

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

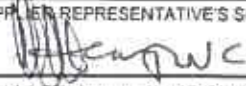
PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	<p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted on January 29, 2021 through February 9, 2021. Survey activities consisted of a review of seven (7) sampled residents. It was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. This includes the facility's non compliance with 42 CFR §483.80 infection control regulations. The resident census was 245.</p> <p>The following is a directory of abbreviations and/or acronyms that may be utilized in the report:</p> <p>Abbreviations AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue DI - deciliter DMH - Department of Mental Health EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911)</p>	F 000	<p>DISCLAIMER: Facility submits this plan of correction under procedures established by the Department of Health in order to comply with Department Directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrongdoing.</p>	4/2/2021
-------	---	-------	---	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE LNHA	(X6) DATE 3/31/21
--	----------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Continued From page 1 G-tube Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM Range of Motion Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record		F 000	4/2/2021	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583			

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 583	Continued From page 2 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for two (2) of seven (7) sampled residents, facility staff failed to provide confidentiality of their personal identifiable	F 583	F583 CORRECTIVE ACTIONS FOR RESIDENTS AFFECTED Resident #6 and #7 were assessed on 1/29/21, residents suffered no negative outcome. In-service provided to employee #7, #5 and all clinical staff members on the importance of providing confidentiality on residents personal identifiable medical information always by 4/2/21 House wide audit conducted by the Director of Nursing or Designee to identify other residents that the facility staff did not ensure that the residents personal identifiable medical information was protected by 4/2/21. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTEDED All the residents in the facility have the potential to be affected. MEASURES TO PREVENT RECURRENCE The Director of Nursing or Designee will conduct house wide audits to ensure resident's personal identification materials are always provided confidentiality by 4/2/21. Staff Development Coordinator will provide In-Service to all clinical staff members on the importance to provide confidentiality of residents personal identifiable medical information by 4/2/21.	4/2/21
-------	---	-------	---	--------

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 583	<p>Continued From page 3</p> <p>medical information. Residents' #6 and #7 Findings included...</p> <p>1. Resident #6 was admitted to the facility on 09/27/2019, with diagnoses that included Pressure Ulcer of Sacral Region and Disruption of External Operation (Surgical) Wound</p> <p>During a tour of unit approximately 10:35 AM, Resident #6's COVID-19 testing slip that included full name, date of birth, and that the resident was "in dialysis" was observed on the counter of the nurses station, visible to anyone who walked by.</p> <p>During a face-to-face interview conducted on 01/29/2021, at approximately 10:35 AM with Employee #7 (Licensed Practical Nurse), she acknowledged the finding and stated, "We are waiting for the resident to come back from dialysis to do his test. The testing slip should've been put inside the medication cart for safe keeping."</p>	F583	<p>F583 MONITORING CORRECTIVE ACTION</p> <p>IDT team members will validate daily during grand rounds to ensure that no resident's personal identifiable medical information is left unprotected by 4/2/21.</p> <p>Unit managers will make constant rounds to ensure all residents personal identification materials are protected daily until 4/2/21.</p> <p>Incoming and outgoing nurse will make rounds to ensure all residents personal identifiable medical information is secured.</p> <p>Findings will be reported to the Director Of Quality Assurance weekly x 4, then monthly x 3 until 4/2/21.</p>	4/2/21
-------	--	------	--	--------

	<p>2. Resident #7 was admitted to the facility on 07/20/2020, with diagnoses that included Heart failure, Anemia, and Coronary Artery Disease.</p> <p>During a tour of unit 4 south on 01/29/2021, at approximately 10:50 AM, Resident #7's medication cream was observed on a treatment cart in the hallway, with their full name, date of birth, and name of the medication fully visible to anyone who walked by the treatment cart.</p> <p>During a face-to-face interview conducted on</p>			
--	---	--	--	--

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 583	Continued From page 4 01/29/2021, at approximately 10:50 AM with Employee #5 (Charge Nurse), she acknowledged the findings and stated, "The medication is given at night and that shift must have forgot to put the medication away." Facility staff failed to provide confidentiality of residents' personal identifiable medical information.	F 583		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements. §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/2/21

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 5</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p>	F880		4/2/21

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 6</p> <p>Based on observation, record review and staff interview, facility staff failed to: have personal protective equipment (PPE) readily accessible, store used/soiled linens appropriately, follow the facility's policy and the Standards of Practice for proper wear of PPE and appropriate eye protection to minimize the potential spread of infections and follow the Standards of Practice for donning face shield on the COVID-19 Unit.</p> <p>Findings included ...</p> <p>I. Facility staff failed to have PPE readily accessible on two (2) units.</p> <p>During a tour of unit 4 north on 01/29/2021, at approximately 10:35 AM, it was observed that there was only one PPE cart for the entire unit of 32 residents, all who were under quarantine for COVID-19 exposure. It was also observed that each resident's room had signage on the door indicating transmission-based contact and droplet precautions were in place for COVID-19 exposure.</p> <p>During a tour of unit 4 south on 01/29/2021, at approximately 10:50 AM, it was observed that there was only one PPE cart for the entire unit of 36 residents, all who were under quarantine for COVID-19 exposure. It was also observed that each resident's room had signage on the door indicating transmission-based contact and droplet precautions were in place for COVID-19 exposure.</p> <p>During a face-to-face interview conducted on 01/29/2021, at approximately 1:10 PM, Employee</p>	F 880	<p>F880</p> <p>CORRECTIVE ACTIONS FOR RESIDENTS AFFECTED:</p> <p>No resident was affected by this practice.</p> <p>1) PPE stations have been mounted on the walls on every unit where the facility failed to provide readily accessible PPE materials</p> <p>2) Soiled linen bins with proper lids were immediately placed on the 4th floor Where the facility failed to store used/soiled Linens appropriately on 1/29/21.</p> <p>Education provided to employee #5 on the importance of making sure that maintenance team replaces broken hampers immediately.</p> <p>Employee was also educated to inform the unit manager of broken hampers so she can follow up with the maintenance team for replacement.</p> <p>Education provided by staff development team on 1/29/21 and ongoing until 4/2/21.</p>	4/2/21	

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 7</p> <p>#4 (Director of Nursing) acknowledged the findings and stated, "We are working on putting PPE stations outside of each resident 's room but have not gotten to the 4th floor yet."</p> <p>Facility staff failed to have PPE readily accessible on two (2) units.</p> <p>II. Facility staff failed to store used/soiled linens appropriately.</p> <p>According to Centers for Disease Control 's (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities, "Contaminated textiles and fabrics are placed into bags or other appropriate containment ... these bags are then securely tied or otherwise closed to prevent leakage ..."</p> <p>https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html</p> <p>During a tour of unit 4 south on 01/29/2021, at approximately 10:50 AM, a container/hamper without a lid and stored soiled linens was observed in the hallway next to a receptacle/container labeled "trash".</p> <p>During a face-to-face interview conducted on 01/29/2021, at approximately 10:50 AM, Employee #5 (Charge Nurse) when asked about the uncovered container stated, "That 's the dirty linen hamper. I reported and made maintenance aware that a new dirty linen container was needed the week prior." Employee #5 acknowledged the findings and stated that she would follow up on the issue.</p>	F 880	<p>F880</p> <p>3) Employee #6 was provided in service on The importance to wear PPE properly to minimize the potential spread of infection and to eat at designated areas only on 1/29/21.</p> <p>Employee verbalized understanding. Staff development team will provide in-service to all the employees in the facility on the importance of wearing PPE correctly at all times in the facility and on the necessity to eat / drink at designated areas.</p> <p>4) In service was provided to employee #8 on 1/29/21 on the importance to follow the Standards of practice for donning a face shield. Employee verbalized understanding.</p>	4/2/21	

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 8</p> <p>Facility staff failed to store used/soiled linens appropriately.</p> <p>III. Facility staff failed to wear PPE properly to minimize the potential spread of infections.</p> <p>According to the facility 's policy entitled, "Staff Drinking and Eating" dated 01/2021, "... due to donning of PPEs (such as face mask and face shield, a staff may have a quick snack and a drink to hydrate him/herself. A staff may do so if he/she is alone or 6 feet apart from everyone, in the hallway or at a workstation..."</p> <p>During a tour of unit 4 south on 01/29/2021, at 11:02 AM, Employee #6 (Painter) was observed walking on the unit, with other residents and staff around, less than six (6) feet apart, with his face mask down on his chin, not covering his mouth or nose and with his face shield tilted up on top of his head, also not covering his mouth or nose, while drinking a can of soda.</p> <p>During a face-to-face interview on 01/29/2021, at 11:02 AM, Employee # 6 acknowledged the findings and stated, "I forgot" when asked why he was not following the facility 's policy for wearing PPE.</p> <p>Review of the in-service training documents entitled, "COVID-19 Infection", "Infection Control" and "Use of PPE" dated 01/14/2021-01/19/2021, showed Employee #6 ' s signature, indicating him receiving training on the previously mentioned education topics.</p> <p>Facility staff failed to wear PPE appropriately to minimize the potential spread of infections.</p>	F 880	<p>F880</p> <p>5) In service was provided to employee #3 and #10 by the Director of Nursing, on the importance to wear the proper eye protection in the facility per the standards of practice and facility's policy while in the facility on 1/29/21. Both employees verbalized understanding.</p> <p>All department heads, IDT team members and Unit Managers did rounds on 1/29/21, to ensure no other employees were wearing their PPE's incorrectly or are wearing the wrong eye protection glasses.</p>	4/2/21
-------	--	-------	---	--------

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 9</p> <p>IV. Facility staff failed to follow the Standards of Practice for donning a face shield.</p> <p>The Center for Disease Control and Prevention 's guidance on the use of Personal Protective Equipment, documented the following:</p> <p>"Put on a full-face shield over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes. Bending forward, hold on to the face shield with both hands, expand the elastic with your thumbs and place the elastic behind your head, so that the foam rests on your forehead. Once the shield is situated, check to make sure it covers the front and sides of the face and no areas are left uncovered."</p> <p>https://www.cdc.gov/vhf/ebola/hcp/ppe-training/n95respirator_gown/donning_13.html</p> <p>During an observation of 2 North (COVID -19 unit) on 01/29/2021, starting at approximately 11:30 AM, Emolovee #8 (Registered Nurse) was observed in the hallway not donning a face shield per the Standards of Practice.</p>	F 880	<p>F880</p> <p>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED</p> <p>All employees in the facility have the potential to be affected.</p> <p>MEASURES TO PREVENT RECCURANCE</p> <p>1) In- service will be provided house wide by Staff development team on the importance to wear PPE's per the standard of practice and facility's policy by 4/2/21.</p> <p>2) IDT team will ensure all employees are wearing their PPE's correctly during rounds daily until 4/2/21.</p> <p>3)Maintenance team will conduct house wide audit to ensure all soiled linen bins have proper lids by 4/2/21.</p>	4/2/21	
	<p>Continued observation showed the foam of the employee 's face shield was noted in her hairline directly above her forehead. Employee #8's face shield was also pointed in an upward position, slightly away from her face leaving her N95 respirator uncovered.</p> <p>During a face-to-face interview on 01/29/2021, at approximately 11:35 AM, Employee #8 was asked, is there a reason why her face shield was not covering her face mask (N95 respirator)? Employee #8 acknowledged the finding and</p>				

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 10</p> <p>stated "No", then repositioned her face shield to cover her face mask.</p> <p>Observation of 2 North (COVID-19 Unit) on the same day at approximately 11:45 AM, revealed Employee #9 (Licensed Practical Nurse), was observed walking out of a resident ' s room, into the hallway not donning her face shield per the Standards of Practice.</p> <p>Continued observation showed the foam of the employee ' s face shield was noted in her hairline directly above her forehead. Employee #9 ' s face shield was also pointed in an upward position, slightly away from her face leaving her N95 respirator uncovered.</p> <p>During a face-to-face interview on 01/29/2021, at approximately 11:45 AM, Employee #9 was asked, is there a reason why her face shield was not covering her face mask (N95 respirator)? Employee #9 acknowledged the finding and stated that it was hard for her to keep her face shield down to cover her face mask.</p> <p>At the time of the survey, Employees #8 and #9 failed to don their face shields per Standards of Practice.</p> <p>V. Facility staff failed to wear proper eye protection in the facility per the Standards of Practice and the facility ' s policy.</p> <p>According to the Center for Disease Control and Prevention ' s, Eye Safety guidance,</p> <p>"Safety glasses provide impact protection but do not provide the same level of splash or droplet protection as goggles and generally should not be</p>	F 880	<p style="text-align: center;">F880</p> <p>4) Unit Managers will conduct frequent rounds on their units to ensure all employees are complying with the proper use of PPE's daily until 4/2/21.</p> <p>5) Departmental heads will ensure all employee wea the proper eye protection in the facility per the standards of practice and facility's policy daily until 4/2/21.</p>	4/2/21	

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 11 used for infection control purposes."</p> <p>https://www.cdc.gov/niosh/topics/eye/eye-infectious.html</p> <p>Review of the facility ' s, "Eye Protection or Face Shield Infection Control and Prevention" policy dated 12/2020, documented that " ...employees may use their own eye protection / face shield so long as it meets the requirements for Infection Control for COVID-19 ..."</p> <p>During an observation of the first floor on 01/29/2021 at approximately 11:20 AM, Employee #10 (Maintenance worker) was observed in the hallway, around other residents and staff, wearing a N95 mask with black glasses with clear shields on either side.</p> <p>During a face-to-face interview with Employee #10 at approximately 11:20 AM, he acknowledged the findings and stated, "I was told that we can wear these types of glasses but must wear an N95 mask" when asked why he was not wearing a face shield.</p> <p>During an observation of 2 North (COVID -19 unit) on 01/29/2021, starting at approximately 11:50 AM, Employee #3 (Staff Development/Educator) was standing very close to a resident (less than 6 feet) in front of Room #204. The employee was encouraging the resident to go back into his room. During this time Employee #3 was wearing black glasses with clear shields on each side of the glasses (Kleenguard Maverick glasses) .</p> <p>During a face-to-face interview on 01/29/2021, at approximately 12:00 PM, Employee #3 was</p>	F 880	<p>F880 MONITORING CORRECTIVE ACTION</p> <p>1)The Director of Nursing / Designee will ensure the IDT team / Unit Managers complete their rounds in a timely manner daily until 4/2/21. Any employee not in compliance, will be provided further education by staff development team.</p> <p>2)The Maintenance Director will conduct rounds to validate that all soiled linen bins have proper lids that are not broken daily until 4/2/21.</p> <p>Findings Will be presented to the Quality Assurance Director weekly x 4, then monthly X3 by 4/2/21.</p>	4/2/21	

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

PRINTED: 03/24/2021
FORM APPROVED
OMB NO. 0938-0391

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 02/09/2021
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	<p>Continued From page 12</p> <p>asked why she was not wearing a face shield while working on the COVID-19 Unit. The employee pointed to her glasses and stated, "I ' m wearing goggles."</p> <p>Research of the Kleenguard Maverick glasses revealed that they were advertised as "safety glasses" and not goggles, as Employee#3 stated during the face-to-face interview.</p> <p>https://www.amazon.com/Kleenguard-Maverick-Glasses-Intergrated-Anti-Fog/dp/B07QMXQLLT/ref=sr_1_7?crid=3G6WQY39UKIUL&dchild=1&keywords=kg+maverick+safety+glasses&qid=1614084583&spr efix=KG%2Caps%2C174&sr=8-7</p> <p>During a telephone interview on 02/09/2021, at approximately 1:00 PM, Employee #3 acknowledged the finding and stated that she was told that the glasses were goggles and not safety glasses.</p> <p>At the time of the survey, Employee #10 and #3 failed to follow the Standards of Practice and the facility ' s policy by not wearing the proper eye protection on the COVID-19 Unit.</p>	F 880		4/2/21	