DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 100 well. The Resident was found with [his/her] head resting on the floor. The staff decided to place a bed alarm up around [his/her] shoulders not at the level of [his/her] bottom since [he/she] moves [his/her] upper body, also the curtain is to be left open. Yesterday morning the Resident was found in the same position, [he/she] was wet, the alarm was not in the proper place and the curtain was closed. Now there is a floor mat down, the bed is in low position. These were interventions after the second fall." Follow up telephone interview was conducted with Employee #9 on March 4, 2015 at 12:28 PM. He/she stated, " I ' ve seen [him/her] fairly wet. [He/she] is on a g-tube (gastrostomy tube) for feeding. I do not see an order for an air mattress. The resident is not on a scoop mattress. That order was discontinued on February 27, 2015. The employee also acknowledged that the care plan was not updated to include that the resident does not use the toilet and the resident ' s increase in urinary incontinence. " A telephone interview was conducted with Employee # 46 CNA, Night Shift on March 2, 2015 at 2:41 PM. He/she stated, " I worked 11-7 on that day. I had 18 residents ' on my assignment. [Resident #292] is a heavy wetter. I checked [him/her] four (4) times on that shift and I changed [him/her] twice on that shift. I did my final rounds on [him/her] around 6:00 AM. I changed the draw sheet in the morning because there were stains on the sheet. I drew the curtain for privacy and I left the bed in a low position. During the night I placed [him/her] on the side. The bed alarm was placed between [his/her]	F 312	4. Unit managers will make daily rounds to ensure residents are well groomed and ADL care provided by staff. DON and her team will make rounds three times a week and visit residents randomly to ensure ADL care is being provided as per the plan of care.. Nursing supervisors on 3-11 and 11-7 shift will do random audits on residents weekly and submit findings to DON. Administrator will meet residents at the Resident Council to discuss improvement in the process. Ambassador rounds will be done weekly and findings will be shared at stand up meeting daily. Trends and findings will be shared in QAPI monthly.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 101 shoulders and buttocks. I don ' t know why [he/she] was wet. I had to take two (2) residents ' to dialyses that were on my team. I left the building around 7:05 AM." A telephone interview was conducted with Employee #45, CNA- 7-3 Shift, on March 2, 2015 at 12:05 PM. He/she stated, " I was not assigned to the resident on this day. We [the Certified Nurse Aides working on the shift] make rounds together. At 7:00 AM on this day [February 19, 2015] I was the first one to enter the room [310] and I saw the [him/her] leaning off the bed with [his/her] head partly on the floor and [his/her] legs were still in the bed, and the curtain [surrounding the resident ' s bed]. We got [him/her] up off [from the leaning position] and noticed that [his/her] entire bed was saturated with urine. Not just the brief the bed. We then called the charge nurse to let [him/her] know." There was no evidence that facility staff provided incontinent care to Resident # 292 who was found in bed with his/her head on the floor and the bed was saturated with urine. The record was reviewed on March 4, 2015.	F 312		
F 323 SS=F	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F-Tag 323 (A 1 2a, 2b, 3, &4) 1. Residents # 148, 25,292, and #115 were all assessed and did not have any negative outcome related to the deficient practice of the facility's failure to maintain a safe environment. Resident #25 , care plan was revised to address that resident will not be left alone in the bathroom. Resident Number 148 care plan was reviewed and revised to include rest periods after dialysis tx.	

F 323

Continued From page 102

This REQUIREMENT is not met as evidenced by:

A. Based on observations, record review and staff interviews for four (4) of 51 sampled residents, it was determined that facility staff failed to maintain a safe environment for one (1) resident who sustained a bump to the head secondary to being hit by an unattended object; failed to supervise two (2) residents who each sustained a fall without injury; failed to implement measures and or provide adequate supervision to help ensure that (one (1) resident did not fall out of bed; and failed to consistently supervise one (1) resident who was observed walking on and off the unit and entering other residents' rooms without permission. Residents' #148, 25, 292 and 115.

The findings include:

1. Facility failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom which resulted in a fall without injury.

According to the annual MDS (Minimum Data Set) dated February 4, 2015, Under Section C, (Cognitive Patterns), the BIMS [Brief Interview for Mental Status] score was 3, which indicated the resident was cognitively impaired. Section I [Active Diagnoses] included Anemia, Cerebrovascular Accident (CVA), End Stage Renal Disease, Altered Mental Status, Pulmonary Embolism [and] Infarction, Unspecified Hypotension. Section G [Functional Status] revealed the resident required extensive assistance of one person for toilet use and extensive assistance of two (2) persons for

F 323

The Maintenance staff was in serviced not to keep any items on top of the paper dispenser to avoid such items from falling on residents.

Resident number 292 care plan was reviewed and revised to include all interventions recommended by the Team. (scoop mattress provided, bed alarm on bed when resident is laying in bed, Curtain will be drawn open)

Resident number 115, care plan was reviewed and revised by IDT members. Team also met to discuss discharge plan as residents wandering behavior is not easily redirected. Staff continues to monitor resident closely to prevent from entering into other residents rooms.

2. All residents' potential to be affected by the deficient practice will be assessed by the IDT members. Care plans will be reviewed and revised to address appropriate interventions to reduce falls. The team will review all A and I's post fall to ensure appropriate measures are implemented and addressed in care plan

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 103 transfers between wheelchair to a standing position. A face-to-face interview was conducted with Employee #12 on February 6, 2015 at approximately 11:48 AM. He/she was asked; " Has the resident had a fall and/or sustained a fracture within the last 30 days? The employee replied, " Yes. " The resident fell in the bathroom on February 4, 2015 on the (7AM-3PM shift). " He/she further stated the resident did not sustain an injury and the last time [he/she] was seen prior to the fall, " [he/she] was sitting on the toilet. " A review of the nurses ' note revealed the following: " February 4, 2015 - Alert and verbally responsive. At 8:30 AM resident was found on the floor of the restroom lying on [his/her] right side. Fall was not witness. MD [Medical Doctor] notified and was told the position resident was found. MD ordered x-ray of the skull, and the right side of the body to rule out fracture ... resident was assessed head to toe. Resident denied pain, all extremities moveable, no bruise or skin tear noted. Ate lunch in dining room and left for dialysis. Neurocheck in progress. Left arm graft site dry/intact no bleeding noted. (+- positive) bruit/thrill present. V/S [Vital Signs] - 100/66 [Blood Pressure], [Pulse]-54, [Temperature] - 97.7, [Respirations] -18. February 4, 2015 - Resident is pleasantly confused with dx [diagnosis] of senile dementia. [He/she] has poor safety awareness/impaired judgment. Denies pain or any kind of discomfort upon assessment. [He/she] enjoyed a back rub during assessment. Staff has been [educated] not to leave [him/her] on the toilet by [him/herself].	F 323	3. Falls Prevention program policy and procedure was reviewed by the team. All new admission, readmission, quarterly and after a fall , a fall risk assessment will be completed . Staff Development will in-service staff on falls prevention, and protocol. All new hires will be in serviced on fall prevention program. Team will evaluate and assess root cause analysis for falls. Licensed nursing staff, C.N.A's and Rehab staff will be in serviced on fall prevention and management program. All new hires will also be in-serviced. 4. The QAPI coordinator will trend all falls monthly. Share findings with staff on all shifts. Results of the findings will be shared at the QA committee. 5/12/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 104 [He/she] is alert, able to self propel in wheelchair on the unit and neuro checks in progress. February 4, 2015 - 14:25 (2:25 PM) - CNA (Certified Nursing Assistant) was educated on the importance of safety and not to leave residents on the toilet unattended if they are not capable to be left alone. " A review of the Rehabilitation Notes revealed the following: " Occupational Therapy - Therapy Progress Report " with dates of service from January 29, 2015 through February 4, 2015 revealed: " STG#3.0- Short Term Goal- Goal Met - Upgrade- Resident will safely perform toileting tasks using standard commode with Mod (A) [moderate assist] with good safety awareness. Baseline- January 29, 2015- Max (A) [maximum assist]; Previous (February 2, 2015) - Max (A) and Current (February 4, 2015) - Mod (A). STG #3.1- New Goal: Patient will safely perform toileting tasks using standard commode with Min (A) - (Minimum Assistance) with good safety awareness. Physical Therapy- PT (Physical Therapy) Evaluation [and] Plan of Treatment- Start of care January 29, 2015 - Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for falls, further decline in function, increased dependency upon caregivers and decrease in level of mobility. Functional Mobility Assessment- Gait- Level Surfaces = Moderate Assist- ... Deviations: Patient exhibits forward lean of trunk and inadequate knee extension which are	F 323	F-Tag 323 (B1-4) 1. The door closer cap missing in room 320 was repaired on February 11, 2015. The door closer cover in room 202 was repaired on February 11, 2015. Empty boxes from dialysis supplies, seven chairs and a ladder were in double doors unlocked easy access residents were emptied on February7th 2015. All resident wardrobes were secured on February 28 & 29, 2015 by facility contractors. 2. All other storage rooms, door closures, door caps and wardrobes were checked by the Director of Maintenance. No other rooms were found to have this deficient practice. 3. A monthly storage room audit tool was created to check for improperly stored items, missing door cap, door closure covers . Maintenance staff after conducting monthly tours will provide audit tools to the director who will check findings and address. Maintenance staff were in serviced on door closer caps, door closer covers, clean and orderly storage areas. 4. The Director of Maintenance will report monthly on any deficient findings after audits are conducted and provide findings to QAPI Committee.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 105	F 323		

associated with the underlying causes of muscle paresis/weakness, lack of /impaired coordination and lack of selective control. Gait Pattern: The patient exhibits the following characteristics during gait: decreased accuracy of movements, decreased velocity, uneven step length and wide base of support. "

A review of the care plan revealed the following:

"Focus- The resident has an alteration in neurological status [related to] Syncope and Collapse, CVA with hemiplegia- Interventions- PT [Physical Therapy], OT[Occupational Therapy], ST[Speech Therapy] evaluate and treat as ordered...

Focus - The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit [related to] Dementia, Impaired balance secondary to CVA with hemiplegia, Interventions: ...Transfers: The resident is able to stand, weight bear, pivot, use arms to support, take steps during transfer. Resident is receiving intermittent assistance. Toilet Use: The resident is able to toilet self, wash hands, hold grab bars, wipe self, and adjust clothing during toileting. "

Facility failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom which resulted in a fall without injury.

A face-to-face interview was conducted with Employee #12 on February 12, 2015 at approximately 10:55 AM regarding the aforementioned findings. He/she stated that he/she was walking down the hallway, when he/she saw the CNA assisting the resident; he/she went into the room to assist him/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 106	F 323		

because the resident was unsteady and was " wobbly. " He/she further stated; he/she heard the CNA tell the resident to " pull the call bell when [he/she] is done. "

A face-to-face interview was conducted with Employee #60 on February 13, 2015 at approximately 12:40 PM. He/she stated prior to Resident #25's fall, the resident was currently on the occupational therapist caseload. He/she further stated, "The resident required moderate assistance with transfers from bed to chair and from wheelchair to toilet. Sometimes [he/she] was maximum assist. " Employee #60 stated the rehabilitation recommendations are communicated to staff in the IDT [Interdisciplinary Team] meeting. Also, every week PT discusses recommendations with the nurses who update the care plan.

A face-to-face interview was conducted with Employee #37 on February 17, 2015 at approximately 10:20 AM. He/she stated, " I assisted [Resident #25] out of the bed into his/her wheelchair. I pushed the wheelchair to the bathroom door, after locking the wheelchair brakes, I assisted [him/her] from the wheelchair onto the toilet seat. The bathroom rail was on the left. I instructed [him/her] to pull the call bell string when [he/she] was done. The charge nurse assisted me when getting the resident from the wheelchair onto the toilet. " He/she further stated that the resident did not complain of being dizzy and [he/she] did not recall if the resident ' s gait was unsteady. He/she left the room to attend to another resident.

The record lacked evidence that the staff ensured that Resident #25 was transferred from the toilet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 107	F 323		

seat as stipulated in the MDS and in accordance to the recommendations from the rehabilitation team.

Facility staff failed to maintain a safe environment for Resident #25 who was left unsupervised in the bathroom. The clinical record was reviewed on February 12, 2015.

2a. Facility staff failed to ensure the environment was free from potential accident hazards as evidenced by a resident who sustained an injury from a fire alert apparatus that was improperly placed on a paper towel dispenser. Subsequently, the apparatus fell and struck Resident #148 in the head.

A review of the facility ' s " Incident Report " dated December 31, 2014 5:00 PM " According to the patient [resident] there was a fire drill and after that, one of the maintenance staff came into the room and removed [his/her] fire alarm because [he/she] wanted to fix it. [He/she] left the fire alarm on top of the shelve [shelf] where the paper towel was. [A] few minutes later, the patient washed [his/her] hands, and when [he/she] tried to reach and get the paper towel to wipe [his/her] hands, the fire alarm fell on [his/her] face and as a result [he/she] has a bump on [his/her] right forehead ... Immediate action taken: Assessment was done for any pain; ice pack was applied at the site and MD [Medical Doctor] was notified about the incident; Medical Treatment Necessary: No "

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 108 Nursing Entry: January 5, 2015 [no time indicated] revealed " Incident reviewed; hematoma to forehead present. Resident denies pain or discomfort at site, Incident determined to be accidental due to unintentional improper placement of object ... Nursing Entry: January 15, 2015 [no time indicated] revealed: "Resident hit by fire alarm left unattended, director of maintenance consulted to educate staff on the incident... " A face-to-face interview was conducted with Employee #36 on February 20, 2015 at approximately 11:30 AM. A query was made regarding the incident and outcome of staff education related to leaving the unattended object in the resident's room. Employee #36 indicated that the in-service was not conducted and that another department [security] might have taken them [smoke detector] down. Employee #36 provided an in-service titled " Resident Safety " sheet signed by staff on February 18, 2015 after the surveyor brought this issue to his/her attention. Facility staff failed to ensure safe practice in the resident's care area secondary to leaving an object unattended that subsequently fell and hit the resident on the head whereby the resident sustained a bump to the right side of his/her forehead.	F 323		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 109	F 323		

2b. Facility staff failed to ensure adequate supervision for Resident #148 who sustained a fall following dialysis.

A review of the clinical record revealed the following: "Progress Note dated January 10, 2015 18:09 [6:09 PM] Supervisors were called at 12:40 PM by Safety [Security] for a resident that fell in the dining room floor. Resident observed on the floor in a sitting position in front of his/her wheelchair. Resident assessed, no bruises/injuries noted at this time. Range of motion performed, resident moved all extremities and denies pain. No s/s [signs/symptoms] of acute distress noted. Resp [respirations] even unlabored, pupils equal round reactive to light. Resident alert and oriented ....Resident stated to Supervisor...I did not stand up, I felt the chair moving under me and I sat down on the floor. I did not hit my head, resident RP [Responsible Party] notified at 13:20 [1:20 PM] and [Physician named] notified 13:30, no new orders received, resident on neuro [neurological] checks... " ; January 10, 2015 18:09 [6:09 PM] ...Resident is status post fall. No signs of acute distress/discomfort noted and no complaints, assessment done as per facility policy during the shift, will continue with plan of care... "

A review of the " Facility Incident Report " dated January 10, 2015 12:30 PM, "Location: first floor main dining room: Description: Supervisors were called at 12:40 PM by Safety [Security] for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 110 resident that fell in the dining room floor. Resident was observed on the floor in a sitting position in front of [his/her] wheelchair. Resident assessed, no bruises/injuries noted at this time. Range of motion performed, resident moved all of [his/her] extremities and denies pain. No s/s [signs/symptoms] of acute distress noted. Resp [respirations] even unlabored, pupils equal round reactive to light. Resident alert and oriented x3 ....Resident stated to Supervisor...I did not stand up, I felt the chair moving under me and I sat down on the floor. I did not hit my head, resident RP [Responsible Party] notified at 13:20 [1:20 PM] and [Physician named] notified 13:30, no new orders received, resident on neuro [neurological] checks... Page 1 of 4 of the incident report revealed, "Resident Description: Resident said [he/she] was trying to sit on the wheelchair and it slid away from [him/her] and [he/she] decided to sit on the floor because [he/she] was tired after coming from dialysis... Page 4 of 4 of the incident report revealed the following dated "January 19, 2015 Resident ambulates, fell due to weakness after dialysis...staff to monitor and assist resident to rest after dialysis ... " A review of the Facility ' s Dialysis communication Sheet, dated January 10, 2015 revealed that the resident returned to the unit at 11:00 AM. There was no evidence in the clinical record to	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	095019		02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 111 reflect that facility staff put measures in place to supervise and or monitor the resident following dialysis. A face-to-face interview was conducted with Employee #9 on February 13, 2015 at approximately 1:00 PM. A query was made regarding if the resident requires assistance when going to and coming from dialysis treatments. Employee #9 indicated that the resident is alert and oriented [he/she] is ambulatory, but when [he/she] goes to dialysis we take [him/her] down in a wheelchair and bring [him/her] back in a wheelchair. A face-to-face interview was conducted with Resident #148 on February 13, 2015 at approximately 4:30 PM. A query was made regarding the above incident. Resident #148 stated " I was not coming from dialysis, I do not know what happen. " A face-to-face interview was conducted on February 19, 2015 at approximately 1:00 PM with Employee #51. A query was made regarding the above incident. Employee #51 stated " I observed [Resident #148] as [he/she] finished eating lunch, [he/she] stood up from [his/her] wheelchair, the chair was not locked and the chair rolled from under [him/her], [he/she] fell on the floor. " There was no evidence that the facility had measures in place to monitor the resident following dialysis.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 112	F 323		

Facility staff failed to ensure adequate supervision for Resident #148 who sustained a fall following dialysis.

3. Facility staff failed to implement measures and or provide adequate supervision to help ensure that Resident #292 did not fall out of the bed.

A review of the quarterly Minimum Data Set dated October 11, 2014, Resident #292 was coded as totally dependent in bed mobility, and toilet use under Section G [Functional Status] The resident was coded as being frequently incontinent of urine and always incontinent of bowel under Section H [Bladder and Bowel].

A review of the nursing notes revealed, " November 15, 2014 at 15:41[3:41PM], Resident was observed laying on the floor, upper extremities was on the floor while [his/her] lower extremities remained on the bed. At that time, bed was [in] a lower position ... "

December 8, 2014 at 10:49 AM, " resident was found on floor at noon ...upon assessment no bruise or laceration found ... "

A review of the February 19, 2015 incident report revealed, " Resident found hanging halfway out of bed with head on the floor. Bed was saturated with urine. "

A review of the care plan revealed the following interventions:
December 8, 2014- the resident had actual fall

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 113	F 323		

with no injury, poor safety awareness. Intervention: Bed alarm will be monitored and maintained by nursing staff to assist with injury prevention. Resident referred to skilled rehab for bed mobility and communication training. Staff will provide education and teach proper techniques for safety, such as call light use and communicating needs.

Interventions: as on February 11, 2015. "Curtain to be drawn back at all times to ensure visual of resident. Neurochecks per facility protocol. Position resident bed alarm at shoulder height to alert staff of changing in position, referral to therapy."

February 19, 2015: resident had an actual fall, found leaning halfway out of bed with head resting on floor. Interventions: as on February 19, 2015. Bed in the lowest position at all times when resident in bed. Fall mats alongside bed. Neurochecks per facility protocol.

The physician's order last signed and dated February 19, 2015 directed, " Scoop mattress for bed secondary to hanging off at bedtime provide safety precautions." The order was dated November 17, 2014, with a start date of November 18, 2014.

Observation: Resident #292 was observed lying in bed on February 20, 2015 at approximately 3:10 PM. The resident was lying on an air mattress (without a scooped edge). The bed was in a low position, the privacy curtain was in the closed position, and a gray mat was observed on the floor on the right side of the bed. The red call light/pad was on the night stand.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 114	F 323		

Continued From page 114

There was no evidence that facility staff followed up on the physician ' s order to obtain a scoop mattress for Resident #292 who was observed with his/her head hanging off the bed and onto the floor and on the floor. The record was reviewed on February 20, 2015. The facility staff acknowledged the finding.

4. Facility staff failed to consistently supervise Resident #115, who was observed walking about the unit entering residents' rooms without permission and wandering off the unit.

During the survey period the following incidents were observed:

February 9, 2015 10:30 AM -Resident #115 [Resident's room was located on Unit 4 North] was observed ambulating without walker and unsupervised. He/she went into a female resident ' s room [Room 429 on Unit 4 South] (Unit 4 South). The resident shouted, " Nurse." The resident was removed from the room by a staff member.

February 9, 2015- 10:45 AM- Resident #115 was ambulating without a walker and was unsupervised. He/she went into the female resident's room [located on 4 South]. Female resident shouted,, " Nurse." The resident was escorted out of the room by the activity coordinator.

February 9, 2015 -10:51 AM- The resident was ambulating without a walker and supervision to the door of Room 429. Immediately [he/she] was redirected by the activity coordinator. He/she; stated; " [Resident ' s Name], do not go in that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 115	F 323		

room. Ladies are in there. " The resident turned around and walked down the hallway corridor.

February 10, 2015 - 11:48 AM- The resident exited [his/her] room. He/she was neatly groomed and ambulated with a walker down the hallway, without supervision.

February 10, 2015 - 11:55 AM- The resident was sitting in the lounge area (walker by his side), located proximal to the nursing station. He/she abruptly got up from the sofa and preceded to the activities area without his/her walker. The resident removed graham crackers from a table and began eating them. A staff member gave the resident his/her walker and stated, " [Resident Name], you know you cannot walk around without your walker. "

February 10, 2015 - 11:56 AM- The resident left the activities area and ambulated with walker to the corridor double doors without supervision.

February 10, 2015 -12:00 PM- Resident #115 returned to activity area. He/she was ambulating with a walker, but without supervision when he/she bumped into a resident. The resident was sitting in a wheelchair with his/her right leg extended on the foot rest. The resident was redirected by the activity coordinator. The resident left the unit again without supervision.

February 10, 2015 - 12:05 PM- Resident returned to the unit without his/her walker. The staff looked for the resident's walker which was found on Unit 4 South)

On February 10, 2015 at 12:30 PM, Employee # 11 was asked about the facility ' s system for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

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

F 323 Continued From page 116 F 323

monitoring residents who wander. He/she stated the resident has a wandergard. The nurse proceeded to the resident ' s room to show the surveyor that the resident was wearing a wandergard. The resident was neither in his /her room nor in the area of the nursing station. Staff proceeded to look for the resident. The resident returned to the nursing station without his/her walker and no supervision at 12:32 PM.

A quarterly MDS [Minimum Data Set] dated January 7, 2015 Under Section G (Functional Status), the resident required limited assistance for walking in the room, corridor and locomotion on and off [unit] with one person physical assist.

A review of the physician ' s notes revealed the following:

" September 4, 2014- 20:14 [8:14 PM]- Type: Psychiatrist- Patient has been seen in [his/her] room. [He/she] is in [his/her] bed and relaxing after dinner, covered with bed spread. Patient is still quite symptomatic. [He/she] is depressed, suspicious, anxious, and guarded. Patient was spending a lot of [his/her] time walking around of the unit tirelessly using [his/her] walker ..."

December 9, 2014- 19:31 [7:31 PM] - Type: Psychiatrist- "Patient continues to walk around of the units with [his/her] walker. At times [his/her] behavior is quite bizarre. Patient presented self with substantial cognitive impairment. On other occasions [he/she] is attempting [his/her] walks without walker and poses risk for fall."

January 13, 2015 - 20:01 [8:01PM] - Type: Psychiatrist- "Patient has been seen for follow up in the day room. [He/she] is receptive to visit and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED
	095019		02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 117 cooperative. Patient has been constantly walking around sometimes without walker and is very reluctant to cooperate with staff at times. [He/she] is still quite sad, anxious, guarded, and inappropriate." A review of the nurse ' s notes revealed the following: January 8, 2015- 16:31 [4:31PM]- Type: Social Services- Quarterly review: "Resident is alert and oriented x1[times one]... [He/she] ambulates throughout the unit daily with a walker. [He/she] frequently requires redirection." January 10, 2015 - 11:23[AM] - Type: Activities- "... [Resident #115] is alert orient x2 [times two], verbally responsive. Resident uses a walker for mobility around the unit. [Resident #115] shows signs of confusion and needs redirection from staff. Resident is a wanderer and needs supervision on and off the unit. However, [Resident #115] is out in the day room 4-5x (four to five times) per week, at times when directed [he/she] joins the morning daily chronicle readings and group discussion. [Resident] like to walk around on and off the unit so staff at times walks with [him/her] to monitor and sometimes assist in redirecting." January 20, 2015 - 17:05 [5:05PM] - Type: Nurses Note-" Resident was walking with walker and tumble on the chair where another resident [was], then staff member help ease resident to the floor." January 20, 2015 - 16:30 (4:30 PM) - Type: Nurses Note- "Resident was walking without walker and tumble on the chair where other resident was sitting in the day room at 2:15 PM.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 118	F 323		

Continued From page 118

Staff member help resident and ease [him/her] to the floor. No injury noted. V/S [Vital Signs]- [Temperature]- 98, [Pulse]-88, [Respirations-20, [Blood Pressure]- 114/74. MD [Medical Doctor] paged, RP [Responsible Party] notified. "

A review of Resident #115 ' s care plan , updated February 4, 2015 revealed: " The resident is an elopement risk/wanderer [as evidenced by] resident wanders aimlessly. Impaired safety awareness. Disoriented to place. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, Wander guard bracelet at all times and monitor placement and function.
Resident was walking without [his/her] walker and [he/she] slipped and fell over another resident who was sitting on the couch. Interventions: Check on resident more frequently. Ensure resident have [his/her] walker at all times. Staff will check on resident more frequently. Monitor resident when moving around and ensure that [he/she] has [his/her] walker with [him/her]. "

There was no evidence that facility staff provided adequate supervision for Resident #115 who exhibited repetitive locomotion and unsafe wandering; who was observed walking about the unit entering resident ' s rooms without permission and wandering off the unit; and facility staff failed to consistently supervise and monitor to ensure that the resident had [his/her] walker at all times as indicated in the plan of care.

A face-to-face interview was conducted with Employees #11 on February 10, 2015 at approximately 1:00 PM. He/she acknowledged the aforementioned findings. The clinical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 119	F 323		

was reviewed on February 10, 2015.

B. Based on observations made during initial tour on February 5, 2015 and on February 11, 2015 between 10:30 AM and 3:00 PM, it was determined that the facility failed to ensure that it was free of potential accident hazards as evidenced by a missing door cap to a door closure in one (1) of 53 resident rooms surveyed; a missing cover to a door closure in one (1) of 53 resident's room surveyed an isolated unlocked, accessible area that was littered with trash such as empty boxes, chairs and a ladder and wardrobe closets in resident rooms were unsecured and posed a potential hazard in 148 of 148 renovated rooms on the 2nd and 3rd floors.

The findings include:

1. The door cap from the door closure in resident room # 320 was missing, exposing electrical wires to residents in one (1) of 53 resident's rooms surveyed.

2. The whole cover to the door closure in room # 202 was missing and mechanical and electrical parts to the door closure were accessible to residents in one (1) of 53 resident's rooms surveyed.

3. Numerous empty boxes of dialysis supplies, seven (7) chairs and a ladder were scattered in an area accessible through an unlocked double door with a sign that read "DANGER, CONSTRUCTION AREA, KEEP OUT". The area was located on the first floor next to the Admission department and was easily accessible to residents, visitors and staff.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 120 The first and second observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings. 4. Facility staff failed to ensure that wardrobe closets in resident rooms were secured. On February 20, 2015 at approximately 3:30 PM, a tour of 148 of 148 resident rooms on 2North (36 rooms), 2South (38 rooms), 3North (36 rooms) and 3South (38 rooms) nursing units was conducted. It was determined that the wardrobe closets [furniture for residents to store personal belongings] were unsecured presenting a potential hazard to residents. The observations of the 3rd floor were made in the presence of Employee # 9. A face-to-face interview was conducted with the Employee # 70 on February 20, 2015 at 4:50 PM. He/she stated, "The contractors are coming on Sunday [February 22, 2015] to secure the wardrobes to the walls." Facility staff failed to ensure that the wardrobes in resident rooms were secured.	F 323	F-Tag 328 (1A, 1B) 1. Resident #99 is no longer here at facility. 2. Residents with a Tracheotomy and/or GT have the potential to be affected. All Residents with Tracheostomy and GT feeding will be assessed by nursing. All tracheostomy residents reviewed by Nursing administration to ensure orders prescribed by MD for Trach care is done q shift , suctioning as needed, O2 administration administered as ordered, emergency trach kit is kept at bed side. Care plan was revised. Residents with GT feeding will be assessed by nursing. All GT feeding residents will be reviewed by Nursing Administration to ensure orders prescribed by MD is followed on a daily basis.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 121 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for one (1) of 51 sampled residents, it was determined that facility staff failed to ensure that one (1) resident received the proper treatment and care for the management of tracheostomy [trach] and respiratory, and failed to ensure that one (1) resident who had a gastrostomy tube received the necessary care according to physician's orders. Resident #99 The findings include: 1A. Facility staff failed to follow the physician's orders to perform tracheostomy care for Resident #99. The December 2014, January and February, 2015 physician ' s "Orders Summary Report" directed: "Tracheostomy care to be performed every shift and as needed for tracheostomy tube; Monitor tracheostomy tube and make sure that it is on midline and patent three times a day; Keep emergency equipments at bedside one time day for respiratory difficulty; Start oxygen weaning as tolerated every shift related to tracheostomy status;	F 328	3. Staff Development will in service nursing staff on care and management of Tracheostomy and GT feeding residents. Competency for trach care will done for professional nurses and repeated annually. Competency for GT care, medication administration and Feeding will be done for professional nurses and repeated annually. All new hires will be in serviced, and competency checks will be performed. All new Admission and readmission charts will be reviewed by Nursing ADON / Unit managers to ensure orders are written accurately and carried out timely. Policy and Procedure for Tracheostomy care and management, GT feeding policy and procedure will be reviewed. Night shift will audit nightly for any blanks in MARs and TARs and report to Nursing management/DON. 4. MAR and TAR will be checked daily by the 11-7 shift for any blanks and the audit will be submitted to DON. The ADON and QA nurse will check all Mar's and Tar's weekly for any blanks and report findings at the QAPI meeting monthly to identify areas for improvement or further education. 5/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 122 Shiley (Laryngectomy tube) size #8 uncuffed one time a day for tracheostomy tube; At 4 liters continuous O2 (oxygen) via trach mask for shortness of breath one time a day. " A review of the Treatment Administration Records dated December 2014 January and February 2015 revealed that allotted signature spaces were left blank indicating that Tracheostomy care" was not performed as follows: " Tracheostomy care to be performed every shift and as needed ' was left blank on December 30, 31, 2014 evening shift and January 2, 2015 evening shift. " " Monitor tracheostomy tube and make sure that it is on midline and patent ' three times a day was left blank on January 27, 2015 at 9:00AM and February 4, 2015 at 9:00AM " Keep emergency equipments at bedside one time day for respiratory difficulty ' was left blank on February 1, 2015 at 9:00AM " Start oxygen weaning as tolerated every shift related to tracheostomy status ' was left blank on February 4, 2015 day shift " Shiley (Laryngectomy tube) size #8 uncuffed one time a day for tracheostomy tube ' was left blank on February 1, 2015 at 9:00AM At 4 liters continuous O2 via trach mask for shortness of breath one time a day ' was left blank on January 8, 2015 at 9:00AM	F 328		

F 328 Continued From page 123 F 328

" Suction every shift and as needed every shift for tracheostomy tube ' was left blank on January 22, 2015 day shift

The facility staff failed to consistently follow the physician's order to provide " Tracheostomy care" for Resident # 99.

A face-to-face interview was conducted with Employee # 3 on February 10, 2015 at approximately 1:30 PM. He/she acknowledged the findings. The record was reviewed February 10, 2015.

1B. Facility staff failed to perform G-tube (Gastrostomy Tube) cares as per the physician ' s order for Resident #99.

A review of Resident #99 ' s clinical record revealed an " Interim Order Form " that included the following G-tube order initiated December 27, 2014 that directed:

"Change feeding (spike cap se/bag) every 4pm in the evening
Check for residual every shift, if 100ml or over, HOLD feeding for 1 hour and recheck, if residual 100 or over notify MD document amount in ML, every shift check residual before feeding, Jevity1.5 (5cans/day) plus Prostat, plus free water, five times a day for tube feeding. "
Prosource (Prostat) 30ml to be mix with the Jevity 1.5 given thru G-tube five times a day for tube feeding.
Use gauze to clean G-tube site with soap and water, apply medication as indicated, and cover

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 124 with gauze and each shift every shift. A review of Resident #99 ' s " Treatment Administration Record " [TAR] dated December, 2014, January, 2015 and February, 2015 revealed that the following treatment for " G-tube orders was left blank (indicating that the treatment was not done): "Change feeding (spike cap set/bag) every 4pm in the evening " was left blank on December 30, 31, 2014. " Check for residual every shift, if 100ml or over, HOLD feeding for 1 hour and recheck, if residual 100 or over notify MD document amount in ML, every shift check residual before feeding " was left blank December 28, 2014 evening shift and December 31, 2014 day shift. " Jevity1.5 (5cans/day) plus Prostat, plus free water, five times a day for tube feeding, Prosource (Prostat) 30ml to be mix with the Jevity 1.5 given thru G-tube five times a day for tube feeding was left blank on December 28, 2014 5pm and 9pm, and December 31, 2014 1am, 4am and 9pm. " Use gauze to clean G-tube site with soap and water, apply medication as indicated, and cover with gauze and each shift every shift " was left blank on January 2, 2015 evening shift. The aforementioned TARs lacked evidence that facility staff performed Resident # 99 G-tube orders every shift as per the physician ' s order as evidenced by lack of initials in the space allotted for signature was left blank.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 125 A face-to-face interview was conducted on February 10, 2015 at approximately 1:30 PM with Employee # 3. He/she acknowledged the aforementioned findings. The record was reviewed February 10, 2015.	F 328	F-Tag 329 (1-3) 1. Resident #135 was assessed and did not experience any negative outcome related to failure to stop administering Rozerem as ordered by MD. This drug was later d/cd and Ambien to continue. Plan of care was updated. Medication error report was completed. Employee #25 was in serviced and counselled.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, and staff interviews for three (3) of 51	F 329	Resident #266 was assessed and did not experience any negative outcomes related to failure to implement GDR. The MD was called and order changed to every other day. A medication error report was completed as the nurse failed to follow MD recommendation. Plan of care was updated and family was notified. Resident#388 was assessed and did not experience negative outcome related to continued use of trazodone even though there was a MD order to discontinue and start resident on Risperidal 0.25mg. The nurse notified MD and d/cd trazadone. Plan of care was updated, and RP notified of changes. Medication error report was completed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 126 sampled residents, it was determined that the facility staff failed to keep one (1) resident free from unnecessary doses of Rozerem [hypnotic medication] after it was discontinued; to ensure that a gradual dose reduction (GDR) was attempted with timeliness for the use of Celexa [antidepressant medication] for one (1) resident; and to keep one (1) resident free from unnecessary doses of Trazadone [medication to treat Insomnia]. Residents' #135, #266, and #388. The findings include: 1. Facility staff failed to keep Resident #135 free from unnecessary doses of Rozerem. A review of the Quarterly Minimum Data Set (MDS) dated October 14, 2014 revealed that the resident's diagnoses included Insomnia. A Review of the physician/prescriber's orders dated February 4, 2015 and timed 5:30 PM revealed the following: "D/C [Discontinue] Rozerem (on Ambien) ... " Review of the medication orders on the February 2015 'Order Summary Report' revealed the following: "Rozerem Tablet 8 MG [milligrams] (Ramelteon) [generic for rozerem] Give 8 mg by mouth at bedtime for insomnia. Administer 30 mins [minutes] before bedtime" Review of the Medication Administration Record [MAR] dated February 2015 revealed the following:	F 329	2. All resident have the potential to be affected by these identified deficient practice. All residents on psychotropic drugs will be reviewed to ensure the accurate medication and does is being administered as per MD orders. All pharmacy consultant recommendations will be reviewed ADON once addressed by MD to ensure follow up is done timely. All MD orders will be audited daily by ADON. 3. Staff development will in-service nursing professional staff on care and management of residents on psychotropic medication and the importance of GDR/keeping resident free from unnecessary medication use. All new hires will also be in serviced on the above topic. The IDT will meet monthly to review residents on Psych medication and make recommendation to psychiatrists for dose reduction. The pharmacy recommendations will be addressed by MD and Nursing within 5 days. Any concerns of an immediate nature will be brought to the attention of the DON for resolution within 24 hours. 4. Nursing leadership will audit all orders from previous 24 hours to ensure correct transcription, and follow thru of all orders. UM/ADON submit order audit daily to DON. Findings will be shared at the monthly QAPI meeting.	5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 127	F 329		

"Rozerem Tablet 8 MG. Give 8 mg by mouth at bedtime for insomnia. Administer 30 mins [minutes] before bedtime"

The allotted signature boxes to indicate the medication was administered were signed from February 1, 2015 to February 10, 2015.

There was documented evidence of an order to discontinue Rozerem on February 4, 2015. However, the facility staff administered six (6) additional doses of the medication. There were no adverse effects experienced by the resident documented on the February 2015 'Side Effects Monthly Flow Sheet.'

On February 11, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Resident #135. He/she was asked if he/she had experienced any changes in his/her sleep pattern or orientation status over the past week? He/she replied, "No."

On February 11, 2015 at approximately 12:20 PM, a face-to-face interview was conducted with Employee #25. He/she was asked to explain the order on February 4, 2014. He/she stated, "It says to discontinue the Rozerem on Ambien." When asked what that meant? He/she stated, "It's unclear, but the Ambien was discontinued." The employee was asked if there was an order to continue the Rozerem? He/she stated, "No."

On February 11, 2015 at approximately 12:25 PM, a face-to-face interview was conducted with Employees #4. He/she was asked to explain the order on February 4, 2014. He/she stated, "It reads to discontinue the Rozerem on Ambien."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 128	F 329		

When asked what that meant? He/she stated, "It means to discontinue the Rozerem." He/she acknowledged the aforementioned findings, and added, "It was a misunderstanding, and the resident should be receiving the Ambien, not the Rozerem."

Facility staff failed to keep Resident #135 free from unnecessary doses of Rozerem. The clinical record was reviewed on February 11, 2015.

2. Facility staff failed to ensure that a gradual dose reduction (GDR) was attempted with timeliness for the use of Celexa for Resident #266.

A review of the Order Summary Report" signed and dated December 5, 2014 revealed that Resident #266 was prescribed "Celexa [antidepressant] tablet 10 mg [milligrams] (Citalopram Hydrobromide) Give: 10 mg orally one [1] time a day related to Depressive Disorder..." original order date November 11, 2014.

An interim physician's order dated February 12, 2015 directed: "Change Celexa to 10 mg po Q [every] AM every other day."

A " Pharmacist's Nursing Unit Inspection Report " dated October 23, 2014 revealed, " Could Celexa be considered for a gradual dosage reduction if no untoward behaviors seen? "

The physician/prescriber placed a check mark in the " Agree " box and wrote, " [Decrease] Celexa 10 mg to [Q] every other day. " Signed by the physician and dated October 31, 2014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 129	F 329		

A review of the pharmacy " Drug Regimen Review " revealed the following:

December, 2014- Please evaluate Celexa for a GDR (Gradual Dose Reduction) with no dep [depression] noted on behavior worksheet.

January 5, 2015- Please evaluate Celexa for a GDR (Gradual Dose Reduction) with no dep [depression] noted on behavior worksheet.

February 2, 2015- Please evaluate Celexa for GDR (Gradual Dose Reduction) with no dep [depression] noted on behavior worksheet. "

A review of the clinical record lacked a documented rationale for not attempting a gradual dose reduction. A period of three (3) months [October 2014 to February 2015] lapsed before the pharmacist ' s recommendation for gradual dose reduction was attempted.

A face-to-face interview was conducted with Employees #5 and 12 on February 12, 2015 at approximately 2:00 PM. Both acknowledged the aforementioned findings. The clinical record was reviewed on February 12, 2015.

3. Facility staff failed to keep the resident free from unnecessary drugs as evidenced by Resident #388 receiving excessive doses of Trazadone.

A physician ' s interim order dated February 2, 2015 directed; " Start Risperdal 0.25mg po (by mouth) BID (twice a day) for Dementia with Psychotic Features. Discontinue all previous Trazadone order. " The order was signed off on

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 130 February 2, 2015 at 4:14 PM. A review of the February 2015 Medication Administration Record [MAR] revealed that Resident #388 received Trazadone 50mg on February 2 and 3, 2015 at 9:00 PM. According to the physician's order the resident should not have received Trazadone on February 2 and 3, 2015. There was no evidence that facility staff administered Trazadone in accordance with the physician ' s order. Facility staff failed to keep the resident free from unnecessary drugs. A face-to-face interview was conducted with Employee #11 on February 11, 2015 at approximately 12:30 PM regarding the aforementioned finding. He/she acknowledged the findings. The record was reviewed February 11, 2015.	F 329	F-Tag 353 1.All residents identified with this deficient practice were assessed to ensure that there were no negative physical outcomes to each resident. Those residents no longer living at facility were not able to be assessed. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The Administrator, HR and DON meet weekly and Bi-weekly with corporate via phone to discuss plans for staffing. We discussed open house for staffing. We have had and are having orientation twice a month at minimum and we have hired a new Staffing Coordinator to call in additional staff or agency if needed.	
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	**02/20/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 131 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that facility staff failed to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The findings include: During the recertification survey from February 5 -20, 2015 the following areas of concern were identified: · Failure to ensure that facility staff informed the resident and/or responsible party of available services in the facility and the charges for those services and failure to obtain documented evidence to demonstrate receipt of explanation for the bed hold policy. Cross reference CFR 483.10, F156. · Failure to ensure that facility staff notified the	F 353	2. All other residents were assessed and audits completed to ensure no negative physical outcome resulted to no other residents due the same deficient practice. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Facility continues to recruit and schedule orientation in order to meet the correct daily Nursing PPD. 3. A new staffing coordinator was hired. HR continues to recruit for all positions. Interviews conducted by Nursing Leadership. Orientation held twice a month. The daily PPD ratio is being projected a day in advance. Staffing coordinator was given expectations to have weekly schedule printed and to identify vacancies and fill vacancies in advance. ADON, Nurse Manager in the house continues to meet with staffing coordinator daily to review the schedule to ensure staffing is scheduled as required to meet federal and state guidelines. Daily PPD is now being discussed at Morning stand up meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 132 attending physician that prescribed medications could not be administered because they were unavailable. Cross reference CFR 483.10, F157 · Failure to prevent the neglect of the resident, as evidenced by the staff's failure to provide Activities of Daily Living [ADL] care to a resident. Cross reference CFR 483.13, F224 · Failure to ensure that an employee who was accused of abusing a resident(s) completed a plan of action that was indicated to correct his/her behavior. Cross reference CFR 483.13, F226. · Failure to ensure that facility staff did not perform treatment in an open area for a resident; to ensure that a urine filled receptacle was removed from the resident ' s night stand prior to his/her lunch consumption; and to ensure that staff who entered a resident's room first knocked and obtained permission before entering a resident ' s room. Cross reference CFR 483.10, F246 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that facility staff revised care plans to address resident care needs. Cross reference CFR 483.20, F280 · Failure to ensure that facility staff implemented measures to safeguard a resident from unintentional trauma and dislodgement when it was determined that the resident removed the catheter on two (2) previous occasions; address the neurologist's	F 353	4. Daily staffing PPD to be review by DON to ensure compliance. Staffing report will be brought through the monthly QAPI process to ensure compliance and identify area for improvement. HR department continues to report monthly on staff vacancies.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 133	F 353		

recommendations in a timely manner for a resident, failed to follow the physician ' s ordered plan of care for residents. Facility staff failed to consistently assess residents for pain, obtain and assess the resident ' s vital signs, obtain diagnostic study reports for a resident; demonstrate accurate knowledge of the dialysis access site assessment for several residents receiving dialysis. Failed to ensure that the PICC (peripherally inserted central catheter) line was removed as ordered by the physician for a resident; administer Glucagon [medication used to raise low blood sugar] as ordered by the physician for a resident; and administer Heparin as ordered by the physician for a resident. Cross reference CFR 483.25, F309

· Failure to ensure that a resident that was lying in the bed saturated with urine received necessary services/maintain good grooming and personal hygiene. Cross reference CFR 483.25, F312

· Failure to ensure/maintain a safe environment to prevent accidents and to provide supervision to residents who were left unsupervised. Cross reference CFR 483.25, F323

· Failure to obtain routine dental services regarding denture replacement for a resident. Cross reference CFR483.55, F412

· Failure to ensure that the pharmacy delivered prescribed medications in a timely manner to meet the needs of all residents. Cross reference CFR 483.60, F425

· Failure to ensure that unnecessary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 134 medications were not provided to residents. Cross reference CFR 483.60, F431 · Failure to ensure all essential resident care equipment was in safe operating condition (glucometers) Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 Failure to ensure that facility policies were reviewed annually; to ensure that sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days; and to ensure that linen was at least three times the amount needed for licensed occupancy. Cross reference CFR 483.75, F492 · Failure to ensure that nursing progress notes were completed with a nurse's signature for a resident; ensure that consultation notes and diagnostic results were readily accessible on the active clinical record for a resident; accurately record the location of a wound for a resident; maintain complete dialysis communication forms for two (2) residents; and to accurately document a resident's name on the facility's admission financial document. Cross reference CFR 483.75, F514. · Failure to ensure that the Quality Assurance Committee developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520	F 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 135 According to 3211.5 of the District of Columbia Municipal Regulations, titled ' Nursing Personnel and Required Staffing Level,' "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 ... " A review of the facility's staff ratios from January 31, 2014 to February 15, 2015. revealed an average of 0.46 for registered nurse staffing and 2.9 for overall direct nursing care. Facility staff failed to ensure that sufficient nursing staff was available to provide nursing and related services. On February 20, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #2 regarding the aforementioned staffing levels for the facility. He/she acknowledged the findings. Cross reference CFR 483.75, F492	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations made on February 10, 2015 at approximately 1:40 PM, it was	F 364	F-Tag 364 1.Retrospectively no changes could be accomplished for those residents identified with this deficient practice. 2. All residents have the potential to be affected by this deviant practice if food temperatures are not correct due to staff failure to serve food timely or food services staff getting trays to units timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 136 determined that the facility failed to serve food at the proper temperature as evidenced by hot foods that tested below 140 degrees Fahrenheit and cold food that tested above 40 degrees Fahrenheit (F) from two (2) test trays. The findings include: Food temperatures from test trays tested as follows: Regular diet Grilled chicken = 110 degrees Fahrenheit Rice = 120 degrees F Green beans = 120 degrees F Milk = 44 degrees F Ice cream = 31 degrees F Puree diet Grilled chicken = 120 degrees Rice = 136 degrees F Broccoli = 136 degrees F Bread = 122 degrees Milk = 44 degrees F Ice cream = 32 degrees F These observations were made in the presence of Employee #32 who acknowledged the findings.	F 364	3. Food Services Department (FSD) made adjustment to thermostat in all plate warmers and the pallets warmers are now being turned on at least 1 hour prior to meal service time. Food Services staffs were in-service on plating food and ensuring that each food service truck gets to unit within 10 minutes. Staff on units with assistance of ambassadors will ensure trays are given to residents in a timely manner. FSD devised tools to monitor and track compliance. 4. FSD will continue to monitor and track any and all deficient practices and provide monthly reports to QAPI committee.	5/12/15
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371	F-Tag 371 1. Anusal head were all cleaned immediately by FSD. No residents were affected from this deficient practice. 2. A weekly audit tool will be use to check and clean all anusal heads. No residents were affected by this deficient practice.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 137 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations that were made during a kitchen tour conducted on February 5, 2015, it was determined that the facility failed to prepare and serve food under sanitary conditions as evidenced by two (2) of six (6) fire suppression outlets located above the grill that were soiled with dust. The findings include: 1. Two (2) of six (6) fire suppression outlets were visibly soiled with dust and needed to be cleaned. This observation was made in the presence of Employee #32 who acknowledged the findings.	F 371	3. A weekly audit tool was developed by Food Services Department to check and ensure that all anusal heads are free of debris. Staff were in-serviced on cleaning all ansul heads and completing the audit tool. 4. The audit tool will be brought through QAPI committee monthly to report any deficient practices.	5/12/15
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and	F 412		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 138 must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 51 sampled residents, it was determined that facility staff failed to obtain routine dental services regarding denture replacement for one (1) resident. Resident #211. The findings include: During a face-to-face interview with the resident on February 12, 2015 at approximately 1:00 PM he/she stated that his/her dentures were lost while he/she was hospitalized last year. According to the resident the dentures were left at the facility but upon return from hospitalization could not be located. A face-to-face interview was conducted with Employee #12 at approximately 3:00PM on February 12, 2015. In response to a question regarding the resident ' s dentures the employee stated that he/she was new to the facility and unaware of a problem with the dentures. The employee and this writer reviewed the nurses ' notes and the dental section of the record and found no documentation that addressed either lost and/or replacement dentures. Employee #12 acknowledged the finding. The record was	F 412	F-Tag 412 1.Resident #211 was assessed and did not experience negative outcomes related to failure to obtain routine dental services regarding denture replacement. Resident #211 was seen by Dentist on 2/20/15. 2.All resident with dentures have the potential to be affected by this deficient practice. Medical record conducted an audit of all residents in need for dental consult. Audit turned to DON. 3. Staff were educated on the importance of follow up with all residents with dental issues, to notify physicians immediately to get dental consults,etc. immediately. 4. Results of monthly audits will be reviewed through the QAPI process to identify any opportunities for improvement and education.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 139 reviewed on February 13, 2015.	F 412	F-Tag 425 (1-2)	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview for two (2) of 51 sampled residents, it was determined that the facility failed to provide routine drugs to its residents as evidenced by failure to ensure that the pharmacy delivered prescribed medications in a timely manner to meet the needs of two (2) residents. Residents #211 and 352.	F 425	1.Resident #211, was assessed by unit managers. Resident did not experience any negative outcome related to facilities failure to obtain prescribed medications from the pharmacy timely. Resident #352 no longer resides at the facility. All residents have the potential to be effected by this deficient practice. 2. All other residents' charts were audited to ensure that no other residents were affected by this same deficient practice. 3.Facility has developed a new process to ensure all new residents medications will be delivered to the facility timely by pharmacy, including late hours fax and medication prep for delivery. Dedicated telephone with supervisor on duty to ensure prompt communication to pharmacy. Back up pharmacy will also be utilized in the event of weather related conditions that could delay the delivery of meds from pharmacy. The backup med box in the facility was updated to include a larger list of meds. Policy and procedure for medication availability was revised. Staff development will in-service all license staff on new procedure. Policy and procedure for medication availability was revised. Staff development will in-service all license staff on new procedure. 4. Results of monthly audits will be reviewed monthly through the QAPI process to identify any opportunities for improvement and education.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 140	F 425		

The findings include:

Review of the facility contract provided to the State Agency Representative with [Pharmacy Name] signed by the facility on October 28, 2014 but not signed by the pharmacy stipulates in Article1.3 titled 'Methods of providing services', Section C: "The Pharmacy will deliver Medication and provide services to the Facility seven (7) days a week, 365 days a year, with modified schedules during national holidays based on daily delivery schedule mutually determined by the Facility and the Pharmacy. Emergency delivery of Medications will be done by the pharmacy during normal business hours, except for circumstances beyond the Pharmacy's reasonable control and emergency services will be available after hours through an answering service with a pharmacist on call."

1. Facility staff failed to obtain prescribed medications from the pharmacy for Resident #211.

A review of the resident's clinical record revealed that the resident was discharged to an area hospital on February 6, 2015 and returned to the facility on February 10, 2015 with prescriptions which included:

Spiriva Hand Inhaler Capsules 18mcg [micrograms] 1 puff inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease) with a start date of February 11, 2015 and

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 141 Xarelto tablet 20mg Give one (1) tablet one time a day for DVT (Deep Vein Thrombosis) prophylaxis. Start date February 11, 2015. A face-to-face interview was conducted with the resident at approximately 3:00 PM on February 13, 2015. He/she informed this writer that he/she had not received some of his/her medications for two (2) days on February 11 and 12, 2015. A review of the Medication Administration Record (MAR) revealed that the nurse's signature was circled in the designated area to indicate that the Spiriva Hand Inhaler and Xarelto were not administered as ordered on February 11, and February 12, 2015. A face-to-face interview was conducted with Employee #12 at approximately 4:00 PM on February 13, 2015. The employee was asked why the resident had not received his/her medications as ordered by the physician. The employee responded: "The medications were not given because they were not received from the pharmacy. They are here now and the resident received them today". The employee acknowledged the finding. The record was reviewed on February 13, 2015. 2. The facility's contract pharmacy failed to deliver medications in a timely manner for Resident #352. A review of the Physician's Order signed and dated by the physician on October 5, 2014 revealed:	F 425		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 142 " Bidil [antihypertensive] 20-37.5mg [milligrams] BID [two times a day] take one tab PO [by mouth] BID - Hypertension " On the back of the MAR documentation revealed: "10/06/2014 0900 meds not given. Pharmacy did not send the meds. Pharmacy was called and they said the meds will be send [sent] tomorrow"; "10/06/2014 1800 Bidil 20-37.5mg not given , medication not available pharmacy notified" A Physicians Order signed and dated by the physician on October 5, 2014 revealed: "Coreg (Carvedilol)[antihypertensive] oral 6.25mg BID [two times a day] Take 1 tab PO BID - HTN " " Wellbutrin (Bupropion Hcl)[antidepressant] - Oral By mouth Dose 150mg BID two times a day Take 1 tab PO BID depression " " Lisinopril [antihypertensive] - Dose 5 mg Take 1 tab PO Daily Hypertension " " Plavix (Clopidogrel Bisulfate)[anti-platelet] Take 1 tab PO Daily CHF " " Abilify (Aripiprazole)[antidepressant] 15mg Take 1 tab PO daily - depression " On the back of the MAR documentation revealed, "10/06/2014 0900 Meds were not given - pharmacy did not send it. Pharmacy was called and they said it will be sent tomorrow " The Physicians Order signed and dated by the physician on October 5, 2014 revealed: " Glipizide[anti-diabetic] 5mg Take 1 tab PO daily Diabetes Mellitus "	F 425		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 143 On the back of the MAR documentation revealed, " 10/06/2014 0900 Meds were not given - pharmacy did not send it. Pharmacy was called and they said it will be sent tomorrow " " Lipitor (atorvastatin) [anti-cholesterol] 40mg bed time hs take 1 tab PO daily - hyperlipidemia " On the back of the MAR documentation revealed, " 10/06/2014 2100 Lipitor not given, medication not available pharmacy notified " " Glipizide [anti-diabetic] ER tablet Extended Release 24 hour 2.5mg Give 2.5mg by mouth one time a day for diabetes " On the back of the MAR documentation revealed: "10/11/2014 0900 Pharmacy did not send Glipizide 2.5mg. Pharmacy was called and it will be send tomorrow; 10/12/2014 0900 Glipizide was not send as promised by pharmacy. Nurse has called pharmacy and fax the order; 10/18/2014 0900 Pharmacy did not send Glipizide 2.5mg. Pharmacy was informed " A face-to-face interview was conducted with Employee #53 on February 11, 2015 at approximately 1:30 PM. He/she acknowledged the aforementioned findings. Facility staff failed to obtain Resident #352' s prescribed medications for administration from the contract pharmacy. The record was reviewed on February 11, 2015.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 144 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 51 sampled residents it was determined that the facility staff failed to maintain the resident's highest practicable level of functioning related to medication therapy as evidenced by failure to review, and make recommendations for one (1) resident regarding the use of a medication with a component to which the resident was allergic. Resident #211. The findings include: A review of the clinical record revealed a physician's order for Xopenex (Levalbuterol HCL) Nebulization Solution 1.25mg/3ml[milligrams per millileter] (Levalbuterol HCL) 1.25mg, inhale orally via nebulizer every 6hrs [hours] for COPD (Chronic Obstructive Pulmonary Disease). The medication was last ordered on February 10, 2015 when the resident returned from a recent hospitalization. The original order date for the medication was September 29, 2014. A review of the list of Allergies in the resident's Order Summary Report dated January 6, 2015	F 428	F-Tag 428 1.Resident #211 was assessed and did not exhibit negative outcomes from failure to review and make recommendations regarding the use of a medication with a component to which the resident was allergic. Pharmacist consultant reviewed resident #211 records and documented appropriately. 2.All residents have the potential to be affected by the deficient practice of using medications with a component to which the resident was allergic. Pharmacist consultants will review all residents' records and document properly. Pharmacist consultants and DON had a meeting, DON emphasized required documentation and follow up timely in residents records when areas of concern are identified. 3.Pharmacist consultants will exit with DON monthly and provide results of consult with specific regards to any resident identified with the use of medication with a component to which resident was allergic. Pharmacist consultant at the time will present a copy of the documentation with regards to risk and benefits 4.Compliance with follow through will be monitored monthly through the QAPI process by the DON and quarterly by the Pharmacist consultants. 5/12/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 145 identified "Albuterol" among the resident's allergies. A review of the Medication Regimen Review documented by the licensed pharmacist did not include the pharmacist's acknowledgement of the resident's allergy to Albuterol, or concerns related to Albuterol as an ingredient in Xopenex which the physician prescribed for the resident. A telephone interview was conducted with the licensed pharmacist on February 19, 2015 at approximately 1:00 PM. The pharmacist was asked whether he/she was aware that it was documented that the resident was allergic to Albuterol and was receiving Openex (Levalbuterol) which comprises Albuterol. He/she responded: "Yes". He/she was asked whether he/she had mentioned the resident's allergy and its relation to the Xopenex in any of his/her reports. He/she responded: "No, I did not..." and added that Xopenex is the least reactive and that the resident's allergic response was about palpitations. further, he/she stated that the resident was on a beta blocker. He/she acknowledged the finding. The pharmacist failed to review and make recommendations for one (1) resident's use of Xopenex (Levabuterol) as it related to the resident's documented allergy to Albuterol. Facility staff failed to maintain the resident's highest practicable level of functioning related to the resident's medication therapy.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 146 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of medication storage, clinical record review, and staff interviews for one (1) of 51 sampled residents, it was determined	F 431	F-Tag 431 (A) 1.Resident #135 did not have any negative outcome from discontinued Ambien card left in narcotic box after the medication was discontinued in error. The medication Ambien that was discontinued in error was re-ordered and resident continued to receive the Ambien. 2.All residents have the potential to of being affected with this deficient practice of discontinuing a narcotic in error and not removing the medication cart from the narcotic box timely. 3. Incident report on medication error for the discontinued ambient was done. The staff responsible for the medication error was educated and counseled. Night Nurses to do audits daily ensuring discontinued medication are removed from the medication cart. Nurse Managers and ADONs audit medication carts daily and remove discontinued narcotics from the medication cart. Discontinued narcotics are given to the DON for destruction with the ADON. 4.Audits will be reviewed by the ADONs and turned into the DON weekly. Compliance with follow through will be monitored through the QAPI process. 5/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 147 that the facility staff failed to maintain controlled medications and biologicals in accordance with currently accepted professional principles as evidenced by: staff failing to maintain Ambien [hypnotic medication] stored on the narcotic cart and available for the resident, as evidenced by Ambien labeled as "D/C'ed [discontinued] and stored for disposal; staff failed to provide documented evidence that the code carts were monitored daily on two (2) of eight (8) units; and staff failed to maintain the code cart [emergency cart] in the rehabilitation department secured and accessible only to designated staff. Resident #135. The findings include: A. Facility staff failed to maintain Ambien [hypnotic medication] stored on the narcotic cart and available for Resident #135. A review of the Quarterly Minimum Data Set (MDS) dated October 14, 2014, revealed that the resident's diagnoses included: End Stage Renal Disease, Insomnia, Cerebrovascular Disease, Diabetes Mellitus, Gastroparesis, Hypertension, Anemia, Depressive Disorder, Dysphagia, and Hyperlipidemia. On February 11, 2015 at approximately 12:05 PM, a medication storage observation was made. During the narcotic count, Ambien was noticed to have "D/C'ed [Discontinued] " labeled on the package. When asked when it was discontinued, Employee #25 responded, "February 5, 2015." When questioned about the policy on discontinuation of narcotics, he/she stated, " ...we keep it stored here for disposal, until the ADON [Assistant Director of Nursing] and the	F 431	F-Tag 431 (B,C) 1. The code cart was secured immediately after being found by the surveyor that day. Nothing could be done retrospectively for carts not being monitored daily. No other residents were affected by the deficient practice. 2. Cart will be locked and check daily to ensure that no resident will have access to it's content. No other residents were affected by this deficient practice. 3. A check list was done to ensure the cart is being checked daily by nursing. The cart will be checked daily by the Director of Rehab or a rehab tech, wherever Rehab is open. Education was given to staff about the importance of securing and checking the crash cart daily. 4. The checklist will be monitored by the DOR and ADONs on a weekly basis to ensure compliance and any deficient practices will be reported monthly to QAPI Committee. 5/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 148	F 431		

DON [Director of Nursing] take them and dispose of them. The ADON is aware that they have been discontinued and are here. We just wait until they come get them..."

Review of the physician/prescribers orders dated February 4, 2015 and timed 5:30 PM revealed the following:
"D/C [Discontinue] Rozerem (on Ambien)..."

Review of the Medication Administration Record [MAR] dated February 2015 revealed the following:
"Zolpidem Tartrate Tablet 10 MG Oral (By mouth) Every evening at bedtime 10 MG Tablet Oral (By mouth) Insomnia Zolpidem 10 MG"

The allotted signature boxes to indicate the medication was administered were signed from February 1, 2015 to February 5, 2015. Thereafter, " D/C " was documented in the boxes.

There was no documented evidence of an order to discontinue the Zolpidem Tartrate. However the facility discontinued the medication on February 5, 2015; labeled the container "D/C'ed," and stored it in the narcotic cart for disposal.

On February 11, 2015 at approximately 12:20 PM, a face-to-face interview was conducted with Employees #25. He/she was asked to explain the order of February 4, 2014. He/she stated, "It says to discontinue the Rozerem on Ambien." When asked what that meant? He/she stated, " It ' s unclear, but the Ambien was discontinued."

The employee was then asked to display the order to discontinue the Ambien. He/she stated, "I don't see the order to discontinue the Ambien."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 149	F 431		

On February 11, 2015 at approximately 12:25 PM, a face-to-face interview was conducted with Employee #4. He/she was asked if he/she was aware that the Ambien was stored in the narcotic box for disposal. He/she stated, "Yes, but I am waiting for [named the ADON] to become available and we will dispose of them. He/she was asked to explain the order on February 4, 2014. He/she stated, "It reads to discontinue the Rozerem on Ambien." When asked what that meant? He/she stated, "It means to discontinue the Rozerem."

When asked if the order was to discontinue the Ambien, he/she replied, "No." When asked if the resident was receiving the Ambien, as ordered? He/she stated, "No, I will clarify the order with the nurse practitioner."

He/she acknowledged the aforementioned findings and later stated, "It was a misunderstanding, and the resident should be receiving the Ambien, not the Rozerem."

Facility staff failed to maintain Ambien stored on the narcotic cart and available for the resident. The clinical record was reviewed on February 11, 2015.

B. Facility staff failed to provide documented evidence that the code carts were monitored daily on two (2) of eight (8) units reviewed.

According to the facility policy titled, 'Protocol for Checking the Crash Cart [code cart', "...Every day at the beginning of every shift, the unit assigned charge nurse will break the sealed lock on the crash cart and check each drawer for supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 150 Each drawer on the crash cart will be checked by the incoming charge nurse to ensure that every item listed is present in the cart..." On February 18, 2015 at approximately 2:00 PM, a medication storage observation was made on the 2 North / 2 South units. A review of the 'Crash Cart Emergency Equipment Check List' revealed that on the day shift of February 18, 2015, the allotted spaces for the staff to document and sign that the cart check was performed, were left blank, which indicated that the code cart was not checked on that shift. On February 18, 2015 at approximately 2:05 PM, a face to face interview was conducted with Employee #47 regarding the aforementioned findings. He/she stated, "I checked the cart, but I forgot to sign." On February 18, 2015 at approximately 2:10 PM, a face to face interview was conducted with Employee #3 who acknowledged the aforementioned findings. On February 18, 2015 at approximately 2:20 PM, a medication storage observation was made on the 4 North/ 4 South units. A review of the 'Crash Cart Emergency Equipment Check List ' revealed that on the evening shift of January 29 and 31, 2015 and on the night shift of January 31, 2015, the allotted spaces for the staff to document and sign that the cart check was performed, were left blank, which indicated that the code cart was not checked on those shifts. On February 18, 2015 at approximately 2:25 PM, a face to face interview was conducted with Employees #5 and 12. Both acknowledged the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 151	F 431		

aforementioned findings.

Facility staff failed to provide documented evidence that the code carts were monitored daily. The records were reviewed on February 18, 2015.

C. Facility staff failed to maintain the code cart in the rehabilitation department secured and accessible only to designated staff.

According to the facility policy titled, 'Protocol for Checking the Crash Cart', "...Every day at the beginning of every shift, the unit assigned charge nurse will break the sealed lock on the crash cart and check each drawer for supplies. Each drawer on the crash cart will be checked by the incoming charge nurse to ensure that every item listed is present in the cart. (Rehab [rehabilitation] crash cart will be checked by an assigned rehab staff daily) ...The cart will then be locked with the sealed lock again and be ready for use ..."

On February 18, 2015 at approximately 2:40 PM, the medication storage observation in the Rehabilitation Department revealed that the code cart was left unsecured, without a sealed lock, and accessible to others.

On February 18, 2015 at approximately 2:50 PM, a face to face interview was conducted with Employee #23 who acknowledged the aforementioned findings.

Facility staff failed to maintain the code cart in the rehabilitation department secured, locked, and accessible only to designated staff.

F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441 SS=D	Continued From page 152 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F-Tag 441 (1) 1. The hand soap was replaced in soiled utility room immediately. No residents were affected by this deficient practice. 2. Housekeep Manager went into all other soiled utility rooms to ensure the soap dispensers all had soap. No other deficiencies were found. No other residents affected by this deficient practice. 3. Housekeeping manager will do weekly checks of random units to ensure no deficient practices are found. All housekeeping staff were in-serviced on the importance of keeping soap dispensers filled in soiled utility rooms. 4. Housekeeping manager will bring any and all deficient practices through monthly QAPI committee .	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 153 This REQUIREMENT is not met as evidenced by: +Based on observations and staff interview for two (2) of 51 sampled residents, it was determined that facility staff failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced failure to; prevent cross contamination of food during a dining observation for one (1) resident, and provide soap in the soiled utility room to sanitize hands following a wound treatment for one (1) resident. Residents' #254 and #104. The findings include: 1. Facility staff failed to practice in a manner that would decrease the spread of infection as evidenced by not having hand soap in the soiled utility room following a wound treatment for Resident #104. Following a wound care treatment an observation conducted on February 11, 2015 at approximately 1:00 PM for Resident #104 Employee #50 entered the soiled utility room to discard soiled items used during the wound treatment. When the employee attempted to sanitize his/her hands, it was observed that there was no soap in the soap dispenser. Employee #50 had go to another location to sanitize his/her hands. This	F 441	F-Tag 441 (2) 1. Resident #254 did not experience any negative outcome related to facility staff failing to prevent cross contamination of food during a dinning observation. Employee # 45 educated by Nurse Manager and ADON provided education on the prevention of cross contamination of food. 2. All residents have the potential to be affected by the staff failing to prevent cross contamination of food. ADONs and Staff Development will review the infection control guidelines and protocols for nursing staff. Education will be provided as need. 3. Nursing Leadership will provide monthly education on infection control guidelines and protocols to ensure compliance. Nursing Leadership and staff Development will review the infection control guidelines and protocols to ensure compliance with state and federal guideline requirements for the prevention of cross conation of food. Ambassador rounds weekly. 4. Results of the Ambassador rounds tool will be reviewed by the QAPI Nurse and brought to the monthly QAPI meeting to ensure compliance. Education will be provided as necessary.	5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 154 finding was acknowledged by Employee #50 at the time of the observation. 2. Facility staff failed to prevent cross contamination of food during a dining observation for Resident #254. During a dining observation conducted on February 6, 2015 with Employee #45 at approximately 1:15 PM. The following was observed: Resident #254 required feeding assistance with his/her meal. After preparing the set up for feeding. Employee #45's cell phone rang Employee #45, using ungloved hands, reached into his/her pocket, retrieved the cell phone and turned it off. The employee then proceeded to feed the resident a piece of bread from [his/her] meal tray without first sanitizing his/her hands. A face-to-face interview was conducted with Employees #9 and 45 on February 18, 2015 at approximately 1:00 PM. Both employees acknowledged the findings.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	F-Tag 456 1.All Diabetics residents were assessed and did not experience any negative outcome related to facility to ensure glucometer controls were performed. 2.All Diabetic residents have the potential to be affected by facilities failure to ensure glucometer control have been performed. All other quality Control sheets were audited. 3. Vendor supplying glucometer in-service all staff on how to calibrate glucometer. Nursing leadership monitor glucometer control sheet daily 4.Audits will be brought to the monthly QAPI meeting to ensure compliance. Education will be provided as necessary.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 155 This REQUIREMENT is not met as evidenced by: Based on the medication storage observation, clinical record review, and staff interviews, it was determined that the facility staff failed to ensure all essential resident care equipment was in safe operating condition, as evidenced by the staff's failure to ensure glucometer controls were performed daily on the 2 South Unit. The findings include: According to the facility policy titled, 'Blood Glucose Monitoring,' "Quality control is coordinated between the nursing staff daily ...Results of the daily control record will be at the nursing station in the facility." On February 11, 2015 at approximately 1:50 PM, the medication storage observation on the 2 South unit revealed that the quality control for glucometer labeled #427711038005464 was not performed on the following days: November 4, 2014, December 28, 2014, and January 22, 23, and 24 - the allotted spaces to record the results on the 'Daily Quality Control Record' were left blank. There was no documented evidence of a 'Daily Quality Control Record' for August 2014 through January 2015 for the glucometer labeled #3214277100004. Additionally, the allotted spaces to record the results on the 'Daily Quality Control Record' were left blank on February 1, 2015 to February 6, 2015. On February 11, 2015 at approximately 2:00 PM, a face to face interview was conducted with Employee #27 who stored glucometer #427711038005464 on his/her medication cart.	F 456		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 156 He/she acknowledged the aforementioned findings and shared that he/she had the training eight months ago, but did not know how to perform the quality control checks because "it' s performed on the night shift." On February 11, 2015 at approximately 2:05 PM, a face to face interview was conducted with Employee #26 who stored glucometer #3214277100004 on his/her medication cart. He/she acknowledged the aforementioned findings and admitted although he/she had training in November, he/she did not know how to perform the quality control for the glucometer. Employees #6 and 28 acknowledged the aforementioned findings. The records were reviewed on February 11, 2015.	F 456		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations made on February 11, 2015 at approximately10:30 AM, it was determined that the facility failed to equip a resident's bedroom with curtains designed to provide full visual privacy for each resident as	F 460	F-Tag 460 1. Both privacy curtains that were too short were replaced immediately by housekeeping staff. 2. All other rooms' privacy curtains were inspected to ensure that no others were found to be too short. No other residents were affected by this deficient practice. 3. Housekeeping manager will do weekly checks of privacy curtains with his audit tool to ensure no other curtains are inappropriately placed in wrong rooms. All housekeeping staff were in-serviced on the importance of having appropriate privacy curtains in residents rooms. 4 The audit tool will be brought through monthly to QAPI committee and all deficient practices reported by housekeeping manager.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 460	Continued From page 157 evidenced by privacy curtains in one (1) of 53 residents' room that were too short to provide full visual privacy when fully extended. The findings include: Two (2) of two (2) privacy curtains in room # 528 were too short to provide full privacy to residents. These observations were made in the presence of Employee #18 and Employee #36 who confirmed the findings.	F 460	F-Tag 463 (A, B1, B2) 1. The call bells were fixed immediately by Maintance staff. All call bells were unwrapped immediately. 2 call bells in the 5th floor shower room were repaired immediately on February 6th 2015 by maintenance staff. Facility contractor Fine Wire Solutions were asked to come in and fix call bell system per unit. 2. All other call bells were checked by the Director of Maintenance to ensure no other residents were affected by this deficient practice. Fine Wire Solutions fixed the call bells on all units to ensure staff could no longer turn off call lights at nursing station. Contractor also placed enunciator panels in the front of each nurse's station to ensure they can hear when call bells sounds. 3. A daily room audit check list to include call bells will continue to be used to ensure call lights are operational. Maintenance staff after conducting daylily tours will provide audit tools to the director who will check findings and address. Maintenance was in serviced on the importance of functional and operational call bells for all residents. Nursing staff was in serviced to respond to call lights immediately and to place any issues with call lights in Reqqer maintenance system immediately and not to wrap call bells around railings in resident rooms or bathrooms. 4. Maintenance Director and nursing will report all and any deficient findings to monthly QAPI Committee.	5/12/15
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: A. Based on observations made during initial tour on February 5, 2015 and on February 11, 2015 between 10:30 AM and 3:00 PM, it was determined that the facility failed to maintain residents' call bell system in good working condition as evidenced by call bells in four (4) of 53 residents' rooms that did not emit an alarm when tested and two (2) of three (3) call bells in the female bathroom on the fifth floor that were wrapped around the grab bar and failed to initiate an alarm when tested.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 158	F 463		

The findings include:

Resident call bells did not operate as intended in four (4) of 53 residents' rooms including rooms # 320C, 335A, # 507A and # 520A, B, D.

Two (2) of three (3) call bells located in the female bathroom on the fifth floor were wrapped around the grab bar and failed to initiate an alarm when tested.

These observations were made in the presence of Employee #18 and Employee #36 who acknowledged the findings.

B. Based on record review, staff and resident interviews for two (2) of 51 sampled residents, it was determined that facility staff failed to ensure that all portions of the residents' Call System functioned when triggered in one (1) room which accommodated four (4) residents. Two of the call bells Residents #163 and 322. (Beds A & C. Bed B was vacant and the resident for Bed D was ambulatory and out of the room during the interview.)

The findings include:

1. Facility staff failed to ensure that all portions of Resident #163's Call System functioned when triggered.

On February 6, 2015 at approximately 2:00 PM during a face-to-face interview with Resident

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 159	F 463		

#163, he/she stated concerns that his/ her call bell was not working so he/she wrote a note to the Employee #1 requesting assistance.

Resident #163 stated that on repeated occasions he/she pressed the call bell to call for help from the facility staff, but after a while, noticed that no one came. He/she added that as a result, he/she waited for long periods before receiving the help he/she needed.

A face-to face interview was conducted with Employee #4 on February 9, 2015 at approximately 11:00 AM. When queried regarding the functioning of the Residents ' Call System, he/she stated that the visual indicator is usually illuminated above the door of the resident's room accompanied by as a sound from the nurses' station when the call bell was activated. He she added that when the call bells are activated the visual indicator and the audible alarm should be seen and heard by staff.

Additionally, on February 9, 2015 at approximately 12:33 PM, a face-to face interview was conducted with Employee #36 regarding his/her awareness of problems, he/she provided the following documentation: " ... I did my investigation in why the call bell in [Room] 329 bed A and C was [were] not working on 1/28/15. The reason is after investigating Maintenance found that the nurses locked out the call bell in room 329 from the system at the nurse ' s ['] station so that the resident[s] cannot call them every few minutes. "

2. Facility staff failed to ensure that all portions of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	Continued From page 160 Resident #322's Call System functioned when triggered. On February 6, 2015 at approximately 10:30 AM during a face-to-face interview with Resident #322, he/she stated that his/ her concerns regarding the call bell started approximately one (1) month ago. Resident #322 added that he/she pressed the call bell to call for help but after a while, noticed that no one came. A face-to face interview was conducted with Employee #4 on February 9, 2015 at approximately 11:00 AM. When queried regarding the functioning of the Residents ' Call System, he/she stated that the visual indicator is usually illuminated above the door of the resident ' s room accompanied by a sound from the nurses ' station when the call bell was activated. He/ she added that when the call bells are activated the visual indicator and the audible alarm should be seen and heard by staff. Additionally, on February 9, 2015 at approximately 12:33 PM, a face-to face interview was conducted with Employee #36 regarding his/her awareness of problems with the call bells. He/she provided the following documentation: " ... I did my investigation why the call bell in [Room] 329 beds A and C was [were] not working on [January 28, 2015]. The reason is, after investigating Maintenance found that the nurses locked out the call bell in room 329 from the system at the nurse ' s ['] station so that the resident[s] cannot call them every few minutes. "	F 463		
F 490	483.75 EFFECTIVE	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490 SS=D	Continued From page 161 ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined that the administration failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety as evidenced by a failure to ensure that resident rights were consistently maintained, to ensure that resident assessments were accurate, initiated and revised as necessary, to ensure that residents attained/maintained the highest practicable physical, mental and psychosocial well-being; ensure that a program was designed to provide a safe, sanitary and comfortable environment; to ensure that sufficient staff was available to provide quality care and services, to ensure that pharmacy services were consistently available to provide routine medications in order to meet the needs of the residents, to implement policies and procedures to prohibit mistreatment and neglect of residents, to ensure that the resident call system was maintained in a safe and operating condition, failed to comply with state and local laws and regulations, failed to maintain clinical records, and provide a program for quality assessments and assurance that implemented plans of action to correct identified quality deficiencies.	F 490	F-Tag 490 1. All residents identified in the statement of deficiencies were assessed and no negative outcomes resulted from any of the deficient practices. Residents are no longer living at the facility were not able to be assessed. 2. All audits were completed for residents having this deficient practice. If and when additional residents were identified corrective action occurred immediately. All residents have the potential to be affected by this deficient practice. 3. System changes to ensure integration, Coordination and monitoring of facility Practices related to resident care and safety Include: hiring a second RN in Staff Development to ensure better education and training of staff to include return demonstration and pre and post test for in-service education. Hiring a new Staffing Coordinator to assist with ensuring staffing and monitoring of vacant positions. Hiring additional Unit secretaries one for each unit to assist with all facility audits. Creating a separate budget for transportation aids in order not to pull CNAs from in-house PPD staffing. Sending all ADONs for manager training to ensure they know about coaching employees bring about desired outcome. Having two or more orientations monthly and doing several open houses per year to ensure appropriate staffing levels. Creating more audit tools. Education and training all staff. increasing sample sizes for all departments when auditing. Monitoring department heads monthly activity and have them doing monthly reporting to ensure they capture pertinent info to report to monthly QAPI.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 162 The findings include: During the recertification survey from February 5 -20, 2015 the following areas of concern were identified: · Failure to ensure that facility staff informed the resident and/or responsible party of available services in the facility and the charges for those services and failure to obtain documented evidence to demonstrate receipt of explanation for the bed hold policy. Cross reference CFR 483.10, F156. · Failure to ensure that facility staff notified the attending physician that prescribed medications could not be administered because they were unavailable. Cross reference CFR 483.10, F157 · Failure to prevent the neglect of the resident, as evidenced by the staff's failure to provide Activities of Daily Living [ADL] care to a resident. Cross reference CFR 483.13, F224 · Failure to ensure that an employee who was accused of abusing a resident(s) completed a plan of action that was indicated to correct his/her behavior. Cross reference CFR 483.13, F226. · Failure to ensure that facility staff did not perform treatment in an open area for a resident; to ensure that a urine filled receptacle was removed from the resident ' s night stand prior to his/her lunch consumption; and to ensure that staff who entered a resident's room first knocked and obtained permission before entering the resident ' s room. Cross reference CFR 483.10, F246 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279	F 490	4.The Administrator, DON and QAPI nurse have developed new structure for QAPI process. Environmental services to order twice the amounts of supplies and linen monthly and report to QAPI nurse. New QAPI tools developed for each department effected by the deficient practices. New tool will be used to monitor the performance Improvement plans and to identify areas for improvement. An Increase in sample size for auditing to cover facility census was implemented. Further education and/or training will be provided when identified by quarterly QAPI committee meetings.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 163 · Failure to ensure that facility staff revised care plans to address resident care needs. Cross reference CFR 483.20, F280 · Failure to ensure that facility staff implemented measures to safeguard a resident from unintentional trauma and dislodgement when it was determined that the resident removed the catheter on two (2) previous occasions; address the neurologist's recommendations in a timely manner for a resident, failed to follow the physician ' s ordered plan of care for residents. Facility staff failed to consistently assess residents for pain, obtain and assess the resident ' s vital signs, obtain diagnostic study reports for a resident; demonstrate accurate knowledge of the dialysis access site assessment for several residents receiving dialysis. Failed to ensure that the PICC (peripherally inserted central catheter) line was removed as ordered by the physician for a resident; administer Glucagon [medication used to raise low blood sugar] as ordered by the physician for a resident; and administer Heparin as ordered by the physician for a resident. Cross reference CFR 483.25, F309 · Failure to ensure that a resident that was lying in the bed saturated with urine received necessary services to maintain good grooming and personal hygiene. Cross reference CFR 483.25, F312 · Failure to maintain a safe environment to prevent accidents and to provide supervision to residents who were left unsupervised. Cross reference CFR 483.25, F323 · Failure to obtain routine dental services regarding denture replacement for a resident. Cross reference CFR483.55, F412 · Failure to ensure that the pharmacy delivered prescribed medications in a timely manner to	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 164 meet the needs of all residents. Cross reference CFR 483.60, F425 · Failure to ensure that unnecessary medications were not provided to residents. Cross reference CFR 483.60, F431 · Failure to ensure all essential resident care equipment was in safe operating condition (glucometers) Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · Failure to ensure that facility policies were reviewed annually; to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days; and to ensure that linen was at least three times the amount needed for licensed occupancy. Cross reference CFR 483.75, F492 · Failure to ensure that nursing progress notes were completed with a nurse's signature for a resident; ensure that consultation notes and diagnostic results were readily accessible on the active clinical record for a resident; accurately record the location of a wound for a resident; maintain complete dialysis communication forms for two (2) residents; and to accurately document a resident's name on the facility's admission financial document. Cross reference CFR 483.75, F514. · Failure to ensure that the Quality Assurance Committee developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520	F 490	F-tag 492 (1)	
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	F 492	1.The annual review form for the Nursing policy and procedure manual has been revised and signed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 165 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: A.Based on observations, policy/record review, and interviews, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by the staff's failure to: provide evidence that facility policies were reviewed annually; ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days; to ensure that linen was at least three times the amount needed for licensed occupancy, and to ensure that the nurse staffing agency utilized by the facility was licensed in the District of Columbia. The findings include: 1. Facility staff failed to provide evidence that facility policies were reviewed annually. According to 3206.3 of the District of Columbia Municipal Regulations, "Policies shall be reviewed by the committee at least annually with written notations, signatures, and dates of review." On February 18, 2015 at approximately 3:15 PM, during a policy review, it was revealed that the policies in the policy manual list numbered	F 492	2.A copy of the annual review form for the nursing policy and procedure manual will be turned into the Administrator upon the day of review. 3.The D.O.N will ensure that the Nursing policy and procedure review form will be updated annually and turned into the Administrator for review. 4. This will be brought through the QAPI process annually to ensure compliance. 5/12/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 166	F 492		

"NSD04-001 to NSD04-160" had blank areas in the "Date Reviewed," "Date Revised," and "Date Approved " spaces allotted for facility documentation. The policies lacked evidence of documented notations, signatures, and dates of review.

On February 18, 2015 at approximately 3:30 PM, a face-to -face interview was conducted with Employee #1 regarding the aforementioned findings. He/she explained that they have a signature page in the original policy book that was signed and dated. He/she provided the signature page for review. When asked about the written notations and revisions, he/she did not provide the requested information.

Facility staff failed to provide evidence that facility policies were reviewed annually. The policies were reviewed on February 18, 2015.

3. Facility staff failed to ensure sufficient nursing staff was available to provide nursing and related services to attain/maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days.

According to 3211.5 of the District of Columbia Municipal Regulations, titled ' Nursing Personnel and Required Staffing Level, ' "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 ... "

The facility failed to ensure that there was

Provider's Plan of Correction:

F-Tag 492 (2) said 3 on 2567

1. Retrospectively nothing can be done for those residents affected by this deficient practice as the facility failed to provide sufficient nurse staffing ratios from January 31 to February 15, 2015.

2.Because the facility failed to provide sufficient nursing staff ratios all other residents have the ability to be affected by this deficient practice.

3. The Administrator has asked the corporate office to looking into items affecting the facilities ability to retain staff and keep staff. Also to ensue that we have sufficient amounts of CNAs we must create a separate budget for transportation aids to stop using CNAs from the units which we need to keep out staffing ratios up. We did hire more RNs and LPNs in march and will continue to recruit and hire. We plan to have an open house in late April to assist with hiring as well.

4. The Human Resources Director will continue to provide updated position controls to the Administrator and she will track and trend and report any deficiencies to the monthly QAPI committee. 5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 167	F 492		

sufficient registered nurse staffing and total nursing staffing from January 31, 2014 to February 15, 2015, as indicated below:

	Registered Nurse Staffing	Total Nursing Staff
January 31, 2014	0.46	2.66
February 1, 2015	0.46	2.80
February 2, 2015	0.43	3.09
February 3, 2015	0.35	2.83
February 4, 2015	0.40	3.09
February 5, 2015	0.44	2.80
February 6, 2015	0.57	3.22
February 7, 2015	0.27	3.15
February 8, 2015	0.38	3.50
February 9, 2015	0.52	3.11
February 10, 2015	0.50	3.28
February 11, 2015	0.38	3.50
February 12, 2015	0.36	2.68
February 13, 2014	0.36	2.61
February 14, 2015	0.50	2.70
February 15, 2015	0.42	2.82

F-Tag 492 (3)

1. Retrospectively nothing could be done as the facility did not have 3 pars of linen in the building. We placed an order for additional linens on March 1, 2015.

2. All other residents had the potential to be affected by this deficient practice until 3 pars of linen are in the building.

3. Regional Housekeeping manager assured administrator that bimonthly purchases will be made to ensure we have a continuous flow of linen into the facility. The administrator did request for an additional 3 par to be purchased by housekeeping contractor. We have received the extra linen. Manager was educated on PAR Levels.

4. A linen audit will be brought through monthly QAPI committee to ensure any deficient practices reported by housekeeping manager. 5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 168 A review of the facility's nursing staffing ratios from January 31, 2014 to February 15, 2015. revealed an average of 0.46 for registered nurse staffing and 2.9 for overall direct nursing care. On February 20, 2015 at approximately 4:00 PM, a face-to-face interview was conducted with Employee #2 regarding the aforementioned findings. After review of the above he/she acknowledged the findings. Facility staff failed to ensure that sufficient nursing staff was available to provide nursing and related services to all residents within the facility. Cross referenced in 483.13 (c), F224. 3. Facility staff failed to ensure that linen was at least three (3) times the amount needed for licensed occupancy. According to 3254. 5 of the District of Columbia Municipal Regulations, "The linen supply shall be at least three (3) times the amount that is needed for the licensed occupancy." The Resident Council Meeting Minutes dated December 10, 2014 revealed the following: "Issue/Discussion - Noted that the units are not getting enough wash towels and linen sent to the unit." On February 12, 2015 at approximately 12:15	F 492	F-tag 492 (4) 1.The nurse staffing agency does have a license in the District of Columbia. On the day the surveyor inquired we did not have a copy of the license in the facility. A copy of the license is on file. No resident were affected by this deficient practice. 2.All residents have the potential to be affected by the deficient practice. The nurse staffing agency Align Staffing's legal name is RehabPlus Group, inc doing business as Align staffing which is how the license is registered. When the surveyor looked up the license one did not exist for align staffing because the license is under the name Rehab Plus Group. 3.The Corporate office is responsible for ensuring that all contracts signed are appropriate and that all license, insurance information etc is up to date and in compliance for the facility. The Administrator will ensure that all such contracts and accompanying paper works are in order in the facility. 4.Any new contracts signed by the Administrator will be brought through the QA committee to ensure compliance.	5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 169	F 492		

PM, the linen storage room shelves were observed in the presence of Employee#18 to have no washcloths or towels, a couple of blankets, six (6) pillows, and a box of blankets was stored in the corner. There was no evidence of emergency linen stocked.

On February 12, 2015 at approximately 12:15 PM, a face-to-face interview was conducted with Employee #18 regarding the linen par level. The employee stated, "The bed capacity is 300 and our par level is two. We send linen to the floor three times a day .The emergency linen is sent in. We make a purchase every two weeks and we recycle the linen on all three shifts." When queried regarding the handling and purchasing process, he/she replied, "Every two weeks we order 50-60 dozen washcloths, 20 dozen towels, 10 dozen flat and fitted sheets. We circulate the linen, as needed. The issue is that we are not getting the linen back to be cleaned."

On February 12, 2015 at approximately 3:20PM a face-to-face interview was conducted with a resident [who requested anonymity] and requested that his linen concern be addressed. He/she stated, "Usually two times a month, they don't have enough towels, sheets, or laundry. About a month ago, two weeks went by before my bed linen was changed. [Named the director of laundry] is aware and he/she said he/she is trying to address the shortage of linen. A resident said he/she witnessed his/her roommate being cleaned with paper towels because they had no linen. This was said in the resident council meeting last year."

On February 12, 2015 at approximately 4:00PM 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
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 170 Resident #259 who stated he filed a complaint about the linen shortage to the manager on the 5 South unit. He/she stated, "I had a bowel movement and called the CNA [Certified Nursing Assistant] at 10:30PM and asked her to change me. She said that she didn't have any problems cleaning me, but that she had no wash cloths or anything to clean me with. I asked her to at least change my diaper, and she did change my diaper. I waited until the next morning to be cleaned." On February 13, 2015 at approximately 11:30 AM, a face-to-face interview was conducted with Employee #14 who acknowledged the aforementioned findings. He/she added, "I went downstairs on February 11, 2015 and spoke with the supervisor in laundry. He/she showed me the carts that were being filled and he/she showed me how laundry is delivered on the 3-11 PM shift. He/she explained that staff tends to hoard linen, they do have a shortage on wash cloths, and they are being ordered." Facility staff failed to ensure linen was at least three times the amount needed for licensed occupancy. The record was reviewed on February 13, 2015. 4.Facility staff failed to ensure that the nurse staffing agency utilized by the facility was licensed in the District of Columbia. The findings include:	F 492	F-Tag 492 (B1, B2) 1. Resident #392 no longer resides in the facility. Resident #148 was assessed. There was no negative effect noted from the deficient practice of physician not completing the H & P timely (72hrs). Retrospectively nothing can be done for resident no longer at the facility. 2. All residents have the potential to be affected by the deficient practice of physician H & P not done timely (72hrs). 3.An audit was created to track physician visits within 72 hours. Medical records will complete a monthly audit to ensure compliance. A new system was developed by Administration for physician assignment to new admission for compliance. Admissions Department and unit secretaries educated. 4. Audits will be turned in to the MD, Administrator and DON to ensure compliance. Results will be present in the monthly QAPI meeting. Areas of concern will be discussed and follow up by Medical Director.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492		F 492		

Continued From page 171

Section 22- 4900.2 of the District of Columbia Municipal Regulations, General Provision directs the following: " Except as otherwise expressed provided in the Act or these rules, no person or entity may operate, or hold himself, herself or itself out as operating a nurse staffing agency for the purpose of rendering temporary nursing services or related health aide services within the District of Columbia, whether public or private, for profit or not for profit, without being licensed as required by the Act and these rules.

On February 20, 2015 at approximately 3:30 PM, a face-to-face interview was conducted with Employee #2 regarding the use of agency staff at the facility. He/she stated, " We do not use agency nurses. "

Review of the nursing contracts revealed a contract with Alignstaffing nursing agency signed by the Nursing Administrator and the " Provider President " and dated March 27, 2014.

Review of the invoices with Alignstaffing revealed that agency staff worked the following days:

Date	LPN	RN
July 5, 2014	6	1
July 6, 2014	6	1
July 7, 2014	3	5
July 8, 2014	2	4
July 9, 2014	3	4
July 10, 2014	4	5
July 11, 2014	3	3
July 13, 2014	0	1
July 14, 2014	0	2
July 15, 2014	0	2
July 17, 2014	0	1
September 6, 2014	0	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _______ B. WING _______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 172 September 7, 2014 3 1 An Agency Licensure search conducted on February 20, 2015 revealed that the agency did not possess a license to operate in the District of Columbia. On February 20, 2015 at approximately 3:45 PM, a face-to-face interview was conducted with Employee #2 who acknowledged the findings. B. Based on clinical record review, resident interview, and staff interviews for two (2) of 51 sampled residents, it was determined that the facility staff failed to comply with applicable federal, state, and local laws and regulations, as evidenced by staff's failure to conduct a comprehensive medical examination and evaluation of the resident's health status at least every twelve (12) months and document it in the medical record; and failed perform the resident's history and physical assessment within 72 hours of admission, as evidenced by the omission of the history and physical document on the clinical record. Residents' #148 and #392. The findings include: 1. Facility staff failed to conduct a comprehensive medical examination and evaluation of Resident #148's health status at least every twelve (12) months, and document it in the medical record, as evidenced by the omission of the annual history and physical in the medical record. According to 3207.11 of the District of Columbia Municipal Regulations, "The Medical Director	F 492		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 173 shall: Ensure that each resident shall have a comprehensive medical examination and evaluation of his or her health status at least every twelve (12) months, and documented in the resident's medical record. A review of the medical record was conducted on February 10, 2015. There was no evidence of an annual history and physical in the medical record for last year 2014 and or 2015 if required at this time. A face-to-face interview was conducted on February 12, 2015 at approximately 11:00 AM with Employee #9. A query was made to determine if an annual history and physical examination was conducted for Resident #148. Employee #9 stated, "I will check medical records to make sure that it was not thinned." Employee #9 was unsuccessful in locating the document and stated, "I will place a call to the Primary Medical Doctor and inform him/her." Facility staff failed to conduct a comprehensive medical examination of the resident's health status at least every twelve (12) months, and document it in the medical record. 2. Facility staff failed to perform Resident #392 ' s history and physical assessment within 72 hours of admission. According to 3207.2 of the District of Columbia	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 174	F 492		

Municipal Regulations, " The Medical Director shall: (i) Ensure that each resident is seen by a physician within seventy-two (72) hours after admission and that the physician has included in the record information identified in sub-section 3231.12.
A review of the admission record revealed the Resident #392 was admitted to the facility on February 9, 2015.

A review of the clinical record lacked documented evidence of a history and physical examination.

A review of the February 2015 'Order Summary Report' lacked documented evidence of the resident's admitting diagnoses.

On February 19, 2015 at approximately 9:30 AM, a face-to-face interview was conducted with Employees #11 regarding the aforementioned findings. He/she acknowledged the absence of the history and physical on the clinical record, and stated that he/she would place a call to the physician regarding the matter.

On February 19, 2015 at approximately 4:00 PM, Employee #11 provided a history and physical for Resident #392, dated February 13, 2015. He/she stated, "I found the physician who completed the history and physical. The physician stated he/she had performed a history and physical prior to this one, but it must have been lost."

There was no evidence that facility staff ensured that the resident's history and physical assessment was performed within 72 hours of admission. The clinical record was reviewed on February 19, 2015.

F-Tag 493

1. All residents identified with this deficient practice were assessed to ensure no negative physical outcome to each resident. Those residents no longer living at facility were not able to be assessed. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The Administrator, HR and DON meet weekly and Bi-weekly with corporate via phone to discuss plans for staffing. We discussed open house for staffing. We have had and are having orientation twice a month at minimum and we have hired a new Staffing Coordinator to call in additional staff or agency if needed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that the Governing Body failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety as evidenced by a failure to: ensure that resident rights were consistently maintained, to ensure that resident assessments were accurate, initiated and revised as necessary, to ensure that residents attain/maintain the highest practicable physical, mental and psychosocial well-being; ensure a program designed to provide a safe, sanitary and comfortable environment; ensure that sufficient staff was available to provide quality care and services, to ensure that pharmacy services were consistently available to provide routine medications in order to meet the needs of the residents, to implement policies and procedures to prohibit mistreatment and neglect of residents, to ensure that the resident call system was maintained in a safe and operating condition, failed to comply with state and local laws and regulations, failed to maintain clinical records, and provide a program for quality assessments	F 493	F-Tag 493 2.All other residents were assessed and audits completed to ensure no negative physical out-come resulted to no other residents due the same deficient practice. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Facility continues to recruit and schedule orientation in order to meet the correct daily Nursing PPD. 3. System changes to ensure integration, Coordination and monitoring of facility Practices related to resident care and safety Include: hiring a second RN in Staff Development to ensure better education and training of staff to include return demonstration and pre and post test for in-service education. Hiring a new Staffing Coordinator to assist with ensuring staffing and monitoring of vacant positions. Hiring additional Unit secretaries one for each unit to assist with all facility audits. Creating a separate budget for transportation aids in order not to pull CNAs from in-house PPD staffing. Sending all ADONs for manager training to ensure they know about coaching employees bring about desired outcome. Having two or more orientations monthly and doing several open houses per year to ensure appropriate staffing levels. Creating more audit tools. Education and training all staff. increasing sample sizes for all departments when auditing. Monitoring department heads monthly activity and have them doing monthly reporting to ensure they capture pertinent info to report to monthly QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 176 and assurance that implemented plans of action to correct identified quality deficiencies. The findings include: The Governing Body failed to: During the recertification survey from February 5 -20, 2015 the following areas of concern were identified: · Failure to ensure that facility staff informed the resident and/or responsible party of available services in the facility and the charges for those services and failure to obtain documented evidence to demonstrate receipt of explanation for the bed hold policy. Cross reference CFR 483.10, F156. · Failure to ensure that facility staff notified the attending physician that prescribed medications could not be administered because they were unavailable. Cross reference CFR 483.10, F157 · Failure to prevent the neglect of the resident, as evidenced by the staff's failure to provide Activities of Daily Living [ADL] care to a resident. Cross reference CFR 483.13, F224 · Failure to ensure that an employee who was accused of abusing a resident(s) completed a plan of action that was indicated to correct his/her behavior. Cross reference CFR 483.13, F226. · Failure to ensure that facility staff did not perform treatment in an open area for a resident; to ensure that a urine filled receptacle was removed from the resident ' s night stand prior to his/her lunch consumption; and to ensure that staff who entered a resident's first knocked and	F 493	4.The Administrator, DON and QAPI nurse have developed new structure for QAPI process. Environmental services to order twice the amounts of supplies and linen monthly and report to QAPI nurse. New QAPI tools developed for each department effected by the deficient practices. New tool will be used to monitor the performance Improvement plans and to identify areas for improvement. An Increase in sample size for auditing to cover facility census was implemented. Further education and/or training will be provided when identified by quarterly QAPI committee meetings.	5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 177 obtained permission before entering a resident ' s room. Cross reference CFR 483.10, F246 · Failure to ensure that facility staff developed care plans with appropriate goals and approaches to address care needs of residents. Cross reference CFR 483.20, F279 · Failure to ensure that facility staff revised care plans to address resident care needs. Cross reference CFR 483.20, F280 · Failure to ensure that facility staff implemented measures to safeguard a resident from unintentional trauma and dislodgement when it was determined that the resident removed the catheter on two (2) previous occasions; address the neurologist's recommendations in a timely manner for a resident, failed to follow the physician ' s ordered plan of care for residents. Facility staff failed to consistently assess residents for pain, obtain and assess the resident ' s vital signs, obtain diagnostic study reports for a resident; demonstrate accurate knowledge of the dialysis access site assessment for several residents receiving dialysis. Failed to ensure that the PICC (peripherally inserted central catheter) line was removed as ordered by the physician for a resident; administer Glucagon [medication used to raise low blood sugar] as ordered by the physician for a resident; and administer Heparin as ordered by the physician for a resident. Cross reference CFR 483.25, F309 · Failure to ensure that a resident that was lying in the bed saturated with urine received necessary services to maintain good grooming and personal hygiene. Cross reference CFR 483.25, F312 · Failure to ensure/maintain a safe environment to prevent accidents and to provide supervision to residents who were left	F 493		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 178 unsupervised. Cross reference CFR 483.25, F323 · Failure to obtain routine dental services regarding denture replacement for a resident. Cross reference CFR483.55, F412 · Failure to ensure that the pharmacy delivered prescribed medications in a timely manner to meet the needs of all residents. Cross reference CFR 483.60, F425 · Failure to ensure that unnecessary medications were not provided to residents. Cross reference CFR 483.60, F431 · Failure to ensure all essential resident care equipment was in safe operating condition (glucometers) Cross reference CFR 483.70, F456 · Failure to ensure that the call bell system was maintained in good working condition. Cross reference CFR 483.70, F463 · failure to ensure that facility policies were reviewed annually; to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days; and to ensure that linen was at least three times the amount needed for licensed occupancy. Cross reference CFR 483.75, F492 · Failure to ensure that nursing progress notes were completed with a nurse's signature for a resident; ensure that consultation notes and diagnostic results were readily accessible on the active clinical record for a resident; accurately record the location of a wound for a resident; maintain complete dialysis communication forms for two (2) residents; and to accurately document a resident's name on the facility's admission financial document. Cross reference CFR 483.75, F514. · Failure to ensure that the Quality Assurance	F 493		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 493	Continued From page 179 Committee developed corrective measures to address the concerns identified during the survey process. Cross reference CFR 483.75, F520	F 493		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for six (6) of 51 sampled residents, it was determined that facility staff failed to maintain clinical records that were complete, readily accessible, and accurate in accordance with accepted professional standards as evidenced by staff failing to: ensure that nursing progress notes were completed with a nurse ' s signature for one (1) resident; ensure that consultation notes and diagnostic results were readily accessible on the active clinical record for one (1) resident; accurately record the location of a wound for one (1) resident; maintain complete dialysis communication forms for two (2) residents; and to accurately document one (1) resident's name on	F 514	F-Tag 514 (1-5) 1. Resident # 148, 211,and 292 were all assessed and did not have any negative outcome from the deficient practice. Progress notes with missing signature were signed. Resident #211 cardiology appointment rescheduled. Resident #286, 291 are no longer at facility. 2. All residents have the potential to be affected by the deficient practice. Other residents with all the same deficient practices cited were audited to ensure no other residents had the same deficient practices. 3. Nurse Managers and ADONs will ensure that all progress notes and paper is signed and entered as a late entry. All nursing staff in-serviced by staff development nurse on the importance of signing progress notes, have good notes to address residents issues, and completing the dialysis communication form correctly. 4. Nurse Manager and ADON will review dialysis communication book and report to the DON weekly. All deficient practices will be brought to the QAPI committee. 5/20/15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 180 the facility ' s admission financial document. Residents' #148, #211, #286, #291, #292 and #388. The findings include: 1.Facility staff failed to ensure that the nursing progress notes for Resident #148 was completed as evidenced by omission of the nurse's signature on two (2) nursing progress note entries. a. A review of the medical record progress note dated January 26, 2015 1800 [6:00 PM] revealed, "Resident remain alert and verbally responsive, was found in a sitting position by [his/her] bedside. Stated that [he/she] was dosing [dozing] while sitting in bed and fell. Was assisted back to bed. Nurse Supervisor notified. Head to toe assessment done, no signs of apparent injury noted. Little bump noted on right forehead, supervisor stated that it is old. Upon palpation, resident denies pain, no signs of apparent distress noted. Neuro [neurological] check initiated no change in mental status noted. R/P [Responsible Party] paged awaiting call back. R/P updated. Fall and safety measures in place. Will continue with plan of care." The entry lacked evidence of who completed the nursing progress note as evidenced by omission of the nurses' signature. b. A review of the nursing progress notes dated January 27, 2015 0400 revealed "patient too [took] personal cell phone and call 911	F 514	F-Tag 514 (6) 1.The admissions department added the name of resident #388 to the form. 2.All other admissions packets were reviewed To ensure names were not omitted from the Admissions packet forms. No other deficient practices were found. 3.Admission department were in-serviced on The importance of forms being filled out Appropriately. 4. The admission department will report on a Monthly basis to the QAPI committee any Deficient practices.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 181 emergency at 11:35 pm - 911 crew arrived at 11:50PM and too [took] resident to [name of local hospital] MD [Medical Doctor] made aware and R/P [Responsible Party]" The entry lacked evidence of who completed the nursing progress note as evidenced by omission of the nurse's signature. A face-to-face interview was conducted with Employee #9 on February 12, 2015 at approximately 3:00 PM. After review of the above he/she acknowledged the findings. Facility staff failed to ensure that the medical record was completed as evidenced by omission of the nurses' signature on two (2) nursing progress note entries. The record was reviewed on February 12, 2015. 2. The facility staff failed to obtain and file in the resident's clinical record a report of a cardiology consultation that was completed three (3) months ago (in November, 2014). Resident #211. A review of the resident ' s clinical record revealed a consultation form which indicated that the resident had received a cardiology consult on November 20, 2014. Further review of the record failed to reveal any evidence of the report of the consultation.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 182 A face-to-face interview was conducted with Employee #12 at approximately 3:00PM on February 13, 2015. The employee was asked for a copy of the consultation report. He/she reviewed the record and acknowledged that the report was not on the record. The employee then stated, " I will get the report. " The employeeacknoeledged the finding. On February 18, 2015 at approximately 10:00AM Employee #12 handed this surveyor a faxed copy of the consultation report. The copy however was not legible and therefore could not be read. The report was dated February 13, 2015 at 5:22PM. The record was reviewed on February 13, 2015. 3. Facility staff consistently recorded the incorrect location of the pressure ulcer on the " Clinical Assessment Reports " for Resident #292. A review of the clinical record revealed that Resident #292 was admitted to the facility on September 11, 2014 with impaired skin integrity to include a Left hip Stage III pressure ulcer. A review of the " Clinical Assessment Reports " for Resident #292 revealed that from November 6, 2014 through February 5, 2015 facility staff recorded the pressure ulcer as follows: Under Section A1. The site of the pressure ulcer was recorded as Rt [right] hip. Section A1. Site of pressure ulcer was recorded as Right hip. Under Section B. "Appearance/Progress": the wound was identified as Left hip stage III. A telephone interview was conducted on March	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 183	F 514		

11, 2015 at approximately 10:00 AM with Employees ' #2, #9, #50, #61 and #62. Employee #61 stated, " The right hip stage III is incorrect. It should be the left hip. "

There was no documented evidence that facility staff consistently recorded the correct location of the pressure ulcer on the " Clinical Assessment Reports " . The record was reviewed on March 11, 2015.

4. Facility staff failed to consistently complete the dialysis communication forms for Resident # 286.

A review of the The Dialysis Communication forms for November 2014 through February 7, 2015 revealed that sections of the forms were incomplete/or left blank. For example:

Part I- " comments or questions " , " glucose [level] " , " did the patient eat before dialysis " , " time taken " , " problems noted and/or resident complaints " , " nurse signature" ; This section has an area designated for the following: Problems noted and/or complaints

____
________ and Comments or incidents
____.

There was no comment in either area.

However, a review of the nurse's progress note dated January 13, 2015 at 16:19 [4:19 PM] revealed the following: " Resident re-admitted from [hospital] ...patient had newly placed permacath on the right thigh [groin] which is double lumen and properly secured ...skin is

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 184	F 514		

warm to touch, dry, and noted with multiple scars on the left neck, bilateral upper chest, right ankle, and scratch marks all over the body ...Peri-wound is noted with discoloration and multiple scratch wounds, right buttocks noted with scratch wound measuring (1.0 cm x 0.5 cm x 0.1 cm) ...Resident was seen scratching self, fingernails trimmed ... "

A face-to-face interview was conducted on February 11, 2015 at approximately 4:20 PM with Employee #11. He/she stated, " The resident has a g-tube and a permacath on [his/her] left side. The resident did not have any behavioral issues. [He/she] itches. He/she took the permacath out twice [from the chest]. After the second time [the catheter was pulled out] it was put in [his/her] thigh [groin] and [he/she] took it out. [He/she] is at the hospital now and [he/she] is Hospice. The resident ' s nails were short.

Employee #11 was asked if the resident had a dermatology consult due to the resident's itching. He/she replied, " No. " The employee was then asked what measures were put in place to address the resident's scratching. He/she replied, " The resident was prescribed Benadryl [antianti-itch medicine] cream and Hospice nurse ordered something for the itching. We also monitored the resident and checked [his/her] vitals. [He/she] pulled at [his/her] clothes and scratched."

A review of the The Dialysis Communication forms for November 2014 through February 7, 2015 revealed that sections of the forms were incomplete/or left blank. For example:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 185	F 514		

Part I- " comments or questions " , " glucose [level] " , " did the patient eat before dialysis " , " time taken " , " problems noted and/or resident complaints " , " nurse signature" ; This section has an area designated for the following: Problems noted and/or complaints

____
_______ and Comments or incidents
____.

There was no comment in either area. However, a review of the nurse's progress note dated January 13, 2015 at 16:19 [4:19 PM] revealed the following: " Resident re-admitted from [hospital] ...patient had newly placed permacath on the right thigh [groin] which is double lumen and properly secured ...skin is warm to touch, dry, and noted with multiple scars on the left neck, bilateral upper chest, right ankle, and scratch marks all over the body ...Peri-wound is noted with discoloration and multiple scratch wounds, right buttocks noted with scratch wound measuring (1.0 cm x 0.5 cm x 0.1 cm) ...Resident was seen scratching self, fingernails trimmed ... "

Part III- " patient status " , glucose [level] " .

A face-to-face interview was conducted on February 11, 2015 at approximately 4:20 PM with Employee #11. The employee reviewed the forms and acknowledged that the communication forms were not completed consistently and that no information was recorded on the forms

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 186	F 514		

regarding the resident's pulling on his/her clothing and scratching him/herself."

It was determined that facility staff failed to consistently complete sections of the forms, to communicate pertinent information regarding the resident ' s clinical status and care needs.

5.. The facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by failure to maintain the dialysis communication forms regarding the resident's hemoglobin for Resident #291.

Review of the MAR revealed that the resident's past medical history included Senile Dementia, Acute Peptic ulcer, peripheral vascular disease, Congestive heart failure, end stage renal disease on dialysis, Type 2 diabetes, and Anemia in chronic kidney disease.

Review of the facility's dialysis communication sheets revealed three parts, Part I completed by facility staff Pre-Dialysis, Part II completed by the dialysis center, and Part III completed by the facility staff Post Dialysis. Communication forms from January 3, 2015 through February 12, 2015 revealed the following:

Part I included; Patient status, medications given, access location, problems noted and/ or resident complaints, comments or incidents. Part II includes pre and post dialysis weights, Post treatment vital signs, Medications given during dialysis, and whether or not labs were drawn in dialysis. Part III includes, the time the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 187 returned, patient status, vital signs, glucose and any additional comments. Review of Dialysis Lab results dated February 3, 2015 revealed a Hemoglobin level of 5.5 Review of two Dialysis Communication forms dated February, 3 2015 revealed the fields, 'Labs Drawn Today' were left blank. Review of the nursing note dated February 4, 2015 at 22:29 [10:29 PM] revealed, " ...Resident remain alert and verbally responsive, assisted with due care, medicated as ordered and well tolerated. Received paperwork from dialysis unit with hemoglobin level of 5.5 ..." A face-to-face interview was conducted with Employee #4. He/she acknowleged that dialysis communication forms did not contain pertinent information related to the resident's Hemoglobin and Hematocrit status. The clinical record was reviewed on February 10, 2015. 6. Facility failed to ensure that Resident #388 ' s name was accurately documented on the facility ' s admission document. Resident #388 was initially admitted to the facility on January 9, 2015 and diagnoses included Status Post Acute Exacerbation of COPD (Chronic Obstructive Pulmonary Disease), Hypertension, Diabetes, and Debility. A review of the admission financial form dated February 2, 2015 revealed the following: " I [Resident ' s Name] hereby grant permission ... ...; Residet [Resident]: [Responsible Party ' s signature]; Date: February 2, 2015, Witness:	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 188 [Employee # signature], Date: February 2, 2015 .... " No name was documented in the area designated for the resident's name. The clinical record lacked evidence that Resident #388 ' s name was documented in the designated space for the resident. Facility failed to ensure that Resident #388 ' s name was accurately documented on the facility ' s admission financial document. A face-to-face interview was conducted with Employee #21 on February 11, 2014 at approximately 11:00 AM regarding the aforementioned finding. He/she acknowledged that Resident #388 ' s name should have been documented on the form indicating that [he/she] was the resident at the facility. The clinical record was reviewed on February 11, 2014.	F 514	F-Tag 520 1.All residents identified with this deficient practice were assessed to ensure no negative physical outcome to each resident. Those residents no longer living at facility were not able to be assessed. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The Administrator, HR and DON meet weekly and Bi-weekly with corporate via phone to discuss plans for staffing. We discussed open house for staffing. We have had and are having orientation twice a month at minimum and we have hired a new Staffing Coordinator to call in additional staff or agency if needed.	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 189	F 514	F-Tag 520 2.All other residents were assessed and audits completed to ensure no negative physical outcome resulted to no other residents due the same deficient practice. All residents have the potential to be affected by the deficient practice of the facility failing to ensure that sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Facility continues to recruit and schedule orientation in order to meet the correct daily Nursing PPD. 3.156- The Admissions department have reviewed and updated the contract to include available services in the facility and the charges for those services and explanation of the bed hold policy. New contract will be rolled out starting 4/20/15 157- New process developed/implemented by the Nursing Department to prevent delay in medication delivery. 224-. All employees received education on abuse prevention.. All new hires will be in-serviced during orientation as to our protocol on grievance and new abuse policy. 226-Employee who was accused of abusing a resident no longer is employed at the facility. All employees with corrective plan of action in their files were reviewed, no other employee's file was found to be out of compliance. All Directors/managers received education from staff development department on the importance of following up on employee Plan of Action. 246-Employee who performed treatment to a resident in an open area is no longer employed at the facility. All employees were educated by staff Development Department, on resident's rights dignity and respect;	
	1			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 190 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, resident and staff interviews, it was determined that the facility's Quality Assessment and Assurance (QAA) committee failed to develop, implement, and/or revise appropriate corrective actions for identified deficient practices as necessary. The findings include: During the recertification survey, the following areas of concern were identified: · 483.10, CFR 156 - failure to inform the resident and/or RP of available services in the facility and the charges for those services and failure to obtain documented evidence to demonstrate receipt of explanation for the bed hold policy. · 483.10, CFR 157 - failure to notify the attending physician that two (2) prescribed medications could not be administered because they were unavailable. · 483.13, CFR 224 - failure to prohibit neglect	F 520	279, 280-All license staff was educated on Developing/revising/ updating care plans timely. 309-All employees were educated to ensure that they understand the importance for the residents to receive necessary care and services to attain or maintain the highest practical well being. 312- Education given to nursing staff on perineal care by staff development. All employees were educated to ensure that they understand the importance for the residents to receive necessary care and services to attain or maintain the higher practical well being 323, 412, 425, 431-All employees were educated to ensure that they understand the importance for the residents to receive necessary care and services to attain or maintain the higher practical well being. 412- Dental in-service done for all nursing staff to reinforce the importance of dental services for each resident. 425- New process developed/implemented by the Nursing Department to prevent delay in medication delivery. 431-Medication cart audits by DON and or designee to ensure compliance with medication storage. 431-Education provided on code cart by staff development department. 456-All licensed staff were educated on operating the glucometer machines on all units., 463-All employees were educated to ensure that they understand the importance making sure call lights are maintained in good working condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 191 of the resident, as evidenced by the staff's failure to provide Activities of Daily Living [ADL] care to a resident. · 483.13, CFR 226 - failure to ensure that an employee who was accused of abusing a resident(s) completed a plan of action that was indicated to correct his/her behavior · 483.10, CFR 246 - staff performed treatment in an open area for one (1) resident; had a filled urine receptacle in close proximity to a resident during lunch consumption; and entered a resident's room without knocking and without obtaining permission to enter. · 483.20, CFR 279 - failure to develop care plans with appropriate goals and approaches to address: care needs for a resident who received dialysis; for a resident who required tracheostomy care; comprehensively assess and initiate a care plan for one resident for self-administration of medications, for a resident who was described as a "Hoarder;" for oral dental care needs for a resident and for care of the hemodialysis access site for a resident. · 483.20, CFR 280 - failure to revise a care plan to include the dialysis treatments days for two (2) residents; to address the resident care needs pre and post dialysis and days the resident is to receive dialysis treatments; to address the correct dialysis days; to review and revise the care plan to include encourage a resident to rest following dialysis treatment; and to revise the care plan to address a resident ' s agitated behavior and hospitalization. · 483.25, CFR 309 - failure to Implement approaches to help prevent one (1) resident from dislodging/removing a permacatheter and femoral catheter; address the neurologist's recommendations in a timely manner for one (1) resident, administer medications for three (3)	F 520	492-All facility policies were reviewed and updated, all facility policy will be reviewed annually. New staffing coordinator was hired 4/06/15. Next day staffing projection to be discussed in daily clinical meetings. Continuous staff recruitment and new hire orientation at least twice per month until regulatory requirements are met consistently.. 514-Retrospectively no corrective action can be done for this deficiency. All licensed staff was educated on the importance of signatures on all documents both electronic and written. And correct identification of wounds when doing wound assessment. Chart audits will be conducted by medical record department to ensure consults and diagnostic results are readily available and accessible on active clinical record. Education was provided all staff including the admission department and the business office on making sure resident's names are placed on all documents. 4.The administrator, DON and QAPI nurse have developed new structure for QAPI process. Environmental services to order twice the amounts of supplies and linen monthly and report to QAPI nurse. New QAPI tools developed for each department effected by the deficient practices. New tool will be used to monitor the performance Improvement plans and to identify areas for improvement. An Increase in sample size for auditing to cover facility census was implemented. Further education and/or training will be provided when identified by quarterly QAPI committee meetings.	5/12/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 192 residents' on their assigned dialysis treatment days; follow physicians' orders to keep a dialysis emergency kit by the bed side for two (2) residents; administer antibiotics as ordered by the physician for one (1) resident; perform tracheostomy care, as ordered by the physician, for one (1) resident; assess pain as ordered by the physician for one (1) resident; assess vital signs as ordered by the physician for one (1) resident; perform care and assessment of a G-tube [Gastrostomy tube] as ordered by the physician for one (1) resident; discontinue Rozerem (hypnotic medication) and continue Ambien (hypnotic medication) as ordered by the physician for one (1) resident; administer anti-hypertensive medications at the appropriate time on dialysis treatment days for one (1) resident; obtain diagnostic study reports for one (1) resident; demonstrate accurate knowledge of the dialysis access site assessment for two (2) residents; ensure that the PICC (peripherally inserted central catheter) line was removed as ordered by the physician for one (1) resident; obtain Hemoglobin and Hematocrit, CBC [blood levels] stat [as soon as possible], and stool for occult blood for anemia, as ordered by the physician for one(1) resident; follow-up on an Ophthalmology consult for one (1) resident; ensure that a scoop mattress was provided as ordered by the physician for one (1) resident; obtain daily weights as ordered by the physician for one (1) resident; administer Glucagon [medication used to raise low blood sugar] as ordered by the physician for one (1) resident; and administer Heparin as ordered by the physician for one (1) resident. · 483.25, CFR 312 - failure to ensure that one resident that was lying in the bed saturated with urine received necessary services to maintain	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ____ B. WING ____	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 193 good grooming and personal hygiene. · 483.25, CFR 323 - failed to maintain a safe environment for two (2) residents who were left unsupervised and failed to consistently supervise one (1) resident who was observed walking on and off the unit and entering other resident rooms without permission. · 483.55, CFR 412 - failure to obtain routine dental services regarding denture replacement for one (1) resident. · 483.60, CFR 425 - failure to ensure that the pharmacy delivered prescribed medications in a timely manner to meet the needs of two (2) residents. · 483.60, CFR 431 - failure to maintain ambien [hypnotic medication] stored on the narcotic cart and available for the resident; failure to provide documented evidence that the code carts were monitored daily on two (2) units; and s failure to maintain the code cart [emergency cart] in the rehabilitation department secured and accessible only to designated staff. · 483.70, CFR 456 - failure to ensure all essential resident care equipment was in safe operating condition (glucometers) · 483.70, CFR 463 - failure to maintain resident's call bell system in good working condition. · 483.75, CFR 492 - failure to provide evidence that facility policies were reviewed annually; ensure sufficient nursing staff was available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 16 of 16 days; and to ensure that linen was at least three times the amount needed for licensed occupancy. · 483.75, CFR 514 - failure to ensure that nursing progress notes were completed with a	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 194	F 520		

nurse's signature for a resident; ensure that consultation notes and diagnostic results were readily accessible on the active clinical record for a resident; accurately record the location of a wound for a resident; maintain complete dialysis communication forms for two (2) residents; and to accurately document a resident's name on the facility's admission financial document.

On February 20, 2015 at approximately 10:30AM, the Director of Quality, the Nursing Home Administrator and the Director of Nursing were interviewed regarding their QAA Committee Meetings and identification of the concerns listed above. At this time it was stated that the committees met monthly.

The QAA Director and the Administrator further stated that all Ftags [Federal tags] cited on the [CMS] 2567 from the previous surveys are monitored. "When complaints are reviewed we may find concerns with documentation. We monitor each identified area for 90 days. Our threshold is 90% to 100%. In December [2014] we were monitoring significant weight changes, tube feeding and dining with dignity. We are piloting a new dining program on 5North to ensure compliance with dining, (e.g. seating, table coverings, serving residents at the same time. The dietitians do daily test trays. They report that they are in compliance. Medical audits are done. Consults such as dental, orthopedic psychiatric, and podiatry are reviewed. We audit records to ensure the history and physicals are completed within 72 hours of a resident ' s admission to the facility. The Medical Director is monitoring unplanned {hospital]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING ______ B. WING ______	02/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 195	F 520		

transfers, pain, medication management ...
Human resources- monitor the recruitment and vacancies. Currently we have a number of vacancies. We are actively recruiting and hiring new employees to fill thevacamcies.
Environmental services reported that in October 2014 the linen par level was 94%. In November and December 2014 the linen par level was 90%."
The Director of Quality stated that the chart audit sample sizewas 30 charts. The building's capacity is 296. Approximately 10% of the resident population is audited each month. For November and December 2014, and January 2015 the chart audit compliance was 95% each month.
The Director of Nursing stated that, "We identified many of the issues [that have been identified by the survey team]. We planned a training but it had to be deferred because of the survey. We realize that the assessment is not the best. We were in the process of changing the medication times for dialysis residents. Medications were not to be given prior to dialysis. We were working on changing the times for medication administration for all of the residents. In September [2014], we had a training on pre and post dialysis assessments for the staff. Dialysis training is done on hire for all nurses."

Although facility staff stated that they have identified these issues, there was no evidence that the Quality Assurance Committee developed corrective measures to address the concerns identified during the survey process.