair ... Resident c/o (complained of) of having severe pain to the left [side of] forehead, no discoloration or swelling noted to the site ... DC (District of Columbia) EMS (emergency medical services) called non-emergency ambulance to transport resident ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 54 11/27/21(Revision date) [Care Plan with focus area] "Actual fall on 10/17/21 with a right forehead abrasion, 11/24/21 fall with no injury, 11/27/21 fall with no injury at the front lobby." Goal: Resident will not speed when moving around in his wheelchair through the next review date. Interventions: Staff will make frequent rounds to resident's room to constantly remind resident to use the call button to call staff for assistance. Increased staff supervision with intensity based on residents' needs. Bed alarm in place. PT (physical therapy) consult for strength and mobility. Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bed-bound..." 11/27/21 at 1:55 PM [Nurses Note] "Resident alert and verbally responsive. He returned from ER ... at 1:35pm (1:35PM) in stable condition... Resident denied pain. CT (computed tomography) scan of the head and face indicated no acute fracture ..." Review of Resident #61's the medical record from 10/17/21, through 11/25/21, showed there was no documented evidence that there was an "increase in staff supervision with intensity" based on residents' needs as directed in the care plan (created dated 10/18/2021). Resident #61 sustained another fall on 11/26/21 with minor injury. During a face-to-face interview conducted on 04/19/21 at 9:30 AM, with Employee #8 (2nd Floor Unit Manager) acknowledged the finding and stated, "He [Resident #61] is not supervised or monitored. He [Resident #61] goes off the unit by himself and always returned with no problem."	L 052		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 55	L 052		8/24/22

4. Facility staff failed to provide adequate supervision and monitoring of Resident #72's location, resulting in a resident-to-resident altercation with Resident #188.

Review of a facility reported incident dated 03/30/22 documented, "...according to the Charge nurse on the unit and the CNA, ...When the two of the residents got close to each other,[Resident #72] punched [Resident #188] in his face with his right hand ..., Subsequently [Resident #188] fell to the floor... no injuries were noted ..."

Resident Background Information

A. Resident #72 was admitted to the facility on 10/25/18 with the following diagnoses: Non-Alzheimer's Dementia, Ventricular Tachycardia, Chronic Kidney Disease, Depression, and Generalized Muscle Weakness.

A review of the Quarterly Minimum Data Set (MDS) for Resident #72 dated 01/29/22 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition.

In Section E (Behavior), Wandering - Presence and Frequency. For the question, "Has the resident wandered. Staff answered, "Behavior of this type occurred 4 to 6 days, but less than daily."

B. Resident #188 was admitted to the facility on 01/21/22 with the following diagnoses: Non-Alzheimer's Dementia, Altered Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 56	L 052		8/24/22

Status, Visual Hallucinations, Restlessness and Agitation.

A review of the Quarterly Minimum Data Set (MDS) for Resident #188 dated 03/03/22 revealed that facility staff coded a Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating that the resident had severely impaired cognition and wandering that occurred daily.

During a tour conducted on 04/11/22 at approximately 9:52 AM 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 #430 [Resident #72] Common behavioral traits, wondering, elopement, med., test refusal...

Resident-to-resident altercation #1

02/24/22 [Physician's Progress Note]: "Patient seen because of altercation with another resident. Patient not injured. He is confused and he was separated from the other resident. He needs redirection as the other resident is in a room he used to occupy..."

Resident-to-resident altercation #2

03/30/22 at 6:13 PM [Situational, Background, Assessment and Request (SBAR) Communication Tool]:" ... Resident #72 then punched Resident #188. 2. Date problem or symptom started: 03/30/2022 ...Psych consult and initiate behavior monitoring ... Additional Comments. [Resident #72] was walking in the hall and [Resident #188] was walking in the hall as well. When the two of them were close, [Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 57	L 052		8/24/22

#72] then punched Resident #188 in his face with his right hand, to the left side of face. Subsequently, [Resident #188] fell to the floor as a result of the punch. The charge nurse saw the incident and then went to separate the residents immediately. [Resident #72] has been placed on 1 on 1 monitoring at this time. The mobile crisis center was updated and will be out to evaluate the resident ...MD aware... Resident's care plan has been updated to reflect the incident. RP ...made aware of the incident as well."

03/03/22 to 03/31/22 [Daily Behavior Documentation] showed that facility staff documented, "Resident exhibits the following: Going through other people. Elopement attempts. Wandering... Behaviors are constant. Behavior problems led to issues with care" 16 times in Resident #72's medical record.

03/30/22 [Physician's Order]: "Psych (Psychiatric) consult secondary to resident-to-resident altercation."

03/30/22 [Physician's Order]: "Provide resident with 1 on 1 sitter until cleared by psych"

Prior to 03/30/22, there was no evidence of an active care plan to address Resident #72's physically aggressive behavior.

The evidence showed that the facility's staff failed to revise Resident #72's plan of care to address his aggressive behaviors resulting in another altercation with Resident #188 resulting in minor injury.

During a face-to-face interview 04/14/22 at approximately 3:30 PM, Employee #7 acknowledged the finding and stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052		L 052		8/24/22

Continued From page 58

Resident #72 was no longer a wanderer.

5. Facility staff failed to provide adequate supervision of Resident #151 to protect and prevent two residents (Residents' #71 and #67) from incidences of aggressive behavior (resident-to-resident altercations).

Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby..."

Resident Background 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.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052		L 052		8/24/22

Continued From page 59

(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: schizophrenia ...Inform 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 ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) "[Resident #151] has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 60	L 052		8/24/22

problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with 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 impaired cognitive function or impaired thought processes r/t (related to) Dementia..."

10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.

Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ________ B. WING ________	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 61	L 052		8/24/22

moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

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.

Resident -to-Resident Altercation #1:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 62	L 052		8/24/22

mark observed on the back of his left hand..."

Resident-to-Resident Altercation #2:

12/30/21 at 11:30 AM [Nurses Note] "... At 2030 (8:30 PM) on 12/29/2 (12/29/21).., Resident #67] 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 #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident- to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents and then on 12/29/21, Resident #151 attacked another resident at the facility.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator) acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 63	L 052		8/24/22

not had any resident-to-resident altercations.

6. Facility staff failed to properly secure Resident #183's wheelchair during a van transport, resulting in the resident falling.

Review of the FRI dated 10/19/21 documented, "...At 6:33PM on 10/19/21, [Resident #183] ...escort reported to the nurse that when resident was on the van going to this appointment resident slipped under his [seat] belt slit out of his wheel chair when the driver held the brake..."

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.

Review of Resident #183's medical record revealed the following:

A Significant Change MDS dated 10/01/21, showed that facility staff coded the following:

In Section C (Cognitive Patterns), a BIMS summary score of "15", that indicated intact cognition.

In Section G (Functional Status), extensive assistance requiring one-person physical assist with ADLs, uses a wheelchair for mobility device and had no limitations in range motion.

10/14/21 at 2:26 PM [Nurses Note] "Resident was on LOA (leave of absence) for appointment. While in the van his wheelchair tilted backward, and he slipped out of his chair. He denied pain as well as not hurting. He was assisted back to a sitting position and the van proceeded to his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052		L 052		8/24/22

Continued From page 64

appointment. [Resident #183] returned to the facility after the appointment and the incident reported to his unit. Head to toe assessment done with range of motion to extremities with equal strength. He remains alert and oriented X3 with bilateral ling (sp) fields clear. No evidence of shortness of breath noted at this time. ... no evidence of redness nor bruising noted ...Resident is wheelchair bound with a left BKA [below knee amputation]. RP (Resident Representative) and MD made aware."

10/14/21 at 3:42 PM [Care Plan Note] "...Resident's wheelchair should be strapped to the bus at all times when ridding (sp) on the bus for safety reasons."

10/14/21 (Initiation date) [Care Plan focus area] "[Resident #183] is at risk for falls r/t (related to) gait/balance problems. Actual fall on 10/14/21 ...In service the van driver to make sure resident is properly strapped on the van before driving off. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to cause."

10/21/21 [Physician's Order] "Yellow star fall program..."

During a face-to-face interview conducted on 04/07/22 at 3:05 PM, Resident #183 stated, "Oh I remember the time I fell backward on the bus and bumped my head a little. I didn't have the tilts on my wheelchair."

During a face-to-face interview conducted on 04/08/22 at approximately 2:00 PM, Employee #34 (Van Driver), he stated, "We were still on the property when it happed ... I secured the straps on each side, there are 4 straps. The wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 65	L 052		8/24/22

Continued From page 65

fell backward, all the straps weren't secured. We (Employee #34 and #35) saw that [Resident #183] wasn't injured and took him to [his scheduled appointment]."

During a face-to-face interview conducted on 04/08/22 at 3:15 PM, Employee #35 (Certified Nurse Aide) stated, "He [Resident #183] flipped back, still in the wheelchair. He fell on his back hard."

The evidence showed that facility staff failed to properly secure Resident #183's wheelchair to the facility van prior to transport.

7. Facility staff failed to provide Resident #409 with adequate supervision, assistance and hip precaution to prevent an avoidable accident after she had left hip surgery.

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.

Review of Resident #409's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 66	L 052		8/24/22

Resident #409 dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating severe 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.

In Section H (Bowel and Bladder) - "Always incontinent" for bladder and bowel

In Section J (Health Conditions), "Yes" to: resident have a fall any time in the last month prior to admission /entry or reentry; resident have fracture related to a fall in the last 6 months prior to admission /entry or reentry; resident have major surgery during the 100 days prior to admission; resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay.

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

07/08/21 at 12:10 PM [Hospital Discharge Summary] "...Hospital Course Patient presented with left hip fracture; status post Arthroplasty (hip replacement). With no postoperative complications ...Discharge Procedure Orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 67	L 052		8/24/22

...Weight Bearing as Tolerated (WBAT); Laterally; Left ...Restrictions as follows: Posterior hip precautions..."

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT. Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

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.

07/09/21 [Physician's Order] "Left hip: monitor left hip for inflammation, pain, and drainage."

07/09/21 at 2:18 PM [Physical Therapy Evaluation and Plan of Treatment Note] "...referred to skilled therapy after having a L (left)) hip hemiarthroplasty that resulted from a fall... Precautions ... (no flexion past 90 degrees, abduction past midline, or internal rotation, WBAT..."

07/09/21 (7:00 AM-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing, assistance with bed mobility, and provided incontinent care for bowel and bladder.

07/09/21 (3:00 PM - 11:00 PM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 68	L 052		8/24/22

mobility, and provided incontinent care for bowel and bladder.

07/09/21 (11:00 PM-7:00 AM)) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder.

07/10/21 [Physician's Order] "Place a pillow between lower extremities after care, turn and reposition when resident is in bed."

07/10/21 [Physician's Order] "Wedge resident appropriately after care, turn and reposition when [the] resident is in bed."

07/10/21 (7:00 AM-3:00 PM) [Treatment Administration Record (TAR)], showed that facility staff documented that they placed a pillow between Resident #409's lower extremities after care, and wedged resident appropriately turning and repositioning when the resident was in bed.

07/10/21 (7:00-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing and bed mobility.

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

07/10/21 at 5:40 PM [SBAR] "...Resident transfer to [Hospita Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052		L 052		8/24/22

Continued From page 69

A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She [Representative] requested her mom to be transfer[ed] to the Hospital..."

07/10/21 at 6:20 PM [Nurses Note] "...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 daughter requested that she (Resident #409) 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 present (sp) 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 request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 70	L 052		8/24/22

requested transportation to the hospital .... ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced [explain what this means] ...tolerated the procedure well ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of the Resident #409's medical record lacked documented evidence that the facility staff that cared for Resident #409 from 07/08/21 to 07/10/21, provided her with adequate supervision, assistance and hip precautions to ensure that Resident #490's hip was not dislocated.

During a telephone interview conducted on 04/14/22, at approximately 12:30 PM, Resident #409's daughter/representative stated, "On 07/10/21, I noticed that my mother looked out of it and flinched when I pulled back the cover to see what was wrong. I didn't see the knee immobilizer on her leg. Her leg was positioned like the letter 'K'. I spoke with the unit manager and told her I wanted to see the doctor. They finally brought in the doctor, who said he wasn't my mother's primary doctor, and he ordered oxycodone for pain. I insisted that my mother get an X-ray for her hip. I was told the X-ray would take a long time (4-6 hours), so I asked the nurse to call 911. She told me she did not have a doctor's order, and I can call 911, so I did. 911 showed up and said it wasn't a medical emergency, so they [911] called a non-emergency vehicle, and my mother was transported to [Hospital Name]."

During a face-to-face interview on 04/19/22, at approximately 3:30 PM, Employee #4 (Educator) stated, "I told the daughter how long it would take (x-ray). She insisted we call 911 to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 71	L 052		8/24/22

Continued From page 71

[Resident #409's hip X-rayed and evaluated at the hospital. Per the daughter's request, with the doctor's permission, a non-emergency ambulance was called. The resident [was transferred out to [Hospital Name]. I did an SBAR of the incident."

During a face-to-face interview on 04/19/22 at approximately 4:00 PM, Employee #8 (2nd Floor Unit Manager) stated that training for residents with hip precautions usually occurs with physical therapy or by the unit managers when the resident is admitted. For Resident #409, Employee #8 stated, "I did the impromptu training in the resident's room. I trained the 2-3 CNAs and two (2) nurses who worked the day and evening shifts on this unit. I reviewed how to put the pillow/wedge between the resident's legs, how to put the hip immobilizer on the resident, and how to roll the resident on her side to prevent her from crossing midline. I reminded staff to keep the bed in the lowest position and keep the call light near the resident." Employee #8 was not able to provide a copy of the "impromptu training" sign in sheet or the handouts that he said were provided to the staff.

8. Facility staff failed to assist Resident #81 with applying her dentures before meals.

During an observation on 03/30/22 at approximately 1:30 PM, Resident #81 the resident was observed with her lunch tray. When asked if she liked the food at the facility, the resident reported that the food in the facility was okay, but she wanted to wear her dentures when she eats. The writer asked if her dentures were with her in the facility and she stated, "Yes."

Resident #81 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 72	L 052		8/24/22

08/22/18 with diagnoses including Cerebral Vascular Accident (CVA), Human Immuno-Deficiency Virus (HIV), Diabetes Mellitus, and Cognitive Communication Deficit.

A review of the Quarterly Minimum Data Set (MDS) for Resident #81 dated 03/06/22 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 "03," indicating that the resident had severely impaired cognition.

In Section G (Functional Status), ADL assistance: for personal hygiene, the resident was totally dependent and required physical assistance from one staff person. For eating/meals, the resident required limited assistance from one staff person.

A review of Resident #81's medical record revealed:

08/23/18 (Date initiated) [Care Plan focus area]: [Resident #81] at risk for ADL Self-care deficit as evidenced by weakness to right side related to CVA. Interventions included: Assist with daily hygiene, grooming, dressing, oral care, and eating as needed ...Encourage to participate in self-care..."

"Focus: [Resident #81] at risk for dental or oral cavity health problem related to health condition (CVA). [Resident #81] is edentulous. Interventions included assist with oral hygiene as needed..."

09/02/21[Denture Quality Assurance Checklist] documented: 1) Patient is satisfied with fit, 2) Patient is satisfied with esthetics, 3) Name is in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 73	L 052		8/24/22

the denture, 4) Denture kit given ..."

09/02/2021 [Dentist Note]: "...Patient satisfied with fit and esthetics..."

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."

The evidence showed that facility staff filed to offer Resident #81 assistance with putting in her dentures at mealtimes.

During a face-to-face interview on 04/01/22 at 1:51 PM, Employee #2 (Director of Nursing/DON) acknowledged that Resident #81's comprehensive care plan did not include assisting the resident with putting in her dentures at mealtimes and that she would update the care plan.

9. Facility staff failed to ensure Resident #82 was seen by audiology to address his ability to hear when communicating with others.

During a face-to-face interview conducted on 03/29/2022 at approximately 10:00 AM, Resident #82 stated, "I can't hear. You have to come

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 74	L 052		8/24/22

closer." No hearing assistive devices were observed on the resident or in his room.

Resident #82 was admitted to the facility on 09/15/2021 with multiple diagnoses that included: Sensorineural Hearing Loss, Schizophrenia and End Stage Renal Disease.

Review of Resident #82's medical record revealed:

A Quarterly MDS dated 01/31/22 that showed facility staff coded a BIMS summary score, "14", indicating intact cognitive response.

09/21/21 [Physician's Orders] "Referral for Audiology consult 2/2 (secondary to) to pt (patient) reports of bilateral hearing loss impacting communication and quality of life 30 days"

09/21/21 (Created date) [Care Plan] "[Resident #82] has, impaired hearing function ... Arrange consultation with ear care practitioner as required..."

Review of Resident #82's electronic and paper health record lacked documented evidence that the facility staff ever scheduled the resident for his audiology consult thus, impacting communication and quality of life.

During a face-to-face interview conducted on 04/05/22 at 2:59 PM, Employee #7 (Clinical Coordinator) acknowledged the finding and stated that Resident #82 was never scheduled for the audiology consult appointment.
Based on record review, resident interview, and staff interview, for one (1) of 105 sampled residents, the facility's staff failed to provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 75 Resident #113 showers. 10. Facility staff failed to ensure Resident #113 received showers. During an observation on 03/29/22 at approximately 11:30 AM, Resident #113 was in bed and a certified nurse aide (CNA) had just finished providing am care. The resident was asked, how often does she receive showers, Resident #113 said, "I don't get showers. I just wash myself up in my bed." 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 Minimum Date Set dated 02/09/22 showed the following: In section C (Cognitive Pattern) - the resident had a Brief Interview for Mental Status Summary Score of "15", indicating the resident had intact cognition. In section G (Functional Status) - Resident #113 was coded as needing supervision and set-up assistance with bathing, not steady and only able to stabilize with staff assistance during surface-to-surface transfers and using a mobility device (wheelchair). In section I (Active Diagnoses) the resident was coded for Generalized Muscle Weakness, Difficulty in Walking, and Chronic Obstructive Pulmonary Disease. Review of a care plan with a revision date of 12/09/19 showed the following:	L 052		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 76	L 052		8/24/22

Continued From page 76

Focus Area - [Resident #113] has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) disease process CVA (Cerebral Vascular Accident). Interventions: provide [Resident #113] with basin and bathing supplies to promote independence, [Resident #113] supervision personal hygiene and oral care.

Review of the shower schedule revealed the resident's scheduled shower days were on Tuesdays and Fridays on evening shift.

Review of Skin Sweep Observation Sheets revealed the following:

04/01/22 (Friday) - the resident provided a bed bath

04/05/22 (Tuesday) - the resident provided a shower

04/07/22 (Friday) - the resident provided a shower

During a face-to-face interview 04/12/22 at approximately 3:00 PM, Resident #113 stated that she was recently relocated to the unit, and she has not had a shower since her relocation "last year". When asked if she had a shower on 04/05/22 and not know where the shower room was located. When asked if she had a shower on 04/05/22 or 04/07/22 as document on skin sweep observation sheets? The resident said" Whoever that is lying bring them to me so I can tell them they are lying. I have not had a shower." The resident stated, "I would love a shower."

During a face-to-face interview on 04/12/22 at approximately 3:15 PM, Employee #56 (Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 77	L 052		8/24/22

Nursing Assistant -CNA) stated that she worked with Resident #113 on the evening shift for about a year and she had never given the resident a shower. The employee said that she set the resident supplies up for the resident to give her own bed bath.

During a face-to-face interview on 04/12/22 at approximately 3:30 PM, Employee #57 (CNA) stated that she worked the resident for about 8 months on the evening shift. The employee said, "She (Resident #113) doesn't take shower." The employee was then asked how does get her scheduled showers? The employee said, "I put hot water in a bowl" for her.

11. Facility staff failed to administer pain medication to Resident #118 in accordance with the physician's order.

Resident #118 was admitted to the facility on 01/28/22 with diagnoses that included, Insomnia, Alcohol Dependence, Hypertension, Displaced Intertorchanteric Fracture of Left Femur, Tobacco Use and History of Falling.

According to the Quarterly Minimum Data Set Dated 04/11/22, Under Section C0500 BIMS Score showed Resident #118 was coded as a "15" indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited.

Under Section J Health Conditions, the resident was coded for Pain and receiving pain medication; Under Section J0600 the resident's pain intensity was 05.

According to the physician's orders the resident receives Oxycodone HCL (Hydrochloride) 5mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 78 (medication is used to help relieve moderate to severe pain) 1 tab (tablet) by mouth every 4 hours as needed for moderate to serve pain (4-10). Review of the February 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 02/04/22 at 14:30- Pain Level = 1; 02/09/22 at 14:48 - Pain Level =1; 02/14/22 at 04:39 - Pain Level =2; 02/16/22 at 09:00 - Pain Level=1; 02/18/22 at 10:30 - Pain Level =3; 02/19/22 at 11:30 - Pain Level =3; 02/26/22 at 08:58 - Pain Level =0; 02/27/22 at 08:01 - Pain Level =0; Review of the March 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 03/01/22 at 08:05- Pain Level = 2; 03/03/22 at 08:07 - Pain Level =2; 03/04/22 at 08:06 - Pain Level =2; 03/12/22 at 10:59 - Pain Level=3; 03/26/22 at 00:06 - Pain Level =0; Review of the April 2022 Medication Administration Record showed Resident #118's pain level when he was administered the medication on the following dates: 04/05/22 at 07:15- Pain Level = 0; There was no evidence that on the aforementioned dates, facility staff administered Oxycodone hcl 5mg to Resident #118 within the perimeters as directed by the physician.	L 052		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 79	L 052		8/24/22

Continued From page 79

During a face-to-face interview with Employee #7 on 04/11/22 at approximately 1:30 PM, He stated, " I believe the nurses were documenting the effectiveness of the pain medication and forgot to document the initial pain level."

12. Facility staff failed to assess Resident #236's pain before administering Tylenol (pain reliever).

Facility staff failed to assess Resident # 236's pain before administering Tylenol.

Resident #236 was admitted to the facility on 10/01/21, with the following diagnoses: Unspecified Cirrhosis of Liver, Fusion of Spine, Cervical Region, Other Chronic Pain, and Other Displaced Fracture of Sixth Cervical Vertebra, and Sequela.

Review of the Quarterly Minimum Data Set (MDS) dated 03/16/22 revealed:

In section C (Cognitive Patterns) Brief Interview for Mental Status Summary Score of "15" was coded by facility staff and indicates intact cognition.

In section J (Health Conditions): J0100 Pain Management "At any time in the last 5 days has the resident?" "Received scheduled pain medication regimen? Facility staff coded "0" No"

"Received PRN pain medication or was offered and declined?" Facility staff coded "0" No."

J0200 "Should a pain assessment interview be conducted?" Facility staff coded "1" Yes.

J0300 "Pain Presence ...Have you had pain or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 80	L 052		8/24/22

hurting at anytime in the last 5 days?" Facility staff coded "0" No.

Review of the care plan with a focus area of: "... potential for alteration in comfort/pain related to immobility, neck and bilateral shoulder pain" revised on 10/05/21, "... interventions: "Administer pain medication as per MD (medical doctor) orders and note the effectiveness. Assess effects of pain on patient such as accompanying symptoms, sleep, appetite, physical activity, relationships with others, emotion's ability to concentrate etc. Evaluate for and report pain signs/symptoms i.e. exact location, character, severity, contributing factors ... Evaluate pain characteristics intensity, location, precipitating /relieving factor. Give PRN medications for breakthrough pain as per MD orders and note the effectiveness."

Review of the physician's orders revealed the following:

03/14/22- "Tylenol Tablet 325 mg Give 2 tablets by mouth every 6 hours as needed for mild pain (1-3) ..."

03/14/22- "Pain relief maximum strength patch 4% Lidocaine Apply to left deltoid topically in the morning for pain for 15 days and remove after 12 hours."

During an observation and interview on 03/29/22 at approximately 12:20 PM, Employee #37 (Registered Nurse) was administering medications to Resident #236 when he asked the Employee for something for pain. Employee #37 administered the Acetaminophen but did not assess the resident's pain level (such as mild, moderate, severe). The surveyor asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 81	L 052		8/24/22

Employee #37 why she did not assess the resident's pain level. The Employee acknowledged that she did nto assess Resident #236's pain level and stated, "No, I didn't ask."

13. The facility's staff failed to follow standards of practice by not providing stoma care for Resident #3 from 12/01/2021 to 02/06/2022.

Review of an intake form for a complaint received by the DC Department of Health, Health Care Regulation and Licensing Administration on 01/26/22 showed the complainant [granddaughter] alleged that on every visit with Resident #3 she and her mother (residents responsible party) had to "clean my grandfather's stoma...no one at the facility does his [stoma] cleaning." The complaint also alleged "I have photos of my grandfather's neck with days old, dried secretion and multiple bouts of mucus plugging."

According to Johns Hopkins, " ...The buildup of mucus and the rubbing of the tracheostomy tube can irritate the skin around the stoma. The skin around the stoma should be cleaned at least twice a day to prevent odor, irritation and infection. If the area appears red, tender or smells badly, stoma cleaning should be performed more frequently ..."

https://www.hopkinsmedicine.org/tracheostomy/living/stoma.html

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 82	L 052		8/24/22

Review of Resident #3's medical record revealed the following:

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 [physician order] instructed, cleanse lari (lary)-tube daily 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 ...

Review of an Admission Minimum Data Set dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services. Continued review showed that Resident #3 was not coded for receiving respiratory therapy services.

Care Plan
Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:
Focus Area-[resident's name] has lary tube r/t (related to) laryngeal cancer.
Goal-[resident's name] will have no abnormal drainage around trachea site through the review date. Will have no s/sx (signs/symptoms) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 83	L 052		8/24/22

infection through the review date.
Interventions- lari-tube care daily, change HME daily, assist with cough as needed...

Further review of Resident #3's comprehensive care plans lacked documented evidence of interventions to address care for stoma site from 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.

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated that when staff cleaned Resident #3's lary-tube daily they provided care to the resident's stoma site. Employee #7 then said, "I have care for the lary-tube in the care plan. I just didn't add stoma site care."

14. 4. Facility staff failed to administer Resident #181's Tiotropium Bromide Monohydrate (Spiriva) Aerosol Inhaler
as ordered and per standards of practice.

Resident #181 was admitted to the facility on 05/28/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 84	L 052		8/24/22

Heart Failure, and End Stage Renal Disease.

A. 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. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor.

Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhaler orally one time a day for COPD (Chronic Obstructive Pulmonary Disease).

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. Subsequently, Resident #181 did not receive 8 of 12 doses of Tiotropium Bromide Monohydrate Aerosol Solution inhaler since it was ordered on 03/18/22.

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. Subsequently, causing Resident #181 to miss 8 of 12 doses of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 85	L 052		8/24/22

medication since it was ordered on 03/18/22.

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.

During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that 03/29/22 was the first time she administered Tiotropium Bromide Monohydrate Aerosol inhaler because she did not know how to administer it. When ask why did she initial that she administered prior to 03/29/22? She said, "It was an error." The employee also said that she did not make anyone aware she did not know how to administer that type of inhaler.

Employee #45 failed to administer Resident #181 Tiotropium Bromide Monohydrate Aerosol inhaler as ordered from 03/18/22 to 03/24/22.

B. During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering Resident #181 Symbicort inhaler two puffs and Tiotropium inhaler two spays inhaler without having the resident rinse her mouth after administration.

According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush...."

https://www.mysymbicort.com/asthma/side-effects.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 052	Continued From page 86 According to Medline, "... after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine..." https://medlineplus.gov/ency/patientinstructions/000041.htm Review of a physician orders revealed the following: 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). During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that she forgot to have the resident rinse her mouth after using each inhaler. Employee #45 failed to follow standards of practice when administering metered dose inhalers for Resident #181.	L 052		8/24/22
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall	L 056	ORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this practice IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: None	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 87 be in addition to any coverage required by subsection 3211.4. This Statute is not met as evidenced by: Based on record review and staff interview, during a review of staffing [direct care and advanced practiced registered nurse per Resident per day hours], it was determined that the facility failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per day for 31 of 31 days in accordance with Title 22 DCMR Section 3211, Nursing Personnel and Required Staffing Levels. The findings included: According to the District of Columbia Municipal Regulations for Nursing Facilities: 3211.5 Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one-tenth (4.1) hours of direct nursing care per resident per day ..." A review of the Nurse Staffing was conducted on 04/20/2022, at approximately 11:00 AM. Of the 31 days reviewed, 31 of the days failed to provide a minimum daily average of four and one-tenth (4.1) hours of direct care per resident per day. Hours of Direct Care per resident per day Saturday, 07/10/2021, showed that the facility provided direct nursing care per resident at a rate 3.5 hours.	L 056	MEASURES TO PREVENT RECURRENCE: In -service will be provided by staff educator/Designee to the staffing coordinator to always ensure that the total number of hours worked per day by the nursing staff who are providing direct patient care is accurately recorded. Also, that all staffing records are 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 of nursing staff directly responsible for residents' care. Findings will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 88	L 056	MONITORING CORRECTIVE ACTION:	8/24/22

Tuesday, 07/20/2021, showed that the facility provided direct nursing care per resident at a rate of 3.6 hours.

Saturday, 08/14/2021, showed that the facility provided direct nursing care per resident at a rate of 3.4 hours.

Wednesday, 08/18/2021, showed that the facility provided direct nursing care per resident at a rate of 3.5 hours.

Tuesday, July 6, 2021, showed that the facility provided direct nursing care per resident at a rate of 3.47 hours.

Friday 08/27/2021, showed that the facility provided direct nursing care per resident at a rate of 3.3 hours.

Monday, 08/30/2021, showed that the facility provided direct nursing care per resident at a rate of 3.5 hours.

Tuesday, 10/19/2021, showed that the facility provided direct nursing care per resident at a rate of 3.6 hours.

Sunday, 02/20/2022, showed that the facility provided direct nursing care per resident at a rate of 3.06 hours.

Monday, 02/21/2022, showed that the facility provided direct nursing care per resident at a rate of 3.45 hours.

Tuesday, 02/22/2022, showed that the facility provided direct nursing care per resident at a rate of 3.29 hours.

Plan of correction (L 056):

MONITORING CORRECTIVE ACTION:
Human Resources Director / Designee will ensure the staffing coordinator is posting a report of nursing staff directly responsible for residents care correctly. This audit will be conducted weekly x 4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 89 Wednesday, 02/23/2022, showed that the facility provided direct nursing care per resident at a rate of 3.23 hours. Thursday, 02/24/2022, showed that the facility provided direct nursing care per resident at a rate of 3.42 hours. Friday, 02/25/2022, showed that the facility provided direct nursing care per resident at a rate of 3.59 hours. Saturday, 02/26/2022, showed that the facility provided direct nursing care per resident at a rate of 3.33 hours. Sunday, 02/27/2022, showed that the facility provided direct nursing care per resident at a rate of 3.1 hours. Monday, 02/28/2022, showed that the facility provided direct nursing care per resident at a rate of 3.12 hours. Wednesday, 03/03/2022, showed that the facility provided direct nursing care per resident at a rate of 3.28 hours. Sunday, 03/13/2022, showed that the facility provided direct nursing care per resident at a rate of 2.9 hours. Monday, 03/14/2022, showed that the facility provided direct nursing care per resident at a rate of 2.8 hours. Tuesday, 03/15/2022, showed that the facility provided direct nursing care per resident at a rate of 3.2 hours.	L 056		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 056	Continued From page 90 Wednesday, 03/16/2022, showed that the facility provided direct nursing care per resident at a rate of 3.3 hours. Thursday, 03/17/2022, showed that the facility provided direct nursing care per resident at a rate of 3.1 hours. Monday, 03/28/2022, showed that the facility provided direct nursing care per resident at a rate of 3.08 hours. Tuesday, 03/29/2022, showed that the facility provided direct nursing care per resident at a rate of 3.13 hours. Wednesday, 03/30/2022, showed that the facility provided direct nursing care per resident at a rate of 3.31 hours Thursday, 03/31/2022, showed that the facility provided direct nursing care per resident at a rate of 3.54 hours Friday, 04/01/2022, showed that the facility provided direct nursing care per resident at a rate of 3.37 hours Sunday, 04/03/2022, showed that the facility provided direct nursing care per resident at a rate of 2.9 hours Monday, 04/04/2022, showed that the facility provided direct nursing care per resident at a rate of 2.6 hours A face-to-face interview was conducted with Employee #20 (Regional Director of Human Resources) at the time of the staffing review, and she acknowledged the findings.	L 056		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 088	3217.3 Nursing Facilities 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 (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: (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 transmission of communicable diseases and infections. The census on the first day of survey was 255. The findings include:	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 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 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 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 088	Continued From page 92 1. Facility staff failed to provide ensure Resident #132's urine collection bag was not resting on the floor. According to the Center for Disease Control (CDC) guidelines for prevention of catheter associated urinary tract infections (CAUTI) includes: "... Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor." (https://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf) On 04/07/22 at approximately 3: 45 PM, Resident #132 was observed resident lying in bed with his urine collection bag resting lying on the floor. Resident #132 was readmitted to the facility on 02/11/22 with diagnoses that included: Urinary Tract Infection, Alzheimer's, Dementia, Epilepsy and Muscle Weakness (Generalized). A review of the Quarterly Minimum Data Set (MDS) for dated 02/17/22 revealed that facility staff coded the following: In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score of "99," indicating severely impaired cognition. During a face-to-face interview on 04/07/22 at 3:48 PM, Employee #47 (Licensed Practicing Nurse/LPN), acknowledged that the catheter bag was on the floor and stated, "It is because his bed is in its lowest position. I attached it up high this morning. I will explain to my CNA (Certified Nurse's Aide) that the bag should not be on the floor."	L 088	MEASURES TO PREVENT RECURRENCE Training will be provided to all staff in the facility by staff educator/ Designee on the importance to ensure that staff put on their PPE's correctly In- service will be provided by staff educator/ designee to all licensed nurses to always ensure that urine collection bag is not on the floor. Unit managers/ Supervisors will conduct rounds on their units to ensure that staff are wearing their PPE's correctly. Findings Will be corrected by 8/24/22. Charge nurses will conduct rounds during their shift to ensure urine collection bag is not on the floor. Findings will be corrected by 8/24/22. QA nurse / Designee will conduct rounds on the unit during their shift to ensure the staff members are wearing their PPE's correctly and that infection control practices are implemented by the staff. Findings will be corrected by 8/24/22 Supervisors will conduct rounds during their shift to ensure infection control practices are implemented per facility's policies. Findings will be corrected by 8/24/22 Unit managers/ Designee will ensure that residents #132 urinary collection bag is not on the floor, and that it is in the privacy bag. Findings will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 088	Continued From page 93 2. Facility staff failed to wear the required PPE while in a resident care area on three (3) of three occurences. 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. 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. On 04/06/22 at 6:10 AM, Employee #26 (Certified Nursing Assistant) was observed providing am care (bed bath) for Resident #55 without wearing a face shield. During a face-to-face interview on 04/06/22 at 6:20 AM, Employee #26 stated that the facility's protocol is to always wear a face shield. She just	L 088	MONITORING CORRECTIVE ACTION: DON/ Designee will conduct house wide audit to ensure that employees are wearing their PPE's correctly and ensure that the bag for urine collection is not on the floor. This audit will take place weekly x3 , then monthly x4. Findings will be addressed immediately, and report presented to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 088	Continued From page 94 forgot to put it (face shield) on.	L 088		8/24/22
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to serve and distribute foods in accordance with professional standards of practice for food services safety as evidenced by hot food temperatures that tested at less than 140° Fahrenheit (F) during food tray assessments on April 4, and on April 12, 2022. The findings include: 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.	L 099	L099 No Resident was affected by this deficient practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility has the potential to be affected by this practice. Food services director will conduct rounds to in the kitchen to ensure that food is distributed in accordance with professional standards of practice, that the residents get their food within the standards temperature. Findings will be addressed immediately but not later than 8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 099	Continued From page 95 Fried Fish (regular diet) = 132° F White Rice (regular diet) = 132° F Green Beans (regular diet)) = 129° F Mixed Vegetables (mechanical) = 138° F Fried Fish (mechanical) = 147° F White rice (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 099	L099 MEASURES TO PREVENT RECURRENCE. In-service will be provided by Staff Educator/ Designee to the dietary 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 food 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 8/25/22. Food service director will 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 conduct food temperature test on the units to confirm that the food temperature of hot food is at 140 degrees per food service standards. Any issues found will be corrected by 8/24/22. MONITORING CORRECTIVE ACTION: Director of food services will monitor and ensure that food is served and distributed in accordance with food standards. This audit will take place weekly x4, then monthly x3. Findings will be corrected and reported to QAPI	8/24/22
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a)Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b)Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c)Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d)Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and	L 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 96 (e)Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on record review and staff interview, for six (6) of 105 sampled residents, facility staff failed to: (1) show documented evidence that the attending physician or designee reviewed the monthly medication regimen review and that they acted upon the pharmacists' recommendations and (2) ensure that the system used for the reconciliation of controlled medications was followed. Residents' 16, #22, #61, #167, #190 and #238. The findings included: Review of the facility policy entitled, "Medication Regimen Review", dated 08/2020 documented, "... Recommendations are acted upon and documented by the facility staff and/or prescriber. The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing ... The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention, e.g., monitor blood pressure..." The facility's policy and procedures for the storage of controlled substances revised on 08/2020 stated: Policy: "Medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations ...Procedures: ...Unless otherwise indicated...the following will be performed"... At each shift	L 128	L 128 CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS: No resident was affected by this practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 97 change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented ... Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and documented on a Control Count Sheet (or similar form) or in accordance with facility policy..." 1. Facility staff failed to act upon the pharmacist recommendation to "Please eval Risperdal for a GDR (gradual dose reduction)..." for Resident #16. Resident #16 was admitted to the facility on 03/14/08, with multiple diagnoses that included: Type 2 Diabetes Mellitus with Hyperglycemia, Heart Failure, Major Depressive Disorder Recurrent Severe Without Psychotic Features, and Dementia in Other Diseases Classified Elsewhere Without Behavioral Disturbance. Review of the Quarterly Minimum Data Set (MDS) dated 03/24/22, revealed: In Section C (Cognitive Patterns) C0100 "Should Brief Interview for Mental Status ... be Conducted?" Facility staff coded "0" No. In Section N (Medications): N0410 "Indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days." Facility staff coded Resident #16 as receiving Antipsychotic, Antidepressant, Anticoagulant and Diuretic during the last 7 days.	L 128	MEASURES TO PREVENT RECURRENCE: The Director of Nursing will create a new control substance form that will enable accurate reconciliation and accounting of all controlled substances. Any issues found will be corrected by 8/24/22. In service will be provided by Staff Educator/ Designee to all licensed clinical staff on how to use the new Control substance form and education on how Diazepam will be counted.one of two vials and two of two vials completed by 8/24/22. Unit Managers will ensure that nurses are using the newly created control form accurately and that there are no holes on the form during their shift. Any issues found will be corrected by 8/24/22. Nurse Supervisors will conduct audits weekly to ensure that the nurses are utilizing the control substance form accurately. Any issues found will be corrected by 8/24/22. ADON and Clinical Coordinator will conduct random rounds to ensure that the nurses are completing the narcotic count sheets correctly. Any issues found will be corrected by 8/21/22. Unit managers will ensure that all pharmacy recommendations are reviewed in a timely manner and the MD/ Designee signs off on them. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 98 N0450 "Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment whichever is more recent? Facility staff coded "1" No "Has a gradual dose reduction (GDR) been attempted?" Facility staff coded "0" No. "Physician documented GDR as clinically contraindicated" Facility staff coded "0" No. N2001 "Drug Regiment Review" This section was blank. Review of the physician's orders revealed the following: 05/21/20, Escitalopram Oxalate Tablet 20 MG give 1 tablet orally one time a day for depression" 06/23/21, "Risperdal tablet 1 MG (risperidone) give 1 tablet by mouth two times a day for psychotic disorder." Review of Resident # 16's Electronic Health Record revealed a pharmacy drug regimen review was conducted on 12/19/21, 01/18/22, 02/14/22, 03/15/22. On these assessments an oval was marked that stated "Recommendations given to the IDT (Inter-disciplinary team). The pharmacy drug regimen review dated 12/19/21, recommendations are "Please eval Risperdal for a GDR especially with a psychotic dx." There is no documented evidence in the medical record of the physician responding to this recommendation. During a telephone interview conducted on 04/19/22 at 10:49 AM, with Employee #23 (Consultant Pharmacist) stated, "Once we submit a report, we give a page to each doctor to	L 128	MONITORING CORRECTIVE ACTION: DON/Designee will conduct audits on all the units to ensure that the nurses are using the controlled medication sheet accurately and that all control substances are always accounted for. This audit will be conducted weekly x4, then monthly x3. Findings will be addressed immediately and reported to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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."

Employee #2 acknowledged there was no documented evidence that a physician reviewed or responded to the pharmacist recommendation.

2. Facility staff failed to show documentation that the attending physician or designee reviewed the monthly medication regimen review and act on the recommendations for Residents' #22, #61, #167, #190 and #238.

2A. Resident #22 was admitted to the facility on 11/09/15 with multiple diagnoses that included Hypertension, Anemia and Hyperlipidemia.

Review of Resident #22's medical record revealed:

An Annual Minimum Data Set (MDS) dated 03/23/22 showed that facility staff coded a Brief Interview for Mental Status (BIMS) summary score of "10", indicating moderate cognitive impairment.

02/04/20 (Revision date) [Care Plan] "[Resident #22] is, at risk for adverse reaction r/t (related to) polypharmacy ... Review Pharmacy consult recommendations and follow up as indicated.

02/04/20 (Revision date) [Care Plan] "[Resident #22] receives 9 or more different medications and is at risk for adverse drug interactions ... Clinical pharmacist medication review monthly and prn. Inform physician of recommendations..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 100	L 128		8/24/22

MRR form for December 2021 read,"Every three (3) months labs overdue". There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

MRR form for January 2022 read, "month (every month) Keppra (antiseizure) overdue". There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

2B. Resident #61 was admitted to the facility on 11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Anemia, Hypertension, Peripheral Vascular Disease, Acute Kidney failure, Systemic Inflammatory response syndrome, and Anxiety.

A review of Resident #61's medical record showed that from July 2021 to February 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed.

2C. Resident #167 was admitted to the facility on 10/25/19 with multiple diagnoses including end-stage Renal Disease, Anemia, Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, and anxiety.

A review of Resident #167's medical record showed that from June 2021 to February 2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 101	L 128		8/24/22

the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed.

2D. Resident #190 was admitted to the facility on 11/27/21 diagnoses that included: End Stage Renal Disease, Hypertensive Emergency, Pressure Induced Deep Tissue Damage of the Sacral Region, Diabetes Mellitus and Anxiety.

Review of Resident #190's medical record revealed:

MRR form for December 2021, read "... could 80mg (milligram) Atorvastatin (cholesterol reducer) be reduced?" There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

MRR form for February 2022, read "... suggest Darbopoetin (antiplatelet) state 'give at HD (hemodialysis) clinic." There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

MRR form for March 2022 read, "Please eval (evaluate) Buspar (antianxiety) ... for serotonin effects ..." There was no evidence that the physician or designee signed the medication review form to indicate that it was reviewed.

2E. Resident #238 was admitted to the facility on 10/28/20 with the following diagnoses: Diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 102	L 128		8/24/22

Continued From page 102

Mellitus, Hypertension, Cirrhosis of the Liver, Hyperlipidemia, Gastro-esophageal Reflux Disease, Chronic Hepatitis, Cerebral Infarction and Dysphagia, Dementia with behavioral.

A review of Resident #238's medical record showed that from October 2021 to March 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed.

During a telephone interview conducted on 04/19/22 at 10:55 AM, Employee #23 (Consultant Pharmacist) was asked about the MRRs for each of the aforementioned residents, to which she stated, "The MRR report forms are submitted to the Administrator, Director of Nursing (DON) and the Unit Managers. They are distributed to the appropriate physician or Nurse Practitioner (NP). Once a response is provided (agree, disagree, other) it goes into the patients chart as part of their permanent record."

During a face-to-face interview conducted on 04/19/22 at 1:11 PM, Employee #2 (DON) acknowledged the findings that Resident #22's, #167's, #190's and #238's MRR were not reviewed. Employee #2 further stated, "At this time, I review the MRRs. They are printed out and given to the assigned Unit Manager who notify the MD (medical doctor) or NP (Nurse Practitioner). Sometimes the recommendations don't require any action. Once they (MD/NP) review and sign the MRR form, it is filed." When asked why facility staff failed to document agree,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 103	L 128		8/24/22

disagree, or other and why there was no physician or designee signature on the medication review form to indicated that it was reviewed, Employee #2 stated, "There is no specific time frame for the reviews to be done, but we try to get them done as soon as possible."

3. Facility staff failed to have a system of medication records that enables accurate reconciliation and accounting for all controlled medications.

During an observation on 03/31/22 at 11:02 AM of Medication Cart 2 on unit 4 South, there was two (2) residents (Residents' #151 and #188) with ordered "Diazepam (antianxiety) 10 MG (milligram) rectal gel". The package was observed with two (2) doses (20 MG in total) however, the narcotic book showed, "amount received 1".

On 03/31/22, starting at 11:18 AM, observation medication cart #1 (narcotic box) revealed two (2) residents with Diazepam rectal gel kits. Each kit contained two (2) gel syringes of Diazepam 10 milligrams each. However, the staff reconciled the two syringes as one (1) kit on the Controlled Drug Administration Record.

During a face-to-face interview on 03/31/22 at 11:44 AM, Employee #61 (Registerd Nurse) stated that the syringes are counted as one (1) and the 2nd syringes is destroyed if not used.

Further review of the Controlled Drug Administration Record revealed a physician order that directed, "Insert 10 mg (milligrams) rectally as needed for seizure. Administer 1 with initial seizure, then repeat in 4 hrs. (hours) once call MD (medical doctor) if ineffective."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 104 During a face-to-face interview conducted on 03/31/22 at 12:02 PM with Employee #2 (DON), she stated, "I spoke to the pharmacist and asked about the Diazepam, she stated they are counting just the kit as 1 not the number of doses." When asked how the facility accounts for the other dose once one dose is administered, Employee #2 stated that she wasn't sure. During a telephone interview, the facility's contracted pharmacist on 03/31/22 at 3:18 PM stated that the two syringes in the Diazepam kit are counted as one because the manufacturer "denotes the kit as one (1)." 4. The facility staff failed to ensure that the system used for the reconciliation of controlled medications was followed on three (3) occurences. 4A. During a tour on the 2 South unit of the facility on 03/29/22 at approximately 12:00 PM, a review of the narcotic card count sheets for Medication Cart #1 revealed the following: On 02/26/22, 03/05/22, 03/08/22, 03/15/22, 03/17/22, and 03/19/22 (6 days), the same licensed nurse signed off as Nurse #1 and Nurse #2, instead of two different nurses signing off that the narcotic card count sheets were correct. On 03/06/22, only one licensed nurse (Nurse #1) signed off. The space for the second licensed nurse to sign (Nurse #2) to sign was left blank. On 03/07/22, only one licensed nurse (Nurse #2) signed off. The space for Nurse #1 to sign was left blank.	L 128		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128		L 128		8/24/22

Continued From page 105

During a face-to-face interview with Employee #2 (DON) on 03/29/22 at 12:30 AM, she stated that when the nurses worked a double shift, the same nurse signed as Nurse #1 and Nurse #2 on the narcotic card count sheets. "I can see how the form (narcotic card count document) is confusing. I am going to be making changes to that."

4B. During a tour on the 5 North unit on 03/31/22 at approximately 10:00 AM, a review of the controlled drugs shift-to-shift count record for Medication Carts #1and #2 revealed the following:

Medication Cart #1: On 03/05/22, 03/06/22, 03/18/22, and 03/19/22, one licensed nurse signed the controlled drugs shift-to-shift count record for two shifts 7:00 AM-3:30 PM and 3:00 PM-11:30 PM.

Medication Cart #2: On 03/06/22, 03/11/22, 03/12/22,03/19/22, 03/26/22, and 03/27/22, one licensed nurse signed the controlled drugs shift-to-shift count record for two shifts 7:00 AM-3:30 PM and 3:00 PM-11:30 PM.

During a face-to-face interview with Employee #2 (DON) on 03/31/22 at 10:35 AM, the employee reviewed the controlled drug shift to shift count record. She then stated, "The only problem that I can see is that they (licensed nurses) may have asked another nurse to count with them and I'm not sure where they are documenting that." She could not provide documented evidence that two licensed nurses conducted a physical inventory of all controlled substances and documented it at each shift change, as stated in the facility's policy.

4C. The facility staff failed to ensure that the system used for the reconciliation of controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 106	L 128		8/24/22

medications was followed.

*A review of the Shift count Narcotic records on Unit 2 North was completed on 04/12/22, at approximately 10:00 AM. The review showed that on April 1 - 12, 2022, the Shift count Narcotic sheet had one nurse's signature was placed in the spaces allotted for one nurse going off duty and one nurse coming on duty to reconcile the Narcotics together for the 7:30 AM to 3:30 PM shift, and 3 PM - 11:30 PM.

*A review of the Shift count Narcotic records on Unit 2 South was completed on 04/12/22, at approximately 10:10 AM. The review showed that on April 1, 2022, 3p-11:30P and 11P -7:30A shift, and on April 4, 2022, 7a -3:30P Shift count Narcotic sheet had one nurse signature in the spaces allotted to the nurses going off duty and coming on duty to reconcile the Narcotics together.

A review of the Shift Verification of Accuracy of Controlled Drug Record to the Actual Narcotic Count [Reconciliation Controlled Drug Count Verification Form] directed, "Shift count sheet for Narcotics balance must be verified by the nurse coming on duty and nurse going off duty at each change of shift"

The evidence showed only on nurse's signature was found signing off duty and on duty on unit 2 north on April 1 -12, 2022 and Unit 2 South on April 1, 2022, and April 4, 2022, indicating that the system's use for an acceptable standard of practice to account for the receipt, usage, disposition, and reconciliation of controlled medications were not followed.

A face-to-face interview was conducted with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 128	Continued From page 107 Employee #8 on 04/12/22, at approximately 11:10 AM. After a review of the documentation, he acknowledged the findings.	L 128	L 161 starts here: CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No Resident was affected by this practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have potential t be affected. DON/ Designee will conduct audit on all carts to ensure that all medications are correctly labeled an stored properly. Any issues found will be corrected by 8/21/22. MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Development team/ Designee to all licensed nursing staff to always ensure that medications are labeled and stored correctly completed by 8/24/22. MDS team has been assigned to ensure that medications are labeled and stored correctly for safety purposes. This exercise will be done during ground rounds daily. Any issues found will be corrected by 8/24/22.	8/24/22
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observations and staff interviews, facility staff failed to ensure that medications and biologicals were properly stored for two (2) of 16 medication carts. The findings include: The facility's policy and procedures for storage of medications revised on 08/2020 stated, "...Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier...All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of the amount remaining ..." 1. Facility staff failed to properly store medications. 1A. During an observation on 03/30/22 at 11:11 AM on Unit 4 South, Medication Cart #1, the following was noted: three (3) vials of Insulin stored for use that had expiration dates of "2/22/22, 2/27/2022 and 3/25/22". 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."	L 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 161	Continued From page 108 1B. 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 161	Charge nurses will ensure that they audit their carts on a weekly basis to ensure that medications are labeled and stored appropriately. Any issues found will be corrected by 8/24/22. ADON/Designee will conduct random rounds on a weekly basis to ensure that medications are labeled and stored correctly. Any issues found will be corrected by 8/24/22. Supervisors will ensure that medication carts are clean and that the 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: DON/ Designee will conduct audits on all medication carts to ensure that the medications are labeled and stored correctly. This audit will be done weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI Committee	8/24/22
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 no longer in use were destroyed or returned to the in-house pharmacy. The findings include: During a tour and observation on the 2 South unit on 03/29/22 at approximately 12:00 PM of Medication Cart #1, the following was noted: two (2) blister packets of Lorazepam (antianxiety) 1 MG (milligram) for a resident who was discharged from the facility on 03/15/22. 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	L 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 162	Continued From page 109 Pharmacist) stated, "Narcotic medications that have been discontinued or if the patient is discharged, have to be returned to the pharmacy or be destroyed by 2 licensed staff. They are not to be stored in the medication cart or medication storage room."	L 162	L162 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this deficient practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED All residents residing in the facility have the potential to be affected. House wide audit will be conducted by Unit managers on all carts to ensure that medications that are not in use are taken off the cart. Any issues found will be corrected by 8/24/22. MEASURES TO PREVENT RECURRENCE In service will be provided to all licensed nursing staff on the importance of destroying narcotics and send back medication when the resident is no longer in the facility completed by 8/24/22. Unit managers will ensure that once a resident is discharged, his/her medication will be reconciled and sent back to the pharmacy. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that medications are taken off the cart once a resident is no longer in the facility.. Any issues found will be corrected by 8/24/22. ADON/Designee will conduct rounds, checking all carts to ensure that all medications that are no longer in use are taken off the cart. Any issues found will be corrected by 8/24/22.	8/24/22
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on observations and staff interviews, facility staff failed to ensure that medications and biologicals were properly labeled for three (3) of 16 medication carts. The findings include: The facility's policy and procedures for storage of medications revised on 08/2020 stated, "...Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier... Procedures: III. Expiration Dating (Beyond-Use Dating) ... When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated... The nurse shall place a "date opened" sticker on the medication and record the date opened, and the new date of expiration. The expiration date of the vial or container will be 30 days from opening unless the manufacturer recommends another date ... If a vial or container is found without a stated date opened, the date opened will automatically default to the date dispensed, and	L 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 168	Continued From page 110 the expiration date will be calculated accordingly..." 1. Facility staff failed to accurately label medications. A. During a tour and observation on the 2 South unit on 03/29/22 at approximately 12:00 PM of Medication Cart #1, the following was noted: one (1) Lantus Insulin pen with no date of when it was first opened, was stored for use; one resident's Humalog Insulin pen was observed stored in a bag labeled Glargine (Lantus) 100 units per ml pen and one vial of Lispro Insulin with no date indicating when it was opened. During a face-to-face interview with Employee #41 (Registered Nurse) on 03/29/22 at approximately 12:00 PM, she acknowledged that the Insulin pens and Insulin vial were not stored correctly and discarded the items. 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." C. During an observation on 03/31/22 at 10:18 AM on Unit 4 North, Medication Cart 1, the following was noted: three (3) Insulin pens and one (1) vial with no date opened or expiration date. During a face-to-face interview at the time of the observation, Employee #48 (LPN) acknowledged	L 168	L 162 MONITORING CORRECTIVE ACTION DON/Designee will conduct house wide audit to ensure that all medications that are not in use are taken off the cart and are either sent back to the pharmacy or destroyed by two RN's if its narcotics. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected and reported to QAPI Committee	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 168	Continued From page 111 the findings and stated that licensed staff are provided education on putting dates when they open a new Insulin vial or pen.	L 168	L168 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: No Resident was affected by this practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have potential to be affected. DON/ Designee will conduct audit on all carts to ensure that all medications are correctly labeled and stored properly. Any issues found will be corrected by 8/2122. MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Development team/ Designee to all licensed nursing staff to always ensure that medications are labeled and stored correctly to be completed by 8/24/22 MDS team has been assigned to ensure that medications are labeled and stored correctly for safety purposes. This exercise will be done during ground rounds daily. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that they audit their carts on a weekly basis to ensure that medications are labeled and stored appropriately. Any issues found will be corrected by 8/21/22. ADON/Designee will conduct random rounds on a weekly basis to ensure that medications are labeled and stored correctly. Any issues found will be corrected by 8/24/22. Supervisors will ensure that medication carts are clean and that the 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.	8/24/22
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: 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 reference date. The findings include: 1. 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. 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) completed these sections on 03/22/22. Additionally, Section Z0500, "RN Assessment Coordinator's Signature and Date to verify completion" was left blank. 2. Resident #188 was admitted to the facility on 01/21/22 with the following diagnoses: Diabetes	L 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 191	Continued From page 112 Mellitus, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Altered Mental Status, Visual Hallucinations, Restlessness and Agitation, Syncope and Collapse Review of Resident #188's Quarterly Minimum Data Set (MDS) dated 03/03/22 revealed an assessment reference date of 03/05/22. Based on the MDS assessment reference date, the required completion date for the MDS was 03/17/22. Section Z0500, "RN Assessment Coordinator's Signature and Date to verify completion" was left blank. The evidence showed that facility staff failed to complete the MDS within the required 14 days (03/17/22). During a face-to-face interview on 04/11/22 at 12:49 PM, Employee #19 (Regional MDS Coordinator) acknowledged the findings and stated that she did not sign the MDS completion dates for Residents #181 and #188	L 191	MONITORING CORRECTIVE ACTION: DON / designee will ensure that medication are labeled and stored correctly in all the carts. on a weekly basis. This audit wil be done weekly x4 then monthly x 3. Findings will be corrected and reorted to QAPI commitee. L191 STARTS HERE: CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #181 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/22. This deficiency cannot be retroactively corrected Resident #188 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/22 This deficiency cannot be retroactively corrected. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. MDS Coordinators will conduct house wide audit to ensure that quarterly assessments are completed within the required 14 days of the assessment reference date and that an RN has signed to verify completion of assessment. Any issues found will be corrected by 8/24/22.	8/24/22
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by: Based on record review and staff interview, for ten (10) of 105 sampled residents, facility staff failed to ensure that the resident's medical records included current assessment information. Residents' #3, #50, #126, #155, #160, #164, #183, #404, #408 and #502. The findings include:	L 200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 113 1. The facility staff failed to ensure Resident #3's Treatment Administration Record for 01/08/22 to 02/07/22 contained accurate information. Resident #3 was admitted to the facility on 12/01/21 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. Review of a physician's order dated 12/02/21 [physician order] instructed stated staff to, "Change HME (Heat Moisture Exchanger) daily Day shift." Review of Treatment Administration Records from 01/08/22 to 02/07/22 showed that the facility's nurses initialed that they changed Resident #3's HME daily on dayshift. However, during a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that Resident #3 did not have HMEs to connect to his lary-tube from 01/08/22 to 02/07/22. When asked why it took so long for Resident #3 to get HMEs, Employee #31 said, "I did not know the size of the resident's lary-tube. And the HMEs we had in house was not compatible with the lary-tube his family provided on 01/08/22." 2. Facility staff failed to code Resident #50's MDS to reflect the need of having 2 person's physical assist. Resident #50 was admitted to the facility on 06/26/14 with multiple diagnoses that included: Morbid Obesity, Anxiety Disorder, Mood Affective Disorder and Major Depressive Disorder. Review of Resident #50's medical record revealed the following:	L 200	L191 MEASURES TO PREVENT RECURRENCE: Training will be provided by Regional MDS coordinator to the MDS team members to always ensure that the quarterly assessments are completed within the required 14 days after the ARD. Any issues found will be corrected by 8/24/22. The Director of Quality Assurance will validate that all quarterly assessments are completed in a timely manner and that an RN has signed to verify completion. Any issues found will be corrected by 8/24/22. MONITORING CORRECTIVE ACTION: The MDS Lead staff member will ensure that quarterly assessments are completed by the MDS team correctly and that an RN signs and date the assessment to verify completion. This audit will be done weekly x4, then monthly x4. Findings will be corrected immediately and reported to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 114 01/30/20 (Revision date) [Care Plan] "[Resident #50] has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, morbid obesity ... the resident requires 2 staff participation to reposition and turn in bed, the resident requires total assistance with personal hygiene care ..." 11/16/20 (Creation Date) [Care Plan] "Alleged abuse ... 2 CNAs (Certified Nurse Aides) to provide ADL care all shift ..." 11/17/20 [Physician's Order] "2 CNAs to provide ADL care all shift" Review of Resident #50's Quarterly MDS dated 09/24/21 showed that facility staff coded "one person physical assist" for ADL assistance with personal hygiene. During a face-to-face interview conducted on 04/19/22 at 12:26 PM with Employee #19 (Regional MDS Coordinator), she acknowledged the finding and made no further comment. 3. Facility staff failed to accurately document the findings of Resident #126's incident investigation on the report. Review of the FRI (Facility Reported Incident) dated 12/27/21 documented "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the 1/4 side rail; resident sustained a laceration on the upper lateral right leg; resident scratched her right leg at the edge of the 1/4 side rail. Writer was made aware of the incident; writer assessed the wound."	L 200	L200: STARTS HERE: CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENT: Resident #3 was sent to the hospital 3/29/22 and did not return to the facility. Resident #126 was assessed on 4/26/22, resident in no apparent distress. The nurses are now indicating the correct site where blood pressure is taken. Right arm or left arm / left leg or right leg.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 115 Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure Unspecified, Presence of Right Artificial Knee Joint, Chronic Kidney Disease, Stage 4 (Severe), and Other Lack of Coordination. Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11", indicating moderately impaired cognition. In section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist" Review of the Facility Reported Incident that was submitted to the Department of Health on 12/23/21 at 6:47 PM showed, " ...During a transfer from wheelchair to bed by two staff residents suddenly sway her leg scratched against the ¼ side rail ...writer was made aware of incident; writer assessed the wound ..." Review of the nursing progress note dated 12/23/2021 at 11:50 AM documented, "...During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the ¼ side rail ..." Review of the facility's investigation of the incident revealed a handwritten statement by the certified nurse aide who was involved in the incident dated 12/22/2021 at 5:15 PM showed, "On 12/22/21, I floated to 3N to work at approximately 5:15 PM [Resident #126] asked me to put her in bed. I took her to her room in transferring her I notice	L 200	Resident # 50 was assessed by Unit Managers on 4/26/2022, resident suffered no negative outcome. MD/RP updated. Coding for MDS is two persons assist for ADL Resident # 155 was assessed by Unit Manager on 4/26/22, resident suffered no negative outcome. MD/RP updated. MDS coding reflects his desire to go home. Resident # 183 was assessed on 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP updated MDS coding reflects multiple falls Resident #502 discharge home 6/2/22 Resident #160 was assessed on 4/26/22, resident suffered no negative outcome. MD/RP updated. MDS will reflect rejection of care IDENTIFICATION OF OTHERS WITH THE POTENTAIL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this practice. MDS coordinators will conduct house wide audit to ensure that MDS staff are coding correctly for residents with two persons physical assist with ADL resident with the desire to return to the community, residents rejecting care, residents with history of fall and residents with diagnosis of dialysis are accurately coded. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 116	L 200	MEASURES TO PREVENT RECURRENCE:	8/24/22

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.

4. Facility staff failed to accurately code Resident #155's MDS to reflect his desire to return to the community.

Resident #155 was admitted to the facility on 11/18/19, with multiple diagnoses that included: 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 a (Brief Interview for Mental Status (BIMS) Summary Score "05", indicating severe cognitive impairment.

Provider's Plan of Correction (continued):

Training will be provided by Staff Educator/ Regional MDS coordinator to the MDS staff on the importance of proper coding.

MDS coordinators will conduct a check on coding to ensure that they are coding correctly for residents who are two persons assist, those on dialysis and those wishing to return to the community. Any issues found will be corrected by 8/24/22.

Unit Manager and Supervisors will ensure that C N A 's are documenting accurately that a resident is two persons assist so that they can be on the same page with MDS documentation and coding. Any issues found will be corrected by 8/25/22.

ADON/Designee will conduct audits to ensure that the residents who are non-compliant with care are documented and that MDS is capturing and coding this aspect correctly. Any issues found will be corrected by 8/24/22.

Training will be provided by Staff Educator/ Regional MDS coordinator to the MDS staff on the importance of proper coding completed by 8/24/22.

MDS coordinators will conduct a check on coding to ensure that they are coding correctly for residents who are two persons assist, those on dialysis and those wishing to return to the community. Any issues found will be corrected by 8/24/22.

Unit Manager and Supervisors will ensure that C N A 's are documenting accurately that a resident is two persons assist so that they can be on the same page with MDS documentation and coding. Any issues found will be corrected by 8/24/22.

ADON/Designee will conduct audits to ensure that the residents who are non-compliant with care are documented and that MDS is capturing and coding this aspect correctly. Any issues found will be corrected by 8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 117 In Section Q (Participation in Assessment and Goal Setting), "Resident participated in assessment "1" meaning yes Q0400 (Discharge Plan): Is active discharge planning already occurring for the resident to return to the community? "No". Does the residents clinical record document a request that this question be asked only on comprehensive assessments? "No" Q0500 (Return to Community), Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? "No" Q0500 (Resident's preference to Avoid being asked question Q0500B again) Does the resident ..want to be asked about returning to the community on all assessments? "Yes" Q0600 (Referral), Has a referral been made to the local contact agency? "No" Review of Care Plan meeting note on 03/04/20 at 12:13 PM showed, " ...care plan meeting was held today 3/4/2020. [Resident #155] and his... RP (representative) was present at the meeting. SW [social worker] reported that he is a full code and long-term care status. The SW is working with [Name] to locate appropriate housing for him but until that time he will remain in long term care." Review of the Social Work Progress Notes 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.	L 200	MONITORING CORRECTIVE ACTION MDS coordinator/ Desigee will conduct audit on coding to ensure all codlings are done accurately. This audit will be done weekly x4 then monthly x3. Findings will be corrected and reported to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 118	L 200		8/24/22

The social worker will follow up with the family"

06/16/21 at 8:42 PM, "The care plan/IDT (Interdisciplinary team) meeting was held today for [Resident #155]. His new RP [Representative] soon to be Power of Attorney and mother of his child ... was present at meeting..."

07/23/21 at 2:50 PM, "The SW return [Resident Representative] call concerning [Resident #155] She stated that he called her and was asking to leave here because he was tired of being here..."

12/29/21 at 5:11 PM, "... the Ombudsman called the SW and the Supervisory SW stated that [Resident's sister] felt as if the SW and the transition worker were holding up the process towards [Resident #155] going into [Name of Assisted Living Facility]."

The evidence showed that Resident #155 expressed a wish to be discharged to the community, however, facility staff failed to accurately code the MDS to reflect this desire.

During a face-to-face interview conducted on 04/18/22 at 1:30 PM, with Employee #18 (MDS Coordinator) she stated, "The social services fills out that section (Section Q)."

During a face-to-face interview conducted on 04/18/22 at 3:00 PM with Employee #13 (5th Floor Social Worker), she acknowledged that the MDS for Resident #155 was not accurately coded and stated, "I fill out the section based on what the team has agreed. This is a systemic issue."

5. Facility staff failed to accurately code the MDS to reflect Resident #160's rejection of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 119	L 200		8/24/22

Resident #160 was admitted to the facility 02/20/12, with multiple diagnoses that included: Morbid Obesity, Diabetes Mellitus, Major Depressive Disorder and Anxiety.

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."

02/25/2022 at 12:54 PM [Care Plan Meeting Note] "Care conference with resident's daughter via phone... At times she is noncompliant with medications..."

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."

A 5-day MDS dated 02/26/22 showed facility staff coded a BIMS summary score "06", indicating severe cognitive impairment and in Section E (Behavior) that no rejection of care behaviors occurred.

During a face-to-face interview conducted on 04/11/22 at 10:03 AM, Employee #18 (MDS Coordinator) acknowledged the finding and stated, "Section E (Behavior) is completed by social services."

6. Facility staff failed to accurately document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 120	L 200		8/24/22

site where they obtained Resident #164's blood pressure.

Resident #164 was admitted to the facility on 07/26/2016 with multiple diagnoses that included: End Stage Renal Disease, Type 2 Diabetes Mellitus, and Hyperlipidemia.

Review of Resident #164's medical record revealed the following:

03/04/2022 [Quarterly MDS], facility staff coded a BIMS summary score of "15", indicating intact cognitive response and "yes" to dialysis in Section O (Special Treatments, Procedures, and Programs).

04/07/2022 [Physician's Order] "Assess dialysis AV (arteriovenous) graft site on left upper arm for bleeding, redness, tenderness, and swelling every shift, (No B/P (blood pressure) and no blood draws on this arm) every shift"

03/18/2022 (Revision date) [Care Plan] "[Resident #164] has Left arm site used for dialysis ...Do not take blood pressure or blood specimens from left arm ..."

Review of the vital signs documentation from 03/18/22 to 04/10/22 showed that facility documented:

03/18/22 at 8:05 PM 136/87 mmHg (millimeters of mercury) Lying l/arm (left arm)
03/22/22 at 9:39 PM 130/74 mmHg Lying l/arm
03/25/22 at 11:11 PM 128/74 mmHg Lying l/arm
03/26/22 at 8:40 PM 128/72 mmHg Lying l/arm
03/27/22 at 11:29 AM 139/74 mmHg Lying l/arm
03/27/22 at 10:41 PM 128/72 mmHg Lying l/arm
03/28/22 at 11:38 PM 130/74 mmHg Lying l/arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 121	L 200		8/24/22

Continued From page 121

03/31/22 at 6:41 PM 128/74 mmHg Lying l/arm
04/09/22 at 1:51 PM 138/76 mmHg Lying l/arm
04/09/22 at 7:35 PM 128/72 mmHg Lying l/arm
04/10/22 at 11:50 AM 120/71 mmHg Lying l/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 with injury to the left knee ... 7/14/2020 had a fall without injury, fell on 10/14/21 on the van without injury."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 122	L 200		8/24/22

Continued From page 122

Review of the Quarterly MDS dated 11/22/21, revealed in section J (Health Conditions) facility staff coded the following:

J1700 - "Fall History on Admission/Entry or Reentry" was left blank

Review of the Quarterly MDS) dated 02/22/22, revealed in section J (Health Conditions), facility staff coded:

J1700 - Did the resident have a fall anytime in the last month prior to admission/entry or reentry, facility staff coded "0", indicating no; Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry?, facility staff coded "0", indicating no

J1800- Has the resident had any falls since admission/entry or reentry or the prior assessment ...whichever is most recent?, facility staff coded "0", indicating no.

The evidence showed that facility staff failed to accurately code Resident #183's MDS on 11/22/21 and on 02/22/22.

During a face-to-face interview conducted on 04/08/22 at 12:35 PM, Employee #18 (MDS Coordinator) acknowledged the finding and stated, "I did not understand the questions being asked."

8. Facility staff documented completing tasks on Resident #404 while he was out of the facility (hospitalized) and recreated an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 123	L 200		8/24/22

A. 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..."

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 showed the following:

09/29/21 [Physician's Order] "Hourly elopement/wandering monitoring and location. every hour..."

02/21/22 [Treatment Administration Record] revealed a check mark and licensed staff initials for the evening shift (3:00 PM- 11:00 PM) in the sections, "Nurse to complete full body skin evaluation on shower days ...on Monday ..."; "Check wonder guard functioning and placement on left ankle every shift, hours ..."; "Apply ... ointment to entire body ..."; "Assess skin around and behind ear and ear lobe for irritation ..."; "Monitor for sign of COVID- 19 ...", indicating that the task was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 124	L 200		8/24/22

The TAR further revealed that facility staff documented a temperature of "97.7" (degrees Fahrenheit) on 12/21/22 for the evening shift.

Continued review showed that from 02/21/22 at 4:00 PM to 02/26/22 at 3:00 AM, facility staff documented 14 times that Resident #404 was "In room (IRM)" in the section, "Hourly elopement/wandering monitoring and location. every hour..."

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."

02/21/22 at 1:43 PM [Nurse's Progress Note] "A call was paced to [Hospital Name] to know about the status of the resident in the ER, spoke with nurse [Registered Nurse's Name] who stated resident is critically ill, he has been intubated and about to be transferred to ICU (intensive care unit). RP (representative)... made aware"

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #7 (Clinical Coordinator) acknowledged the findings and made no further comments.

B. Facility staff failed to maintain the integrity of an "Incident/Accident Report" related to a resident-to-resident altercation resulting in serious injury to the resident.

During a face-to-face interview conducted on 03/30/22 at 12:15 PM, Employee #1 (Administrator) provided the survey team with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 126	L 200		8/24/22

(Registered Nurse), #28 (Nursing Supervisor), #29 (CNA) and a typed statement with the name and signature of Resident #82, absent of date and time.

During a face-to-face interview conducted on 03/31/22 at 3:30 PM, Employee #1, was asked why there are two versions of the facility's investigation report. She stated, "I couldn't find it (the original) on Saturday (03/26/22). I redid the report and had the employees rewrite their statements." Employee #1 also stated that she completed the incident/accident report form with dated 02/22/22, wrote in and signed Employee #7's name and signature on the report because he was out of the country at the time. Employee #1 continued to say, "Employee #6 (Administrator in Training) found the original documents (dated 2/21/22) in the shred box and those were the documents that were emailed [on 03/30/22]."

During a face-to -face interview conducted on 04/04/22 at 12:48 PM, Employee #7 (Clinical Coordinator) Employee #7 was asked about the incident/accident report that was provided to the survey team on 03/30/22 as part of the facility's investigation documents. Employee #7 stated that he completed the incident/accident form and submitted it to Employee #1 (Administrator) on 02/21/22. When showed a copy of the "Incident/Accident Report" document dated 02/22/22 with his name and signature, Employee #7 stated, "That is not my writing. This is not the incident report that I filled out and provided to the Administrator."

During a face-to-face interview conducted on 04/11/22 at 5:49 PM with Employee #6, she stated, "I was not part of the original incident report. I got involved in the part of the process at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 127	L 200		8/24/22

the point when we couldn't find it (original investigation documents). The original incident report was done by [Employee #7]. When we couldn't find it, I filled out the incident/accident report forms [to include writing in Employee #7's name on the signature line]. That's my handwriting. She [Employee #1] just signed it [the form on the administrator signature line]."

During a face-to-face interview conducted on 04/11/22 at 5:49 PM, Employee #6 (Administrator in Training) acknowledged and admitted to recreating the "Incident/Accident Report" related to resident-to-resident altercation resulting in serious injury to Resident #404.

9. Facility staff inaccurately documented to doing assessments on Resident #408 who has hospitalized.

Review of the FRI dated 02/22/22 documented, "...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident
had reported fallen to anyone..."

Resident #408 was admitted to the facility on 05/25/21 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

Review of Resident #408's medical record revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200		L 200		8/24/22

Continued From page 128

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment.

02/17/22 at 11:29 AM [Social Work Progress Note] "[Resident #408] was transferred to [Hospital Name]..."

02/17/2022 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle ... [Physician's Name] notified and she gave order to send resident to the ER (emergency room) for 2nd opinion ..."

02/17/2022 at 5:02 PM [Social Work Progress Note] "Resident was sent to the hospital. The 6-108 was completed and forwarded to Ombudsman ..."

Review of Resident #408's electronic medical record revealed that despite the resident being hospitalized, facility documented to completing the following resident assessments:

02/27/2022 at 9:14 AM Safe Smoker
02/27/2022 at 10:20 AM Dental/Oral
02/28/2022 at 12:17 PM Elopement Risk
02/28/2022 at 12:18 PM Use of Side Rail(s)
02/28/2022 at 12:19 Bladder and Bowel.

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #7 (Clinical Coordinator) acknowledged the findings and stated, "The assessments automatically pop up if they are still in the system even though the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 129	L 200		8/24/22

Continued From page 129

resident maybe out of the facility."

10. Facility staff failed to accurately code Resident #502's MDS for dialysis.

Resident #502 was admitted to the facility on 03/17/22 with multiple diagnoses including End-Stage Renal Disease, Anemia, Chronic Pancreatitis, Chronic Viral Hepatitis C, Hypertension, Peripheral Vascular Disease and Hyperlipidemia.

Review of Resident #502's medical record revealed the following:

03/17/22 [Physician's Order] "Dialysis: Tuesday, Thursday, Saturday..."

03/17/22 [Quarterly MDS], showed that facility staff coded the following:

In Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) summary score of "15", indicating intact cognitively.

In Section O (Special, Treatments Procedures and Programs), O0100 under other ... Dialysis, facility staff coded "1" ... indicating not on Dialysis.

The evidence showed that facility staff failed to accurately code Resident #502's MDS to reflect that Resident #502 was on Dialysis.

During a face-to-face interview conducted on 04/19/22 at 1:40 PM, Employee #19 (MDS Coordinator) acknowledged the finding and stated, "I will review this (MDS assessment)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	Continued From page 130	L 201	L201	
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition;	L 201	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 182 was assessed on 4/26/22 by unit manager, resident in no apparent distress. MD/RP updated. Resident refused to take the pneumococcal vaccine. Risk versus benefits explained. Resident #603 was assessed by unit manger on 4/26/22, resident suffered no negative outcome. Responsible party accepted that pneumococcal vaccine should be administered to the resident. It will be administered 6/15/22. House wide audit in progress for pneumococcal vaccine administration. Any issues found will be corrected by 8/25/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED. All resident eligible for to receive pneumococcal vaccine have the potential to be affected by this practice House wide audit is ongoing to identify resident that the facility staff did not ensure they have taken or at least offered to administer the pneumococcal vaccine. Any issues found will be corrected by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	Continued From page 131 (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff	L 201	MEASURES TO PREVENT RECURRENCE. In- service will be provided to all nursing staff to ensure that they offer to administer pneumococcal vaccine at no cost to them. Licensed clinical staff will ensure that they re-offer to administer pneumococcal vaccine to residents who refused and ensure proper documentation is in place. Any issues found will be corrected by 8/24/22. Review will be conducted by supervisors to ensure that the consent for pneumococcal vaccine is signed upon admission and that the contents of the consent is implemented. Any issues found will be corrected by 8/24/22. The pneumococcal consent form has been added to the admission package so assist responsible party to determine if they want their loved ones to take the vaccine or not. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 201	Continued From page 132 failed to ensure that there was documentation in the resident's medical record of the information/education provided regarding the benefits and risks of immunization, the administration or the refusal of or medical contraindications to the vaccine(s). Residents' #182 and #603. The findings include: Review of the policy entitled, "Pneumococcal Policy and Procedure" (not dated) documented, "It is the policy of [facility Name] to offer to all residents pneumococcal upon admission and administer in accordance with the recommendations of the Centers of Disease Control (CDC) and the facility Medical Director..." 1. Resident #182 was admitted to the facility on 05/07/21 with diagnoses that included Hypertension, Heart Failure, Type 1 Diabetes Mellitus and Anemia in Chronic Kidney Disease. According the Quarterly Minimum Data Set (MDS) dated 03/04/22, facility staff coded Resident #182 with a Brief Interview for Mental Status (BIMS) score of "14", indicating intact cognitive response. Review of Resident #182's electronic and paper health record lacked documented evidence that facility staff provided information/education to the resident or their representative regarding the benefits and risks of the influenza and pneumococcal immunization or the refusal of the vaccine(s). 2. Resident #603 was admitted to the facility on 03/14/22 with diagnoses that included: Unspecified Fracture of Left Patella and Upper	L 201	MONITORING CORRECTIVE ACTION: DON/Designee will conduct house wide audit to ensure that pneumococcal status for each resident is documented. This audit will take place weekly x3, then monthly. Findings will be addressed and reported to QAPI Committee	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

L 201 Continued From page 133 | L 201 | 8/24/22

End of Right Humerus, Seizures and Anemia.

According the Admission MDS dated 03/20/2022, in Section C (Cognitive Status), facility staff coded Resident #603 as "resident is rarely/never understood."

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."

It should be noted that Employee #5 was not able provide the survey team with any documentation for Residents' #182 or #603 vaccine(s) education, consent or refusal.

L 204 3232.2 Nursing Facilities | 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, and description of the incident;

(b)The name of the witnesses;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 134 (c)The statement of the victim; (d)A statement indicating whether there is a pattern of occurrence; and (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 incident ...If suspected abuse/inappropriate behavior are between two residents, residents will be immediately separated from each other and monitored until appropriate interventions are implemented...All employees will sign a memo attesting, their understanding and compliance to abuse standards..." Review of the facility's policy also showed that neglect was defined as "the 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..." The policy revealed that 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."	L 204	L 204 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 3 was discharged 3/29/22,this deficient practice cannot be retroactively corrected. Resident # 409 was discharged home on 9/28/20 this deficient practice cannot be retroactively corrected. Resident #71 was assessed from head to toe on 4/26/22, resident suffered no negative outcome from the incident that occurred between him and another resident. MD/RP notified on 4/26/22 Resident #67 was assessed from head to toe by Unit Manager from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22 Resident #151 was assessed from head to toe by Unit Manager on 4/26/22, resident suffered no negative outcome from the incident that happened between him and another resident. MD/RP updated 4/26/22. Resident #221 discharged this deficient practice cannot be retroactively corrected. Resident # 408 was sent to ER on 2/12/22 and did not come back. Resident #11was assessed from head to toe by Unit 4/26/22 resident suffered no negative outcome. MD/RP notified on 4/20/22. Resident #50 was assessed from head-to-toe Unit manager on 4/26/22, suffered no Issues.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 135 Review of the facility policy entitled, "Investigation Process" dated 02/2022 showed, " ...The facility will ensure thorough investigation during an incident or occurrences that may involve our residents, employees, volunteers, and visitors ... interview and/or obtain statement from victim/resident ... interview and/or obtain statements from alleged perpetrators, interview and or obtain statements from potential witnesses ... [Facility Name] will use the following... components to eliminate and/or minimize the risk associated with resident abuse: screening, training, prevention, identification, protection, and reporting response..." 1.The facility's staff failed to conduct an investigation for Resident #3's airway (stoma) being occluded by a medical device HME subsequently, causing the resident to be transferred to the emergency room (ER) for dislodgment. According to Johns Hopkins Medicine (https://www.hopkinsmedicine.org/tracheostomy/resources/glossary.html#Tracheotomy) a HME is a humidifying filter that fits onto the end of the trach tube and comes in several shapes and sizes. It is also known by several other terms including Thermal Humidifying Filters, Swedish nose, Artificial nose, Filter, Thermovent T. 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	L 204	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.: All residents residing in the facility have the potential to be affected by this deficient practice. Clinical care coordinator/Designee will conduct house wide audit to ensure that all resident-to-resident altercation are fully investigated, and that all staff present provided statements. Any issues found will be corrected by 8/24/22. Unit Managers/ Supervisors will conduct house wide audit to ensure that all alleged threat of violence is investigated and reported. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 136 (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 resident's medical record revealed the following: -12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27 ...upon assessment, resident alert and oriented to person and place. ...Resident has a lary tube with cap [HME] in place ... -12/01/21 at 20:29 [physician assistant physician progress note]- Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... -12/02/21 [physician order]- Change HME daily day shift. -12/02/21 at 13:15 [respiratory therapy assessment]- Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear...	L 204	MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed nurses by Staff Educator on the importance of completing accident/incident report accurately and to report their findings to DOH within 8 hours if the incident resulted in an injury and within 72 hours for incidents without injury. Unit Managers will ensure that all staff members provide written statements on resident incidents/ accidents situations. Any issues found will be corrected by 8/24/22. Supervisors will ensure all incident/accident reports are completed accurately. Any issues found will be corrected by 8/24/22. Charge nurses will ensure that they collect statements from staff about incident/accident that occurred during their shifts and ensure that incidents are reported. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 137 -12/03/21 [physician order] - transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma. -12/03/21 at 14:42 [nursing progress note] - The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma (airway) was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...Resident's daughter ...called and spoke with Respiratory Therapist ...wanted to find out if resident was alive, in distress or pain and asked ...how she determine that since resident is non-verbal ... 911 called at 1345 and they arrived at 1400 ... v/s (vital signs): 121/80 (blood pressure), 63 (pulse), 18 (respirations), 97.8 (temperature), O2 Sat (saturation) 99% RA (room air). -12/04/21 [hospital discharge summary]- Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (x-ray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for	L 204	Unit Managers will validate during grand rounds daily that incidents that 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 by Nurse Supervisors, ADON/ Designee, to ensure that incidents are investigated ,that the incident forms are completed accurately and that incidents are reported in a timely manner to Department of Health. Any issues found will be corrected by 8/24/22 MONITORING CORRECTIVE ACTION: DON/Designee will audit all incident report to ensure that they are fully investigated upon and that each incident report has employees' statements. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to the QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 138 "How to Clean a Tracheostomy Tube, Adult." -12/04/21 at 07:54 [nursing progress note] - Resident came back from the hospital ...on arrival 129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air. -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 stable ...vitals: 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 Review of the comprehensive care plan with an initial date of 12/04/21 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer. 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.	L 204	L 204 STARTS HERE: CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 3 was discharged 3/29/22,this deficient practice cannot be retroactively corrected. Resident # 409 was discharged home on 9/28/20 this deficient practice cannot be retroactively corrected. Resident #71 was assessed from head to toe on 4/26/22, resident suffered no negative outcome from the incident that occurred between him and another resident. MD/RP updated on 4/26/22 Resident #67 was assessed by Unit Manager from head to toe on 4/26/22, resident suffered no negative outcome. MD/RP update on 4/26/22 Resident #151 was assessed by Unit Manager on 4/26/22, resident suffered no negative outcome from the incident that happened between him and another resident. MD/RP updated on 4/26/22 Resident #221 discharged this deficient practice cannot be retroactively corrected. Resident # 408 was sent to ER on 2/12/22 and did not come back	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 139	L 204	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.:	8/24/22

Interventions- lari-tube care daily, change HME daily, assist with cough as needed...

Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22.

Review of a complaint received by the DC Department of Health on 01/26/22 from alleged that Resident #3 was rushed to the ER on 12/03/21, because there was an HME put into his (Resident #3) neck stoma (airway)."

Resident #3 was unable to be interviewed at the time of the survey because he was discharged to the hospital on 03/29/2022.

During a telephone interview on 04/12/22 at 11:35 AM, the resident's responsible party (granddaughter) stated that the clinical coordinator and the respiratory therapist called her informing her that the HME was stuck in her grandfather's stoma. When asked if they informed her what happened, she said, "No, neither one of them could explain, but [name of clinical coordinator] said sometimes there are things that happened that we can't explain."

During a face-to-face interview on 04/12/22 at approximately 5:00 PM, Employee #32 (LPN) stated, I cleaned something in his neck two times a shift. Respiratory sees him (Resident #3) all the time. I had training from respiratory, but I don't remember when." The employee also stated, "I don't remember the resident (Resident #3) using a HME."

During a face-to-face interview on 04/13/22 at

Provider's Plan of Correction (L 204):

IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED.:

All residents residing in the facility have the potential to be affected by this deficient practice.

Clinical care coordinator/Designee will conduct house wide audit to ensure that all resident-to-resident altercation are fully investigated, and that all staff present provided statements. Any issues found will be corrected by 8/24/22.

Unit Managers/ Supervisors will conduct house wide audit to ensure that all alleged threat of violence is investigated and reported. Any issues found will be corrected by 8/24/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 140	L 204		

Continued From page 140

2:25 PM, Employee #7 (Clinical Coordinator) reported that when the respiratory therapist informed him that an HME was stuck in the resident's stoma (airway), he had Resident #3 transferred to the emergency room for evaluation. The employee then shared that Resident #3 was not in any distress when the HME was lodged in his stoma (airway). When asked if an investigation was conducted to determine how the incident of the HME being lodged in Resident #3's stoma (airway) happened, Employee #7 stated, "No." The employee also said the respiratory therapist was responsible for changing the resident's HME.

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma. If he (Resident #3) did not get the HME out of his stoma it would have been detrimental." The employee stated that she worked three to four days a week, and on the days, she was not in the facility nursing staff was responsible for cleaning Resident #3's lary-tube and changing the HME. Also, Employee #31 said that she provided nursing staff education on how to care for Resident #3's lary-tube and HME and documented the training on a clipboard in her office. The employee also said she required nursing staff to do a return demonstration to ensure competency.

During a face-to-face interview on 04/14/22 at approximately 3:00 PM, Employee #33 (RN) stated that respiratory therapy provided her with training on tracheostomy care, but they did not provide education on laryngectomy's, lary-tubes, or HMEs. The employee said that although she

Provider's Plan of Correction (L 204) — Complete Date: 8/24/22

MEASURES TO PREVENT RECURRENCE:

In-service will be provided to all licensed nurses by Staff Educator on the importance of completing accident/incident report accurately and to report their findings to DOH within 8 hours if the incident resulted in an injury and within 72 hours for incidents without injury.

Unit Managers will ensure that all staff members provide written statements on resident incidents/ accidents situations .Any issues found will be corrected by 8/24/22

Supervisors will ensure all incident/accident reports are completed accurately; Any issues found will be corrected by 8/24/22.

Charge nurses will ensure that they collect statements from staff about incident/accident that occurred during their shifts and ensure that incidents are reported. Any issues found will be corrected by 8/24/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 141 regularly worked on the floor where Resident #3 resided, she could not remember working with him. A review of in-service training documents lacked 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." There was no evidence that facility staff developed a person-centered approach to care for and provide necessary services to Resident #3 who had a laryngectomy. Subsequently, Resident #3's airway (stoma) was occluded by a medical device HME, causing him to be transferred to the ER for dislodgment of the device. 2. Facility staff failed to interview and/or obtain statements from all staff involved in Resident #11's care in an allegation of neglect. Resident #11 was admitted to the facility on 04/22/15 with diagnoses that included: Bipolar Disorder, Anxiety Disorder, Major Depressive Disorder and Convulsions. Review of Resident #11's medical record revealed: 12/17/21 [Quarterly Minimum Data Set (MDS)]	L 204	Unit Managers will validate during grand rounds daily that incidents that 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 by Nurse Supervisors, ADON/ Designee, to ensure that incidents are investigated ,that the incident forms are completed accurately and that incidents are reported in a timely manner to Department of Health. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 142	L 204	MONITORING CORRECTIVE ACTION:	8/24/22

where staff coded, a Brief Interview for Mental Status (BIMS) summary score of "03", indicating severe cognitive impairment, "total dependence" with "one person physical assist" for personal hygiene and "frequently incontinent" for urinary and bowel continence.

Review of Facility Reported Incident (FRI) dated 03/18/22 showed, " ... [Resident #11's] daughter wrote a grievance on 03/14/22 stating that her father had not been changed since 03/12/22 during the night shift until 03/13/22 at 18:30 (6:30 PM). She stated that her father was soaked in urine and had feces when she came in to visit ..."

Review of the facility's investigation documents provided to the writer on 04/12/22 revealed that the facility staff failed to follow its policy for investigating allegations of neglect evidenced by failure to interview and/or obtain statements from all staff that took care of Resident #11 from 11:00 PM on 03/12/22 to 11:00 PM on 03/13/22.

During a face-to-face interview conducted on 04/12/22 at 2:39 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated, "I was not able to get everyone's statements."

3. Facility staff failed to investigate two incidences of resident-to-resident altercations involving Residents' #71, #67 and #151.

Review of the FRI dated 12/09/21 documented, "... At 0730AM, the security officer ... observed [Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit

Provider's Plan of Correction (L 204):

DON/Designee will audit all incident report to ensure that they are fully investigated upon and that each incident report has employees statements. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to the QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 143	L 204		8/24/22

Continued From page 143

him on his chest x 2 in the lobby ..."

Resident Background 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.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 144 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: schizophrenia ...Inform 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 ..." 07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..." 10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with 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 impaired cognitive function or impaired thought processes r/t (related to) Dementia..." 10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ...	L 204		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 145	L 204		8/24/22

Continued From page 145

Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol..."

10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.
Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 146	L 204		8/24/22

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 #67] 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 #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 147	L 204		8/24/22

PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident-to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents.On 12/29/21, Resident #151 attacked another resident at the facility.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator) acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has not had any resident-to-resident altercations.

4. Facility staff failed to thoroughly investigate an alleged resident-to-resident threat of violence by Resident #221.

Review of the FRI (Facility Reported Incident) dated 03/29/22, documented "...resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day we will find the roommate hurt ..."
Resident #221 was re-admitted to the facility on 10/28/21 with multiple diagnoses including, Cognitive Communication Deficit, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Paraplegia Unspecified and Paranoid Schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 148	L 204		8/24/22

Review of the Quarterly MDS dated 03/23/22 revealed that the facility staff coded the following: In section C (Cognitive Patterns), a BIMS Summary Score "15", indicating intact cognition.

Review of the document titled "SBAR (Situation Background Assessment Recommendation)-physician /NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool" dated 03/28/22 at 12:27 PM, showed "...Today, resident explained to the charge nurse that he did not like rooming with his roommate. He stated that if he were to continue to be in that room that one day, we will find the roommate in a pool of blood. A nurse stayed by the resident's side until the resident could be transferred to another room. Prior to being transferred to the room he was introduced to the new potential roommate and stated that the change would be fine..."

Review of the facility's incident investigation documentation that was signed and dated on 03/28/22, consisted of the following: two handwritten employee statements, a copy of a resident face sheet, a form titled "Incident/Accident report", a form titled "Quality Assurance and Performance Improvement Employee /Resident investigation report, a SBAR note, a form titled Pain evaluation for cognitively impaired & Intact.

The facilities investigative report lacked documented evidence of the following: an interview or assessment of Resident #221's roommate, interviews with all staff that may have knowledge of the incident, resident and staff education/training related to care approaches following the resident-to-resident incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 149	L 204		8/24/22

Continued From page 149

During a face-to-face interview conducted on 04/18/22 at approximately 1:00 PM, Employee #2 (Director of Nursing) acknowledged the findings.

5. Facility staff failed to interview and/or obtain statements from all staff involved in Resident #408's care the day an injury of unknown origin was discovered.

Review of the FRI dated 02/22/22 documented, "...Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP (Nurse Practitioner) ... X-ray report received this morning with impression of Acute fracture of the left distal femur, Acute hairline fracture of the right lateral femoral condyle ... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident
had reported fallen to anyone..."

Resident #408 was admitted to the facility on 05/25/2021 with multiple diagnoses that included: Hemiplegia and Hemiparesis, Hypocalcemia, Muscle Weakness and Lack of Coordination.

Review of Resident #408's medical record revealed the following:

01/04/22 [Quarterly MDS], facility staff coded the following: a BIMS summary score "04", indicating severe cognitive impairment, extensive assistance to total dependence with two plus persons physical assist" for transfers , mobility and personal hygiene, no impairment in range of motion.

02/16/22 at 2:27 PM [Nurse Practitioner (NP) Progress Note] "Assessment and f/u knee pain ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 150	L 204		8/24/22

seen today for assessment due to c/o pain on both knees. She admits to moderate pain in her knees, dull and affecting her sleep ... Plan [x-ray] on both knees..."

02/17/22 at 7:38 AM [Nurses Note] "Resident's X-ray of the both knees (Positive) for LT (left) knee: There is a fracture of the distal femur with displacement ... RT (right) Knee: There is irregularity and impaction and a cortical hairline fracture of the distal lateral femoral metaphysis which is impacted... A call placed to the NP ..."

02/17/22 12:05 PM [Nurses Note] " ... Resident complained of right knee pain yesterday 2/16/22 and she was assessed by NP ... NP ordered X-rays of bilateral knees. X-ray report received this morning with impression of acute fracture of the left distal femur, acute hairline fracture of the right lateral femoral condyle in normal alignment... All staff who worked with resident from 2/9/22 to 2/16/22 all shifts will be interviewed to determine if resident had a fall or if resident had reported fallen to anyone. [Physician's Name] notified and she gave order to send resident to the ER for 2nd opinion..."

Review of the facility's investigation documents provided to the surveyor on 04/18/22 at 10:36 AM revealed that facility staff failed to interview and/or obtain a statement from the licensed staff assigned to Resident #408 on 02/16/22 during the day shift (7:00 AM - 3:00 PM).

During a face-to-face interview conducted on 04/18/22 at approximately 1:30 PM with Employee #43 (3rd Floor Unit Manager), she acknowledged the finding and made no further comments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 151	L 204		8/24/22

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 152	L 204		8/24/22

In Section J (Health Conditions), "Yes" to: resident have a fall any time in the last month prior to admission ...had a fracture related to a fall in the last 6 months prior to admission ... and had major surgery during the 100 days prior to admission ...

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

Review of Resident #409's medical record revealed the following:

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT (weight bearing as tolerated). Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain ..."

07/10/21 at 5:40 PM [SBAR] "...Resident transfer to [Hospital's Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 153	L 204		8/24/22

in person. Notes: She requested her mom to be transfer[ed] to the Hospital ..."

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 request ...Resident 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 204	Continued From page 154	L 204		8/24/22

Continued From page 154

Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced ...she tolerated the procedure well however did take 4 tries to get the hip in ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of Resident #409's medical record revealed no documented evidence that facility staff identified or investigated the resident's injury (dislocated hip) as an unusual occurrence.

During a face-to-face interview on 04/20/22 at approximately 4:00 PM, Employee #8 (Unit Manager), 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."

L 206 — 3232.4 Nursing Facilities — L 206

Each incident shall be documented in the resident's record and reported to the licensing agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence.
This Statute is not met as evidenced by:
Based on record review and staff interview, for two (2) of 105 sampled residents, facility staff failed to report the unusual occurrences for Residents #3 and #409.

The findings include:

Review of the facility's policy titled, "Prohibition of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 155 Abuse" with a revision date of 02/22, showed neglect was defined as the 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. The policy revealed that 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." 1.The facility's staff failed to report Resident #3's airway (stoma) being occluded by a medical device HME subsequently, causing the resident to be transferred to the emergency room (ER) for dislodgment to the state agency. According to Johns Hopkins Medicine a HME is a humidifying filter that fits onto the end of the trach tube and comes in several shapes and sizes. It is also known by several other terms including Thermal Humidifying Filters, Swedish nose, Artificial nose, Filter, Thermovent T. (https://www.hopkinsmedicine.org/tracheostomy/resources/glossary.html#Tracheotomy) 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	L 206	L206 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #3 was discharged 3/29/22, this deficient practice cannot be retroactively corrected Resident #409 was discharged 9/28/2021, this deficiency cannot be retroactively corrected. Resident #408 was sent to ER on 2/12/22, this deficiency cannot be retroactively corrected . IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: No resident residing in the facility has and HME stoma. Unit Manager / Designee will conduct audit on their units to ensure that injuries of unknown origin were investigated and reported. Any issues found will be corrected by 8/25/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C **04/20/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 156 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 resident's medical record revealed the following: -12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27 ...upon assessment, resident alert and oriented to person and place. ...Resident has a lary tube with cap [HME] in place ... -12/01/21 at 20:29 [physician assistant physician progress note]- Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ... -12/02/21 [physician order]- Change HME daily day shift. -12/02/21 at 13:15 [respiratory therapy assessment]- Type- initial assessment, Resident was alert and oriented with lary tube and holder in place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear... -12/03/21 [physician order] - transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma.	L 206	MEASURES TO PREVENT RECURRENCE: Supervisors will conduct daily rounds to ensure that residents with stoma site that aids with respiration present with clean stoma sites. Any issues found will be corrected by 8/25/22. In- service will be provided by Staff Educator /Designee to all Licensed nursing staff (LPN/ RN) on how to assess resident with a stoma and to report their findings completed by 8/25/22. Charge nurses /Designee will ensure to investigate and report injuries of unknown origins immediately they are noted. Any issues found will be corrected by 8/25/22. Respiratory therapist will ensure that residents with respiratory issues are in no form of respiratory distress every shift. Any issues found will be corrected by 8/25/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 157	L 206	MONITORING CORRECTIVE ACTIONS:	8/24/22

-12/03/21 at 14:42 [nursing progress note] - The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma (airway) was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...Resident's daughter ...called and spoke with Respiratory Therapist ...wanted to find out if resident was alive, in distress or pain and asked ...how she determine that since resident is non-verbal ... 911 called at 1345 and they arrived at 1400 ... v/s (vital signs): 121/80 (blood pressure), 63 (pulse), 18 (respirations), 97.8 (temperature), O2 Sat (saturation) 99% RA (room air).

-12/04/21 [hospital discharge summary]- Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (x-ray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult."

-12/04/21 at 07:54 [nursing progress note] - Resident came back from the hospital ...on arrival

Plan of correction (L 206):

DON/Designee will conduct audits to ensure that resident with a stuck stoma incident is reported, and that injuries with incident of unknown origin are also investigated and reported. This audit will be conducted weekly x4, then monthly x3, findings will be corrected immediately and reported to QAPI committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 158	L 206		8/24/22

Continued From page 158

129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air.

-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 stable ...vitals: 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

Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:
Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer.
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...

Further review of Resident#3's comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 159	L 206		8/24/22

care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22.

Review of a complaint received by the DC Department of Health on 01/26/22 from alleged that Resident #3 was rushed to the ER on 12/03/21, because there was an HME put into his (Resident #3) neck stoma (airway)."

Resident #3 was unable to be interviewed at the time of the survey because he was discharged to the hospital on 03/29/2022.

During a telephone interview on 04/12/22 at 11:35 AM, the resident's responsible party (granddaughter) stated that the clinical coordinator and the respiratory therapist called her informing her that the HME was stuck in her grandfather's stoma. When asked if they informed her what happened, she said, "No, neither one of them could explain, but [name of clinical coordinator] said sometimes there are things that happened that we can't explain."

During a face-to-face interview on 04/12/22 at approximately 5:00 PM, Employee #32 (LPN) stated, I cleaned something in his neck two times a shift. Respiratory sees him (Resident #3) all the time. I had training from respiratory, but I don't remember when." The employee also stated, "I don't remember the resident (Resident #3) using a HME."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) reported that when the respiratory therapist informed him that an HME was stuck in the resident's stoma (airway), he had Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 160	L 206		8/24/22

transferred to the emergency room for evaluation. The employee then shared that Resident #3 was not in any distress when the HME was lodged in his stoma (airway). When asked if an investigation was conducted to determine how the incident of the HME being lodged in Resident #3's stoma (airway) happened, Employee #7 stated, "No." The employee also said the respiratory therapist was responsible for changing the resident's HME.

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma. If he (Resident #3) did not get the HME out of his stoma it would have been detrimental." The employee stated that she worked three to four days a week, and on the days, she was not in the facility nursing staff was responsible for cleaning Resident #3's lary-tube and changing the HME. Also, Employee #31 said that she provided nursing staff education on how to care for Resident #3's lary-tube and HME and documented the training on a clipboard in her office. The employee also said she required nursing staff to do a return demonstration to ensure competency.

During a face-to-face interview on 04/14/22 at approximately 3:00 PM, Employee #33 (RN) stated that respiratory therapy provided her with training on tracheostomy care, but they did not provide education on laryngectomy's, lary-tubes, or HMEs. The employee said that although she regularly worked on the floor where Resident #3 resided, she could not remember working with him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206		L 206		8/24/22

Continued From page 161

A review of in-service training documents lacked 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."

There was no evidence that facility staff developed a person-centered approach to care for and provide necessary services to Resident #3 who had a laryngectomy. Subsequently, Resident #3's airway (stoma) was occluded by a medical device HME, causing him to be transferred to the ER for dislodgment of the device.B. 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.

2. The facility's staff failed to report Resident #409's dislocated hip (unusual occurrence) to the state agency.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 162	L 206		8/24/22

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.

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT (weight bearing as tolerated). Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach..."

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

07/10/21 at 5:40 PM [Situational, Background Assessment Request (SBAR) Communication Tool] " ...Resident transfer to [Hospital Name] ... Date problem or symptom started: 07/10/2021 ... Background ... S/P (status post) left hip Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She requested her mom to be transfer[ed] to the Hospital ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 163	L 206		8/24/22

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 request ...Resident 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 Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced ...she tolerated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 206	Continued From page 164 procedure well however did take 4 tries to get the hip in ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..." A review of Resident #409's medical record revealed no documented evidence that facility staff reported this unusual occurence to the Department of Health. 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."	L 206		8/24/22
L 339	3247.16 Nursing Facilities There shall be adequate clearance space at the front and each of the sides of the toilet, as well as adequate room for other fixtures and equipment, as needed. This Statute is not met as evidenced by: Based on observation and resident and staff interview, for one (1) of 105 sampled residents, the facility's staff failed to provide Resident #113 access to the bathroom and an elevated toilet seat causing the resident to be dependent on staff to use the bathroom. The findings include: During an observation on 03/29/22 at approximately 11:30AM, Resident #113's bathroom was locked, and the surveyor had to access the bathroom from the neighbor's side. It	L 339		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 339	Continued From page 165 was also observed that the bathroom did not have an elevated toilet seat. 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 Minimum Date Set dated 02/09/22 showed Resident #113 had a BIMs summary score of "15," indicating the resident had intact cognition. Further review of the MDS revealed Resident #113 was coded for needing supervision and requiring the physical assistance of one person for toilet use, not moving on and off the toilet during this assessment period, not being steady and requiring staff assistance for stability during surface-to-surface transfers, and using a wheelchair. Additionally, the resident was coded for occasional urinary incontinence and frequent incontinence of bowel. Review of physician's orders from 06/19/14 to 04/12/22 lacked documented evidence of an order for an elevated toilet seat. Review of a care plans showed the following: Focus Area- [resident's name] has occasionally urinary incontinence related to loss of bladder muscle tone (revision date of 12/03/19). Interventions: -Brief use: the resident uses disposable briefs. Change when wet and prn (as needed). -Check for incontinence frequently and provide incontinent care as needed. Focus Area -[resident's name] has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) disease process CVA (Cerebral Vascular Accident).	L 339	L339: STARTS HERE: CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #113 was assessed on 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP updated. Rehab team will provide an elevated toilet seat in the resident's bathroom. Unit Manager explained to resident in the next room to residents #113's room to always leave the bathroom door unlock when not in use. Resident verbalized understanding to be corrected immediately but no later than 8/24/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents with shared bathroom have the potential to be affected. House wide audit will be conducted by DON/Designee to identify resident who need elevated toilet seats. Any issues found will be corrected by 8/24/22. House wide audit will be conducted by Unit Managers and the maintenance team to ensure shared bathroom can easily be accessible by the residents. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 339	Continued From page 166 Goal- [resident's name] will improve current level of function in transfer and personal hygiene. Intervention-toilet resident upon arising, after meals and at bedtime. Review of an invoice dated 11/11/21 showed that the facility ordered a Bariatric Commode [an elevated toilet seat that's placed over a toilet]. During a face-to-face interview on 03/29/22 at approximately 2:00 PM, Resident #113 stated that her next-door neighbor, who she shares a bathroom with, keeps the bathroom door locked, so she cannot access the bathroom. The resident also said that not having access to the bathroom was "ok" because the toilet is too low, and she can not independently transfer from the toilet to her wheelchair. When asked how she uses the bathroom, Resident #113 said that she uses the brief (incontinent pad), cleans herself up, and calls staff to remove the used brief. During a face-to-face interview on 04/12/22 at 2:59 PM, Employee #59 (Restorative Aide) stated that she had not worked with the resident on transferring from the toilet to the wheelchair because the resident needed an elevated toilet seat. During a face-to-face interview on 04/12/22 at 3:40 PM, Employee #55 (Occupational Therapist) stated, "We ordered her an elevated toilet seat, but it never came in." The employee said that she made her supervisor aware the resident's elevated toilet seat had not been delivered. During a face-to-face interview on 04/12/22 at 3:15 PM, Employee #56 (Certified Nursing Assistant) stated that she had worked with the resident for about a year, and the resident does	L 339	MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Educator to all CNA's on the importance to notify the charge nurse if a resident is having difficulties using the bathroom because the toilet seat is too low completed by 8/24/22. Charge nurse will notify the therapy team when they get report that a resident is having difficulties using the toilet so the resident can be assessed for the use of an elevated toilet seat. Any issues found will be corrected by 8/24/22. Therapy team will ensure residents who need elevated toilet seat are assessed and provided one as soon as possible so that the resident will not depend on staff for toileting. Any issues found will be corrected by 8/24/22. Nurse aides are encouraged to frequently check the bathroom door between room 315 and room 316 to ensure the bathroom door is unlocked. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 339	Continued From page 167 not call for assistance for the bathroom. The employee stated that the resident "changes herself" when she soils her brief. Employee #56 then said that when Resident #113 changes her soiled brief, she puts it in a trash bag and calls the desk saying, "Come get the trash."	L 339	MONITORING CORRECTIVE ACTIONS: The DON/ Designee will conduct rounds to ensure all residents who need an elevated toilet seat are assessed by the therapist and assign one if applicable. Maintenance team will conduct frequent rounds on all units to ensure that shared bathroom is easily accessible by all parties. Findings will be corrected immediately and reported to QAPI Director /committee weekly x4 and monthly x 3.	8/24/22
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by damaged privacy curtains in six (6) of 76 resident's rooms, soiled bathroom vents in five (5) of 76 resident's rooms, a foul, offensive odor in (5) of 76 resident's rooms and malfunctioning packaged terminal air conditioner (PTAC) units in three (3) of 76 resident rooms. The findings include: During an environmental walkthrough of the facility on March 30, 2022, at approximately 4:00 PM, and on April 4, 2022, between 10:00 AM and 3:45 PM, the following were observed: 1. Privacy curtains were torn and separated from the rails in six (6) of 76 resident's rooms including rooms #211, #308, #309, #310, #311, and #329. 2. Bathroom vents were soiled with dust in five (5)	L 410	L 410 STARS HERE: CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: All rooms will be assessed, to ensure that they are clean and free from odor, and that the environment is clean and homelike .Findings were corrected by 8/21/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All rooms in the facility have the potential to be affected by this deficient practice. Damaged privacy curtains in rooms #211, #308, #309,#310, #311 NA #329 are clean and undamaged. Room #420, #428, #502, #516, #524 are cleaned with no smell of urine noted. Bathroom vents in rooms # 401, #405,#428, #420, #529 are clean. Air conditioners in rooms 329,#508, #524 were checked, Findings will be corrected by 8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From page 168 of 76 resident's rooms specifically rooms #401, #405, #428, #420, and #529. 3. A strong urine odor was evident in resident room #420, #428, #502, #516, and #524, five (5) of 76 resident's rooms surveyed. 4. PTAC (Packaged Terminal Air Conditioner) units did not function as intended and failed to reach set temperatures in three (3) of 76 resident rooms (#209, #508 and #524). These findings were acknowledged by Employee #16, and/or Employee #17, during a face-to-face interview on April 4, 2022, at approximately 4:00 PM.	L 410	MONITORING CORRECTIVE ACTIONS: Director of Maintenance and Housekeeping director will validate that all privacy curtains , bathroom vents, air condition units are functioning properly and that the rooms are free from odor weekly x4 then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	8/24/22
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on record reviews and staff interviews, for one (1) of 105 sampled residents, facility staff failed to ensure that Resident #64 was treated with respect and dignity evidenced by failure to provide an environment that enhances the resident's quality of life, was based on his individuality and medical condition. The findings include: Resident #64 was admitted to the facility on 04/29/15 with diagnoses that included: Acquired	L 521	L521 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #180 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/ RP notified on 4/26/22. Comprehensive care plan to address behavior of urinating on the bathroom floor, smearing bathroom with feces will be updated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 521	Continued From page 169 Absence of Unspecified Leg below Knee, Pathological Fracture, Unspecified Femur, Initial Encounter for Fracture, Muscle Weakness (Generalized), Spinal Stenosis, Site Unspecified. According to the quarterly Minimum Data Set dated 01/22/22, the resident was coded as "15" under Section C0500 BIMS Score indicating that he is cognitively intact. Under Section G0110 Functional Status, the resident was coded as "3", indicating he required extensive assistance for toilet use, with one-person physical assist. Under Section G0110 Functional Status, the resident was coded as "3", indicating he required extensive assistance for personal hygiene, with one-person physical assist. Under Section H (Bladder and Bowel) the resident was coded as such: H0200 (Urinary Toileting Program) = No H0300 (Urinary Incontinence) = 2, indicating he was frequently incontinent H0400 (Bowel Continence) = 2, indicating he was frequently incontinent H0500 (Bowel Toileting Program) = No During an environmental tour on 03/30/22, at approximately 4:00 PM, a strong urine odor was present in the bathroom that services the residents in room #515 and #516 on unit 5 North. Resident #64, in room #516, complained that Resident #180, in room #515 frequently urinates on the bathroom floor, and smears the bathroom	L 521	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED;' All residents residing in the facility have the potential to the affected. Licensed clinical team members (LPN/RN) conducted house wide audit on 4/22/2022 to ensure that no other resident is smearing feces on the floor. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 521	Continued From page 170 with feces. He said that although he would like to use the toilet, he does not, because of the smell. This, he said, has been going on since Resident #180, in room #515, moved in sometime last year. Resident #64 said, as a grown man, he is embarrassed to have staff clean him and change his diaper, but he has no choice. Staff is aware he said, and staff has even seen Resident #180 urinate on the floor. When asked if he would like to move, Resident #64 said he was not moving because of Resident #180's behavior, and he was told a long time ago that the resident who complains is the one who should move. Face-to-face interviews were conducted on 04/07/22, between 1:15 PM and 2:00 PM: Employee #51 (RN on 5 North) confirmed that Resident #180 often urinates on the floor, in his room and in the bathroom. He also gets feces on his hand and under his nails. Staff is aware of these behaviors and clean his hands and nails regularly. Employee #51 said that Resident #64 will sometimes ask for help to go to the bathroom but mostly uses diapers. Employee #52 (CNA) said that Resident #180 sometimes urinates on the floor in his room and in the bathroom, and his hands must be cleaned every time he goes to the bathroom because he gets feces on his hand. Staff is aware of Resident #180 behavior, and he documents it. Employee #52 further stated, Resident #64 uses a diaper and does not get up. Employee #50 (CNA) said that Resident #180	L 521	MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed clinical staff members, Rehab staff and C N A ‘s by staff educator / Designee to always ensure that resident is not smearing the bathroom with feces completed by 8/24/22. Unit Managers and Supervisors will conduct weekly rounds to ensure residents are not smearing the floors with feces. Any issues found will be corrected by 8/24/22. Charge nurses will conduct rounds during their shifts to ensure residents are not smearing the floors with feces. Any issues found will be corrected by 8/24/22. CNA'S will ensure residents are not smearing floors with feces daily. Any issues found will be corrected by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 521	Continued From page 171 pees on the floor, gets poop on his hands and messes up the bathroom. Resident #64, she said, uses the diapers. Employee #53 (CNA) has worked on 5 North for 5 years. She also said that Resident #180 pees on the floor and gets feces on his fingers when he tries to wipe himself. Nursing staff is aware, and she documents it. Employee #53 stated that Resident #180 used to go to the toilet but " ... stopped using the toilet because it ' s always messy". A review of Resident #64's medical records on 04/08/22 at approximately 10:00 AM on show a care plan for Bowel Irregularity with specific interventions to "encourage resident to sit on toilet to evacuate bowels if possible". However, through resident and staff interviews, there were no indications that Resident #64 is urged by staff to use the toilet. Employee #54 alternates as a RN between 5 North and 5 South. During a face-to-face interview on 04/08/22, at 10:35 AM, he revealed that Resident #64 uses diapers only and acknowledged the findings.	L 521	Unit Managers will ensure that residents with behavior of urinating on the bathroom floor, smearing the bathroom with feces have a care plan for such behavior in place. Such resident will be assessed for toileting program. Any issues found will be corrected by 8/24/22. .MONITORING CORRECTIVE ACTIONS: DON/Designee will audit residents' chart to ensure that all resident centered care plans are revised, updated and implemented as indicated. This audit will take place weekly x4, then monthly x3, findings will be corrected immediately and reported to QAPI committee.	8/24/22
L 529	3269.1l Nursing Facilities (l) To be free from mental or physical abuse; This Statute is not met as evidenced by: Based on observation, record review, resident and staff interviews, for seven (7) of 105 sampled residents, facility staff failed to ensure residents were free from abuse (willful infliction of injury)	L 529		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 172 and neglect as evidenced by: failure to prevent the willful infliction of serious injury of Resident #404 by Resident #82; failure to implement person center care measures for Resident #151 who had incidences of aggressive behavior towards Resident #71 and willful infliction of injury to Resident #67; failure to ensure staff received 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 (stoma) was not occluded by a medical device Heat Moisture Exchanger (HME) subsequently, the resident to be transferred to the Emergency Room (ER) for dislodgment; and failure to have available lary-tube and HME (medical equipment) for treatment and care of Resident #3's stoma subsequently, the resident was transferred to the ER a second time for replacement of the Lary-tube. Actual harm was determined to be present for Residents #404, #71, #67, #409, and #3. The findings include: Review of the facility policy entitled, "Prohibition of 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,	L 529	L 529 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 404 was sent to the hospital on 2/21/22 and did not return. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected by this practice. DON/ Designee will conduct house wide audit to ensure that the nurses are monitoring and providing ongoing assessments and interventions for residents with behavior issues. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 173 "Resident-to-Resident Altercation/Incidents" revised in 01/2022 documented, "... When a resident is observed or identified as being aggressive to having aggressive behavior or has the potential for abusing other residents, an assessment of strategies to prevent such incidents from occurring will be provided by the Interdisciplinary Team (IDT)..." 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 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 ..." Review of a Complaint dated 03/26/22 documented, "...family is hoping for answers after they say their father was brutally beaten at a nursing home in the District. [Representative's Name] ... in an interview that his father [Resident	L 529	MEASURES TO PREVENT RECURRENCE: In- service will be provided by Staff Educator/ Designee to Licensed Nurses on the importance to ensure that residents with behavior are monitored and supervised during their shift completed by 8/24/22. Competency check list will be completed by Licensed nurses to indicate that they understand how to work with residents with aggressive behavior. Any issues found will be corrected by 8/24/22. ADON/Designee will ensure that nurses are monitoring and supervising residents with aggressive behavior during their shift. Any issues found will be corrected by 8/24/22. Unit Mangers will validate that resident with behavior problems are monitored and supervised every shift, and that there is documentation to justify supervision. Any issues found will be corrected by 8/24/22. Charge nurses will conduct rounds to ensure that residents with aggressive behavior are being supervised every shift. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 174 #404] was attacked while living at the [Facility Name]. [Resident #404] died from his injuries on March 20 (2022)..." 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 staff coded: a Brief Interview for Mental Status (BIMS) 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 antipsychotic 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:	L 529	Unit Managers will assess residents and determine if they qualify for one-on-one supervision secondary to aggressive behavior, if they qualify, that services will be provided until seen by psych doctor. Unit Managers will ensure that every intervention in the care plan for intrusive behavior is being implemented. Any issues found will be corrected by 8/24/22. Education will be provided to residents with a BIMS score of 12 and above to report any resident who is intrusive to the charge nurses or CAN'S. Frequent rounds will be conducted by Licensed nurses and C N A during their shift to monitor residents who and nonverbal or unable to identify an intruder. Any identified intruder will be redirected out of the room and supervised completed by 8/24/22 Family members will be updated if their loved one is exhibiting intrusive behavior either through mail or telephone or during interdisciplinary meetings. Documentation of intrusive behavior will be documented , plan of care updated, and implementations carried out as indicated. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 175 12/16/21 [Quarterly MDS] showed facility staff coded a BIMS summary score of "03", indicating severe cognitive impairment. In Section E (Behavior), no potential indicators of psychosis, no physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) occurred "1 to 3 days", wandering behaviors "occurred daily" In Section G (Functional Status), walk in room (how resident walks between locations in his/her room), "Supervision with one person physical assist" and no functional limitation in range of motion In Section P (Restraints and Alarms), 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 Behavior Documentation showed the following: 02/02/22 at 2:12 PM "... Elopement attempts.	L 529	MONITORING CORRECTIVE ACTION: DON/Designee will conduct audits to ensure that residents are accounted for, monitored, and supervised every shift. This audit will be conducted weekly x4, then monthly x3. Findings will be addressed immediately and reported to QAPI committee.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 176 Wandering ....sleeping in other people's bed... Behaviors are constant." 02/03/22 at 1:12 PM "... sleeping in other people bed. Behaviors are constant." 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 bed...Behaviors are constant." 02/11/22 at 11:16 AM "... sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "...sleeping on other peoples bed...Behaviors are constant." 02/14/22 at 2:10 PM "...sleeping on other peoples bed...Behaviors are constant." 02/16/22 at 1:28 PM "...sleeping on other peoples bed...Behaviors are constant." 02/18/22 at 2:19 PM "...sleeping on other people's bed...Behaviors are constant." 02/19/22 at 1:18 PM "...sleeping on other peoples bed...Behaviors are constant." 02/20/22 at 12:23 PM "...sleeping on other peoples bed...Behaviors are constant." Skin Observation Tool dated 02/21/22 at 2:40 AM documented, "Observations... face... Blood was coming from his mouth, we managed to stop it by applying cold compress and ice..."	L 529		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 177	L 529		8/24/22

Situation Background Assessment Request (SBAR) dated 02/21/22 at 4:00 AM showed, "Situation... The resident got hit by his roommate... Background: Altered mental status... Resident Reports Pain? 'No'. Non-verbal indicators of pain evident? 'No'. Functional Status unchanged... Skin/Wound Status- (area was left blank) ... Assessment ... (area was left blank) ... Additional comments ... At approximately 02:30 am ... The writer observed [Resident #404] sitting on the floor near roommate's bed (420 bed A) with blood coming out of his left ear, face. The writer immediately notify the supervisor and called 911. DC (District of Columbia) police. I saw [Resident #82] also sitting on his walker facing [Resident #404]. The writer asked [Resident #82] what happened, resident stated 'I hit him because he came to my bed.' DC fire department arrived at the unit at 3:10 am and left with [Resident #404] in a stretcher accompanied by two ambulance attendants to [Hospital Name]. [Physician Name] and RP (representative) was made aware."

02/21/22 at 4:16 AM [Nursing Supervisor Progress Note] "The Charge Nurse reported that While making routine rounds, Resident [#404] was observed sitting on the floor beside Room 420 A. Resident was noted with some blood on the left side of his face, a quick assessment was made, he was assessed for pain and discomfort. Resident could not describe what happened. This is his base line. A quick assessment was done, Range of motion exercise was done, ice was applied to the left side of the face, vital signs was monitored T. (temperature) 96.5, P. (pulse) 82, R. (respirations) 18, B.P. (blood pressure) 140/90, Spoe (sp) (oxygen saturation) 97% on Room Air."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 178	L 529		8/24/22

Continued From page 178

02/21/22 at 1:43 PM [Nurses Note] "A call was placed to [Hospital Name] to know about the status of the resident [#404] in the ER, spoke with nurse [Registered Nurse's Name] who stated 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 ..."

Review of this evidence showed that facility staff had knowledge of and documented Resident #404's intrusive behavior of going into other resident's 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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 179	L 529		8/24/22

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] 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:

Review of the FRI dated 12/09/21 documented, " ... At 0730AM, the security officer ... observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 180	L 529		8/24/22

[Resident #151] assaulting another resident [Resident #71] at the front of the building ..."

Review of the FRI dated 01/02/22 documented, " ...At 2030 on 12/29/2 (12/29/21), [Resident #67] alleged to the receptionist that [Resident #151] hit him on his chest x 2 in the lobby ..."

Resident Background Information for Residents'

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.

In Section E (Behavior):

E0100. Potential Indicators of Psychosis - Delusions (misconceptions or beliefs that are firmly held, contrary to reality) - "yes"

E0200. Behavioral Symptoms: Physical behavioral symptoms directed towards others (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 181	L 529		8/24/22

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: schizophrenia ...Inform 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 ..."

07/27/21 (Revision date) "[Resident #151] at risk for changes in behavior problems related to: agitation ..."

10/18/21 (Revision date) "[Resident #151] has problematic manner in which resident acts characterized by inappropriate behavior; resistive to treatment/care related to: Cognitive Impairment (Dementia, Schizophrenia). Non compliant with 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 182	L 529		8/24/22

impaired cognitive function or impaired thought processes r/t (related to) Dementia..."

10/20/21 (Revision date) "[Resident #151] uses psychotropic medications r/t behavior management, Paranoid Schizophrenia ... Monitor/record occurrence of for target behavior symptoms ... violence/aggression towards staff/others) and document per facility protocol ..."

10/22/21 (Revision date) "Resident #151] has behavior problem r/t (Combative, Spilling water on the entire floor, disrobing) r/t Schizophrenia. Non-compliant letting roommate into the room, moving chair into another room and refusing to stop ... Combative, agitation, hitting multiple staff members, trying to break down doors in the Administration area and rolling on the floor ... 1:1 staff monitoring for safety until seen by psych or sitter is available ..."

B. Resident #71 was admitted to the facility on 08/20/18 with multiple diagnoses that included Schizoaffective Disorder, Unspecified Dementia without Behavioral Disturbance and Hypertension.
Review of Resident #71's medical revealed, a Quarterly MDS dated 10/23/21where facility staff coded a BIMS summary score of "09", indicating moderate cognitive impairment, no potential indicators of psychosis and no physical or verbal behavioral symptoms, limited assistance with one person physical assist for ADLs, no limitations in range of motion and no skin conditions.

C. Resident #67 was admitted to the facility on 09/29/08 with multiple diagnoses that included Unspecified Intellectual Disabilities, Psychotic Disorder with Hallucinations, and Unspecified Dementia without Behavioral Disturbance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 183	L 529		8/24/22

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 #67] 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 #67] and he denied any pain ... At 2040 (8:40 PM) [Resident #151] was observed at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 184	L 529		8/24/22

gate trying to exit. He was redirected back to the building ... stood by the building entrance trying to grab and hit staff exiting the building ... will not let staff exit or enter the building. The DC Police Department was called and notified at 2340 (11:50 PM). 2 MPD ... responded at 2345 (11:45 PM). During interview with [Resident #151], he was not cooperating; he made attempts to hit one of the Police Officers. [Resident #151] was taken into custody ... [Resident #67]... was assessed this AM (morning). He alleged being hit on the lateral abdomen over his previous surgical site. No swelling, discoloration or open area observed during assessment. He denied pain ..."

Review of Resident #151's medical record showed documented aggressive behaviors and a resident-to-resident altercation on 12/08/21. There was no documented evidence that facility staff revised Resident #151's plan of care to protect other residents; and then on 12/29/21, Resident #151 attacked another resident at the facility. In both instances the resident was removed from the facility due to his aggressive behaviors towards other residents.

During a face-to-face interview conducted on 04/14/22, Employee #7 (Clinical Coordinator) acknowledged the findings and stated that Resident #151 has been on 1:1 since he was admitted back to the facility in 01/2022 and has not had any resident-to-resident altercations.

3. Facility staff failed to ensure staff received training to provide person centered care (related to hip precautions) for Resident #409 after she had left hip surgery.

Review of an intake form for a complaint received by the State agency on 12/06/21 documented "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 185	L 529		8/24/22

...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.

Review of Resident #409's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) for Resident #409 dated 07/11/21 revealed that facility staff coded the following:

In Section C (Cognitive Patterns), the Brief Interview for Mental Status (BIMS) Summary Score was "99," indicating severe 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.

In Section H (Bowel and Bladder) - "Always incontinent" for bladder and bowel

In Section J (Health Conditions), "Yes" to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 186	L 529		8/24/22

resident have a fall any time in the last month prior to admission /entry or reentry; resident have fracture related to a fall in the last 6 months prior to admission /entry or reentry; resident have major surgery during the 100 days prior to admission; resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay.

In Section O (Special Treatments, Procedures, and Programs), start date for Occupational and Physical Therapy "07/09/2021."

07/08/21 at 12:10 PM [Hospital Discharge Summary] "...Hospital Course Patient presented with left hip fracture; status post Arthroplasty (hip replacement). With no postoperative complications ...Discharge Procedure Orders ...Weight Bearing as Tolerated (WBAT); Laterally; Left ...Restrictions as follows: Posterior hip precautions..."

07/08/21 at 8:29 PM [Admission Note] "...Resident was admitted from [Name of Local Hospital] for rehabilitation post left hip Arthroplasty ...Resident has hip abduction with pillow and WBAT. Fall and safety precautions initiated: resident location close to nurses' station with close monitoring, call light and commonly used items within close reach ..."

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.

07/09/21 [Physician's Order] "Left hip: monitor left hip for inflammation, pain, and drainage."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 187 07/09/21 at 2:18 PM [Physical Therapy Evaluation and Plan of Treatment Note] " ...referred to skilled therapy after having a L (left) hip hemiarthroplasty that resulted from a fall... Precautions ... (no flexion past 90 degrees, abduction past midline, or internal rotation, WBAT ..." 07/09/21 (7:00 AM-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing, assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/09/21 (3:00 PM - 11:00 PM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/09/21 (11:00 PM-7:00 AM) [CNA Documentation], facility staff documented that Resident #409 received assistance with bed mobility, and provided incontinent care for bowel and bladder. 07/10/21 [Physician's Order] "Place a pillow between lower extremities after care, turn and reposition when resident is in bed." 07/10/21 [Physician's Order] "Wedge resident appropriately after care, turn and reposition when [the] resident is in bed." 07/10/21 (7:00 AM-3:00 PM) [Treatment Administration Record (TAR)], showed that facility staff documented that they placed a pillow between Resident #409's lower extremities after care, and wedged resident appropriately turning and repositioning when the resident was in bed.	L 529		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 188	L 529		8/24/22

07/10/21 (7:00-3:00 PM) [CNA Documentation], facility staff documented that Resident #409 received a bath/shower and assistance with dressing and bed mobility.

07/10/21 at 3:29 PM [Physician's Progress Note] "Patient seen at the request of Nurse Manager and the family. Patient reportedly has increasing pain at the site of surgery, worse with movement ...added oxycodone (narcotic pain reliever) prn (as needed) for 14 days for breakthrough pain..."

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 Arthroplasty done on 7/5/2021 ... A-Assessment ... Resident is alert and verbally responsive, no apparent distress noted. No change in mental status noted ...R-Request - Person contacted: [Name of Resident Representative] was at bedside. Communicated in person. Notes: She [Representative] requested her mom to be transfer[ed] to the Hospital ..."

07/10/21 at 6:20 PM [Nurses Note] "...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 daughter requested that she (Resident #409) 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 present (sp) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 189	L 529		8/24/22

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 request ...Resident was taken out from the facility at 5:50 [PM] to [Hospital 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 .... ED (Emergency Department) Course/Critical Care ...2:30 AM: The patient's hip was reduced (a procedure for treating a hip dislocation without surgery) ...tolerated the procedure well ...Narratives: 02:27 PM... plan to discharge back to [Name of Facility]. 03:51 PM ... cleared for discharge. Request knee immobilizer for discharge..."

A review of the Resident #409's medical record lacked documented evidence that the facility staff that cared for Resident #409 from 07/08/21 to 07/10/21, provided her with adequate supervision, assistance and hip precautions to ensure that Resident #490's hip was not dislocated.

During a telephone interview conducted on 04/14/22, at approximately 12:30 PM, Resident #409's daughter/representative stated, "On 07/10/21, I noticed that my mother looked out of it and flinched when I pulled back the cover to see what was wrong. I didn't see the knee immobilizer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 190	L 529		8/24/22

on her leg. Her leg was positioned like the letter 'K'. I spoke with the unit manager and told her I wanted to see the doctor. They finally brought in the doctor, who said he wasn't my mother's primary doctor, and he ordered oxycodone for pain. I insisted that my mother get an X-ray for her hip. I was told the X-ray would take a long time (4-6 hours), so I asked the nurse to call 911. She told me she did not have a doctor's order, and I can call 911, so I did. 911 showed up and said it wasn't a medical emergency, so they [911] called a non-emergency vehicle, and my mother was transported to [Hospital Name]."

During a face-to-face interview on 04/19/22, at approximately 3:30 PM, Employee #4 (Educator) stated, "I told the daughter how long it would take (x-ray). She insisted we call 911 to have [Resident #409's] hip X-rayed and evaluated at the hospital. Per the daughter's request, with the doctor's permission, a non-emergency ambulance was called. The resident [was transferred out to [Hospital Name]. I did an SBAR of the incident."

During a face-to-face interview on 04/19/22 at approximately 4:00 PM, Employee #8 (2nd Floor Unit Manager) stated that training for residents with hip precautions usually occurs with physical therapy or by the unit managers when the resident is admitted. For [Resident #409], Employee #8 stated, "I did the impromptu training in the resident's room. I trained the 2-3 CNAs and two (2) nurses who worked the day and evening shifts on this unit. I reviewed how to put the pillow/wedge between the resident's legs, how to put the hip immobilizer on the resident, and how to roll the resident on her side to prevent her from crossing midline. I reminded staff to keep the bed in the lowest position and keep the call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 191	L 529		8/24/22

Continued From page 191

light near the resident." Employee #8 was not able to provide a copy of the "impromptu training" sign in sheet or the handouts that he said were provided to the staff.

There was no evidence that facility staff provided the necessary staff training and staff supervision to meet Resident #409's needs status post hip surgery.

4. The facility's staff failed to ensure Resident #3's 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, keep a supply of respiratory medical equipment in the facility that was necessary to care for and treat Resident #3's laryngectomy and stoma subsequently, the resident had to be transferred to the ER for a replacement; and obtain/provide Resident #3's with HMEs.

These failures resulted in actual harm to Resident #3.

4A. The facility's staff failed to ensure Resident #3's airway (stoma) was not occluded by a medical device HME subsequently, causing the resident to be transferred to the emergency room (ER) for dislodgment.

According to Johns Hopkins Medicine (https://www.hopkinsmedicine.org/tracheostomy/resources/glossary.html#Tracheotomy) a HME is a humidifying filter that fits onto the end of the trach tube and comes in several shapes and sizes. It is also known by several other terms including Thermal Humidifying Filters, Swedish nose, Artificial nose, Filter, Thermovent T.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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 resident's medical record revealed the following:

-12/01/21 at 19:54 [admission nursing progress note]- Resident underwent awake tracheostomy with direct laryngoscopy and biopsy on 10/27/27 ...upon assessment, resident alert and oriented to person and place. ...Resident has a lary tube with cap [HME] in place ...

-12/01/21 at 20:29 [physician assistant physician progress note]- Pt. (patient) seen at bedside appears alert and stable ...Pt. also has tracheostomy and doing well ...vitals: 126/81 (blood pressure), 86 (pulse, 18 (respiration), 97.6 (temperature), 95% RA (oxygen saturation rate on room air) ...

-12/02/21 [physician order]- Change HME daily day shift.

-12/02/21 at 13:15 [respiratory therapy assessment]- Type- initial assessment, Resident was alert and oriented with lary tube and holder in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 193	L 529		8/24/22

place with an HME. Lary tube cleaned, tube holder changed. HME changed. Pre-treatment assessment respiratory rate 18, SPO2 98% [on] room air, lung sounds clear ... Post-treatment assessment respiratory rate 18, SPO2 (peripheral capillary oxygen saturation) 99% on room air, lung sounds clear...

-12/03/21 [physician order] - transfer resident to the nearest ER (emergency room) for further evaluation related to stuck HME in stoma.

-12/03/21 at 14:42 [nursing progress note] - The respiratory therapist notified writer that resident has an HME stuck in the stoma (airway). Resident has a lari-tube. Resident was assessed and no respiratory distress noted. Resident denied pain. No bleeding noted. O2 (oxygen) Sat (saturation) checked immediately and was 99% RA (room air). [Doctor's name] notified. He gave instruction to transfer resident to nearest ER (emergency room) for further evaluation. Resident's granddaughter notified and wanted to know what happened. The respiratory therapist explained ...when she did care for lari-tube and changed HME on yesterday 12/2/21, the stoma (airway) was clear but today she observed that there was an HME stuck in the stoma. The therapist explained to the granddaughter that maybe the HME initially stuck down in stoma (airway) and the resident coughed it up ...Resident's daughter ...called and spoke with Respiratory Therapist ...wanted to find out if resident was alive, in distress or pain and asked ...how she determine that since resident is non-verbal ... 911 called at 1345 and they arrived at 1400 ... v/s (vital signs): 121/80 (blood pressure), 63 (pulse), 18 (respirations), 97.8 (temperature), O2 Sat (saturation) 99% RA (room air).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 194	L 529		8/24/22

-12/04/21 [hospital discharge summary]- Diagnosis-tracheostomy malfunction. Diagnostic radiology XR (x-ray) neck soft tissue, XR chest PA (posterior-anterior) and LAT (lateral) 2 view. Call for follow-up appointment with physician within 2 to 4 days [provided education tool] for "How to Clean a Tracheostomy Tube, Adult."

-12/04/21 at 07:54 [nursing progress note] - Resident came back from the hospital ...on arrival 129/89 (blood pressure), 18 (respiratory rate) 98% (oxygen saturation rate) on room air.

-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 stable ...vitals: 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

Review of the comprehensive care plan with an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 195 initial date of 12/04/21 showed the following: Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer. 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... Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22. Review of a complaint received by the DC Department of Health on 01/26/22 from alleged that Resident #3 was rushed to the ER on 12/03/21, because there was an HME put into his (Resident #3) neck stoma (airway)." Resident #3 was unable to be interviewed at the time of the survey because he was discharged to the hospital on 03/29/2022. During a telephone interview on 04/12/22 at 11:35 AM, the resident's responsible party (granddaughter) stated that the clinical coordinator and the respiratory therapist called her informing her that the HME was stuck in her grandfather's stoma. When asked if they informed her what happened, she said, "No, neither one of them could explain, but [name of clinical coordinator] said sometimes there are things that happened that we can't explain." During a face-to-face interview on 04/12/22 at approximately 5:00 PM, Employee #32 (LPN) stated, I cleaned something in his neck two times	L 529		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 196	L 529		8/24/22

Continued From page 196

a shift. Respiratory sees him (Resident #3) all the time. I had training from respiratory, but I don't remember when." The employee also stated, "I don't remember the resident (Resident #3) using a HME."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) reported that when the respiratory therapist informed him that an HME was stuck in the resident's stoma (airway), he had Resident #3 transferred to the emergency room for evaluation. The employee then shared that Resident #3 was not in any distress when the HME was lodged in his stoma (airway). When asked if an investigation was conducted to determine how the incident of the HME being lodged in Resident #3's stoma (airway) happened, Employee #7 stated, "No." The employee also said the respiratory therapist was responsible for changing the resident's HME.

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that she informed the staff that Resident #3's HME was "stuck in his stoma (airway). I'm not sure how the HME got stuck in his stoma. If he (Resident #3) did not get the HME out of his stoma it would have been detrimental." The employee stated that she worked three to four days a week, and on the days, she was not in the facility nursing staff was responsible for cleaning Resident #3's lary-tube and changing the HME. Also, Employee #31 said that she provided nursing staff education on how to care for Resident #3's lary-tube and HME and documented the training on a clipboard in her office. The employee also said she required nursing staff to do a return demonstration to ensure competency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 197	L 529		8/24/22

During a face-to-face interview on 04/14/22 at approximately 3:00 PM, Employee #33 (RN) stated that respiratory therapy provided her with training on tracheostomy care, but they did not provide education on laryngectomy's, lary-tubes, or HMEs. The employee said that although she regularly worked on the floor where Resident #3 resided, she could not remember working with him.

A review of in-service training documents lacked 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."

There was no evidence that facility staff developed a person-centered approach to care for and provide necessary services to Resident #3 who had a laryngectomy. Subsequently, Resident #3's airway (stoma) was occluded by a medical device HME, causing him to be transferred to the ER for dislodgment of the device.

4B. 2. The facility failed to 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 198	L 529		8/24/22

Continued From page 198

to the ER for a replacement.

According to the University of Arkansas for Medical Science, a lary tube is a flexible silicone tube designed to maintain the stoma right after the laryngectomy surgery. A lary tube is used to maintain the airway and can be following a laryngectomy. (https://patientslearn.uams.edu/wp-content/uploads/sites/95/2018/03/Lary_Tube_Care.pdf)

Review of Employee #31's (Respiratory Therapist) signed and dated 06/03/19 job description, showed that she was responsible for providing necessary material and equipment for resident (sp) to perform required therapy.

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 MDS assessment dated 12/03/21 revealed that the Brief Interview Mental Summary Score section was blank, indicating the resident was not assessed. Additionally, the resident was coded for receiving Tracheostomy care and speech therapy services.

Review of the resident's medical record revealed a physician's order dated 12/02/21that stated, "Cleanse Lari-tube daily on day shift."

Further review of Resident #3's medical record revealed the following nursing progress notes:

-01/07/22 at 4:51 PM: "It was observed today that resident Laryn [lary] tube is out. He was assessed by the respiratory therapist and recommended to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 199	L 529		8/24/22

send resident out to the ER for laryn [lary] tube replacement. 911 arrived ...left 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 oriented...Resident 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 tube...resident ... 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 placement, taken to ER 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 #3 from 01/05/22 to 01/12/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 200	L 529		8/24/22

Continued From page 200

Review of complaint #DC00010525 showed the complainant alleged that Resident #3 was sent to the ER on 01/07/22 for a lary tube replacement due to facility throwing out the one (lary-tube) he had.

During a telephone interview on 04/12/22 at 11:35 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."

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that when the resident's lary tube was misplaced (01/07/22) she had the resident sent out the ER for replacement. The employee then reported that while Resident #3 was in the emergency room the emergency room staff called her to inquire about the size of the resident's lary-tube, but she could not give the physician the size because she did not know the size of the resident's lary- tube. When asked if it was her responsibility to order respiratory supplies, Employee #31 said, "Yes" but she could not order Resident #3's lary-tube because she "did not know the size." When asked if she made the resident's physician or medical director aware, the employee stated, "No, I don't talk the doctors. I made [Administrator's name] and [Clinical Director's name] aware several times.

Through interview with Employee #31 there was no evidence that facility staff knew the size of Resident #3's Lary Tube to order replacements, therefore, none were available in the facility for use. Subsequently, Resident #3 was sent to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ________ B. WING ________	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 201	L 529		8/24/22

emergency room for replacement of the lary tube.

4C.Facility staff failed to obtain/provide Resident #3 with HMEs that were necessary to help reduce mucus production and coughing by humidifying and filtering the air breathed through his stoma from 01/08/22 to 03/02/22.

According to Oxford University Hospital, it is important to keep your mucus thin so that it is easy to cough up [mucous]. You should always wear a stoma protector such as a ...Heat Moisture Exchange (HME: baseplate and cassette). These are available on prescription and will moisten mucous ...
https://www.ouh.nhs.uk/patient-guide/leaflets/files/11587Pstoma.pdf

Review of complaint #DC00010525 revealed allegations that the facility did not have lary-tubes and HMEs for Resident #3.

Review of Resident #3's medical record showed the following Physician's orders:

12/02/21 [Physician's Order] "Change HME daily Day shift."

12/02/21 [Physician's Order] "Change Lari-Tube daily Day shift."

The medical record also contained the following nursing notes:

01/07/22 at 4:51 PM [nursing progress note]- It was observed today that resident larynx tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for larynx tube replacement. 911 arrived ...left at 4:40 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 202	L 529		8/24/22

However, review of respiratory therapy assessment / infection screener progress notes lacked documented evidence the respiratory therapist assessed or provided care for Resident #3 from 01/05/22 to 01/12/2022.

-01/07/22 at 6:10 PM [nursing progress note] - [MD's Name] called from HUH (Howard University 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 [nursing progress note] - Resident returned from HUH at 2:30 AM in stable condition ...vs (vital signs): 144/75 (blood pressure), 18 (respiration), 70 (pulse), 96.8 (temperature), O2 SAT (oxygen saturation) 95% RA (room air).

-01/08/22 at 4:02 PM [nursing progress note] - Resident alert and oriented. Resident tolerated -feeding and all medications. Resident observed with difficult breathing with the new lary tube placed from hospital 1/7/21. Resident's family took him to [Name of Hospital] for follow-up and possible change of lary [laryngectomy] tube ...resident ...O2 sat (oxygen saturation) 98.

Review of Treatment Administration Records from 01/08/22 to 03/02/22 showed that the facility's nurses initialed they changed Resident #3's HME daily on dayshift. However, it should be noted that per the respiratory therapist (Employee #31) the HME could not be changed from 01/08/22 to 03/02/22 because the facility did not have HMEs compatible to connect with Resident #3's lary-tube.

Review of the comprehensive care plan with an initial date of 12/04/21 showed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 203 Focus Area- [resident's name] has lary tube r/t (related to) laryngeal cancer, 01/07/22 sent out for laryn (sp) tube placement, taken to ER 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... Further review of Resident#3's comprehensive care plans lacked documented evidence of interventions to address care for Resident #3's use of a lary-tube and HME from 12/01/22 to 12/03/22. 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: 02/22/22 at 9:30 AM -"On February 7th and February 8th, I emailed [Employee #31's name- respiratory therapist] in reference to Resident #3's name lary-tubes and HME's being ordered. In prior conversation she (Employee #31) stated that she needed to know the size of tube so that she (Employee #31) could order his (Resident #3) supplies. I gave her the information on the 7th (02/07/22). Checked back with her the following Monday 02/14/22) and she stated she order the belonging (Lary-tubes and HMEs) ...She (Employee #31) has the information and the items (lary-tubes and HMEs) need to ordered	L 529		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 204	L 529		8/24/22

Continued From page 204

ASAP."

03/07/22 at 12:54 PM- Has anyone looked into his (Resident #3) lary tubes and HMEs being ordered. I gave the needed information, and he still hasn't received those supplies that [Employee #31's name- respiratory therapist] ordered on February 7th of 2022. She stated that she would get back with me and never did. Theses supplies are important necessities to his current state he is in."

03/25/22 at 12:47 PM -It was told to me that the HME's and lary-tubes were ordered for [Resident #3's name] back in February. Medicaid is requesting the invoices for said orders ...Can you send me any and all documentation in reference to these invoices?

During a telephone interview on 04/12/22 at 11:35 AM, the resident's emergency contact (granddaughter) stated, "He was without a lari-tube several times and they (lari-tube) had to be replaced by the treatment (chemo infusion center) center. She further stated, "I emailed [Employee #31; respiratory therapist] on 02/07/22 and 02/08/22 size for supplies (lari-tube, collar, and straps) but she never responded. I called her (Employee #31) a week later (02/14/22) and she said [Employee #7-Clinical Coordinator] approved the supplies and she (Employee #31) ordered them."

During a face-to-face interview on 04/13/22 at 2:25 PM, Employee #7 (Clinical Coordinator) stated, "We had a problem with supplies one time, and I told the respiratory therapist (Employee #31) and she ordered them."

During a face-to-face interview on 04/14/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 205	L 529		8/2422

approximately 2:00 PM, Employee #11 (Social Worker) stated that Resident #3's granddaughter emailed him on 02/22/22, 03/22, and 03/29/22 inquiring about order for supplies (HMEs and Lary-tubes).

During a telephone interview on 04/14/22 at 2:35 PM, Employee #31 (Respiratory Therapist) stated that Resident # 3 did not a have HME to connect to his lary-tube from "01/08/22 to until they were ordered and received by the facility [03/03/22]". When asked why it took so long for Resident #3 to get the HME, Employee #31 said "I did not know the size of the resident's lary-tube. And the HMEs we had in house was not compatible with the lary-tube his family provided on 01/08/22." The employee then said she reached out to the granddaughter on 01/12/22 or 01/13/22 to get the name of the lary-tube so she could order an HME, but the granddaughter said, "The doctor told me (granddaughter) that the HME is not important", and she did not send me the size of the lary-tube until 02/07/22." Employee #31 said that she did call the resident's physician once to get the size of his lary-tube once, but he did not call her back. However, she made Employee #1 (Administrator) and Employee #7 (Clinical Coordinator) aware multiple times that Resident #3 did not have HMEs.

It should be noted that nursing staff documented in Treatment Administration Records that they changed the resident's HME on the following 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 529	Continued From page 206	L 529		8/24/22

However, it should be noted the invoiced provide by the facility with an order date of 03/02/22 showed the facility did not receive HMEs until 03/03/22, at which time they received 30.

During a face-to-face interview on 04/20/22 at approximately 2:00 PM, Employee #44 (Admission Director) stated that newly admitted residents' medical supplies are ordered and in the facility before the resident's admission. When asked if Resident #3's lary-tubes and HME were ordered and in the facility before his admission (12/01/22), she stated, "I don't know because I was not in the facility at that the time he was admitted. It should be noted that the one (1) invoice the facility provided to the surveyor had a date of 03/02/22, which documented that the facility received one (1) lary-tube and 30 HMEs on 03/03/22.

L 535 — 3270.2 Nursing Facilities — L 535

The facility shall conduct a discharge assessment of each resident within fourteen (14) days after admission and twice annually thereafter. The discharge assessment shall include:

This Statute is not met as evidenced by:
Based on record review and staff interview, for six (6) of 105 sampled residents, facility staff failed to: (1) have a discharge plan for one resident; (2) record/document information related to the resident's discharge plan to the community in the clinical record;(3) ensure the residents discharge needs were adequately identified and the results developed into a discharge plan. Residents' #155, #170, #227, #237, #406 and #412.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	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 resident ...Do 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 the following: 01/13/22 at 1:59 PM " ...They (Residents family)	L 535	CORECTIVE ACTION FOR THE AFFEDTED RESIDENTS: Resident #155 was assessed by Unit manager on 4/26/22, resident in no apparent distress. MD/RP updated. Discharge planning in progress. Resident # 170 was assessed on 4/26/22, resident in no apparent distress.MD updated. discharged planning in progress. Resident #227 was discharged home 4/1/22 Resident # 237 was assessed on 4/26/22, resident suffered no negative outcome. Discharge plan in progress. Resident #406 was sent to the hospital 2/10/22 and did not return to the facility. Resident # 412 was discharged home on 5/26/21	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 208 talked about things they felt like the facility and the SW were not doing ...They are not happy with the care at [facility] and they wanted him (Resident) moved to another facility ..." Review of the social work progress notes revealed the following: 11/29/21 at 4:17 PM "[Resident Representative] informed the social worker that she is trying to get him into ... assisted living. She stated that she needed certain documents to get him into the facility ... The SW (Social Worker) has called and requested for the social security income statement. They were supposed to fax it but there were some problems. The SW (Social Worker) also requested they mailed it ... In addition, the SW will meet her at the DMV (Department of Motor Vehicles) for [Resident #155] to get his ID (identification) ..." 12/29/21 at 5:11 PM, " ... [name of staff in ombudsman office] the Ombudsman called the SW (Social Worker) and the Supervisory SW [name] stated that [Resident's sister] felt as if the SW and the transition worker were holding up the process towards [Resident #155] going into [Assisted Living Facility]" 01/06/22 at 3:18 PM, "The SW called [Assisted Living SW] ... [and]... She asked him what could she do to assist with the process of getting [Resident #155] into... assisted living facility ..." 03/29/22 at 1:05 PM, "...supervisor with ADRC (Aging and Disability Resource Center) sent an email out to the family and SW stating as follows ...I was able to contact ... at [assisted living facility] regarding the assessment that was completed for [Resident #155]. [Assisted Living	L 535	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Resident who are due for discharge have the potential to be affected by this practice. House wide audit will be conducted by social services team members to determine that there are no delays in the discharge process. Will ensure that documentation about the discharge process in in the residents' record and ensure that discharge needs are in place. Any issues found will be corrected by 8/24/22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 209 SW] is currently looking into and will be sending it to me. In the event he cannot access the assessment he is willing to have another nurse come out and re-do the assessment." Further review of the medical record lacked documented evidence of a discharge plan for Resident #155. During a face-to -face interview conducted on 04/14/2022 at 3:44 PM, Employee #13 (Social Worker) acknowledged the finding and stated, "We started talking about other placements. The man from [assisted living facility] is coming back out to do another assessment ... this is a systemic issue." 2. Facility staff failed to record/document information related to the resident's discharge plan to the community in the clinical record for Residents #170 and #227. 2A. Resident #170 was admitted to the facility on 08/16/18, with diagnoses which included, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Cirrhosis of Liver, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Muscle Weakness, Dependence on Renal Dialysis, and Hemiparesis. According to the Quarterly Minimum Data Set Dated 02/14/22, Under Section C0500 BIMS Score showed Resident #170 was coded as "15", indicating that she was cognitively intact. Under Section E Behavior, the resident was coded as no behaviors exhibited. Under Section G (Functional Status), the resident was coded as requiring supervision with set up under bed mobility, locomotion on and off unit,	L 535	MEASURES TO PREVENT RECURRENCE: Licensed Social workers will ensure that the discharge plan for residents who are due for discharged is carried out in a timely manner. Any issues found will be corrected by 8/24/22. Licensed Social services team will ensure that documentation about resident's discharge plan to the community is placed in the resident clinical records. Any issues found will be corrected by 8/24/22. Licensed Social services team will ensure that residents discharge needs are identified and ensure these needs are developed into a discharge care plan. Any issues found will be corrected by 8/24/22. In service will be provided by staff educator/ designee on the importance of carrying out discharge process in a timely manner completed by 8/24/22	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 210	L 535	MONITORING CORRECTIVE 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.

Under G0600 Mobility Devices the resident was coded as not using mobility devices.

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 met ...review progress toward discharge during discharge meetings."

Social Work Progress Note dated 03/11/22 at 7:02 AM, read, "The SW (social worker) sat with [Resident #170] and assisted her in filling out the application for [Name of Assisted Living-LS], provided to her [Name of Transition Worker] ...The SW left a message in the presence of [Resident #170] and will attempt to call her again today regarding the completion of the packet so that it can be submitted with the proper documentation ASAP (as soon as possible)."

During a face-to-face interview with Employee #13 (Social Worker) on 04/11/22 at 3:20 PM she stated, "...We transitioned from [Name of Organization] to [Name of Organization]. We kept checking back with [Name of Case

Social services Director will audit residents' chart to ensure that there are no delays in discharge planning, that there is adequate documentation about resident's discharge plans. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected, and report presented to QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 211	L 535		8/24/22

Manager], we are now working with [Name of Organization] and [Name of Case Manager] to get her (Resident #170) into another Assisted Living ...We will try [Name of Assisted Living] again to see if they are taking dialysis patients again, because that was months ago. [Name of Organization] is based of mental health and they have no openings for placement at this time...I have the application for [Name of Assisted Living]. We are still in the process of submitting it and the resident has to have an interview."

Through interview with Employee #13 it was determined that the actions taken toward discharge planning for Resident #170 have not been documented in her active clinical record. Also, from 03/10/22 to present, there was no evidence of an outcome from Employee #13's follow up with the [Transition Worker] regarding the status of the application.

2B. Resident #227 was admitted to the facility on 03/08/22 with diagnoses which included, Cognitive Communication Deficit, Cerebral Infraction, Chronic Obstructive Pulmonary Disease, Emphysema, Hypertension, Multiple Fractures of Ribs, and Non-Pressure Chronic Ulcer of Right Lower Leg with Necrosis of Muscle.

According to the Admission Minimum Data Set dated 03/14/22, Under Section C0500 BIMS Score showed Resident #227 was coded as a "12", indicating that he was cognitively intact.

Under Section E (Behavior), the resident was coded as no behaviors exhibited.

Under Section G (Functional Status), the resident was coded as requiring Supervision with one-person physical assist under bed mobility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ____ B. WING ____	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 212	L 535		8/24/22

and locomotion on and off unit; He required limited assistance with one-person physical assistance for transferring, dressing, toilet use, and personal hygiene.

Under Section G0400, Functional Limitation in range of motion, the resident was coded as having impairment on one side of upper and lower extremity.

Under G0600, Mobility Devices the resident was coded 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."

Review of the focus care plan "Resident shows potential for discharge and resident, relative, or representative expresses wish for discharge home" ...Interventions: Arrange transportation family will transport [Resident #227]. Assess future placement setting to determine if resident's needs can be met at home."

Review of the Social Work Progress Note dated 04/01/22 at 12:42 PM showed, "[Resident #227 D/C (discharged) home. Upon discharge this writer contact APS (Adult Protective Services) to file an APS report. [Resident #227] seemed puzzled upon discharge however this writer provided the son with his care navigator number and information ...Son stated that he will contact his case manager and follow up with her ..."

During a face-to-face interview with Employee #12 on 04/07/22 at 4:45 PM he stated, "We were told that he had a caseworker in the community through his insurance ...He has an assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 213	L 535		8/24/22

from Liberty ... in the system. The resident didn't want to wait to be discharged. He was irritated to be here. He wanted to go home ...I did not want him to go AMA (against medical advice). I called the case worker and left several messages and provided the number to the family. I was worried about the resident because he was not calm. That's why I call APS adult protective services. He was adamant about leaving. The son and resident told me that he had an aid. The son came (to the facility) with someone who said she was going to care for him. I didn't feel comfortable about him leaving with her. The resident was adamant about leaving the facility."

During a face-to-face interview with Employee #43 on 04/07/22 at 5:11 PM she stated, "The resident was supposed to leave on Tuesday 04/05/22. His son didn't come on Tuesday. He [Resident #227] was angry and wanted to go home with someone else. The son came on Friday and got him. The son was off on Friday and picked him up. He kept going to the social workers door saying he wanted to go home. He had a lot of anxiety."

There was no evidence that Employee #12 updated Resident #227's clinical record with the status of the liberty assessment and outcome. Employee #12 failed to document the date and time that he left a message for the resident's community case worker to discuss the resident's transitioning back into the community safely. There was no documentation in the clinical record regarding the resident's anxiety and behavior related to being discharged from the facility to the community.

Employee #12 acknowledged the findings on 04/05/22 at 4:45 PM; and Employee # 43

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 214	L 535		8/24/22

acknowledged the findings on 04/05/2022 at 5:11 PM.

3. Facility staff failed to ensure that Resident #237's, #406's and #412's discharge needs were adequately identified and the results developed into a discharge plan.

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 (Participation in Assessment and Goal Setting) Resident participated in assessment "Yes"

Q0300 Residents overall expectation Section was not coded

Q0400 Discharge plan: Is active discharge planning already occurring for the resident to return to the community? "Yes"

Review of the care plan notes revealed the following:

12/7/2021 at 9:11 AM, "...[Resident #237] is interested in obtaining his own housing and returning to the community the social worker is working with him towards that goal. He ... doesn't have his needed documents and the SW will assist him in obtaining them ..."

Review of the social work progress notes revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 215	L 535		8/24/22

Continued From page 215

03/17/2022 at 9:21 AM, "The SW (Social Worker) will be going to pick up birth certificates for [Resident #237] and additional residents to begin the process of discharge"

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.

Review of the Admission Minimum Data Set (MDS) dated 02/03/22 showed facility staff coded the following:

In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "15", indicating intact cognition

In section G (Functional Status): Bed Mobility "Supervision" requiring "Setup"

Transfer "Limited assistance" requiring "One-person physical assist"

Dressing "Limited assistance" requiring "One-person physical assist"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 216	L 535		8/24/22

Toilet use "Extensive assistance" requiring "One-person physical assist"

Mobility Devices "Cane/Crutch" "Wheelchair"

In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes"

Q0300, resident's overall goal ... "Expects to remain in this facility"

Q0400 Is active discharge planning already occurring for the resident to return to the community? "No"

Q0600 Has a referral been made to the local contact agency? "No-referral not needed"

Review of the social work progress notes revealed the following:

02/04/22 at 4:35 PM "...Spoke with [Resident #406] in reference his discharge plan and he stated that he does not have housing now at this time. Prior to his hospitalization he lived in a shelter. Housing resources for males will be explored and the appropriate referrals and recommendations will be implemented. Identification is a issue that need to be resolved in order to apply for housing. The discharge goal for [Resident #406] is to return to the community at some point..."

Review of the nursing progress notes showed the following:

02/08/22 at 4:16 PM "... He was observed on in the lobby with some of his belongings. His nephew was on his way to visited him, and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 217	L 535		8/24/22

met resident at the front entrance with some of his belonging and asking his nephew to take him home. A meeting was held with [Resident #406's Relative], SW, admission and the unit manager. Resident attests he did mot (SP) know that he needs to sign a paper to leave AMA (Against Medical Advice). We convivence (sp) [Resdient #406] to stay until Friday coming when he will have a proper discharged (sp). However, he went outside with his [Relative] and all of a sudden he snatched into his case worker car. Resident was removed from the car, and brought inside the facility by his [Relative]. He agreed to wait until Thursday or Friday to be discharge. Psych. consult, and elopement risk initiated for preventive measure. He refused wander guard..."

02/10/22 at 8:13 AM "[Resident #406] was transferred to [hospital name]..."

Review of the care plan initiated on 02/07/22, with a focus area of "Safe and appropriate discharge." Showed the following interventions "...on discharge to community, encourage...to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety fear, distress., The clinical team along with [Resident #406] and ... RP (resident representative) will establish a pre-discharge plan with specific needs being discussed and addressed prior to discharge."

Further review of Resident #406's medical record lacked documented evidence of any updates, modifications or plans for the resident to safely discharge from the facility.

During a face-to-face interview conducted on 04/11/22 at 4:00 PM with Employee #10 (Director of Social Work) acknowledged the finding and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 218	L 535		8/24/22

Continued From page 218

stated, "He was only here a short time he wanted to leave AMA, it was not safe for him" and provided no explanation why there was nothing documented in the discharge plan about Resident #406 wanting to leave the facility against medical advice.

3C. Resident #412 was admitted to the facility on 02/26/21 with multiple diagnoses including, Hemiplegia Unspecified Affecting Left Nondominant Side, Cervical Disc Disorder With Myelopathy Cervicothoracic Region, and Other Abnormalities of Gait and Mobility.

Review of the Admission Minimum Data Set (MDS) dated 03/07/21, showed that facility staff coded the following:

In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summery Score "15" indicating intact cognition.

In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes"

Q0300, resident's overall goal, "Expects to be discharged to the community"

Indicated the information source for Q0300A "Resident"

Q0400 Is active discharge planning already occurring for the resident to return to the community? "No"

Review of the social work progress notes revealed the following:

03/01/21 at 12:52 PM, "This is an initial care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ___ B. WING ___	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 219	L 535		8/24/22

conference meeting with the IDT (Interdisciplinary team) and resident. ...plans are to discharge home"

04/28/21 at 8:46 AM, "The Social [Worker] met with [Resident #412's] POA (Power of Attorney) today to begin the discharge process. Family is interested in participating in [agency name] The referral for the Waiver Program was completed ... the Clinical Team will meet again to continue discharge plkanning (sp)"

05/10/21 at 1:48 PM, "[Resident #412] will be assessed for services in the community by [Agency name], 5/14/21 at 11:00 AM. The assigned Nurse will telephone [Resident #412] in his room if there are any additional information or questions sthe (sp) Nurse will consult this Social Worker"

05/25/21 at 5:52 PM, "... [Resident #412] cou (sp) further benefit from our skilled service program however he has requested to be discharged. ... [Resident #412] and his Responsible party have put in place a plan of care for the family to follow until the HHA (Home Health Agency) have been identified and put in place...[Resident # 412] will be discharged from [Facility].

Review of the care plan initiated on 03/01/21 revealed a focus area of "...Expectation id for the resident to have a safe an appropriate discharge home."
Goal "The resident will be able to communicate verbal needs and required services to meet needs prior to discharge." Interventions "Discharge planning meeting will be held with IDT, resident and family"

Review of a physician's orders showed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: ______ B. WING ______	C 04/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 535	Continued From page 220 05/26/21 "Discharge resident home with skilled musing (sp) PT (physical therapy)/OT (occupational therapy)/HHA and scripts (prescriptions) on 5/26/21." Further review of Resident #412's medical record lacked documented evidence of any updates, modifications or plans for the resident to safely discharge from the facility. During a face-to-face interview conducted on 04/11/22 at 3:51 PM, Employee #10 (Director of Social services) acknowledged the finding and stated, "When he came there was no way he could safely discharge."	L 535		8/25/22