PRINTED: 07/27/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	IPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A, BUILOI	NG_	3		
		095019	B. WING			1	20/2022
NAME OF DE	ROVIDER OR SUPPLIER	083018	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				50	00 NANNIE HELEN BURROUGHS AVE. NE		
DEANWOO	DD REHABILITATION AN	ID WELLNESS CENTER		W	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
E 000	Initial Comments		Е	000			8/24/22
F 000	An Emergency Prepiconducted at your fact Department of Health Licensing Administrat CFR 483.73. Based interview, it was foun compliance with Emerguirements for Med Participating Provide 483.73. The facility c INITIAL COMMENTS On March 26, 2022, survey was initiated a facility documentation CMS-Philadelphia miconverted into an animarch 29, 2022. This the facility from March 29, 2022. This the facility from March 29, 2025. The following complating survey activities consampled residents. The survey was 255. The following complating survey: DC00010 DC00010663, DC000 DC00010531, DC000 DC00010531, DC000 DC00010694, DC000 DC00010694, DC000 DC00010694, DC000 DC00010634, DC000 DC00010634, DC000 DC00010675, DC000 DC00010575, DC000 DC00010575, DC000 DC00010575, DC000	rs and Suppliers, 42 CFR ensus was 255. an unannounced complaint at this facility. After review of an and conferring with anagement, this survey was mual recertification survey on a survey took place onsite at th 26, 2022 - April 20, 2022. sisted of a review of 105 the facility's census during	F	000	Deanwood Rehabilitation wellness center Disclaimer: The facility submits this ple correction under procedure established by the depart Health in order to comply departments directives to conditions which the departments directives to conditions related to Loncare. This should not be as either a waiver of the fright to appeal or to challe accuracy or severity of all deficiencies or any admissany wrongdoing.	an of res ment of with the change artment er state g term construe acility's enge the	d
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Any deficiency statement ending with an esterisk (*) 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.

FORM CMS-2567(02-99) Provious Versions Obsciete

Event ID:LBNA11

Facility ID: GRANTPARK

If continuation sheet Page 1 of 345

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		04/20/2022
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F 000	DC00010443, DC00 DC00010405, DC00 DC00010335, DC00 DC00010330, DC00 Federal and Local de to the investigation of DC00010694, DC00 DC00010663, DC00 DC00010665, DC00 DC00010485, DC00 DC00010435, DC00 DC00010336, DC00 DC00010314, This survey did ident care at 42 CFR 483(483.25(d)(2) F689. T conducted on April 2 After analysis of the that the facility was requirements of 42 CR equirements for Lo Substandard quality F689 and F610 and the extended survey The following deficie observation, record r interviews. The following is a dir and/or acronyms that report:	010464, DC00010471, 010438, DC00010412, 010400, DC00010373, 010334, DC00010314. eficiencies were cited related ff: DC00010721, 010656, DC00010689, 010651, DC00010576, 010525, DC00010503, 010464, DC00010443, 00010405, DC00010330, 010464, DC000103	FC			8/24/22

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F 000	AV- Arteriovenous BID - Twice- a-c B/P - Blood Pre cm - Centime CFR- Code of CMS - Centers for Services CNA- Certified D.C District of DCMR- District of Regulations D/C- Discont DI- Deciliter DMH - Departmen EKG - 12 lead Ele EMS - Emergency F - Fahrenheit FR French G-tube- Gastrosto HR- Hour HSC - Health So HVAC - Heating vol ID - Intellectua IDT - Interdiscip IPCP- Infection F Program LPN- Licensed I L - Liter Lbs - Pounds (UMAR - Medical D MDS - Minimum I Mg - milligrams M- minute	nt Reference Date s lay ssure sters Federal Regulations or Medicare and Medicaid I Nurse Aide ty Residential Facility Registered Nurse Practitioner Columbia Columbia Municipal inue at of Mental Health at of Health actrocardiogram or Medical Services (911) Improve Center entilation/Air conditioning al disability linary team Prevention and Control Practical Nurse unit of mass) a Administration Record octor	F 00		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		LETED
		095019	B. WING _			04/2	20/2022
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F 550 SS=D	mm/Hg - millimeters MN midnight N/C- nasal cannot nasal c	s per deciliter s of mercury anula al e Protection Association titioner on screen and Resident ous Endoscopic Attorney s order sheet d I Dietitian Jurse f Motion ole party Background, Assessment, are Center Administration Record cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and	F 5		F 550 CORRECTIVE ACTION THE AFFECTED RESIDENT: Resident #64 was assessed if head to toe on 4/26/22 by Uni Manager, resident is free from Resident suffered no negative outcomes. MD/RP notified on 4/26/22 Resident #180 was assessed head to toe on 4/26/22 by Uni Manager, resident suffered no negative outcomes. MD/Notifi 4/26/22. Resident was provide a urinal and taught proper use urinal. Return demonstration indicated understanding. Roo cleaned and free from urine on Resident was encouraged to the bathroom. Staff encourage ensure resident is using his uncorrectly. Resident will be assefor toileting program immediated in later than 8/24/22. Room and bathroom floor was cleaned immediately and will cleaned daily by housekeeping.	from it o ed on ed with e of the was dor. use ed to rinal sessed tely but s be	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L LIDENTIFICATION AND ADED			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 550	with respect and dign resident in a manner promotes maintenancher quality of life, recoindividuality. The faci promote the rights of \$483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless seemed as a resident or or resident of the Unit \$483.10(b)(1) The faci resident can exercise interference, coercior from the facility. §483.10(b)(2) The resident can exercise interference, coercior from the facility. §483.10(b)(2) The resident can exercise of interference, coercior from the facility. §483.10(b)(1) The resident can exercise of interference, coercior from the facility. §483.10(b)(1) The resident can exercise of interference, coercior from the facility. §483.10(b)(1) The resident can exercise of interference, coercior from the facility. §483.10(b)(1) The seed that the facility is and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on record revione (1) of 105 sample failed to ensure that the facility is a sample failed to ensure that the failed to ensure the failed to ensure that the failed t	ty must treat each resident ity and care for each and in an environment that be or enhancement of his or ognizing each resident's lity must protect and the resident. Cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. Of Rights. right to exercise his or her of the facility and as a citizen ted States. Cility must ensure that the his or her rights without an discrimination, or reprisal	F	550	THE POTENTIAL TO BE AFFE All residents with independent care have the potential to be affected have the Director of housekeeping of the corrected by 8/24/22 House wide audit will be conducted the Director of Nursing and United Managers to ensure that there residents are urinating on the fluissues found will be corrected by 8/24/22 MEASURES TO PREVENT RECURRENCE: In service will be provided by Secure that all rooms and baths are always cleaned and free from by 8/24/22 In service will be provided to the nursing staff by the Staff education Designee on the importance of sure that are using it appropriated 8/24/2022	evel of fected. cted by or rooms of free and will cted by the fector. Any by the fet fet fet fet fet fet fet fet fet fe	

	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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							8/25/22	
F 550	Continued From pag	e 5	F 5	550				
	provide an environm	ent that enhances the ife, was based on his dical condition.			5Unit Managers will make free rounds during their shift to ensure residents are not urinating on Any issues found will be corre 8/24/22	ure that the floor.		
	Resident #64 was ac 04/29/15 with diagnor Absence of Unspecif Pathological Fracture Encounter for Fracture (Generalized), Spinal According to the quadated 01/22/22, the runder Section C0500 he is cognitively intactured in the compact of the compa	dmitted to the facility on present that included: Acquired fied Leg below Knee, e., Unspecified Femur, Initial re, Muscle Weakness of Stenosis, Site Unspecified. Interly Minimum Data Set resident was coded as "15" of BIMS Score indicating that ct. O Functional Status, the eas "3", indicating he required erfor toilet use, with assist. O Functional Status, the eas "3", indicating he required erfor personal hygiene, with assist. adder and Bowel) the eas such: ting Program) = No ntinence) = 2, indicating he was			Charge nurses will ensure that residents are provided ADL cand ensure they are free from odor. Any issues found will be corrected by 8/24/22. Ambassadors' rounds will be conducted by interdisciplinary members (social services tear activities, nursing) to ensure the rooms and bathrooms are clear free from odor. Any issues found addressed by 8/24/22. Resident *will be assessed for training by Unit Manager by immediately but no later than all find fullified, resident will be stabledder training exercise. Room cleaning schedule will be provided to Unit managers by housekeeping staff by 8/24/20 assist them to validate weekly rooms and bathrooms are clear free of odor. Unit manager will ensure residis treated with dignity and residuring their shift.	team n, neir an and nd will be bladder 3/24/22. rted on a ee 22 to that the aned and lent # 64	l	

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F 550	H0500 (Bowel Toiletin During an environment approximately 4:00 P present in the bathroor residents in room #51 Resident #64, in room the bathroom floor with feces. He said the use the toilet, he doesn't have his diaper, but he has staff is aware he said Resident #180 urinate he would like to move not moving because of and he was told a lon who complains is the Face-to-face interview 04/07/22, between 1: Employee #51 (RN of Resident #180 often to room and in the bathry his hand and under he these behaviors and tregularly. Employee #51 said the said	ntal tour on 03/30/22, at M, a strong urine odor was om that services the 5 and #516 on unit 5 North. In #516, complained that Im #515 frequently urinates Ir, and smears the bathroom at although he would like to shot, because of the smell. It is going on since Resident moved in sometime last It is a grown man, he is staff clean him and change is no choice. If, and staff has even seen it is on the floor. When asked if it is, Resident #64 said he was of Resident #180's behavior, it is gitted ago that the resident one who should move. It is North) confirmed that urinates on the floor, in his floom. He also gets feces on its nails. Staff is aware of clean his hands and nails	FS	550	MONITORING CORRECT ACTIONS: The Director of Nursing(DO Designee, the housekeepin director, will conduct validate rounds, weekly to confirm all rooms are cleaned and from odor. Any issues four be addressed by 8/24/22. Floor cleaning schedule with given to Unit Managers by housekeeping staff to be unduring the validation process. The Unit Managers will confounds to ensure no reside urinating on the floor and the floors are clean. This awill be done weekly x 4 and monthly x3. and report presented to QAPI Commits.	DN) / ng ation that free nd will ill be sed ess. nduct ent is hat audit d then	8/24/22	

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F 550	Employee #52 (CNA) sometimes urinates of in the bathroom, and every time he goes to gets feces on his han #180 behavior, and hemployee #52 further a diaper and does not the floor, get messes up the bathrouses the diapers. Employee #50 (CNA) pees on the floor, get messes up the bathrouses the diapers. Employee #53 (CNA) years. She also said the floor and gets fect tries to wipe himself, she documents it. Employee #53 stated go to the toilet but " because it 's always A review of Resident 04/08/22 at approxim care plan for Bowel Ir interventions to "encotoilet to evacuate bow through resident and no indications that Reto use the toilet. Employee #54 alternations and 5 South. Design to the goes to the toilet.	said that Resident #180 on the floor in his room and his hands must be cleaned of the bathroom because he d. Staff is aware of Resident e documents it. It stated, Resident #64 uses it get up. It said that Resident #180 Is poop on his hands and from. Resident #180 pees on les on his fingers when he In Nursing staff is aware, and It hat Resident #180 used to It stopped using the toilet messy". It stated that Resident #180 used to It stopped using the toilet messy". It stated that Resident #180 used to It stopped using the toilet messy". It stated that Resident #180 used to It stopped using the toilet messy". It stated that Resident #180 used to It stopped using the toilet messy". It stated that Resident #180 used to It stopped using the toilet messy that Resident #180 used to It stopped using the toilet used that Resident #180 used to It stopped using the toilet used that Resi	F	550		8/24/22

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F 558 F 558 SS=D	Reasonable Accomm CFR(s): 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of re preferences except wendanger the health other residents. This REQUIREMENT by: Based on observation interview, for one (1) the facility's staff failed access to the bathrous seat causing the resident for the findings include: During an observation approximately 11:30 bathroom was locked access the bathroom was also observed the have an elevated toiled Resident #113 was a 06/19/14. The resident Muscle Weakness, Charles Walking, and Osteoper Review of a Quarterly 02/09/22 showed Resummary score of "15 had intact cognition."	th to reside and receive with reasonable sident needs and when to do so would or safety of the resident or is not met as evidenced and resident and staff of 105 sampled residents, do to provide Resident #113 or and an elevated toilet dent to be dependent on soom. In on 03/29/22 at MM, Resident #113's la, and the surveyor had to from the neighbor's side. It at the bathroom did not et seat. Indicating the resident #13's la, and the surveyor had to from the neighbor's side. It at the bathroom did not et seat. In on 03/29/22 at MM, Resident #113's la, and the surveyor had to from the neighbor's side. It at the bathroom did not et seat. In on 03/29/22 at MM, Resident #113's lad a BIMs of the man and an all MS of the model of the MDS is indicating the resident for indicating th		5558	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: Resident #113 was assessed from to toe on 4/26/22 by Unit Manager. Resident suffered no negative outo MD/RP notified on 4/26/22.Unit material ensured that resident has access to bathroom. Rehab team will provide an elevate toilet seat in the resident's bathroot immediately but no later than 8/24/Unit Manager taught and instructed resident in the next room to resider #113's room to always leave the bathroom door unlock when not in on 4/26/2022. . IDENTIFICATION OF OTHERS WITHE POTENTIAL TO BE AFFECT. All residents with shared bathroom the potential to be affected. House wide audit will be conducted DON/Designee to identify resident need elevated toilet seats. Any issued found will be corrected by 8/24/22. House wide audit will be conducted Unit Managers and the maintenance team to ensure shared bathroom creasily be accessible by the resident Any issues found will be corrected 8/24/22.	omes. nager of the ed m 2022. I ints use ITH ED: have I by who ues I by se an ts.	8/24/22
	supervision and requ	13 was coded for needing iring the physical assistance et use, not moving on and off					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMP	X3) DATE SURVEY COMPLETED				
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F 558	steady and requiring during surface-to-sur wheelchair. Additiona for occasional urinar incontinence of bowe	assessment period, not being staff assistance for stability face transfers, and using a ally, the resident was coded y incontinence and frequent	F	558	4Supervisors will monitor weekly ensure residents with shared bathroom always have access to bathroom. Any issues found will be addressed by 8/24/22	the	8/24/22
	04/12/22 lacked doctorder for an elevated	umented evidence of an toilet seat.			MEASURES TO PREVENT RECURRENCE:		
	Focus Area- [residen urinary incontinence muscle tone (revision Interventions: -Brief use: the reside Change when wet ar	the resident uses disposable briefs. hen wet and prn (as needed). incontinence frequently and provide difficulties using the bathroom because inappropriate toilet seat so that prope intervention is implemented by 8/24/2		the og cause o oper 24/2022 by team int is			
	Focus Area -[resident's name] has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) disease process CVA (Cerebral Vascular Accident). Goal- [resident's name] will improve current level of function in transfer and personal hygiene. Intervention-toilet resident upon arising, after meals and at bedtime.				having difficulties using the toilet seed resident can be assessed for the elevated toilet seat. Any issues for the be corrected by 8/24/22 Therapy team will ensure resident need elevated toilet seat are asset provided one by 8/24/2022 to ensure residents will have no difficulty us toilet.	use of a und will ts who essed ar ure that ing the	nd :
	the facility ordered a elevated toilet seat the During a face-to-face approximately 2:00 F her next-door neighboathroom with, keeps	dated 11/11/21 showed that Bariatric Commode [an nat's placed over a toilet]. e interview on 03/29/22 at PM, Resident #113 stated that or, who she shares a s the bathroom door locked, s the bathroom. The resident			Nurse aides are encouraged to freecheck the bathroom door betweer 315 and room 316 and other shar bathrooms to ensure the bathroom unlocked and accessible to both reduring their shift. Any issues found corrected by 8/9/22. Unit manager ensure resident # 113 has access bathroom by 8/24/22	n room ed n door i esident d will be will	s s

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F 558	also said that not have was "ok" because the can not independent! her wheelchair. When bathroom, Resident # brief (incontinent pad calls staff to remove to the calls staff to remove to the calls staff to remove the calls from the calls for about a call for about	ing access to the bathroom toilet is too low, and she y transfer from the toilet to n asked how she uses the 113 said that she uses the 1, cleans herself up, and he used brief. interview on 04/12/22 at 159 (Restorative Aide) stated ted with the resident on toilet to the wheelchair needed an elevated toilet interview on 04/12/22 at 155 (Occupational Therapist) her an elevated toilet seat, The employee said that she aware the resident's ad not been delivered. interview on 04/12/22 at 156 (Certified Nursing she had worked with the ear, and the resident does for the bathroom. The the resident "changes Is her brief. Employee #56 Resident #113 changes her it in a trash bag and calls me get the trash."		5558	Unit manager / Designee will ed (remind) residents who share a bathroom with other resident in adjoining room, to leave the docunlocked when not in use. Finding the corrected by 8/24/22 and the corrected by 8/24/22 and the council meeting to leave the bath door unlocked when not in use, when the council meeting to leave the bath door unlocked when not in use, and the council meeting to leave the bath door unlocked when not in use, when the council meeting to leave the bath door unlocked when not in use, and the council meeting to leave the bath rounds to ensure all residents where assessed by the rehab team and assigned one if applicable by 8/2 Maintenance team will conduct the during their shift to ensure that shathrooms are easily accessible both residents, any issues found addressed and reported to QAP director /committee weekly x4, the monthly x3	the or ngs will cate nt hroom CCTION ekly ho d 24/22 rounds shared e by d will be I	8/24/22

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DEANWO	OD REHABILITATION AN	ID WELL NESS CENTED		5000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	not limited to the right (1) through (11) of thi §483.10(f)(1) The resactivities, schedules (waking times), health care services consist assessments, and plaapplicable provisions §483.10(f)(2) The res	sident choice, including but the specified in paragraphs (f) is section. ident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other of this part.	F 56	CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #233 was assessed thead to toe on 4/26/22 by Unit manager, resident suffered no negative outcome. Resident st that she likes her new room. RP/MD notified on 4/26/22	rom	8/24/22
	§483.10(f)(3) The res	s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the		IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE Residents who are being reloca secondary to Covid 19 have the to be affected.	CTED: ted	
	§483.10(f)(8) The resparticipate in other acreligious, and communinterfere with the right facility. This REQUIREMENT by: Based on observation interviews for one (1) residents, facility staff who had been moved outbreak, the opportuprevious room or previous room or previous room or previous were lifted. The findings include:	ctivities, including social, inity activities that do not ts of other residents in the is not met as evidenced in, record review, and out of 105 sampled failed to offer a resident due to a COVID-19 inity to move back to her vious unit once COVID-19 d. Resident #233.		House wide audit was conducted Mangers/ Designee to identify rowhom the facility admissions confailed to relocate back to their prooms after they have completed isolation / quarantine days for promoths. No resident complained or she wanted to be relocated.	esidents ordinator revious d their ast two	
		dmitted to the facility on ses including Diabetes				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		LETED
		095019	B. WING			04/	20/2022
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	04//	20/2022
					000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CENTER			VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page 12		F	561	F561 MEASURES TO PREVEN RECURRENCE:	Т	8/24/22
F 561	Mellitus with Diabetic Disease, Stage 4, an Unspecified Occlusion Unspecified Cerebell Quarterly Minimum Discibility staff coded Remanner: Section C (Cognitive Mental Status Summathat the resident was A review of Resident revealed: 01/01/22 at 9:53 AM Transfer]: "[Resident from Room 209B to Find precautionary measured During an observation the writer observed Finesting in her bed. On trash bag with some in them. Another trast belongings was sittin resident's bed. During with the resident at the observation, she exp	Neuropathy, Chronic Kidney d Cerebral Infarction Due to n or a Stenosis of ar Artery. Pata Set dated 03/16/22 esident #233 in the following Patterns) Brief Interview for ary Score was 15, indicating cognitively intact. #233's medical record [Activities Note -In-house #233's Name] was relocated Room 502A as a re related to Covid-19." In on 03/31/22 at 11:30 AM, Resident #233 in her room in the bedside table was one of the Resident's belongings in a chair adjacent to the graface-to-face interview	F	561	*In-service will be provided by S Educator to all nursing staff men on the importance of asking resi if they desire to be relocated to t previous room after isolation /quarantine and put a documentation in place by 8/24/2 Unit Managers will conduct roun during their shift to ensure all res who are due for relocation post isolation and quarantine are give opportunity to determine if they of go back to their previous room of Any issues found will be correcte 8/24/22. In-service will be provided to the admissions coordinator, nursing and Licensed social workers on importance of ensuring that resid are given the opportunity to state they want to go back to their pre room or not. Documentation of outcome will be in place by 8/24 Admission coordinator will read of residents who are due for relo	dents heir 2022. ds sidents en the wish to r not. ed by staff the dents e if vious 2022. the list	
	and still had the form belongings in it. She wanted to go back to floor. She said when fifth floor, she was to but the facility staff had The resident then as				post quarantine / isolation to the interdisciplinary team (social work Activities director, clinical staff) of morning meetings to remind their the relocation date so that plans be made to meet with the reside determine if they desire to move not. Any issues found will be corby 8/24/22.	rkers, during m of can nt to or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		D BE	(X5) COMPLETION DATE	
F 561	PM with Resident #2 she voiced the follow January 2022, my mo COVID outbreak in the that was decided or was doing fine in a rowas put in a room with They put her in a room on place to put her clawas only going to be During a face-to-face 12:51 PM Employees that she was aware of transfer from the second asked if anyone had copportunity to move be she responded, "The she wanted to move ID During a face-to-face 12:51 PM, Employee stated, "When a reside another room, the resworker or nurse know worker or nurse know With Resident #233, her daughter/represe spoke with her was be February. There were	terview on 04/01/22 at 12:07 33's representative/daughter ing concerns: "In early other was moved due to a e facility. I am not sure how what criteria they used. She om with one roommate and h three other residents. m with no tv, no phone, and othes. We thought the move temporary" interview on 04/06/22 at #13 (Social Worker), stated if Resident's #233's room ond to the fifth floor. When offered the resident the back to her old room or unit, resident never told me that back." interview on 04/06/22 at #44 (Admissions Director), tent wants to transfer to bident usually lets the social of what room(s) are available. I had been speaking with intative. The last time I back at the beginning of e no rooms available on the hat time. Rooms on the cond floor] became ry. I have 9-10 rooms going to call her and let her know the	F 5	ADON/ Designee will conducted to ensure residents have completed their isolat quarantine days are off the Residents who wish not to relocated to their original romust indicate by document desire to stay in the room. The responsible party will be up of this decision. These aud be conducted weekly x4 and monthly x3. Any issues will corrected and reported to the committee.	uct who on/ unit. oe oms ng their The dated ts will d be	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	7 0-9/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 582 SS=D	documented evidence Resident #233 the or original room or unit. Medicaid/Medicare CCFR(s): 483.10(g)(17) The final	coutbreak, there was no be that facility staff offered opportunity to return to her coverage/Liability Notice (7)(18)(i)-(v) facility must-caid-eligible resident, in admission to the nursing resident becomes eligible for ervices that are included in the sunder the State plan and the may not be charged; and services that the which the resident may be count of charges for those caid-eligible resident when the items and services (g)(17)(i)(A) and (B) of this facility must inform each the time of admission, and the resident's stay, of services the stay of charges for those the care/ Medicaid or by the end of coverage are made to items and the change as soon as is	F 582	F 582 CORRECTIVE ACTION FOR T	e : home home S WITH CTED: harge d. de are due are later

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE COMP	
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NAME OF P	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	20/2022
					000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		WASHINGTON, DC 20019			
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F 582	facility must inform th 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or est deposit or charges aliper diem rate, for the resided or reserved of facility, regardless of discharge notice requive) The facility must resident representative the resident within 30 date of discharge from (v) The terms of an acceptable of an individual facility must not conflict these regulations. This REQUIREMENT by: Based on record revitwo (2) of 105 sample failed to ensure that the representative was pulater than noon of the date indicated/date liss skilled services. Res The findings include: "The Notice of Medical stipulates that every I has the right to appear non-coverage to the CorganizationThe Quorganization will notificated."	e resident in writing at least ementation of the change. Or is hospitalized or is not return to the facility, the othe resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually retained a bed in the any minimum stay or direments. The facility of any and all refunds due days from the resident's method to the resident's method facility. It is not met as evidenced diew and staff interview, for the residents, facility staff wo (2) residents or their rovided the NOMNC form no day before the effective sted as discontinuance of didents' #209 and #553. The Non-Coverage form of Quality Improvement and the decision of Quality Improvement of you of its decision as soon or no later than two days after	F	582	MEASURES TO PREVENT RECURRENCE: In service will be provided by Sta Educator to all social services won the importance of ensuring the residents who are due for dischanotified of the discontinuation of skilled services at least four days advance. This will be completed 8/24/2022. Repeat in-service will done as needed. Rehab Director will notify the interdisciplinary team members staff, activities staff, nutritionist) number of days left for skilled rehave during daily morning meeting that everyone will be on the loop ensure a timely discharge. Any is found will be corrected by 8/24/2 MDS coordinators will assist in determining when a resident is close to discontinuation skilled services, so that the cut of can be presented to the resident responsible party in a timely man Any issues found will be corrected 8/24/2022.	orkers nat arge are their s in by I be (clinical of the sidents ngs, so to ssues 2022. on of off letter t or the nner.	8/24/22

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095019	B. WING		C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	
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F 582	Original Medicare" 1. Resident #209 was 02/16/22, with diagnor Obstructive Pulmona Hypertension, and Verage was March 21, 2022 appeal rights. Made a 03/21/22 and the resbeginning date was 0 Facility staff failed to or their representative form no later than no effective date indicated discontinuance of ski 2. Resident #553 was 01/06/22, with diagnor Transplant Status, Ty Chronic Obstructive I End Stage Renal Dis According to the NOI last day of coverage was 01/18/22 Explarights. Made aware of and the resident final was 01/19/22. Facility staff failed to or their representative Non-Coverage no late.	s admitted to the facility on oses that included Chronic ry Disease, Anemia, ertebral Sacral Fracture. MNC form, Resident #209's for Skilled Nursing ServicesExplained NOMNC and aware of effective date-ident financial liability 03/22/2022. ensure that Resident #209 e was provided the NOMNC on of the day before the ed/date listed as lled services. s admitted to the facility on oses that included Kidney ype 2 Diabetes Mellitus, Pulmonary Disease, Asthma, ease and Heart Failure. MNC form, Resident #553's for Skilled Nursing Services ained NOMNC and appeal of effective date-01/18/2022 incial liability beginning date ensure that Resident #553 e was provided the Notice of er than noon of the day ate indicated/date listed as	F 58	F 582 MONITORING	es ure due their days as skilled be nd s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED C	
		095019	B. WING			20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	·		
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F 582	During a face-to- fac	ce interview on 04/20/22 at	F 58	22		8/24/22	
	Services) reviewed lidecuments and acki	e #10 (Director of Social Resident #209's and #553's nowledged the findings. able/Homelike Environment -(7)	F 58	4F584 CORRECTIVE ACTION FOR AFFECTED RESIDENT:	? THE		
	but not limited to red supports for daily liv The facility must pro §483.10(i)(1) A safe	ight to a safe, clean, nelike environment, including eiving treatment and ing safely.		All rooms and bathrooms will audited, to ensure that they a and free from odor, and that environment is clean and hor issues found will be corrected 8/24/22.	re clean the nelike .Any		
	use his or her perso possible. (i) This includes ens receive care and sel physical layout of the independence and condition to the	uring that the resident can rvices safely and that the e facility maximizes resident loes not pose a safety risk. exercise reasonable care for resident's property from loss		IDENTIFICATION OF OTHE THE POTENTIAL TO BE AF All rooms in the facility have potential to be affected by thi practice. Damaged privacy curtains in #211, #308, #309,#310, #31	FECTED: the s deficient rooms		
	services necessary and comfortable inte §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private	keeping and maintenance to maintain a sanitary, orderly, erior; bed and bath linens that are e closet space in each eccified in §483.90 (e)(2)(iv);		are presently clean and undamage Room #420, #428, #502, #51 presently cleaned with no sm noted. Bathroom vents in rooms # 4 #405,#428, #420, #529 are p clean.	6, #524 are lell of urine		
	§483.10(i)(5) Adequ levels in all areas;	ate and comfortable lighting		Air conditioners in rooms 329 #524 were checked. Any issu			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		095019	B. WING			04/	
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	DATE
F 584	levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observatio staff failed to provide necessary to maintain environment as evide curtains in six (6) of 7 bathroom vents in five a foul, offensive odor and malfunctioning paconditioner (PTAC) unresident rooms. The findings include: During an environment facility on 03/30/22, a and on 04/04/22, betwoe pM, the following was 1. Privacy curtains we the rails in six (6) of 7 rooms #211, #308, #309, #310, 2. Bathroom vents we of 76 resident's rooms #405, #428, #420, and #529.	table and safe temperature ally certified after October 1, a temperature range of 71 to a temperature r	F	584	F584 MEASURES TO PREVENT RECURRENCE: In service will be provided by Standard Development team to the housekeeping and maintenance members on the importance of ensuring that all residents rooms privacy curtains that are in good condition, that all bathroom's veclean and in good working condition that all air conditioners are and functioning well. This will be completed by 8/24/2022. Repeatin-service will be provided as new Unit Managers will conduct round their units weekly to ensure that privacy curtains, bathroom vent condition units are in good condition and functioning properly. Any is found will be corrected by 8/24/2/2. Maintenance and housekeeping will conduct daily rounds in all the rooms to ensure that all privacy curtains, vents and air condition are functioning, and that the roof free from odor Any issues found corrected by 8/24/22.	e team s have nts are ition, ne odor clean e t eded. ids on the es, air ition sues 22. team ne units ms are	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING		04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	, , , , , , , , , , , , , , , , , , , ,	
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F 584 F 600 SS=H	of 76 resident's rooms st 4. PTAC units did no failed to reach set ten resident rooms (#209 During a face-to-face approximately 4:00 P acknowledged by Em Director) and Employ Services Director). Free from Abuse and CFR(s): 483.12(a)(1)	o2, #516, and #524, five (5) urveyed. It function as intended and inperatures in three (3) of 76, #508 and #524). Interview on 04/04/22, at M, these findings were ployee #16 (Maintenance ee #17 (Environmental	F 58	Director of Maintenance Housekeeping director of Validate that all privacy curtains, bathroom vent condition units are functioning properly and the rooms are free from weekly x4 then monthly	e and will s, air I that odor x3.	
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's message of the second involuntary seclusions. This REQUIREMENT by: Based on observation and staff interviews, for residents, facility staff were free from abuse	right to be free from abuse, ition of resident property, efined in this subpart. This lited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or or or al punishment, or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			04/	20/2022
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				5	0000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			NASHINGTON, DC 20019		
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F 600	#404 by Resident #82 person center care m who had incidences of towards Resident #77 to Resident #67; faillu training to provide per Resident #409 post his subsequently the resident #409 post his subsequently the resident to ensure (stoma) was not occlude the Moisture Exchait the resident to be trained available lary-tube and for treatment and care subsequently, the resident to the treatment and care subsequently, the resident #404, #71, The findings include: Review of the facility Abuse" [not dated], dwillful infliction of injurity harm, pain or mental in this definition of ab must have acted delitindividual must have harm Neglect, is faremployees or service and services to a resident avoid physical harm, emotional distress"	serious injury of Resident 2; failure to implement easures for Resident #151 of aggressive behavior I and willful infliction of injury re to ensure staff received rson-centered care to ip replacement, dent sustained a dislocated Resident #3's airway uded by a medical device nger (HME) subsequently, nsferred to the Emergency gment; and failure to have id HME (medical equipment) e of Resident #3's stoma ident was transferred to the replacement of the ermined to be present for #67, #409, and #3. policy entitled, "Prohibition of ocumented, "Abuse is the ry resulting in physical anguish Willful, as used use, means the individual berately, not that the intended to inflict injury or ilure of the facility, its providers to provide goods dent that are necessary to pain, mental anguish or	F	3000	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #404 expired in the hospital deficiency cannot be retroactively concerned by the continuous deficiency cannot be retroactively concerned by the continuous 1;1 monitoring until evaluated by doctor. Resident was placed in a pri room on 2/22/22 and on 1:1 continuous monitoring. Resident taken into cust DC police department on 7/20/22, cono residing at the facility. Resident #3 was discharged home of facility 3/29/22 Resident #67 was assessed head to Clinical Care Coordinator on 4/26/20 bruises, redness and pain. Resident pain. Resident suffered no negative outcomes. MD/RP notified on 4/26/20 Resident will be monitored by staff of aggressive behavior every shift. MD notified on 4/26/2022 Unit Manager, resinot suffer any negative outcome. ME notified on 4/26/20. Resident is on continuous 1;1 monitoring for aggres behavior every shift with reevaluation psych doctor until further notice.	ead to toe ator, mes. t's d; he was psych vate ous ody by urrently rom the 22. ead to toe 222. or /RP	
	Review the facility po	licy entitled,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			(X3) DATE SURVEY COMPLETED C	
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	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019			
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F 600	revised on 01/2022 resident is observed aggressive to having the potential for abu assessment of strate incidents from occur Interdisciplinary Tea Review the facility p and Protections as a revised on 03/2022 right to be free from mental abuse" 1. Facility staff failed of serious injury of F#82 evidenced by fa#404's plan of care is resident-to-resident Review of a Facility 02/23/22, document observed [Resident besides his roommanurse noticed blood and mouth. The nurs #404's] left ear and tear or abrasion incl #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he fill Review of a Complat documented, "fam they say their father	and Altercation/Incidents" documented, " When a lor identified as being graggressive behavior or has sing other residents, an egies to prevent such rring will be provided by the m (IDT)" olicy entitled, "Your Rights a Nursing Home Resident" documented," You have the verbal, sexual, physical, and to prevent the willful infliction Resident #404 by Resident illure to adjust Resident resulting in a altercation. Reported Incident (FRI) dated ed, " The charge nurse 404] sitting on the floor te's bed #420A; the charge on [Resident #404's] left ear se assessed [Resident mouth and there was no skin uding his face [Resident ed he said, "that man keeps bed side and when I asked as side of the bed, he punched and chest and I punched him tell"	F	600	Resident #409 was discharged to another facility 9/28/21. All residents with stoma sites will assessed and any issues will be addressed by 8/24/22 IDENTIFICATION OF OTHERS VITHE POTENTIAL TO BE AFFECT Residents with behavior problems those with stoma to aide in respiration have the potential to be affected. House wide audit will be conducted Clinical care Coordinator, Unit Managers / Designee to ensure the residents have been assessed for aggressive behavior with the potential abuse others, that care plans for residents with behavior issues cleindicate the kind of behavior the residents with behave adequate supervision, and the staff members are fully trained on care for residents with aggressive behavior. Any issues found will be addressed by 8/24/2022. Residents with wandering behavior be redirected, supervised, and more every shift by charge nurses and the staff members are fully trained on care for residents with wandering behavior be redirected, supervised, and more every shift by charge nurses and the staff members are fully trained on care for residents with wandering behavior and more redirected, supervised, and more every shift by charge nurses and the staff members are fully trained on care for residents with wandering behavior.	VITH FED: and ation ed by nat ntial to arly esident ehavior nat how to	l

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DEANWO	OD REHABILITATION AN	ID WELL NESS CENTED		50	000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	JD REHABILITATION AN	ID WELLNESS CENTER		W	ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	22	F	500	F600 MEASURES TO PREVENT RECURRE	ENCE:	8/24/22	
	#404] was attacked w Name]. [Resident #40 March 20 (2022)" Review of a Complair documented, "Avoid Patient assaulted in n was assaulted 02/22/ facility by another res	dable death. Comments: ursing home. Beneficiary 2022 in skilled nursing ident. He sustained blunt eding noted on his left ear ansferred to an acute			In-service will be provided by Staff educe designee to all Licensed Nursing staff of importance to ensure that residents with behavior have a person-centered care clearly state the type of behavior they are exhibiting and that they are provided supervision during their shift by 8/25/20. Repeat in-service will be provided as in Training will be provided by Staff Educe Designee to all licensed nursing staff of importance of creating a person -center plan for all the residents based on their diagnosis	on the h plan that are 022. eeded. ator/ n the red care		
	09/15/21with multiple	admitted to the facility on diagnoses that included: stage Renal Disease and			Training will be provided by Staff Educator/Designee to all licensed nurs on stoma care and the importance of c person-centered care plan for the resid reflect their diagnosis, especially for rewith hip replacements by 8/24/2022. Rein-service will be provided as needed.	reating a lents to esidents		
	(MDS) dated 01/31/2: coded: a Brief Intervie summary score of "12 response, no physica directed towards othe one person physical a living (ADLs), used a	erly Minimum Data Set 2 showed that facility staff ew for Mental Status (BIMS) 1", indicating intact cognitive I or behavior symptoms ars, required supervision with assist for activities of daily walker for mobility and			Charge nurses will ensure that residents with aggressive behavior are supervised and monitored during their shifts, and that there is documentation in place. Any issues found will be corrected by 8/24/22. In service will be provided by rehab director to all licensed nurses on how to assess residents with hip replacement and to C N A 's on how to assist residents with Hip replacement by			
	12/06/16 with diagnost Unspecified Dementia Disturbances, Vascula Behavioral Disturbance Ischemic Attack.	s admitted to the facility on ses that included: a without Behavioral ar Dementia without ces and Transient Cerebral			8/24/2022. In-service will also be provided by staff educator / Designee to all nursing staff to carry out CPR on a resident with a s 8/24/2022	on now		
	Review of Resident #	404's medical record						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	LETED
		095019	B. WING _			04/	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 0411	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	revealed the following 12/16/21 [Quarterly Nooded a BIMS summa severe cognitive impa In Section E (Behavior psychosis, no physical directed towards other pushing, scratching, sexually), verbal behavior behavi	IDS] showed facility staff ary score of "03", indicating airment. Or), no potential indicators of all behavioral symptoms ares (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred ing behaviors "occurred ing behaviors "occurred in his/her with one person physical anal limitation in range of arm, "Used daily" (Revision date) "[Resident opement: cognitive a Observed wondering at 5/28/2021. Wandering to the	F	800	Charge nurses will ensure that resider with stoma site and on a respiratory equipment are assessed every shift arensure documentation is in place. Equipment must be clean by respirator therapist/ licensed nurses weekly. Any issues found will be corrected by 8/24/2 ADON/Designee will ensure that resider equiring one on one staff monitoring secondary to intrusive and aggressive behavior, are placed on 1:1 until evaluate by psychiatrist/Designee. Any issues fawill be corrected by 8/24/22. Supervisors will conduct rounds during shift to ensure that resident with aggree behavior are monitored and adequate supervision is provided. Updates providuring validation meeting. Any issues will be corrected by 8/24/22. Unit Managers will audit charts to ensure that residents on their unit have personal care plan based on their diagnosis. Any issues found will be corrected by 8/24/22. Unit managers/supervisors will ensure residents with hip replacement are assessed daily to ensure care plan implementations are being followed. Supervisors will be notified about residential day issues found will be corrected by 8/24/22. In service will be provided by staff educator / Designee to all restorative at C N A's and licensed nurses on how the assist resident with hip replacements is 8/24/2022.	ents ated ound g their ssive ded found ure n that dents ily.	8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE			
		095019	B. WING _			04/2	20/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
DEANWO	OD DELIADII ITATION AN	D WELLNESS CENTED		5000 NANNIE HELEN BURROUGHS AVE. NE					
DEANWO	OD REHABILITATION AN	D WELLNESS CENTER		WASHINGTON, DC 20019					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 600 Continued From page 24 showed the following: 02/02/22 at 2:12 PM " Elopement attempts. Wanderingsleeping in other people's bed Behaviors are constant." 02/03/22 at 1:12 PM " sleeping in other people bed. Behaviors are constant."		F	500	Unit mangers will audit charts to ensicare plans are updated/ revised for a residents monthly. Findings will be coby 8/24/22.	II	8/24/22			
		g in other people's bed nt." ' sleeping in other people onstant."			Facility administrator/ Designee will e that respiratory medical equipment's current supply every week. Findings corrected immediately until 8/24/22. Training will be provided by staff edu designee to all Licensed Respiratory on the importance of documenting af	are in will be cator/ therapist ter			
l t	02/07/22 at 1:52 PM " bed. Behaviors are co 02/09/22 at 1:47 PM "			assessing a resident especially abno findings and indicate what immediate were taken to resolve the issue. Find be corrected by 8/24/22.	actions ings will				
	bed. Behaviors are constant." 02/10/22 at 12:17 PM "sleeping in other peoples bedBehaviors are constant." 02/11/22 at 11:16 AM " sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM "sleeping on other peoples bedBehaviors are constant."				Unit manager will ensure that charge nurses are documenting on all residents during thei shift and that the documentation reflects the residents' condition weekly. Findings will be corrected by 8/24/22. Unit managers will ensure weekly that incident reports are completed and that the names and room numbers of all parties involved are indicated. Findings will be corrected by 8/24/22 Resident #67 is not on the same unit as resident #71				
	02/14/22 at 2:10 PM 'bedBehaviors are c	'sleeping on other peoples onstant."			Unit manager will ensure any resider replacement has a person centered or by 8/24/22				
	02/16/22 at 1:28 PM " bedBehaviors are c	'sleeping on other peoples onstant."							
	02/18/22 at 2:19 PM bedBehaviors are co	sleeping on other people's onstant."							
	02/19/22 at 1:18 PM 'bedBehaviors are c	sleeping on other peoples onstant."							
	02/20/22 at 12:23 PM peoples bedBehavio	· ·							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE : COMPL	
		095019	B. WING _			04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	LO/LULL
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	documented, "Observed coming from his mou applying cold compress Situation Background (SBAR) dated 02/21/2 "Situation The resign roommate Backgro Resident Reports Paindicators of pain evidunchanged Skin/W blank) Assessmer Additional comments am The writer observed on the floor near room with blood coming out writer immediately not 911. DC (District of C [Resident #82] also s [Resident #404]. The what happened, resign the came to my bed.' at the unit at 3:10 am #404] in a stretcher at ambulance attendant [Physician Name] and made aware." 02/21/22 at 4:16 AM Progress Note] "The While making routine was observed sitting 420 A. Resident was the left side of his fact made, he was assess Resident could not de is his base line. A qui	Il dated 02/21/22 at 2:40 AM vations face Blood was th, we managed to stop it by ss and ice" Il Assessment Request 22 at 4:00 AM showed, lent got hit by his und: Altered mental status n? 'No'. Non-verbal dent? 'No'. Functional Status bund Status- (area was left blank) At approximately 02:30 erved [Resident #404] sitting nmate's bed (420 bed A) to fhis left ear, face. The tify the supervisor and called olumbia) police. I saw litting on his walker facing writer asked [Resident #82] lent stated 'I hit him because DC fire department arrived and left with [Resident ccompanied by two sto [Hospital Name]. d RP (representative) was	F 6	600	For other residents with the pote be affected by aggressive behav other residents, education will be provided to those with BIMS of 1 above to report anyone that is approaching them aggressively the nurses or CNA's by 8/25/2022. Fresidents with low BIMS score, will be made every two hours by employees working on the unit, the ensure no one is exhibiting an aggressive behavior towards the Any issues found will be address 8/25/22. Education will be provided by standard to C N A'S, housekeep staff, unit secretaries, environments staff on care plan interventions for residents with aggressive and wandering behaviors, MONITORING CORRECTIVE ACCEPTIVE ACC	cior of e 2 and co the corrounds o em. sed by aff bing ental or CTION: kly ents e that are plan nat they o shift. weekly with shift	8/25/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	monitored T. (temper (respirations) 18, B. Spoe (sp) (oxygen status of the resider nurse [Registered National Resident (#404) is controlled intubated and about (intensive care unit) During a tour conduct approximately 3:00 document was obsetted the nurses station through 10/2021 4 South Behavior Document #404] Common behavior Document wondering, elopement wondering, elopement word in the status of this evided had knowledge of all #404's intrusive behavior sident's rooms and beds. a. Although the facilia address Resident #resident units; there care plan was updatates intrusive behavior plan was	de of the face, vital signs was erature) 96.5, P. (pulse) 82, R. P. (blood pressure) 140/90, saturation) 97% on Room Air." I [Nurses Note] "A call was Name] to know about the nt [#404] in the ER, spoke with lurse's Name] who stated critically ill, he has been to be transferred to ICU. RP made aware."	F6			8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		095019	B. WING			C 4/20/2022	
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019	DE	7/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 600	residents such as pure for physical injury, ir activity, upset that he in their bed. c. Although the staff was being monitored wandering into other in their beds. There monitoring the resident manage the resident During a face-to-face 04/04/22 at 12:48 PC Coordinator) stated, plan updates, creating During care plan reveat orders, nurse's not updates as needed. aware that Resident behaviors of going in and sleeping in other #7 stated, "I was ne nurses on the unit. I a wanderer, I was ne into rooms or else he	s behavior impacted other utting himself or others at risk natrusion on their privacy or e in their room and sleeping record that Resident #404 d hourly, he was still found r resident rooms and sleeping is no evidence that ent was readjusted to	F 60			8/24/22	
	about the, "4 South Behavior Document #404's behavior, Em see it." 2. Facility staff failed supervision and imp interventions for Res prevent Residents #	terventions. When asked List of Residents for Daily ation" that stated Resident aployee #7 stated, "I didn't I to provide adequate lement the plan of care sident #151 to protect and 71 and #67 from incidences ior (resident-to-resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		095019	B. WING _			04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT		
F 600	Review of Facility Rethe following altercate the following altercate Review of the FRI da At 0730AM, the sea [Resident #151] assate [Resident #71] at the Review of the FRI daAt 2030 on 12/29/2 alleged to the recept him on his chest x 2 Resident Backgroun A.Resident #151 was 10/22/20 with multiple Unspecified Psychos Benign Prostatic Hyperical Review of Resident are revealed: 12/08/21 [Admission BIMS summary score cognitive impairment In Section E (Behavier) and the following protection in Section	ful infliction on injury. exported Incidences showed cions involving Resident #151: ated 12/09/21 documented, " excurity officer observed aulting another resident of front of the building" ated 01/02/22 documented, " (2 (12/29/21), [Resident #67] ionist that [Resident #151] hit in the lobby" d Information for Residents' on the diagnoses that included: sis, Epileptic Syndrome and perplasia. #151's medical record MDS], facility staff coded a te of "07", indicting severe to reptions or beliefs that are to reality) - "yes"	F	500		8/24/22	
	behavioral symptom (e.g., hitting, kicking,	s directed towards others pushing, scratching, hers sexually) - "Behavior of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C		
		095019	B. WING			04/20/2022	
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	IE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 600	symptoms directed threatening others, at others) - "Behavi days", Impact on Resignificant risk for properties in physical injury? "yes privacy or activity or disrupt care or living. In Section G (Funct Daily Living (ADL) A transfer, walk in rocolocomotion on unit, #151 required "superphysical assist" Review of the Care 07/27/21 (Revision positive PASARR (Resident Review) Levaluation, it was doneeds Specialized Section and the MD (medical doctor serious health declinagreed to may need Inform the MD of ar require additional eremove services' 07/27/21 (Revision for changes in behalagitation"	to 3 days", verbal behavioral towards others (e.g., screaming at others, cursing or of this type occurred 4 to 6 esident Put the resident at hysical illness or injury? "yes"; put others at significant risk of s"; significantly intrude on the f others? "yes"; significantly g environment? "yes" dional Status): Activities of Assistance - bed mobility, or, walk in corridor, locomotion off unit, Resident ervision" and "one person Plan revealed: date) "As evidenced by a Preadmission Screening and evel I screen and Level II etermined that the resident Services while in the Nursing schizophreniaInform the color if the Individual has a ne and services previously did to be modified or deleted. The significant changes may valuation to add, modify or	F 60			8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING			04/2	20/2022
	ROVIDER OR SUPPLIER DD REHABILITATION AN	ID WELLNESS CENTER	•	50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	to treatment/care relations to treatment/care relations, Schizoph taking medications, In non compliant with Scompliant with Wader and hitting" 10/20/21 (Revision daimpaired cognitive fur processes r/t (related 10/20/21 (Revision dai	propriate behavior; resistive sted to: Cognitive Impairment renia). Non compliant with on compliant with vital signs, naving and showers. Non reguard placement kicking steel "[Resident #151] has notion or impaired thought to) Dementia" The propriate behavior of the propriate of the formula to be a complete or the propriate of the propriate	F	600			8/24//22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ON	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER			SS, CITY, STATE, ZIP CODE HELEN BURROUGHS AVE. NE N, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((E <i>A</i>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	behavioral symptoms person physical assistrange of motion and C. Resident #67 was 09/29/08 with multipl Unspecified Intellect Disorder with Halluci Dementia without Be Review of Resident #Quarterly MDS dated coded a BIMS summintact cognitive responsion of psychosis, no physymptoms, limited to one person physical limitations in range of Altercation #1 involving 12/08/21 at 11:18 AM 0730AM, the [Securi [Receptionist's Name assaulting another refront of the building receptionist ran to the both residents [Reserved] [Resident #15 both reason him. I don't know whasked [Resident #15]	sis and no physical or verbal s, limited assistance with one st for ADLs, no limitations in no skin conditions. admitted to the facility on e diagnoses that included ual Disabilities, Psychotic nations, and Unspecified thavioral Disturbance. #67's medical revealed, a st 11/06/21 where facility staff tary score of "14", indicating onse, no potential indicators sical or verbal behavioral extensive assistance with assist for ADLs and no f motion. Ing Residents #151 and #71: In [Nurses Note] " At try Officer's Name] and the electron of the security officer and the eresidents and separated sident #71] was interviewed. Inped on me in front of the number of the greet this came from today'	F	500			8/24/22
	The MPD (Metrop was called took [R aggressive behavior [Hospital Name] at 0	olitan Police Department) esident #151] because of his and transported him to 809 (AM) for evaluation. essessed and small scratch					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022		
	ROVIDER OR SUPPLIER OD REHABILITATION A	IND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019	DDE	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 600	Altercation #2 involved 12/30/21 at 11:30 Al (8:30 PM) on 12/29/alleged to the recephim on his chest x 2 notified the supervise [Resident #67] and I (8:40 PM) [Resident gate trying to exit. He building stood by grab and hit staff exit or enter the Department was cal (11:50 PM). 2 MPD PM). During interview was not cooperating of the Police Officers into custody [Resthis AM (morning). Flateral abdomen over No swelling, discoloduring assessment. Review of Resident showed documenter resident-to-resident There was no docur staff revised Reside protect other resider Resident #151 attact facility. In both instar removed from the facility at face-to-face During a face-to-face	ing Residents #151 and #67: M [Nurses Note] " At 2030 2 (12/29/21), Resident #67] tionist that [Resident #151] hit in the lobby; the receptionist or; the supervisor assessed the denied any pain At 2040 1 #151] was observed at the the building entrance trying to siting the building will not let the building. The DC Police led and notified at 2340 1 responded at 2345 (11:45 1 wwith [Resident #151], he the made attempts to hit one the si. [Resident #151] was taken tident #67] was assessed the alleged being hit on the the provious surgical site. Tration or open area observed He denied pain" #151's medical record diaggressive behaviors and a altercation on 12/08/21. The mented evidence that facility the thing the sident was collisty due to his aggressive	F	500		8/24/22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			04/2	20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGH: WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 600	Resident #151 has be admitted back to the not had any resident- 3. Facility staff failed training to provide pet to hip precautions) for had left hip surgery. Review of an intake f by the State agency was "99," indiccognition.	dings and stated that een on 1:1 since he was facility in 01/2022 and has to-resident altercations. to ensure staff received rson centered care (related r Resident #409 after she orm for a complaint received on 12/06/21 documented " gery on 07/08/21, was ter on 07/10/21 with "leg ter 'K'" Resident #409 was or a dislocated hip and hip dmitted to the facility on ses that included: Encounter are, Presence of Left zheimer's Disease ted Falls, Muscle Weakness ther Abnormalities of Gait #409's medical record g: Data Set (MDS) for 07/11/21 revealed that	F	500			8/24/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	١ , ,	(X3) DATE SURVEY COMPLETED		
		095019	B. WING			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	·	7172072022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	resident was totally or more person's phymore staff. For bed in limited physical assist member. For dressir extensive physical a member. In Section H (Bowel incontinent" for blade incontinent" for blade incontinent for	se, and personal hygiene, the dependent and required two ysical assistance from two or mobility, the resident required stance from one staffing, the resident required ssistance from one staff and Bladder) - "Always der and bowel Conditions), "Yes" to: any time in the last month antry or reentry; resident have fall in the last 6 months prior or reentry; resident have a major surgical exprior inpatient hospital stay care during the SNF stay. Al Treatments, Procedures, at date for Occupational and 7/09/2021." M [Hospital Discharge al Course Patient presented status post Arthroplasty (hip no postoperative charge Procedure Orders Tolerated (WBAT); Laterally; as follows: Posterior hip [Admission Note] nitted from [Name of Local	F 60	00		8/24/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		V 1120/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	pillow and WBAT. Faintiated: resident loowith close monitoring used items within closed mobility and probowel and bladder. 07/08/21 (3:00 PM-1 Documentation, look of the probowel and bladder.) 07/09/21 at 2:18 PM and Plan of Treatmetherapy after having that resulted from a flexion past 90 degree or internal rotation, look of the probowel and provided and bladder. 07/09/21 (7:00 AM-3 Documentation], fac Resident #409 receives mobility, and provided and bladder. 07/09/21 (3:00 PM - Documentation], fac Resident #409 receives mobility, and provided and bladder. 07/09/21 (11:00 PM-Documentation], fac Resident #409 receives mobility, and provided and bladder.	all and safety precautions ration close to nurses' station g, call light and commonly use reach" 1:00 PM) [CNA lility staff documented that given a bath, assisted with vided incontinent care for so Order] "Left hip: monitor left pain, and drainage." [Physical Therapy Evaluation not Note] " referred to skilled a L (left) hip hemiarthroplasty fall Precautions (no uses, abduction past midline, VBAT" 1:00 PM) [CNA lility staff documented that used a bath/shower and using, assistance with beduction of the common	F			8/24/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	<i>'</i>
		095019	B. WING _			C 04/20/202	22
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPL	(5) LETION ATE
F 600	between lower extreiner reposition when resident reposition when resident appropriately after care [the] resident is in between resident and repositioning who care, and wedged reand repositioning who received a bath/show dressing and bed mo control of the family. Patient seen at the and the family. Patient at the site of sum and the family. Patient seen at the and the family. Patient at the site of sum at the	s Order] "Place a pillow mities after care, turn and dent is in bed." s Order] "Wedge resident are, turn and reposition when ad." :00 PM) [Treatment rd (TAR)], showed that facility at they placed a pillow 409's lower extremities after sident appropriately turning en the resident was in bed. PM) [CNA Documentation], atted that Resident #409 wer and assistance with	F6			8/2	24/22
	Person contacted: [N Representative] was in person. Notes: Sh						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CC (X3) D.		
		095019	B. WING _		,	C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	•	 	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	at bedside visiting to was seen by the me At about 4 PM daug (Resident #409) need because she want[eleg was not dislocated daughter that [the] indoctor in her present there was any concent have order[ed] an X want[ed] her mom to immediately becaused one and read right X-ray can be gotten take b/n (between) a done[Physician's doctor said an X-ray be done so the resident the hospital via nonfurther evaluation pewas taken out from [Hospital Name]." 07/12/21 at 6:34 PM Summary] "The patification of the daughter was the days Her daughter was the resident that her left leg was They were concerned with the surgery at the requested transporta (Emergency Department)2:30 AM: The patification of the patification of the concerned with the surgery in the surgery)tolerated	I [Nurses Note] "Family was aday from 11:45 AM Resident dical director at 12:30 PM, hter requested that she aded an X-ray to be done d] to make sure her mothers' and. Writer explains[ed] to the asident has been seen by the at (sp) just a few hours ago. If a pern note[d] the doctor would array. She insisted that she are be sent to the hospital array to be a sent to the hospital array to be a sent to the Array to be a sent and from the doctor, but it will array. Writer told her that an a from the doctor, but it will array was notified and the array to be a sent should be transfer[red] to be a sent should be transfer[red] to be a sent should be transfer[red] to be a sent of the array	F 6			8/24/22	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	•	U4/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	discharge. Request discharge" A review of the Rest lacked documented that cared for Resident discharge The review of the Rest lacked documented that cared for Resident 7/10/21, provided assistance and hip Resident #490's hip Resident #490's hip Resident #490's daughter/re 07/10/21, I noticed and flinched when what was wrong. I not her leg. Her leg 'K'. I spoke with the wanted to see the othe doctor, who sai primary doctor, and pain. I insisted that her hip. I was told the time (4-6 hours), so the she did and I can call 911, said it wasn't a medicalled a non-emerging was transported to During a face-to-face approximately 3:30	ident #409's medical record devidence that the facility staff dent #409 from 07/08/21 to her with adequate supervision, precautions to ensure that to was not dislocated. interview conducted on kimately 12:30 PM, Resident presentative stated, "On that my mother looked out of it I pulled back the cover to see didn't see the knee immobilizer was positioned like the letter aunit manager and told her I doctor. They finally brought in the wasn't my mother's the ordered oxycodone for my mother get an X-ray for the X-ray would take a long to I asked the nurse to call 911. In don't have a doctor's order, so I did. 911 showed up and dical emergency, so they [911] gency vehicle, and my mother [Hospital Name]."	F6	· · · · · · · · · · · · · · · · · · ·		8/24/22
	(x-ray). She insiste [Resident #409's] h the hospital. Per th doctor's permission	aughter how long it would take d we call 911 to have hip X-rayed and evaluated at e daughter's request, with the h, a non-emergency lled. The resident [was				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	IE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	of the incident." During a face-to-fac approximately 4:00 Unit Manager) state with hip precautions therapy or by the unresident is admitted Employee #8 stated in the resident's roo and two (2) nurses wevening shifts on the pillow/wedge be to put the hip immost how to roll the reside from crossing midlin the bed in the lowes light near the reside able to provide a cosign in sheet or the provided to the staff. There was no evide the necessary staff to meet Resident #4 surgery. 4. The facility's staff #3's airway (stoma) medical device Hea subsequently, causi transferred to the Endislodgment, keep a equipment in the faccare for and treat Restoma subsequently transferred to the Endislogrement to the Endislogrement in the faccare for and treat Restoma subsequently transferred to the Endislogrement to the	e interview on 04/19/22 at PM, Employee #8 (2nd Floor d that training for residents usually occurs with physical it managers when the For [Resident #409], , "I did the impromptu training m. I trained the 2-3 CNAs who worked the day and s unit. I reviewed how to put tween the resident's legs, how bilizer on the resident, and tent on her side to prevent her e. I reminded staff to keep t position and keep the call py of the "impromptu training" thandouts that he said were	F6			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		LETED
		095019	B. WING _				C 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		5000	EET ADDRESS, CITY, STATE, ZIP CODE NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019	1 0-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag		F	800			8/24/22
	#3.	ed in actual harm to Resident Dlaint received by the DC					
	Department of Health resident's family men #3 was rushed to the could have been fata	n on 01/26/22 from the mber alleged that Resident ER on 12/03/21, "which IIbecause there was an sident #3) neck stoma					
	humidifying filter that tube and comes in se Also known by sever Thermal Humidifying Artificial nose, Filter, https://www.hopkinsr	ding to Johns Hopkins Medicine, HME is a difying filter that fits onto the end of the trach and comes in several shapes and sizes. Known by several other terms including: hal Humidifying Filters, Swedish nose, ial nose, Filter, Thermovent T. //www.hopkinsmedicine.org/tracheostomy/rees/glossary.html#Tracheotomy					
	Resident #3 was admitted to the facility on 12/01/2021 with multiple diagnoses including Malignant Neoplasm of Larynx, Carcinoma of Larynx, Acquired Absence of Larynx, and Tracheostomy Status. The resident was discharged to the hospital on 03/29/2022.						
	12/03/21 revealed the Summary Score sect the resident was cod Tracheostomy care a Continued review she	sion Minimum Data Set dated at the Brief Interview Mental tion was blank. Additionally, ed for receiving and speech therapy services. owed that Resident #3 was ng respiratory therapy					
	Review of the resider the following:	nt's medical record revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	•	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 600	note]- Resident und with direct laryngosd upon assessment person and place with cap [HME] in place in place in progress note]- Pt. (appears alert and starcheostomy and doublood pressure), 86 (temperature), 95% on room air) 12/02/21 [physician day shift. 12/02/21 at 13:15 [rassessment]- Typewas alert and orient place with an HME. holder changed. HM assessment respiration respiration air, lung sound assessment respiration air, lung sound assessment respiration assessment respiration air, lung sound clear 12/03/21 [physician the nearest ER (emevaluation related to 12/03/21 at 14:42 [rrespiratory therapist has an HME stuck in Resident has a lari-	dmission nursing progress erwent awake tracheostomy copy and biopsy on 10/27/27, resident alert and oriented toResident has a lary tube ace hysician assistant physician patient) seen at bedside ablePt. also has oing wellvitals: 126/81 (pulse, 18 (respiration), 97.6 RA (oxygen saturation rate	F 6			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	N (X3)	
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER DD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	•	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	(saturation) checker RA (room air). [Doo instruction to transful (emergency room) Resident's grandda know what happen explainedwhen suchanged HME on yuliarway) was clear there was an HME therapist explained maybe the HME in (airway) and the real companied in the companied of the companied o	eeding noted. O2 (oxygen) Sate and immediately and was 99% otor's name] notified. He gave for resident to nearest ER for further evaluation. The respiratory therapist she did care for lari-tube and vesterday 12/2/21, the stoma but today she observed that stuck in the stoma. The to the granddaughter that titially stuck down in stoma sident coughed it up thercalled and spoke with oistwanted to find out if in distress or pain and asked the that since resident is called at 1345 and they arrived signs): 121/80 (blood e), 18 (respirations), 97.8 Sat (saturation) 99% RA (room	F 6	00		8/24/22
	Diagnosis-tracheos radiology XR (xray (posterior-anterior) for follow-up appoint to 4 days [provided Clean a Tracheoste 12/04/21 at 07:54 [Resident came base 129/89 (blood pres 98% (oxygen satur 12/04/21 [physician	discharge summary]- stomy malfunction. Diagnostic) neck soft tissue, XR chest PA and LAT (lateral) 2 view. Call intment with physician within 2 leducation tool] for "How to omy Tube, Adult." nursing progress note] - ck from the hospitalon arrival sure), 18 (respiratory rate) ation rate) on room air. n order] - Do not occlude stoma int] is an obligate neck				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECT TAG CROSS-REFERENT TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	note] - Re-admission hospitalized for trach seen at the bedsidevitals: 130/67 (block (respirations), 97% Froom air)resp (resauscultate),BL (bilated However, further revidocumented evidency (Respiratory Therapicare for Resident #3 (post being sent to the Review of the Decer Administration Reconstruction Change HME daily of The facility's nurse in that she changed Review of the comprinitial date of 12/04/2 Focus Area-[residen (related to) laryngea Goal-[resident's named track will have no shifted in the reventions of Reconstruction of Recon	nysician assistant progress of follow-up, pt (patient) was be eostomy malfunction. Pt. appears alert and stable of pressure), 71 (pulse), 17 RA (oxygen saturation rate on piration): lung CTA (Clear to erally). Diew of progress notes lacked be that the Employee #31 st) assessed or provided from 12/03/21 to 12/06/21 are emergency room). Diem 2021 Treatment red showed the following: lay shift (start date 12/03/21). Diesident #3's HME on dayshift rehensive care plan with an end showed the following: lay shift (start date 12/03/21) and the site through the review site (signs/symptoms) of review date. De care daily, change HME	F6	500		8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NI WASHINGTON, DC 20019	<u> </u>	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Department of Healt that Resident #3 wa 12/03/21, because to (Resident #3) neck so Resident #3 was untime of the survey be the hospital on 03/25. During a telephone in AM, the resident's recoordinator and the her informing her that grandfather's stomatinformed her that has neither one of them clinical coordinator] things that happene. During a face-to-face approximately 5:00 stated, I cleaned son a shift. Respiratory stime. I had training fremember when." The don't remember the a HME."	Intreceived by the DC In on 01/26/22 from alleged Is rushed to the ER on Inere was an HME put into his Istoma (airway)." Table to be interviewed at the Inecause he was discharged to Interview on 04/12/22 at 11:35 Interview on 04/13/22 at 11:35 Int	F6	*		8/24/22
	informed him that ar resident's stoma (air transferred to the en The employee then	respiratory therapist n HME was stuck in the way), he had Resident #3 nergency room for evaluation. said that Resident #3 was not ne HME was lodged his stoma				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		095019	B. WING			C 04/20/2022	
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	·		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	conducted to detern HME being lodged (airway) happened' The employee also was responsible for During a telephone PM, Employee #31 that she informed the HME was "stuck in sure how the HME (Resident #3) did not stoma it would have employee stated the days a week, and offacility nursing staff Resident #3's lary-that Also, Employee #3' nursing staff educated Resident #3's lary-that documented the transfer office. The employee nursing staff to do a ensure competency During a face-to-face approximately 3:00 stated that respirate	ed if an investigation was mine how the incident of the in Resident #3's stoma? Employee #7 stated, "No." said the respiratory therapist changing the resident's HME. interview on 04/14/22 at 2:35 (Respiratory Therapist) stated the staff that Resident #3's his stoma (airway). I'm not got stuck in his stoma. If he ot get the HME out of his the been detrimental." The the at she worked three to four on the days, she was not in the fewas responsible for cleaning the HME. I said that she provided tion on how to care for the and HME and the and the said she required a return demonstration to yet. The provided the required the recommendation of the recommend	F 6	00		8/24/22	
	they did not provide lary-tubes, or HME: although she regula Resident #3 resided working with him.	stomy care, but they did not e education on laryngectomy's, s. The employee said that arly worked on the floor were d, she could not remember the training documents lacked fince that staff was provided ry-tubes or HMEs.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCT	ION	(X3) DATE COMP	SURVEY
		095019	B. WING _			1	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		5000 NANNIE I	ESS, CITY, STATE, ZIP CODE HELEN BURROUGHS AVE. NE N, DC 20019	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	approximately 3:30 F stated that the respiraresponsible for provid lary tube and HME. T respiratory therapist written documentatio staff. However, she is records of education therapist." There was no eviden developed a personand implemented mecare to Resident #3 v Subsequently, Resiductly a medicate to be transferred to the device. 4B.Review of an intained in the lary state of the control of the Unit Medical Science, a lattube designed to mait the laryngectomy.	interview on 04/14/22 at M, Employee #4 (Educator) atory therapist was ding staff education on the The employee said that the was to provide her with an of education provided to aid, "I don't have any provided by the respiratory ce that facility staff centered approach to care asures necessary to provide who had a laryngectomy. ent #3's airway (stoma) was all device HME, causing him he ER for dislodgment of the exercise form for a complaint Department of Health on complainant [granddaugter] at #3 was sent to to the ER on the one (lary-tube) he had." Versity of Arkansas for any tube is a flexible silicone antain the stoma right after gery. A lary tube is used to and can be following a stams.edu/wp-content/upload ary_Tube_Care.pdf #31's (Respiratory	F	500			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMP	ATE SURVEY DMPLETED C	
		095019	B. WING _				20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		5000	EET ADDRESS, CITY, STATE, ZIP CODE 0 NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019	, , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	' •	Continued From page 47 description, showed that she was responsible for		600			8/24/22	
	providing necessary	material and equipment for orm required therapy.						
	12/01/2021 with mul Malignant Neoplasm	mitted to the facility on tiple diagnoses including of Larynx, Carcinoma of sence of Larynx, and s.						
	12/03/21 revealed th Summary Score sec	deview of an Admission MDS assessment dated 2/03/21 revealed that the Brief Interview Mental ummary Score section was blank, indicating the esident was not assessed.						
		dent was coded for receiving and speech therapy services.						
		nt's medical record revealed lated 12/02/21that stated, aily on day shift."						
	Further review of the revealed the following	resident's medical record g:						
	-01/07/22 at 4:51 PM: "It was observed today that resident Laryn [lary] tube is out. He was assessed by the respiratory therapist and recommended to send resident out to the ER for laryn [lary] tube replacement. 911 arrivedleft at 4:40 PM."							
	[Name of Hospital] n	1: "[MD's Name] called from eed to know the size RT (respiratory therapy) note ed at admission."						
		1: "Resident returned from t 2:30 AM in stable condition						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3)) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	NE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	air)."; and -01/08/22 at 4:02 ForientedResident breathing with the inhospital 1/7/22. Re [Name of Hospital] change of lary tube saturation) 98." Review of the compinitial date of 12/04 Focus Area-[resided (related to) larynge for laryn (sp) tube plaryn (sp) tube repl Goal-[resident's nadrainage around tradate. Will have no infection through the Interventions-laritically, assist with confection through the Interventions-laritically assessment/infection lacked documented therapist assessed #3 from 01/05/22 to Review of complaint and allege the ER on 01/07/22 due to facility throw resident had. During a telephone AM, the resident's expected to the Intervention of Intervention of the Intervention of the Intervention of Inter	saturation) 95% RA (room "M: "Resident alert and observed with difficult new lary tube placed from sident's family took him to for follow-up and possibleresident O2 sat (oxygen prehensive care plan with an //21 showed the following: nt's name] has lary tube r/t al cancer, 01/07/22 sent out olacement, taken to ER for acement. me] will have no abnormal achea site through the review s/sx (signs/symptoms) of the review date. ube care daily, change HME ough as needed bry therapy on screener progress notes d evidence the respiratory or provided care for Resident	F 6			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095019	B. WING _		0	C 4/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	that my grandfather's I visited him 5 days p them so long to get h During a telephone ir PM, Employee #31 (I that when the resider (01/07/22) she had the for replacement. The while Resident #3 was the emergency room about the size of the could not give the phesident was respiratory supplies, but she could not ord because she "did not asked if she made the medical director awas I don't talk the doctor name] and [Clinical Eseveral times. Through interview with no evidence that facil Resident #3's Lary To therefore, no were as Subsequently, Resident #3 with HMEs that we mucus production and the subsequent was production and the subsequent was subsequently and the subsequentl	daughter said, "I told them lary tube was missing when rior. I asked them why it took is lary-tube replaced." Interview on 04/14/22 at 2:35 Respiratory Therapist) stated at's lary tube was misplaced are resident sent out the ER employee then reported that is in the emergency room staff called her to inquire resident's lary-tube, but she yisician the size because she of the resident's lary-tube. The responsibility to order Employee #31 said, "Yes" er Resident #3's lary-tube know the size." When the resident's physician or re, the employee stated, "No, is. I made [Administrator's pirector's name] aware The Employee #31 there was ity staff knew the size of ube to order replacements, railable in the facility for use. The replacement of the lary tube. In the do obtain/provide Resident are necessary to help reduce do coughing by humidifying eathed through his stoma	F 6			8/24/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		0-112012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE
F 600	important to keep you easy to cough up [mit wear a stoma protect Moisture Exchange (cassette). These are and will moisten much https://www.ouh.nhs./11587Pstoma.pdf Review of complaint allegations that the frand HMEs for Resident Atthe following Physician's Day shift." 12/02/21 [Physician's Day shift." 12/02/21 [Physician's daily Day shift." The medical record anursing notes: 01/07/22 at 4:51 PM was observed today out. He was assessed and recommended to for larynx tube repla 4:40 PM. However, assessment / infectic lacked documented of the the table to the table ta	University Hospital, it is ur mucus thin so that it is ucous]. You should always tor such as aHeat HME: baseplate and available on prescription rous auk/patient-guide/leaflets/files #DC00010525 revealed acility did not have lary-tubes ent #3. #3's medical record showed an's orders: S Order] "Change HME daily S Order] "Change Lari-Tube also contained the following [nursing progress note]- It that resident larynx tube is do by the respiratory therapist of send resident out to the ER cement. 911 arrivedleft at review of respiratory therapy on screener progress notes evidence the respiratory r provided care for Resident	F 6			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING				20/2022	
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 041	20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	at admission. 01/08/22 at 6:32 AM Resident returned fro conditionvs (vital a pressure), 18 (respira (temperature), O2 S/ RA (room air). 01/08/22 at 4:02 PM Resident alert and or feeding and all medio with difficult breathing placed from hospital took him to [Name of possible change of laresidentO2 sat (o Review of Treatment from 01/08/22 to 03/0 facility's nurses initial #3's HME daily on da be noted that per the (Employee # 31) the from 01/08/22 to 03/0 not have HMEs comp Resident #3's lary-tul Review of the comprinitial date of 12/04/2 Focus Area-[resident (related to) laryngeal for laryn (sp) tube pla laryn (sp) tube replact Goal-[resident's nam drainage around trace	[nursing progress note] - om HUH at 2:30 AM in stable signs): 144/75 (blood ation), 70 (pulse), 96.8 AT (oxygen saturation) 95% [nursing progress note] - riented. Resident tolerated cations. Resident observed g with the new lary tube 1/7/21. Resident's family f Hospital] for follow-up and ary [laryngectomy] tube oxygen saturation) 98. Administration Records 02/22 showed that the led they changed Resident ayshift. However, it should a respiratory therapist HME could not be changed 02/22 because the facility did patible to connect with be. ehensive care plan with an 1 showed the following: 's name] has lary tube r/t cancer, 01/07/22 sent out accement, taken to ER for	F	600			8/24/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
		095019	B. WING			C 04/20/2022
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 600	daily, assist with confurther review of Recare plans lacked dinterventions to add use of a lary-tube at 12/03/22. Review of the of an showed the facility cassette HMEs and Further review of the entry "recevied [on] Review of emails from party to Employee # the following: 02/22/22 at 9:30 AM February 8th, I emains respiratory therapis name lary-tubes and prior conversation sthat she needed to she (Employee #31 supplies. I gave her (02/07/22). Checked Monday 02/14/22) abelonging (Lary-tub (Employee #31) has items (lary-tubes and ASAP." 03/07/22 at 12:54 Phis (Resident #3) la ordered. I gave the	e review date. abe care daily, change HME augh as needed esident#3's comprehensive ocumented evidence of ress care for Resident #3's and HME from 12/01/22 to invoice dated 03/02/22 ordered one box of 30 1 laryngectomy (Lary) tube. e invoice showed hand written	F	600		8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIATI	
F 600	#31's name- respirat February 7th of 2022 get back with me and are important necessin." 03/25/22 at 12:47 PN HME's and lary-tube #3's name] back in Frequesting the invoices and me any and all to these invoices? During a telephone in AM, the resident's ere (granddaughter) stat lari-tube several time be replaced by the trender) center. The gemailed [Employee # therapist] on 02/07/2 supplies (lari-tube, conever responded. In the week later (02/14/22 #7's name - Clinical supplies and she (Endame) During a face-to-face 2:25 PM, Employee stated, "We had a proposition of the respondent of the propose with the state of the propose with the prop	cory therapist] ordered on 2. She stated that she would do never did. Theses supplies sities to his current state he is 4. It was told to me that the swere ordered for [Resident February. Medicaid is sees for said ordersCan you documentation in reference on the swere ordered for [Resident February. Medicaid is sees for said ordersCan you documentation in reference on the swere ordered for [Resident February. Medicaid is sees for said ordersCan you documentation in reference on the swere ordered for said ordersCan you documentation in reference on the swere ordered for said ordersCan you documentation in reference on the swere ordered for said ordered for said (lari-tube) had to reatment (chemo infusion granddaughter then said, "I styr's name -respiratory and 02/08/22 size for ollar, and straps) but she sailled her (Employee #7) a) and she said [Employee Coordinator approved the mployee #7) ordered them." The interview on 04/13/22 at spiritually coordinator ordered for supplies one espiratory therapist	F6	500		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019	E	04/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	PM, Employee #31 (that Resident # 3 did to his lary-tube from ordered and received When asked why it to get the HME, Employee the HMEs we had in how the lary-tube his fam. The employee then a granddaughter on 0° name of the lary-tube HME, but the grandd told me (granddaugh important", and she the lary-tube until 02 that she did call the get the size of his larcall her back. Howev (Administrator) and I Coordinator) aware of the lary-tube until 02 that she did call the get the size of his larcall her back. Howev (Administrator) and I Coordinator) aware of the size of his larcall her back. Howev (Administrator) and I Coordinator) aware of the size of his larcall her back. Howev (Administrator) and I Coordinator) aware of the size of his larcallity before the residents' medical standard facility before the residents' medical standard facility before the residents' medical standard facility before the facility admitted. It should be invoice the facility produce of 03/02/22, who was not in the facility produ	nterview on 04/14/22 at 2:35 Respiratory Therapist) stated I not a have HME to connect "01/08/22 to until they were d by the facility [03/03/22]". look so long for Resident #3 looyee #31 said "I did not resident's lary-tube. And the use was not compatible with ily provided on 01/08/22." loaid she reached out to the I/12/22 or 01/13/22 to get the le so she could order an laughter said, "The doctor later) that the HME is not did not send me the size of I/07/22." Employee #31 said loresident's physician once to lory-tube once, but he did not lover, she made Employee #1 Employee #7 (Clinical multiple times that Resident less. e interview on 04/20/22 at	F 60			8/24/22	

C	
095019 B. WING 04/20/	
NAME OF PROVIDER OR SUPPLIER O95019 B. WING 04/20/2 STREET ADDRESS, CITY, STATE, ZIP CODE	0/2022
DEANWOOD REHABILITATION AND WELLNESS CENTER 5000 NANNIE HELEN BURROUGHS AVE. NE	
WASHINGTON, DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 Continued From page 55	8/24/22
Review of Treatment Administration Records showed that nusing staff documented that they changed Resident #3's HME on the following dates: 01/09/22 to 01/25/22, 01/27/22 to 02/02/22, 02/04/22 to 02/08/22, 02/11/22 to 02/08/22, 02/11/22 to 02/14/22, 02/18/22 to 03/01/22. However, it should be noted that the one (1) invoice provided by the facility with an order date of 03/02/22 showed the facility did not receive HMEs until 03/03/22, at which time they received 30. During a face-to-face interview on 04/20/22 at approximately 2:00 PM. Employee #44 (Admission Director) stated that newly admitted residents' medical supplies are ordered and in the facility before the resident's admission. When asked if Resident #3's lary-tubes and HME were ordered and in the facility before the resident's admission (12/01/22), she stated, "I don't know because I was not in the facility at that the time he was admitted." It should be noted that the one (1) invoice the facility provided to the surveyor had a date of 03/02/22, which documented that the facility received one (1) lary-tube and 30 HMEs on 03/03/22. Foot Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL							
		095019	B. WING _			1	20/2022
NAME OF PE	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/.	20/2022
				5	0000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			NASHINGTON, DC 20019		
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F 607	Continued From page	e 56	F 6	607			8/24/22
		nt written policies and procedures that:			F 607 CORRECTIVE ACTION FOR THE		
§483.12(b)(1) Prohib		t and prevent abuse,			AFFECTED RESIDENTS:		
	neglect, and exploitat				Resident #11 was assessed from hea	d to toe	
	misappropriation of re	esident property,			by Charge nurse on 4/26/22, no signs abuse or neglect noted, no redness, s	welling	
		2(b)(2) Establish policies and procedures stigate any such allegations, and			nor discolorations noted. MD/RP notified on 4/26/22		
	§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:				Resident #50 was assessed from hea by Charge nurse 4/26/22, no signs of nor neglect noted. No swelling, redne discoloration noted .MD/RP notified o 4/26/22	abuse ss nor	
	Based on record revieight (8) of 105 samp failed to implement its investigating allegation injuries of unknown s	lew and staff interview, for led residents, facility staff is policies and procedures for ons of abuse, neglect and ource. Residents' #11, #50, . #408 and #409.			Resident #67 was assessed from hea by Charge nurse on 4/26/22, no signs abuse / neglect noted . No swellings r nor discoloration noted.MD/RP notifie 4/26/22.	of edness	
	The findings include:	#67, #71, #151, #221, #408 and #409. The findings include: Review of the facility policy entitled, "Prohibition of			Resident #71 was assessed by Unit Manager on 4/26/22 no signs of abuse/ neglect noted. No swellings, reddened area nor discoloration noted.MD/RP notified on 4/26/22		
	Abuse" (not dated), documented, " Reports on abuse are reviewed and investigation conducted by the director of nursing within 24 hours following the incidentIf suspected abuse/inappropriate behavior are between two				Resident #151 was assessed from he toe by Unit Manager on 4/26/22, no si abuse/neglect noted. No redness, sw nor discoloration noted. MD/RP notifie 4/26/22	gns of elling	
	from each other and interventions are imp	vill be immediately separated monitored until appropriate lementedAll employees will	ed until appropriate Resident #221 signed out of the facility				
	compliance to abuse	g, their understanding and standards" Review of the			Resident #408 was sent to the ER on and did not return.	2/12/22	
	defined as "the failure employees or service and services to a resi avoid physical harm,	nowed that neglect was e of the facility, its providers to provide goods dent that are necessary to pain, mental anguish, or The policy revealed that			Resident #409 was discharged home 9/28/21	on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MU		COMP	(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 607	any unusual occurrer Director of Nursing of the investigation will be the Administrator." Review of the facility Process" dated 02/20 will ensure thorough incident or occurrence residents, employees interview and/or obtation victim/resident intestatements from allegand or obtain statements [Facility Name] will components to eliminassociated with resideral training, prevention, in reporting response 1. Facility staff failed statements from all statem	an incident/accident form for ices and submit it to the designee A final report of pereported and signed by policy entitled, "Investigation ic22 showed, " The facility investigation during an est hat may involve our volunteers, and visitors in statement from rview and/or obtain ited perpetrators, interview ents from potential witnesses use the following ate and/or minimize the risk ent abuse: screening, dentification, protection, and it interview and/or obtain that involved in Resident action of neglect. In the facility on ses that included: Bipolar order, Major Depressive sions.	F	607	F607 IDENTIFICATION OF RESIDENTS WIT POTENTIAL TO BE AFFECTED: All residents in the facility have the pote be affected. House wide audit will be conducted by C Coordinator, Unit Managers and Supervensure that policies and procedures on and neglect are implemented as indicate the residents. That all incidents are thore investigated, and that staff involved in the investigation provide statements of what occurred. Any findings will be corrected 8/24/2022. DON/Designee will audit all incidents/ are reports to ensure that investigations of a incidents were carried out appropriately statements were obtained from employed worked on the unit were the incident too are in order Any issues found will be corby 8/24/22.	ntial to Clinical isors to abuse ed on all bughly e by ccident ill and that es who k place	8/24/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	JULTIPLE CONSTRUCTION (X ILDING			(3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
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F 607	and bowel continence Review of Facility Re 03/18/22 showed, " wrote a grievance on father had not been of during the night shift of PM). She stated that urine and had feces were Review of the facility's provided to the writer the facility staff failed investigating allegation failure to interview an all staff that took care PM on 03/12/22 to 11 During a face-to-face 04/12/22 at 2:39 PM, Nursing) acknowledge was not able to get even 2. Facility staff failed of fresident-to-residen Residents' #71, #67 at Review of the FRI dat " At 0730AM, the se [Resident #151] assa [Resident #71] at the Review of the FRI dat At 2030 on 12/29/2	ported Incident (FRI) dated . [Resident #11's] daughter 03/14/22 stating that her hanged since 03/12/22 until 03/13/22 at 18:30 (6:30 her father was soaked in when she came in to visit" s investigation documents on 04/12/22 revealed that to follow its policy for ons of neglect evidenced by d/or obtain statements from of Resident #11 from 11:00 :00 PM on 03/13/22. interview conducted on Employee #2 (Director of ed the finding and stated, "I veryone's statements." to investigate two incidences t altercations involving and #151. ted 12/09/21 documented, ecurity officer observed ulting another resident front of the building" ted 01/02/22 documented, " (12/29/21), [Resident #67] onist that [Resident #151] hit in the lobby"	F 6	607	In-service will be provided by Staff Ed to all staff members on the importance providing a written statement of any in that occur on the units by 8/24/2022. Repeat in-service will be provided as needed. Training will be provided by Staff Educator/Designee to Licensed nursing on how to carry out an investigation accurately by 8/24/2022. Training will be provided to RN'S and son the importance of carrying out an investigation once an unusual occurre occurs to find out why and how the inforced by 8/24/2022. Charge nurses will ensure that all nuraides, nurses, and members of other departments provide a written statemente once an incident occurs on the unit. A issues found will be corrected by 8/24/20. ADON/Designee will ensure that ever incident is thoroughly investigated uponce it occurs and that employees provitten statements. Any issues found addressed by 8/24/22. Supervisors will ensure that all incider reports are completed accurately and statements are in the binder on a weebasis. Any issues found will be corrected 8/24/22.	lucator e of nicident ng staff LPN' nence cident se ent ny //22. ly on ovide will be ont that ekly	8/24/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING _				2 0/2022
	ROVIDER OR SUPPLIER	ID WELLNESS CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022
				٧	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	10/22/20 with multiple Unspecified Psychosi Benign Prostatic Hypo Review of Resident # revealed:	s admitted to the facility on e diagnoses that included: is, Epileptic Syndrome and erplasia.	F6	607	Unit managers/ will ensure that all injuries of unknown origin are investigated and all employees who worked with the resident provide a written statement. Any findings will corrected by 8/24/22		8/24/22
	12/08/21 [Admission MDS], facility staff coded a BIMS summary score of "07", indicting severe cognitive impairment.				F607 MONITORING CORRECTIVE ACTION		
	firmly held, contrary to E0200. Behavioral Sybehavioral symptoms (e.g., hitting, kicking, grabbing, abusing oth this type occurred 1 to symptoms directed to threatening others, so at others) - "Behavior days", Impact on Ressignificant risk for phyimpact on others pphysical injury? "yes"	cators of Psychosis - potions or beliefs that are poreality) - "yes" Imptoms: Physical directed towards others pushing, scratching, ners sexually) - "Behavior of pound 3 days", verbal behavioral powards others (e.g., poreaming at others, cursing pot of this type occurred 4 to 6 poident Put the resident at posicial illness or injury? "yes"; put others at significant risk of pothers? "yes"; significantly			DON/Designee will conduct auditivalidate that all incidents /accide that occurred in the facility are further investigated, that employees whorked the day of the incident provide written statements, that policies and procedures for abust and neglect are followed as indicated. This audit will be done weekly x4 then monthly x3, finding will be corrected immediately an reported to QAPI Committee	nts illy o se ngs	
	Daily Living (ADL) As transfer, walk in room locomotion on unit, lo	nal Status): Activities of sistance - bed mobility, i, walk in corridor, icomotion off unit, Resident vision" and "one person					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		095019	B. WING		04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 607	Continued From paç	ge 60	F 60	77	8/24/22
	positive PASARR (F Resident Review) Le evaluation, it was de needs Specialized S Facility. Related to:: MD (medical doctor) serious health declir agreed to may need Inform the MD of an require additional everemove services" 07/27/21 (Revision of for changes in behat agitation" 10/18/21 (Revision of problematic manner characterized by inate to treatment/care related by inate to treatment/care related by inate to treatment/care related by inate to treatment/care related by inate to treatment/care related by inate to treatment/car	date) "As evidenced by a readmission Screening and evel I screen and Level II stermined that the resident services while in the Nursing schizophreniaInform the if the Individual has a ne and services previously to be modified or deleted. It is a significant changes may realuation to add, modify or realuation to add, modify or leaded) "[Resident #151] at risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services previously to be modified or deleted. It is a risk vior problems related to: In the Individual has a ne and services while in the Nursing services with the Individual has a nead services while in the Nursing services with the Individual has a nead services previously to be modified to be a related to the Individual has a nead services previously the Individual has a nead services previously to be modified to be a related to the Individual has a nead services previously to be a related to the Individual has a ne			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		COMPLETED
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	NE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	10/22/21 (Revision behavior problem roon the entire floor, on the entire	date) "Resident #151] has 't (Combative, Spilling water disrobing) r/t Schizophrenia. Ing roommate into the room, nother room and refusing to agitation, hitting multiple staff break down doors in the and rolling on the floor 1:1 safety until seen by psych or " It is admitted to the facility on pole diagnoses that included order, Unspecified Dementia	Fé	507		8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	ATE SURVEY DMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019		0412012022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	Altercation #1 involved 12/08/21 at 11:18 Al 0730AM, the [Secur [Receptionist's Namassaulting another refront of the building. receptionist ran to the both residents [Refle said, 'the man jubuilding for no reason him. I don't know whasked [Resident #15] [Resident #71]. He said. The MPD (Metrop was called took [Faggressive behavior [Hospital Name] at 0 [Resident #71] was mark observed on the Altercation #2 involved 12/30/21 at 11:30 Al (8:30 PM) on 12/29/alleged to the recephim on his chest x 2 notified the supervis [Resident #67] and I (8:40 PM) [Resident gate trying to exit. He building stood by grab and hit staff exist or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existaff exit or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existaff exit or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existaff exit or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existaff exit or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existaff exit or enter the Department was called 11:30 Al (8:30 PM) [Resident gate trying to exit. He building stood by grab and hit staff existant and the province of the p	assist for ADLs and no	F 6	07		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	·	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	was not cooperating of the Police Officer into custody [Rest this AM (morning). Iateral abdomen ov No swelling, discold during assessment. Review of Resident showed documenter resident-to-resident There was no docust aff revised Resider protect other resident #151 attacked anot. During a face-to-face 04/14/22, Employed acknowledged the Resident #151 has admitted back to the not had any resident #3. Facility staff failed policies and proceed by failure to thoroug resident-to-resident #221. Review of the FRI dated 03/29/22, docexplained to the chroming with his row were to continue to we will find the room Resident #221 was 10/28/21 with multiplications.	w with [Resident #151], he g; he made attempts to hit one rs. [Resident #151] was taken sident #67] was assessed He alleged being hit on the er his previous surgical site. The oration or open area observed. He denied pain" #151's medical record and aggressive behaviors and a raltercation on 12/08/21. mented evidence that facility ent #151's plan of care to ints. On 12/29/21, Resident her resident at the facility. The interview conducted on the error of the error of the was the facility in 01/2022 and has interoresident altercations. The dot implement their written ures on abuse as evidenced ghly investigate an alleged at threat of violence by Resident (Facility Reported Incident) cumented "resident arge nurse that he did not like formmate. He stated that if he be in that room that one day	F 6			8/24//22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
		095019	B. WING _				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER	1	500	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Affecting Left Non-D Unspecified and Par Review of the Quarter revealed that the fact In section C (Cogniti Summary Score "15 Review of the docume Background Assessing Recommendation)-p Practitioner)/PA (Phy Communication Tool PM, showed "Todate charge nurse that he roommate. He stated to be in that room the roommate in a pool of the resident's side untransferred to another transferred to the roomew potential roommendation that wood the resident of the facility documentation that wood the resident face sheet, "Incident/Accident reassurance and Perfemployee /Resident	ng Cerebral Infarction ominant Side, Paraplegia anoid Schizophrenia. erly MDS dated 03/23/22 ility staff coded the following: ve Patterns), a BIMS ", indicating intact cognition. ment titled "SBAR (Situation ment hysician /NP (Nurse vsician Assistant) " dated 03/28/22 at 12:27 ay, resident explained to the edid not like rooming with his d that if he were to continue at one day, we will find the of blood. A nurse stayed by ntil the resident could be er room. Prior to being om he was introduced to the nate and stated that the e" "'s incident investigation was signed and dated on of the following: two se statements, a copy of a	F	607			8/24//22
		pative report lacked be of the following: an nent of Resident #221's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019	DE	14/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	knowledge of the incieducation/training rel following the resident During a face-to-face 04/18/22 at approxim (Director of Nursing) 4. Facility staff failed statements from all s #408's care the day a was discovered. Review of the FRI daResident complaine yesterday 2/16/22 an (Nurse Practitioner) . morning with impress left distal femur, Acut right lateral femoral c worked with resident shifts will be interview had a fall or if resident shifts will be interview had a fall or if resider had reported fallen to Resident #408 was a 05/25/2021 with multi Hemiplegia and Hem Muscle Weakness an Review of Resident # revealed the following: a BIMS sur severe cognitive impa assistance to total de	swith all staff that may have dent, resident and staff ated to care approaches ated to care approaches ately 1:00 PM, Employee #2 acknowledged the findings. Ito interview and/or obtain taff involved in Resident an injury of unknown origin at the dollar ted 02/22/22 documented, " and of right knee pain down assessed by NP and X-ray report received this sion of Acute fracture of the enairline fracture of the enairline fracture of the ondyle All staff who from 2/9/22 to 2/16/22 all wed to determine if resident and the anyone" Idmitted to the facility on injele diagnoses that included: iparesis, Hypocalcemia, and Lack of Coordination. E408's medical record g: IDS], facility staff coded the mmary score "04", indicating	F6	507		8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 607	motion. 02/16/22 at 2:27 PM Progress Note] "Assessed today for assess both knees. She adm knees, dull and affect on both knees" 02/17/22 at 7:38 AM X-ray of the both knee knee: There is a fract displacement RT (rirregularity and impact fracture of the distal lawhich is impacted A 02/17/22 12:05 PM [Notes to the complained of right knees to the	ENurse Practitioner (NP) Issment and f/u knee pain Isment due to c/o pain on Its to moderate pain in her Ing her sleep Plan [x-ray] [Nurses Note] "Resident's Its (Positive) for LT (left) Ing the distal femur with Itight) Knee: There is Ition and a cortical hairline Interest femoral metaphysis It call placed to the NP" Inclures Note] " Resident Ince pain yesterday 2/16/22 Ind by NP NP ordered Iterest femoral metaphysis Iterest f	Fé	607		8/24/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		095019	B. WING		C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	, 0.120,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 607	During a face-to-face 04/18/22 at approxin Employee #43 (3rd Facknowledged the fir comments. 5. Facility staff failed policies and procedule evidenced by failure unusual occurrence dislocated hip. Review of an intake by the State agency after having hip surpositioned like the lesent to the hospital for surgery. Resident #409 was a 07/08/21 with diagnor for Orthopedic Afteroartificial Hip Joint, Al (Unspecified), Repeat	e interview conducted on nately 1:30 PM with Floor Unit Manager), she nding and made no further to implement its written ares for abuse and neglect to identify and investigate the of Residents #409's form for a complaint received on 12/06/21 documented "argery on 07/08/21, was ater on 07/10/21 with "leg tter 'K'" Resident #409 was for a dislocated hip and hip	F 60	,	8/24/22
	dated 07/11/21 reveal the following: In Section C (Cognitissummary score of "S resident had severel In Section G (Function)	terly MDS for Resident #409 aled that facility staff coded live Patterns), a BIMS 99", indicating that the y impaired cognition. Donal Status), ADL assistance: se, and personal hygiene, the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		LETED
		095019	B. WING _				C 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		5000	ET ADDRESS, CITY, STATE, ZIP CODE NANNIE HELEN BURROUGHS AVE. NE HINGTON, DC 20019	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From pag or more person's phy more staff. For bed mobility, the physical assistance of For dressing the resi physical assistance of In Section J (Health resident have a fall a prior to admission in the last 6 months of major surgery during admission In Section O (Special and Programs), start Physical Therapy "07 Review of Resident of revealed the following "Resident was admitted the following of the programs of the programs of the following of the programs of the following of the programs of the programs of the following of the programs of the pr	resident required limited rom one staff member. dent required extensive rom one staff member Conditions), "Yes" to: ny time in the last month and a fracture related to a fall prior to admission and had the 100 days prior to I Treatments, Procedures, date for Occupational and 7/09/2021." #409's medical record g: [Admission Note] nitted from [Name of Local		607			8/24/22
	"Patient seen at the rand the family. Patien pain at the site of suradded oxycodone (as needed) for 14 days	[Physician's Progress Note] request of Nurse Manager nt reportedly has increasing rgery, worse with movement (narcotic pain reliever) prn ays for breakthrough pain"					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZI 5000 NANNIE HELEN BURROUG WASHINGTON, DC 20019		V-1/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT	TE DATE
F 607	started: 07/10/2021. post) left hip Arthropl A-Assessment Reresponsive, no appar change in mental sta Person contacted: [N Representative] was in person. Notes: She transfer[ed] to the Hours of th	Date problem or symptom Background S/P (status asty done on 7/5/2021 sident is alert and verbally rent distress noted. No tus notedR-Request - lame of Resident at bedside. Communicated e requested her mom to be ospital" [Nurses Note-Late Entry] side visiting today from 11:45 een by the medical director at at 4 PM [the] daughter eeded an X-ray to be done d] to make sure her mothers' ad. Writer explains[ed] to the esident has been seen by the ce] just a few hours ago. If rn note[d] the doctor would ray. She insisted that she be sent to the hospital e she need[ed] an X-ray to be away]. Writer told her that an from the doctor, but it will -4 hours for the X-ray to be Name] was notified and the will take about 4-6 hours to eent should be transfer[red] to emergency transport for r family requestResident the facility at 5:50 [PM] to	F	607		8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X	(3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	<u>'</u>	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	that her left leg was They were concerne with the surgery at t requested transport Procedure -joint red (procedure for treati surgery, using mani to put the hip back ii Department) Course patient's hip was red procedure well howe hip inNarratives: back to [Name of Fa for discharge. Requ discharge" A review of Residen revealed no docume staff identified or inv (dislocated hip) as a	inder her covers and found significantly inwardly rotated. It is designificantly invalid to the hospital uction: closed joint reduction in graph a hip dislocation without pulation of thigh bone (femur) in place) ED (Emergency in place) ED (Emergency in place) ED (Emergency in place) ED (Emergency in it is designed in the discharge in the control of t	F	507		8/24/22
F 609 SS=D	Manager), stated, "" weekend, when I wa the facility did not in incident was docum and in an SBAR." Reporting of Allegec CFR(s): 483.12(c)(1 §483.12(c) In respon neglect, exploitation must:)(4) nse to allegations of abuse, , or mistreatment, the facility e that all alleged violations	F	609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	1 041	20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609	source and misappro are reported immedia hours after the allegal that cause the allegal serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate correctives This REQUIREMENT by: Based on record revitore (3) of 105 samp failed to: (1) report the Resident #3 and Reseresults of the investiginjury of unknown originary of unknown originary of unknown originary with a revision neglect was defined a its employees or servitogoods and services to	ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events ation involve abuse or result in or not later than 24 hours if the allegation do not involve all in serious bodily injury, to be facility and to other the State Survey Agency and the state state law provides are law through established. The results of all administrator or his or her active and to other officials in the law, including to the State in 5 working days of the eged violation is verified a action must be taken. The is not met as evidenced are and staff interview, for all of residents, facility staff the unusual occurrences for ident #409 and (2) report the action for Resident #408's gin.	F	609	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #3 was discharged hon 3/29/22, this deficient practicannot be retroactively corrected. Resident #409 was discharged home 9/28/2021, this deficient cannot be retroactively corrected. Resident #408 was sent to ER 2/12/22, this deficiency cannot retroactively corrected.	ome ice ed I Ey ed.	8/24/22	

	TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X3)		COMPI	X3) DATE SURVEY COMPLETED			
		095019	B. WING _			04/2	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	revealed that staff ar incident/accident for occurrences and sub Nursing or designee investigation will be radministrator." 1. Facility staff failed and moisture excharstoma (unusual occudislocated hip (unusuagency. A. Resident #3 was a 12/01/21 with multipl Malignant Neoplasm Larynx, Acquired Abstracheostomy Status Review of an intake by the DC Departme Regulation and Licer 01/26/22 showed the [granddaughter] alleg rushed to the ER on been fatalbecause his (Resident #3) neon been fatal for the exception of the exception	al distress. The policy e to, "complete an in for any unusual omit it to the Director ofA final report of the reported and signed by the to report Resident #3's heat ager (HME) being stuck in his arrence) and Resident #409's all occurrence) to the state admitted to the facility on e diagnoses including of Larynx, Carcinoma of sence of Larynx, and s. form for a complaint received ant of Health, Health Care asing Administration on e complainant ged that Resident #3 was 12/03/21, "which could have there was an HME put into ack stoma (airway)." sion Minimum Data Set at showed that facility staff dental Summary Score" Diagnoses), Cancer, of Laynx, Surgical Aftercare Respiratory system, stomy Status and Malignant	F	609	IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFE The facility currently has one rewith an HME stoma. (tracheosto Unit Manager / Designee will conveekly audit on their units to enthat injuries of unknown origin a investigated and reported. Also ensure resident with respiratory diagnosis are in no form of respirators, that the facility have adequate respiratory supply to the resident respiratory needs. Also issues found will be addressed 8/24/22	esident my) onduct sure are to viratory meet Any	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095019	B. WING _			04/:	20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLN	ESS CENTER			CITY, STATE, ZIP CODE EN BURROUGHS AVE. NE DC 20019	1 0-111	
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE FIND TAG REGULATORY OR LSC IDENTIFIED TO THE PROPERTY OF THE PROP	PRECEDED BY FULL	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
In Section O (Special Treatmer and Programs), the resident was receiving tracheostomy care ar services. The resident was not respiratory therapy services. Review of the resident's medic the following: Physician's Orders: 12/02/21 "Change HME daily do 12/03/21 "Transfer resident to 15 further evaluation related to student [patient] is an obligate of tracheostomy and doing well (blood pressure), 86 (pulse, 18 (temperature), 95% RA (oxyge on room air) " 12/02/21 at 1:15 PM [Respirated Assessment] "Type- initial assesswas alert and oriented with lary place with an HME. Lary tube of holder changed. HME changed assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air, lung sounds clear I assessment respiratory rate 18 room air lung sounds clear I assessment respiratory rate 18 room air lung sounds clear I assessment respiratory rate 18 room air lung sounds clear	as coded for and speech therapy coded for all record revealed all record reck HME in stoma. The neck breather. In Assistant reen at bedside also has avitals: 126/81 (respiration), 97.6 in saturation rate. The record revealed all record revealed all record rec	F 6	MEASUR RECURR Supervisor during the with stomal present wissues for 8/24/2022 In- service Educator nursing strassess report the Charge nuinvestigate unknown issues for residents no form of their shift 8/24/22 Unit manaweekly au with respired document be correct DON / De accidents	ors will conduct daily resir shift to ensure that resirt that aids with resirth clean stoma sites. And will be corrected by 2. We will be provided by Some pro	esidents spiration Any taff sed to id to 2. ift. Any y 8/24/22 that s are in uring esses by nduct idents essed ngs will dents/ ne week	2

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		095019	B. WING		04/2	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
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F 609	"The respiratory there resident has an HME Resident has a lari-tuand no respiratory disdenied pain. No bleek (saturation) checked RA (room air). [Docto instruction to transfer (emergency room) fo Resident's granddauk know what happened explainedwhen she changed HME on yes was clear but today san HME stuck in the explained to the gran HME [was] initially stand the resident coug 1345 (1:45 PM) and the PM). However, review assessments / infectid documented evidence therapist assessed of #3 from 12/02/21 to 12/04/21 [Hospital Di "Diagnosis-tracheost radiology XR (xray) in (posterior-anterior) and for follow-up appointre to 4 days [provided et Clean a Tracheostom 12/06/21 at 4:13 PM Progress Note] "Re-at 12/06/21 at 4:13 PM Progress No	[Nursing Progress Note] apist notified writer that stuck in the stoma (airway). Ibe. Resident was assessed stress noted. Resident ding noted. O2 (oxygen) Sat immediately and was 99% or's name] notified. He gave resident to nearest ER or further evaluation. If the respiratory therapist is did care for lari-tube and sterday 12/2/21, the stoma of the observed that there was stoma. The therapist didaughter that maybe the fuck down in stoma (airway) of the provided at 1400 (2:00 or of respiratory therapy on screener notes] lacked in the therapist of the therapist of the provided care for Resident (2/06/21." In scharge Summary] only malfunction. Diagnostic leck soft tissue, XR chest PA and LAT (lateral) 2 view. Call ment with physician within 2 ducation tool] for "How to my Tube, Adult."	F 609	MONITORING CORRECT ACTIONS: DON/Designee will conduct audits to ensure that resid with a stuck stoma incident reported, and that injuries incident of unknown origin also investigated and reported audit will be conducted weekly x4, then monthly xi findings will be corrected immediately and reported QAPI committee.	ent ent t is with are orted. ed 3,	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 609	and stablevitals: (pulse), 17 (respiration saturation rate on rolling CTA (Clear to a During a telephone PM, Employee #31 that she informed the HME was "stuck in Its sure how the HME of During a face-to-face 11:24 AM, Employee asked when, per the unusual occurrence was stuck in his storinvestigated to ensure the student of the storing the sto	n at the bedside appears alert 130/67 (blood pressure), 71 ions), 97% RA (oxygen pom air)resp (respiration): auscultate), BL (bilaterally)." interview on 04/14/22 at 2:35 (Respiratory Therapist) stated le staff that Resident #3's his stoma (airway). I'm not got stuck in his stoma." The einterview on 04/18/22 at le #2 (Director of Nursing) was a Abuse Policy, during the lawhen Resident #3's HME ma should staff have lire the resident was not law and the give you an accurate lake form for a complaint lite agency on 12/06/21 for having hip surgery on rived two days later on lositioned like the letter 'K'" sent to the hospital for a hip surgery. admitted to the facility on loses that included: Encounter care, Presence of Left	F 6	09		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 609	the following: In Section C (Cognitissummary score of "99 resident had severely 07/08/21 at 8:29 PM "Resident was adm Hospital] for rehabilita ArthroplastyReside pillow and WBAT (we Fall and safety precallocation close to nursimonitoring, call light a within close reach" 07/10/21 at 3:29 PM "Patient seen at their and the family. Patient at the site of suradded oxycodone ((as needed) for 14 da 07/10/21 at 5:40 PM Assessment Request Tool] "Resident trade problem or sym Background S/P (see Arthroplasty done on Resident is alert at apparent distress not status notedR-Rece [Name of Resident Reduction of R	led that facility staff coded ve Patterns), a BIMS D', indicating that the vimpaired cognition. [Admission Note] itted from [Name of Local ation post left hip ent has hip abduction with ight bearing as tolerated). utions initiated: resident es' station with close and commonly used items [Physician's Progress Note] equest of Nurse Manager at reportedly has increasing gery, worse with movement narcotic pain reliever) properties for breakthrough pain" [Situational, Background (SBAR) Communication ansfer to [Hospital Name] ptom started: 07/10/2021	F6	609		8/24/22

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F 609	AM Resident was so 12:30 PM At about requested that she is because she want[eleg was not dislocated daughter that [the] is doctor in her present there was any conchave order[ed] an X want[ed] her morn to immediately because done and read right X-ray can be gotten take b/n (between) done[Physician's doctor said an X-ray be done so the resident the hospital via nonfurther evaluation powas taken out from [Hospital's Name]." 07/12/21 at 6:34 PM Summary] "The pating Facility], where she few days Her daughter that her left leg was They were concerned with the surgery at the requested transport Procedure -joint red (procedure for treating surgery, using manital to put the hip back in Department) Course patient's hip was red	deside visiting today from 11:45 een by the medical director at it 4 PM [the] daughter needed an X-ray to be done ed] to make sure her mothers' ed. Writer explains[ed] to the esident has been seen by the esident has been stay ing es she need[ed] an X-ray to be [away]. Writer told her that an from the doctor, but it will es she need[ed] an X-ray to be Name] was notified and the evil will take about 4-6 hours to dent should be transfer[red] to emergency transport for er family requestResident the facility at 5:50 [PM] to If [Hospital Discharge ent presents from [Name of has been staying for the past eighter and son-in-law went to ender her covers and found significantly inwardly rotated. ed something is going wrong	F 609		8/24/22	

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F 609	back to [Name of Fa for discharge. Requ discharge" A review of Residen revealed no docume staff reported this upper proving a face-to-face (Unit Manager/Regi approximately 4:00 happened on a weet am not sure why the file a report. The incomprogress notes and 2. Facility staff failed investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Review of the FRI desired investigation for Resunknown origin. Resident general femoral worked with resident shifts will be interview had a fall or if resident anyone" Resident #408 was 05/25/21 with multip Hemiplegia and Heri	02:27 PM plan to discharge acility]. 03:51 PM cleared est knee immobilizer for at #409's medical record ented evidence that facility nusual occurence to the th. the interview with Employee #8 stered Nurse) on 04/20/22 at PM, he stated, "The incident exend, when I was not here. I be facility did not investigate or cident was documented in the	F 6	09		8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 609	following: a BIMS sur severe cognitive impa assistance to total de persons physical assi personal hygiene and motion. 02/16/22 at 2:27 PM Progress Note] "Asse knee pain seen too c/o (complain of) pair to moderate pain in her sleep Plan [x-ra 02/17/22 at 7:38 AM X-ray of the both knee knee: There is a fract displacement RT (irregularity and impact fracture of the distal lawhich is impacted A 02/17/22 at 12:05 PM complained of right knee was assessed X-rays of bilateral knee this morning with impathe left distal femur, a right lateral femoral calignment All staff w from 2/9/22 to 2/16/22 to determine if reside had reported fallen to	ADS], facility staff coded the many score "04", indicating airment, extensive pendence with two plus ist for transfers, mobility and it no impairment in range of [Nurse Practitioner (NP) essment and f/u (follow up) lay for assessment due to in on both knees. She admits er knees, dull and affecting ay] on both knees" [Nurses Note] "Resident's es (Positive) for LT (left) ure of the distal femur with right) Knee: There is estion and a cortical hairline ateral femoral metaphysis in a call placed to the NP" I [Nurses Note] " Resident nee pain yesterday 2/16/22 ed by NP NP ordered ess. X-ray report received ression of acute fracture of acute hairline fracture of the ondyle in normal who worked with resident 2 all shifts will be interviewed in thad a fall or if resident anyone. [Physician's Name] e order to send resident to	F	609			8/24/22

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F 609	provided to the surver revealed the facility's results of Resident #4 injury of unknown origing a face-to-face 04/18/22 at approxim (Clinical Coordinator) and stated, "The inverthe resident was sen hospital. She did not us to conclude the investigate/Prevent/CCFR(s): 483.12(c)(2): §483.12(c) (1) In responsing lect, exploitation, must: §483.12(c)(2) Have eviolations are thorough \$483.12(c)(3) Prevented the eviolation of the eviolation of the eviolation of the evidence of the	s investigation documents yor on 04/18/22 at 10:36 AM taff failed to report the 408's investigation of an gin to the state agency. interview conducted on ately 1:00 PM, Employee #7 acknowledged the finding stigation was not concluded. It immediately to the come back to the facility for vestigation." correct Alleged Violation -(4) se to allegations of abuse, or mistreatment, the facility vidence that all alleged the further potential abuse, or mistreatment while the gress.		610			8/24/22

				LETED			
		095019	B. WING _			04/	20/2022
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F 610	six (6) of 105 sample failed to: (1) conduct occurrences for Resi conduct investigation altercations with Res and (3) conduct a the Resident #221's thre roommate. The findings include: Review of the facility Abuse" with a revision neglect was defined its employees or sengoods and services to necessary to avoid panguish, or emotionare vealed that staff ar incident/accident for occurrences and sub Nursing or designee investigation will be radministratorIf sus behavior are between be immediately sepamonitored until approimplemented All enattesting, their under abuse standards" 1.Facility staff failed Resident #3's heat and (HME) being stuck in occurrence) and Resident was allowed the conduction occurrence.	d residents, facility staff investigations for unusual dents' #3 and #409; (2) as of resident-to-resident idents' #67, #71 and #151; brough investigation of at of violence against his Is policy titled, "Prohibition of at of violence against his Is policy titled, "Prohibition of at of violence against his Is policy titled, "Prohibition of at of 02/2022, showed as the failure of the facility, vice providers to provide o a resident that are hysical harm, pain, mental all distress. The policy to "complete an an for any unusual whit it to the Director of A final report of the eported and signed by the pected abuse/inappropriate in two residents, residents will rated from each other and opriate interventions are inployees will sign a memo standing and compliance to to conduct investigations for and moisture exchanger in his stoma (unusual ident #409's dislocated hip	F	510	CORRECTIVE ACTION FOR TH AFFECTED RESIDENTS: Resident # 3 was discharged 3/29/22, this deficient practice can retroactively corrected. Resident # 409 was discharged hon 9/28/20 this deficient practice be retroactively corrected. Resident #71 was assessed from to toe on 4/26/22, for bruises redrand pain. resident suffered no neoutcome from the incident that on between him and another resident denied pain. MD/RP updated 4/26/21 Resident #67 was assessed by Umanager from head to toe on 4/26/25 for bruises, redness and pain , resident grain and pain .MD/RP update 4/26/25 redness bruises and pain. Resides suffered no negative outcome. Resident #151 was assessed from to toe by Unit Manager on 4/26/25 redness bruises and pain. Resides suffered no negative outcome from incident that happened between hand another resident and denied MD/RP updated on 4/26/22. Resident #221 signed out AMA on 5/19/22 this deficient practice can retroactively corrected. Resident # 408 was sent to ER on the side of the practice can retroactively corrected.	ome cannot head ness gative curred at and 6/22, sident esident /22 m head 2 for ent m the nim pain.	8/24/22
		e diagnoses including			2/12/22 and did not return to the f		

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DEANWO	OD REHABILITATION AN	D WELLNESS CENTER		50	00 NANNIE HELEN BURROUGHS AVE. NE		
				W	ASHINGTON, DC 20019		
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F 610	Continued From page	: 82	F 6	10	F610		8/24/22
		of Larynx, Carcinoma of ence of Larynx, and			IDENTIFICATION OF OTHERS VITHE POTENTIAL TO BE AFFECT	ΓED.:	
	by the DC Departmer	orm for a complaint received it of Health, Health Care sing Administration on			All residents residing in the facility the potential to be affected by this deficient practice.		
	01/26/22 showed the [granddaughter] alleg rushed to the ER on 2 been fatalbecause his (Resident #3) nec	complainant ed that Resident #3 was 2/03/21, "which could have there was an HME put into k stoma (airway)."			Clinical care coordinator/Designed conduct house wide audit to ensu that all resident-to-resident alterca are fully investigated, and that all present provided statements. Any issues found will be corrected by	re ation staff	
	(MDS) dated 12/03/2 left "Brief Interview M section blank.	on Minimum Data Set 1 showed that facility staff ental Summary Score"			8/24/22. Unit Managers/ Supervisors will conduct house wide audit to ensu that all alleged threat of violence is		
	Following Surgery of	of Laynx, Surgical Aftercare Respiratory system, tomy Status and Malignant			investigated and reported. Any iss found will be corrected by 8/24/22	ues	
	and Programs), the re	ny care and speech therapy t was not coded for					
	Review of the resider the following:	t's medical record revealed					
	Physician's Orders:						
	12/02/21 "Change HM	/IE daily day shift"					
		sident to the nearest ER for					

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		WASHINGTON, DC 20019			
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	F 6	10 F610		8/24/22	
		MEASURES TO PREV RECURRENCE:	ENT		
seen at bedside It. also has Ivitals: 126/81 18 (respiration), 97.6 gen saturation rate ratory Therapy ssessment, Resident ary tube and holder in se cleaned, tube ged. Pre-treatment 18, SPO2 98% [on] Post-treatment 18, SPO2 (peripheral 99% on room air, g Progress Note] stified writer that in the stoma (airway). sident was assessed noted. Resident ted. O2 (oxygen) Sat liately and was 99% ine] notified. He gave int to nearest ER r evaluation. otified and wanted to espiratory therapist are for lari-tube and		licensed nurses by State the importance of compaccident/incident report to report their findings the forty-eight hours except accidents that resulted is to be reported within occurrence by 8/24/202 in-service will be conducted. Unit Managers will ensure members provide writted on resident incidents/ a situations. Any findings corrected by 8/24/22. Supervisors will ensure incident/accident report completed accurately. A found will be corrected. Charge nurses will ensure collect statements from incident/accident that of their shifts and ensure the compact of their shifts and ensure the content of their shifts and the content of their shifts and their shifts and the content of the content of their shifts and the content of their shifts and the content of the content of their shifts and the conte	if Educator on oleting accurately and o DOH within to incidents or in harm which eight hours of 22. Repeat cted as needed. The statements or in statements or incidents will be all as are Any issues by 8/24/22 are that they staff about occurred during that incidents		
TEN CE CONTRACTOR OF THE CONTRACTOR	cian Assistant) seen at bedside Pt. also has IIvitals: 126/81 18 (respiration), 97.6 //gen saturation rate ratory Therapy ssessment, Resident lary tube and holder in the cleaned, tube ged. Pre-treatment 18, SPO2 98% [on] Post-treatment 19, SPO2 (peripheral 199% on room air, ag Progress Note] otified writer that in the stoma (airway). seident was assessed moted. O2 (oxygen) Sat liately and was 99% me] notified. He gave ent to nearest ER er evaluation. otified and wanted to respiratory therapist are for lari-tube and 12/2/21. the stoma	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) F 6: Oma in neck. The te neck breather" cian Assistant) seen at bedside Pt. also has IIvitals: 126/81 18 (respiration), 97.6 //gen saturation rate ratory Therapy ssessment, Resident lary tube and holder in the cleaned, tube gged. Pre-treatment a 18, SPO2 98% [on] Post-treatment a 18, SPO2 (peripheral 99% on room air, or g Progress Note] totified writer that in the stoma (airway). seident was assessed moted. Resident or other of the gave and to nearest ER are evaluation. or offied and wanted to respiratory therapist are for lari-tube and	TOP DEFICIENCIES BE PRECEDED BY FULL WITHYING INFORMATION) TO DEFICIENCIES BE PRECEDED BY FULL WITHYING INFORMATION) TAG PREFIX TAG PREVIX TAG PREVIX TAG PREVIX TAG PREVIX TAG PREVIX RECURRENCE: In-service will be provice licensed nurses by Staff the importance of compaccident/incident report to report their findings to be reported within occurrence by 8/24/202 in-service will be conducted. SPO2 (peripheral 18, SPO2 98% [on] Post-treatment 18, SPO2 (peripheral 199% on room air, Ing Progress Note] of the previous provide writted in the stoma (airway). In the stoma (air	TOF DEFICIENCIES BE PRECEDED BY FULL WITEYING INFORMATION) TOF DEFICIENCIES BE PRECEDED BY FULL WITEYING INFORMATION) PREFIX TAG F610 F610 MEASURES TO PREVENT RECURRENCE: In-service will be provided to all licensed nurses by Staff Educator on the importance of completing accident/incident report accurately and to report their findings to DOH within forty-eight hours except incidents or accidents that resulted in harm which is to be reported within eight hours of occurrence by 8/24/2022. Repeat in-service will be conducted as needed. Unit Managers will ensure that all staff members provide written statements on resident incidents/ accidents sor accident incidents/ accidents on accident will be corrected by 8/24/22. Supervisors will ensure all incident/accident reports are completed accurately. Any issues found will be corrected by 8/24/22 Charge nurses will ensure that they collect statements from staff about incident/accident that occurred during their shifts and ensure that incidents are reported. Any issues found will be corrected by 8/24/22	

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DEANWO	OD REHABILITATION AN	ID WELL NESS CENTED	5000 NANNIE HELEN BURROUGHS AVE. NE		5000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ND WELLNESS CENTER		١	WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	was clear but today s an HME stuck in the sexplained to the gran HME [was] initially strand the resident coug 1345 (1:45 PM) and t PM). However, review assessments / infection documented evidence therapist assessed or #3 from 12/02/21 to 1 12/04/21 [Hospital Disposis-tracheoster radiology XR (xray) in (posterior-anterior) are for follow-up appointred 4 days [provided ecclean a Tracheostom 12/06/21 at 4:13 PM Progress Note] "Re-acceptation. Pt. seen and stablevitals: 13 (pulse), 17 (respiration saturation rate on rocclung CTA (Clear to accept the progress of the pr	the observed that there was stoma. The therapist ddaughter that maybe the cuck down in stoma (airway) ghed it up911 called at they arrived at 1400 (2:00 to of respiratory therapy on screener notes] lacked that the respiratory provided care for Resident 2/06/21." scharge Summary] omy malfunction. Diagnostic teck soft tissue, XR chest PA and LAT (lateral) 2 view. Call the nent with physician within 2 ducation tool] for "How to the Tube, Adult." [Physician Assistant the dission follow-up, pt tized for tracheostomy at the bedside appears alert 30/67 (blood pressure), 71 the short of the provided care for Resident and the staff that Resident #3's stoma (airway). I'm not	F	610	Unit Managers will validate duri grand rounds daily that incident that occurred in the facility have been reported to DOH and that responsible party has been notified. Any issues found will be addressed by 8/24/22. Audit will be conducted by Nurs Supervisors, ADON/ Designee, ensure that incidents are investigated, that the incident forms are completed accurately and that incidents are reported timely manner to Department of Health. Any issues found will be corrected by 8/24/22.	s the e se to	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION		E SURVEY IPLETED
		095019	B. WING _			04	1/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		5000 NA	ANNIE HELEN BURROUGHS AVE. NE INGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	was stuck in his storr investigated to ensur neglected by staff? T know the situation to answer." B. Resident #409 wa 07/08/21 with diagno for Orthopedic Afterc Artificial Hip Joint, Al: (Unspecified), Repeat (Generalized), and C and Mobility. Review of an intake f by the State agency cafter having hip sur observed two days la positioned like the lef sent to the hospital for surgery. A review of the Quart dated 07/11/21 reveat the following: In Section C (Cognitic summary score of "90 resident had severely 07/08/21 at 8:29 PM "Resident was adm Hospital] for rehability ArthroplastyReside pillow and WBAT (we Fall and safety precallocation close to nurse	the should staff have the resident was not the employee stated, "I don't give you an accurate as admitted to the facility on ses that included: Encounter are, Presence of Left cheimer's Disease ted Falls, Muscle Weakness ther Abnormalities of Gait and the complaint received on 12/06/21 documented grey on 07/08/21, was ter on 07/10/21 with "leg ter 'K'" Resident #409 was or a dislocated hip and hip are left that facility staff coded are Patterns), a BIMS of the complaint received that facility staff coded are Patterns), a BIMS of the complaint indicating that the complaint indicating that the complaint indicating that the complaint indicating that the complaint indicating as tolerated). The complaint indicating as tolerated indication initiated: resident es' station with close and commonly used items	F 6	10 M At Dre in in st cc x3	IONITORING CORRECTIVE CTION: ON/Designee will audit all inceport to ensure that they are forestigated upon and that each cident report has employees tatements. This audit will be conducted weekly x4, then mo 3. Findings will be corrected namediately and reported to the API committee	cident fully ch onthly	8/24/22

STATEMENT OF AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONST	RUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING				20/2022
	OVIDER OR SUPPLIER DD REHABILITATION AN	ID WELLNESS CENTER	•	5000 NA	NDDRESS, CITY, STATE, ZIP CODE NNIE HELEN BURROUGHS AVE. NE IGTON, DC 20019	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	"Patient seen at the rand the family. Patier pain at the site of suradded oxycodone ((as needed) for 14 da 07/10/21 at 5:40 PM Assessment Request Tool] "Resident tra Date problem or sym Background S/P (s Arthroplasty done on Resident is alert an apparent distress not status notedR-Req [Name of Resident R bedside. Communicar equested her mom to Hospital" 07/10/21 at 6:20 PM "Family was at bed AM Resident was se 12:30 PM At about requested that she no because she want[ed leg was not dislocate daughter that [the] re doctor in her presen[there was any concernave order[ed] an X-ray can be gotten fake b/n (between) 2-	[Physician's Progress Note] equest of Nurse Manager int reportedly has increasing gery, worse with movement inarcotic pain reliever) prin inys for breakthrough pain" [Situational, Background is (SBAR) Communication insfer to [Hospital Name] ptom started: 07/10/2021 intatus post) left hip 7/5/2021 A-Assessment ind verbally responsive, no ed. No change in mental ituest - Person contacted: itepresentative] was at ited in person. Notes: She is be transfer[ed] to the [Nurses Note-Late Entry] side visiting today from 11:45 en by the medical director at	F	510			8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(×	(3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIF 5000 NANNIE HELEN BURROUGH WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 610	be done so the reside the hospital via non-further evaluation per was taken out from to [Hospital's Name]." 07/12/21 at 6:34 PM Summary] "The patient Facility], where she is few days Her daug visit her looked unthat her left leg was an They were concerned with the surgery at the requested transportary Procedure -joint redu (procedure for treating surgery, using manipate to put the hip back in Department) Course patient's hip was reduced procedure well hower hip in Narratives: to back to [Name of Fafor discharge" A review of Resident revealed no docume staff identified or inverse (dislocated hip) as a failed to conduct an During a face-to-face approximately 4:00 FM Manager) stated, "The weekend, when I was staff in the staff identified or inverse in the staff identified or inve	will take about 4-6 hours to ent should be transfer[red] to emergency transport for a family requestResident the facility at 5:50 [PM] to [Hospital Discharge ent presents from [Name of the past ghter and son-in-law went to ender her covers and found significantly inwardly rotated. It is done the facility inwardly rotated. It is done the significantly inwardly rotated. It is done the hospital action: closed joint reduction and a hip dislocation without coulation of thigh bone (femur) in place) ED (Emergency /Critical Care2:30 AM: The function in the place of the cover did take 4 tries to get the cov	F	310		8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NI WASHINGTON, DC 20019	<u> </u>	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	and in an SBAR." 2. Facility staff failer of resident-to-reside Residents' #71, #67 Review of the Facility dated 12/09/21 doc security officer of assaulting another front of the building Review of the FRI of "At 2030 on 12/29 alleged to the recephim on his chest x 22 Resident Background A. Resident #151 w 10/22/20 with multipular Unspecified Psychologenign Prostatic Hy Review of Resident revealed: 12/08/21 [Admission BIMS summary scoognitive impairment of the properties of the prope	d to investigate two incidences ent altercations involving and #151. ty Reported Incident (FRI) umented, " At 0730 AM, the oserved [Resident #151] resident [Resident #71] at the" dated 01/02/22 documented, (12/29/21), [Resident #67] obtionist that [Resident #151] hit in the lobby" and Information as admitted to the facility on oble diagnoses that included: osis, Epileptic Syndrome and operplasia. #151's medical record an MDS], facility staff coded a re of "07", indicting severe nt. vior): dicators of Psychosis - septions or beliefs that are	F 6	10		8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	ETION
F 610	behavioral symptoms (e.g., hitting, kicking, grabbing, abusing off this type occurred 1 to symptoms directed to threatening others, so at others) - "Behavior days", Impact on Ressignificant risk for phyimpact on others p physical injury? "yes" privacy or activity of disrupt care or living of the company of the care of the company of the care of the	directed towards others pushing, scratching, hers sexually) - "Behavior of to 3 days", verbal behavioral hwards others (e.g., breaming at others, cursing of this type occurred 4 to 6 hident Put the resident at resical illness or injury? "yes"; but others at significant risk of thers? "yes"; significantly benvironment? "yes" mal Status): Activities of sistance - bed mobility, h, walk in corridor, homotion off unit, Resident revision" and "one person lan revealed: ate) "As evidenced by a be eadmission Screening and be la screen and Level II bermined that the resident bervices while in the Nursing chizophreniaInform the fif the Individual has a be and services previously to be modified or deleted. Significant changes may fulluation to add, modify or ate) "[Resident #151] at risk	F 61		8/2	24/22
	for changes in behaving agitation"	or problems related to:				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		095019	B. WING		,	C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	problematic manner characterized by inato treatment/care re (Dementia, Schizop taking medications, non compliant with a compliant with Wad and hitting" 10/20/21 (Revision impaired cognitive f processes r/t (related 10/20/21 (Revision psychotropic medicanagement, Paral Monitor/record occusymptoms violents taff/others) and do 10/22/21 (Revision behavior problem r/on the entire floor, on Non-compliant lettir moving chair into an stop Combative, members, trying to Administration area staff monitoring for sitter is available" B. Resident #71 wa 08/20/18 with multip	date) "[Resident #151] has appropriate behavior; resistive lated to: Cognitive Impairment hrenia). Non compliant with non compliant with vital signs, shaving and showers. Non er guard placement kicking date) "[Resident #151] has unction or impaired thought and to) Dementia" date) "[Resident #151] uses ations r/t behavior moid Schizophrenia arrence of for target behavior ce/aggression towards cument per facility protocol" date) "Resident #151] has to (Combative, Spilling water disrobing) r/t Schizophrenia. In groommate into the room, nother room and refusing to agitation, hitting multiple staff break down doors in the and rolling on the floor 1:1 safety until seen by psych or to be diagnoses that included order, Unspecified Dementia	F 6			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(×	(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	Review of Resident # Quarterly MDS dated coded a BIMS summ moderate cognitive ir indicators of psychos behavioral symptoms person physical assis range of motion and in C. Resident #67 was 09/29/08 with multiple Unspecified Intellecture Disorder with Hallucin Dementia without Bellecture Tespo of psychosis, no physical and interest in the Saymptoms, limited to one person physical a limitations in range of Altercation #1 involvin 12/08/21 at 11:18 AM 0730AM, the [Securit [Receptionist's Name assaulting another refront of the building. Treceptionist ran to the both residents [Reserved] [Resident #15: [Resident #71]. He said [Resident #71]. He said [Resident #71]. He said [Resident #71]. He said [Resident #71].	271's medical revealed, a 10/23/21where facility staff ary score of "09", indicating inpairment, no potential is and no physical or verbal is, limited assistance with one of for ADLs, no limitations in no skin conditions. admitted to the facility on addingnoses that included ital Disabilities, Psychotic nations, and Unspecified in avioral Disturbance. 267's medical revealed, a 11/06/21 where facility staff ary score of "14", indicating inse, no potential indicators iscal or verbal behavioral extensive assistance with assist for ADLs and no fimotion. Ing Residents #151 and #71: I [Nurses Note] " At y Officer's Name] and the observed resident [#151] is ident [Resident #71] at the late of the security officer and the extension in the interviewed on me in front of the interviewed on me in front of the interviewed on the ere this came from today'	F 6	510		8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE 10 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page was called took [Reaggressive behavior a [Hospital Name] at 08 [Resident #71] was a mark observed on the Altercation #2 involvin 12/30/21 at 11:30 AM (8:30 PM) on 12/29/2 alleged to the receptihim on his chest x 2 inotified the supervisor [Resident #67] and he (8:40 PM) [Resident #67] and he (8:40 PM) [Resident #67] and he building stood by the grab and hit staff exit staff exit or enter the Department was called (11:50 PM). 2 MPD . PM). During interview was not cooperating; of the Police Officers into custody [Resident abdomen over No swelling, discolors.]	esident #151] because of his and transported him to 809 (AM) for evaluation. Seessed and small scratch be back of his left hand" Ing Residents #151 and #67: I [Nurses Note] " At 2030 (12/29/21), Resident #67] conist that [Resident #151] hit in the lobby; the receptionist r; the supervisor assessed be denied any pain At 2040 #151] was observed at the was redirected back to the ene building entrance trying to sing the building will not let building. The DC Police and notified at 2340 responded at 2345 (11:45 a) with [Resident #151], he he made attempts to hit one [Resident #151] was taken lent #67] was assessed a alleged being hit on the his previous surgical site. attion or open area observed		510			8/24/22
	04/14/22 at 2:45 PM, in Training) was aske investigation docume incidences of residen involving Residents # Employee stated, "It v	interview conducted on Employee #6 (Administrator d to provide the facility's nts related to the two t-to-resident altercations 71, #67 and #151. The					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	TIPLE CONSTRUCTION		OATE SURVEY OMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGH: WASHINGTON, DC 20019		0-1/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Continued From pag The evidence showe implement its written investigations evider investigation of two raltercations. 2. Facility staff failed alleged threat of viole Review of the FRI (F dated 03/29/22, doct explained to the charrooming with his room were to continue to be we will find the room Resident #221 was r 10/28/21 with multipl Cognitive Communic Hemiparesis Followin Affecting Left Non-Dounspecified and Parkerevealed that the fact In section C (Cognitive Summary Score "15"	d that facility staff failed to policies and procedures for need by failure to conduct an esident-to-resident to thoroughly investigate an ence by Resident #221. facility Reported Incident) fumented "resident rge nurse that he did not like mmate. He stated that if he ein that room that one day mate hurt" e-admitted to the facility on e diagnoses including, ration Deficit, Hemiplegia and fing Cerebral Infarction forminant Side, Paraplegia anoid Schizophrenia. erly MDS dated 03/23/22 fility staff coded the following: we Patterns), a BIMS) ', indicating intact cognition.				8/24/22
	Background Assessr (Nurse Practitioner)/I Communication Tool PM, showed "Toda charge nurse that he roommate. He stated to be in that room that roommate in a pool of	nent titled "SBAR (Situation ment Request)-physician /NP PA (Physician Assistant) "dated 03/28/22 at 12:27 y, resident explained to the did not like rooming with his did that if he were to continue at one day, we will find the of blood. A nurse stayed by ntil the resident could be				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE.
F 610	transferred to the roomew potential roomem change would be fined. Review of the facility documentation that would be supported to the facility documentation that would be fined. The facility documentation that would be supported to the facility documentation that would be supported by the facility documentation that would be supported by the facility documentation that would be supported by the facilities investiged by the facilit	er room. Prior to being om he was introduced to the late and stated that the late and stated that the late" It's incident investigation was signed and dated on of the following: two late statements, a copy of a late form titled port", a form titled "Quality ormance Improvement investigation report, a SBAR in evaluation for cognitively late incident investigation was signed and dated on of the following: two late statements, a copy of a late form titled port", a form titled "Quality ormance Improvement investigation report, a SBAR in evaluation for cognitively	F	510		8/24/22
	04/18/22 at approxim	nately 1:00 PM, Employee #2 acknowledged the findings.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		ATE SURVEY DMPLETED
		095019	B. WING			C 04/20/2022
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	Resident #408's inj interview evidenced obtain statements of Resident #408's can Review of the FRI of "Resident complayesterday 2/16/22 of (Nurse Practitioner) morning with impresent distal femur, Acright lateral femoral worked with resident worked with resident shifts will be interviewed a fall or if resid anyone" Resident #408 was 05/25/21 with multiple Hemiplegia and H	d to thoroughly investigate ury of unknown origin d by failure to interview and/or from all staff involved in re. dated 02/22/22 documented, ained of right knee pain and she was assessed by NP) X-ray report received this ssion of Acute fracture of the lute hairline fracture of the lute hairline fracture of the lute condyle All staff who not from 2/9/22 to 2/16/22 all lewed to determine if resident ent had reported fallen to	F 6			8/24/22
	persons physical as and personal hygic motion. 02/16/22 at 2:27 PN Progress Note] "As seen today for asse both knees. She ad	M [Nurse Practitioner (NP) sessment and f/u knee pain essment due to c/o pain on limits to moderate pain in her ecting her sleep Plan [x-ray]				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA		
F 610	on both knees" 02/17/22 at 7:38 AM X-ray of the both knee knee: There is a fract displacement RT (i irregularity and impact fracture of the distal lawhich is impacted A 02/17/22 12:05 PM [N complained of right knand she was assessed X-rays of bilateral knethis morning with impact this morning with impact this morning with impact the left distal femoral calignment All staff of from 2/9/22 to 2/16/23 to determine if reside had reported fallen to notified and she gave the ER for 2nd opinion. Review of the facility's provided to the surverevealed the facility's results of Resident #4 injury of unknown origing a face-to-face 04/18/22 at approxim Employee #7(Clinical acknowledged the fin investigation was not was sent immediately	[Nurses Note] "Resident's es (Positive) for LT (left) ure of the distal femur with right) Knee: There is stion and a cortical hairline ateral femoral metaphysis A call placed to the NP" Nurses Note] " Resident nee pain yesterday 2/16/22 ed by NP NP ordered ression of acute fracture of acute hairline fracture of acute hairline fracture of the bondyle in normal who worked with resident 2 all shifts will be interviewed in thad a fall or if resident anyone. [Physician's Name] order to send resident to n" Is investigation documents yor on 04/18/22 at 10:36 AM taff failed to report the 108's investigation of angin. Interview conducted on ately 1:00 PM with Coordinator), he	F	510		8/24/22	

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095019	B. WING _				20/2022
S CENTER		5000 N	IANNIE HELEN BURROUGHS AVE. NE		
ECEDED BY FULL	ID PREFIX TAG		•		(X5) COMPLETION DATE
a/22 at 10:36 AM interview and/or sed staff /16/22 during . onducted on 0 PM with anager), she ade no further nents) e- ts- esident to sfer or acility unless- ecessary for the nt's needs ppropriate s improved ger needs the e facility is behavioral e facility would reasonable and to have paid ay at the facility. Int does not for third party			AFFECTED RESIDENTS: Resident #3 was discharged hon 3/29/22. Resident # 126 was assessed head to toe on 4/26/22, by Uni Manager, resident suffered no negative outcome.MD/RP noti 4/26/22 Resident #155 was assessed head to toe on 4/26/22 by unit manager, resident suffered no	from it fied on from	8/2422
	EFICIENCIES ECEDED BY FULL NG INFORMATION) On documents B/22 at 10:36 AM interview and/or sed staff /16/22 during on decided on O PM with anager), she ade no further ments i) Je- its- esident to asfer or acility unless- ecessary for the int's needs ppropriate si improved ger needs the e facility is behavioral e facility would reasonable and to have paid tay at the facility. Int does not for third party including	CATION NUMBER: 095019 B. WING EFICIENCIES ECCEDED BY FULL NG INFORMATION) F 6 on documents 3/22 at 10:36 AM interview and/or sed staff /16/22 during b. onducted on D PM with anager), she ade no further ments F 6 ge- ats- esident to asfer or acility unless- ecessary for the at's needs ppropriate s improved ger needs the e facility is behavioral e facility would reasonable and to have paid any at the facility. Int does not for third party	D95019 B. WING STREE SOOD N WASH EFICIENCIES ECCEDED BY FULL NG INFORMATION) F 610 On documents 3/22 at 10:36 AM interview and/or sed staff /16/22 during Denducted on	Deficiency of the nents of the earlity is behavioral per facility would reasonable and to have paid ay at the facility, int does not for third party of the net service of the control on the control of the control on the control on the control of the control on the control of	Deficiencies Consider the properties of the party of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			04/:	20/2022		
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	<u> </u>			
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F 622	Medicare or Medicaio resident refuses to paresident who become admission to a facility resident only allowab or (F) The facility cease: (ii) The facility may not resident while the apply \$431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility muthat failure to transfer when the facility transfer in paragraphs (c)(1)(i section, the facility more discharge is documedical record and a communicated to the institution or provider. (i) Documentation in the facility must include: (A) The basis for the city of this section. (B) In the case of paresection, the specific more med, and the service facility to meet the needs, and the service facility to meet the needs.	If, denies the claim and the ay for his or her stay. For a se eligible for Medicaid after of the facility may charge a le charges under Medicaid; so to operate. On transfer or discharge the opeal is pending, pursuant to opter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to awould endanger the health ent or other individuals in the must document the danger or discharge would pose. The circumstances specified (A) through (F) of this ust ensure that the transfer mented in the resident's ppropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot obts to meet the resident se available at the receiving need(s). In required by paragraph (c)	F	322	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facili have the potential to be affected House wide audit will be conducted by Unit Managers, DON/ ADON/ Supervisors to ensure that care plan goals. are sent to the receive hospital when the resident is transferred. Any issues found with be addressed by 8/24/22	ted /	8/24/22		

OLIVILIV	O T OIK MEDIO/ IIKE &	- INLEDIO (ID OLIVIOLO			OWID INC	7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
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DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE.	NE	
52,				WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	Continued From page (A) The resident's ph discharge is necessa (A) or (B) of this secti (B) A physician when necessary under para this section. (iii) Information provid must include a minim (A) Contact information responsible for the ca (B) Resident represe contact information (C) Advance Directive (D) All special instruct ongoing care, as app (E) Comprehensive of (F) All other necessal copy of the resident's consistent with §483. any other documenta a safe and effective t This REQUIREMENT by: Based on record rev three (3) of 105 samp staff failed to ensure: transfer, or relocation included accurate info	ysician when transfer or ry under paragraph (c) (1) on; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider um of the following: on of the practitioner are of the resident. Intative information including the information including are plan goals; ary information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ransition of care. The is not met as evidenced are and staff interview for olded residents, the facility's (1) Resident #3's discharge, form dated 12/03/21 ormation and (2) Resident re plan goals were sent to			all licensed aff Educator/ of sending dent when spital. as needed. care plan asfer ident to the orrected by at charge ent's care e resident e hospital. ected by	8/24/22
	#3's discharge, trans 12/03/21 included the Resident #3 was adn	ailed to ensure Resident fer, or relocation form dated e accurate information. nitted to the facility on e diagnoses including				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 622	Continued From page	÷ 100	F	522	F622		8/24/22
	Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status				MONITORING CORRECTIVE ACTIONS:		
	Review of the Reside showed a physician's instructed, "transfer re (emergency room) for to stuck HME in stom 12/03/21 at 2:42 PM "The respiratory there resident has a lari-tu and no respiratory dis denied pain. No bleed (saturation) checked RA (room air). [Docto instruction to transfer (emergency room) for Resident's granddaug know what happened explainedwhen she changed HME on yes was clear but today s an HME stuck in the sexplained to the gran-HME initially stuck do the resident coughed	order dated 12/03/21 that esident to the nearest ER further evaluation related a." (Nursing Progress Note) pist notified writer that stuck in the stoma (airway). The Resident was assessed extress noted. Resident ding noted. O2 (oxygen) Sat mediately and was 99% or's name] notified. He gave resident to nearest ER further evaluation. The respiratory therapist edid care for lari-tube and exterday 12/2/21, the stoma the observed that there was stoma. The therapist ddaughter that maybe the wn in stoma (airway) and it up911 called at 1345-100. However, review of			DON/Designee will validate that clinical coordinator, Unit manage and supervisors ensured that ca plan goals were printed and sensitive with the resident when the resident was sent to the hospital. Finding will be corrected immediately. The audit will be conducted weekly at then monthly x3, report will be presented to QAPI committee.	re t ent s nis	
	screener notes] lacke that the respiratory th provided care for Res 12/06/21."	d documented evidence					
	12/03/21 from the fac						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
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F 622	Transfer - Hospital an appointment [and] During a face-to-face 11:32 AM, Employee Services) stated that the information that F to the hospital from a facility's census. 2. The facility's staff f #126's and #155's cat the receiving hospital transferred out. A. Resident #126 wa 11/16/21 with multiple Failure Unspecified, Knee Joint, Chronic K (Severe), and Other Knee Joint, Chronic Knee Joint, Indicating cognition. 03/29/22 at 3:59 PM "Resident was observight knee surgical ar Practitioner)was made resident out to [Orthopedic to evalual with possible Abcess	interview on 04/18/22 at #11 (Director of Social it was an error, and she got desident #3 was transferred in appointment from the ailed to ensure Residents are plan goals were sent to (s) when the residents were sadmitted to the facility on ediagnoses including Heart Presence of Right Artificial (didney Disease, Stage 4 Lack of Coordination. #126's medical record Data Set (MDS) dated at the facility staff coded a ental Status (BIMS) summary moderately impaired [Nurses Progress Note] yed with swelling around the ea and the NP (Nurse ade aware and she order to Hospital Name] for the right knee surgical area	F 622			8/24/22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			
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F 622	goals in the transfer preceiving hospital. B. Resident #155 wa 11/18/19, with multipl Essential (Primary) Horopharyngeal Phase Coordination, Hemipl Following Unspecified Affecting Left Dominal A Quarterly MDS date facility staff coded Resummary score of "Occognitive impairment Review of the docum Background Assessin Communication Tool" PM, "Resident is aler Resident complaint of abdomen. NP order hospital for further evat 3:15 PM, arrived a resident at 4:04 PM to left with the following ordered (sp) to be transfer with the followin	Resident #126's care plan backet provided to the sadmitted to the facility on e diagnoses that included: hypertension, Dysphagia, e., Unspecified Lack of egia and Hemiparesis d Cerebrovascular Disease ant Side. Bed 02/18/22, showed that esident #155 with a BIMS 5", indicating severe Bent titled, "Situation nent Request (SBAR) showed, 03/30/22 at 6:40 at and verbally responsive f chest pain radiating to the ered to be transferred to the raluation. Writer called 911 at 3:23 PM and left with the [Hospital name]. Resident	F	522			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	1 04/	ZGIZGZZ
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F 623 SS=E	send Resident #126 plan goals to the reconstruction Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care Or (ii) Record the reasons discharge in the resuccordance with parand (iii) Include in the not paragraph (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be resident resident in the safety of include in the safety of include in the safety of includent i	is or Resident #155's care beiving provider. Is Before Transfer/Discharge is 1-(6)(8) be before transfer. Isfers or discharges a mustiful and the resident's the transfer or discharge and move in writing and in a per they understand. The copy of the notice to a coffice of the State inbudsman. In sort of the transfer or ident's medical record in ragraph (c)(2) of this section; In this section. In g of the notice. In the notice of transfer or ident's medical record in this section. In g of the notice in this section in this section. In g of the notice of transfer or ident's medical record in this section. In g of the notice in this section must be in this section must be in the notice of transfer or i	F 62	2	me ospital he e Unit D/RP aken by	8/24/22
	be endangered, und this section; (C) The resident's h	dividuals in the facility would der paragraph (c)(1)(i)(D) of ealth improves sufficiently to diate transfer or discharge,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 623	(D) An immediate tra required by the residunder paragraph (c) (E) A resident has not days. §483.15(c)(5) Contenotice specified in paragraph (c) (i) The reason for trace (ii) The effective data (iii) The location to watransferred or dischastiv) A statement of trace (iv) The name, and telephone number completing the form hearing request; (v) The name, address such request obtain an appeal of the completing the form hearing request; (v) The name, address telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and advelopmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and developmental disabilities, the mailing telephone number of the protection and developmental disabiliti	(1)(i)(B) of this section; ansfer or discharge is lent's urgent medical needs, (1)(i)(A) of this section; or of resided in the facility for 30 and the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; e of transfer or discharge; he resident's appeal rights, address (mailing and email), her of the entity which ests; and information on how form and assistance in and submitting the appeal less (mailing and email) and if the Office of the State abudsman; ty residents with intellectual	F	IDENTIFICATION OF O WITH THE POTENTIAL AFFECTED: All residents residing in have the potential to be this practice. House wide audit will be by Unit Managers and C coordinator to ensure the reason for transfer to ho indicated on all residents been sent to the hospita the responsible parties a of a resident s room relo documented in the resid clinical record. Any issue corrected 8/24/22. Unit manager will ensure written notification is ser resident's #233 respons about room relocation by	the facility affected by affec	d e e

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION G	COMP	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	20/2022	
DEANWO	OD REHABILITATION A	ND WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	E. NE		
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F 623	Continued From pag	ne 105	F 6	F623		0/24/22	
	established under th for Mentally III Individ	e Protection and Advocacy duals Act.		MEASURES TO PREVEN RECURRENCE:	ΙΤ		
	effecting the transfer must update the reci as practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification protected to the State Survey A State Long-Term Cathe facility, and the resident well as the plan for the relocation of the resident with the state survey A State Long-Term Cathe facility, and the resident well as the plan for the relocation of the resident with the state survey A State Long-Term Cathe facility, and the resident well as the plan for the resident with the state of the state	ges to the notice. The notice changes prior to The or discharge, the facility pients of the notice as soon the updated information The in advance of facility closure to closure, the individual who is the facility must provide frior to the impending closure Agency, the Office of the The Ombudsman, residents of the transfer and adequate dents, as required at § This not met as evidenced		In service will be provided Educators / Designee to a nursing staff to ensure the reason for transferring a resident to the hospital is indicated as in the package that is sent resident to the hospital by Repeat in-service provided as need Supervisors will ensure when the nurses are indicating the for transfer of a resident to hospital and notify the resparty. Any issues found we corrected by 8/24/22,	all licensed at the esident to not provided t with the 8/24/2022. eded. eekly that the reason of the ponsible		
	Based on record rev six (6) of 105 sample failed to: (1) notify R #406's representativ the resident's transfe provide written notific	view and staff interview, for ed residents, the facility staff esident #3's, #132's and e(s) in writing the reason for er to a hospital and (2) cation to Resident #82's, epresentatives of room		Unit Managers will ensure weekly basis that the charare including the reason for to hospital and that the reparty is updated. Any issure will be corrected by 8/24/2	ge nurses or transfer sponsible es found		
	#132's and #406's re reason for the reside 1A. Resident #3 was	to: (1) notify Resident #3's, epresentative(s) in writing the ent's transfer to a hospital.		ADON/Designee will ensuthat the licensed nurses in reason for transfer once it determined that the reside to the hospital and update responsible party. Any iss will be corrected by 8/24/2	ndicate the is ent must go the ues found		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 623	Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status Review of the Resides showed a physician's instructed, "Transfer (emergency room) fo to stuck humified mois stoma." 12/03/21 at 2:42 PM "The respiratory thera resident has an HME Resident has a lari-tu and no respiratory dis denied pain. No bleed (saturation) checked RA (room air). [Docto instruction to transfer (emergency room) fo Resident's granddaug know what happened explainedwhen she changed HME on yes was clear but today s an HME stuck in the explained to the gran HME initially stuck do the resident coughed and they arrived at 14 respiratory therapy as screener notes] lacke that the respiratory th provided care for Res 12/06/21."	of Larynx, Carcinoma of sence of Larynx, and of lar	F	523	Unit Mangers/Designee will ensithat nurses notify responsible particles of a resident's room relocation. A issues will be corrected by 8/24/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	arties Any /22. all son lso are This 4,	8/24/22

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED	
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F 623	evidence the resident aware in writing Resident ware in writing Resident to the emergency roof the emergency stated that Resident #3's repress transfer to the ER on 1B. Resident #132 won 02/11/22 with diagract Infection, Alzhe and Muscle Weaknes A review of the Quarrevealed that facility with a BIMS Summan that the resident had 02/02/22 11:44 AM [I resident was noted we congestion, labored I (shortness of breath) 88% 911 called and am. After assessment service) left with resinearest ER (Emerge documents were sen medication and treat recent lab results, phystatus, Report given (representative) notif 02/02/22 at 7:00 AM "Late Entry: [Resider	facility lacked documented t's representative was made dent #3's reason for transfer om on 12/03/21. e interview on 04/18/22 at #11 (Director of Social she did not notify in writing entative of the reason for his 12/03/21. The as readmitted to the facility gnoses that included: Urinary elmer's, Dementia, Epilepsy ss (Generalized). Terry MDS dated 02/17/22 staff coded Resident #132 ry Score of "99," indicating severely impaired cognition. Nurses Note]: "At 10.15 AM with crackles, chest oreathing and SOB with sat (saturation) at d arrived to the unit at 10.40 nt. EMS (emergency medical dent at 11.05 am and to the ncy Room). The following t with resident; face sheet, ment list, bed hold policy, pysician progress note, code to ER nurse RP fied" [Social Work Progress Note] nt #132] was transferred to with the bed hold and fair	F	523			8/24/22	

AND DI AN OF CORRECTION IDENTIFICATION NUMBER			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		095019	B. WING			C 04/20/2022
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	NE	04/20/2022
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F 623	2:45 PM with Emplo Services), she stated transferred to the holy phone, we compligive it to the resident send the forms to the lit should be noted the able to provide document the copy of the resident #132's repwritten copy of the resident #406 which was a send the forms to the lit should be noted the able to provide document the copy of the resident #406 which was a send the copy of the resident #406 which was a send the copy of the resident provided and Following Cerebral I revealed, an Admission where facility staff copy of "15", indicating into 02/10/22 at 8:13 AM "[Resident #406] was name]" The medical record that Resident #406 or provided a written copy of the resident #406 or provided a written written written written written wri	e interview on 04/11/22 at yee #10 (Director of Social d, "When a resident is spital we contact the family ete a notice of transfer and t's representative. We also e Ombudsman." at Employee #10 was not mented evidence that resentative(s) was provided a eason of transfer on 02/22/22. was admitted to the facility on le diagnoses including, End e, Alcohol Abuse Hemiplegia and Hemiparesis infarction. #406's medical record ion MDS dated 02/03/2022, oded a BIMS summary score	F6	323		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	D WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		V.120/2022
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F 623	to Resident #82's, #2 representative(s) of ro 2A. Resident #82 was 09/15/21with multiple Schizophrenia, End S Sensorineural Hearin Review of Resident # revealed: A Quarterly Minimum 11/23/21 that showed Interview for Mental S score, "00", indicating impairment. 01/27/22 [Physician's to room 420A" Review of Resident # health record lacked of show that Resident # provided written notifithe relocation. During a face-to-face 04/04/22 at 12:14 PM Social Worker) acknow stated, "I don't see ar move to room 420 A." 2B. Resident #233 wa 05/26/21 with diagnor Mellitus with Diabetic	33's and #404's com relocation. admitted to the facility on diagnoses that included: stage Renal Disease and g Loss. 82's medical record Data Set (MDS) dated facility staff coded a Brief status (BIMS) summary severe cognitive Orders] "Relocate resident 82's electronic and paper documented evidence to 82's representative(s) were cation of or the reasons for interview conducted on perform the facility of the finding and the finding and the finding and the finding biabetes including Diabetes Neuropathy, Chronic Kidney Cerebral Infarction Due to mor a Stenosis of	F	523		8/24/22

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION IG	(X3	COMPLETED		
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F 623	facility staff coded R Interview for Mental "15," indicating that intact. A review of Residen revealed: 01/01/22 at 9:53 AM Transfer]: "[Residen room [insert room #] a precautionary mea Review of Resident documented evidene #233 or their represe written notification or relocation. During a face-to-fact 12:51 PM, Employed acknowledged the fit 2C. Resident #404 v 12/06/16 with diagnor Unspecified Dement Disturbances, Vasco Behavioral Disturbat Ischemic Attack. Review of Resident revealed, a Quarterl showed facility staff score of "03", indicat impairment.	esident #233 with Brief Status Summary Score of the resident was cognitively I [Activities Note -In-house t #233's] was relocated from to [room on the fifth floor] as asure related to Covid-19." #233's medical record lacked be to show that Resident entative(s) were provided f the reasons for the e interview on 04/06/22 at e #13 (Social Worker) inding.	F 6	23		8/24/22	

l ' '		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Review of Resident # documented evidence #404's representative notification of or the r During a face-to-face 04/04/22 at 12:14 PM Social Worker) acknow made no further come Notice of Bed Hold Pc CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfethe resident goes on nursing facility must perfectly the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed perfectly the resident of the plan, under § 447.40 (iii) The nursing facility	404's medical record lacked e to show that Resident e(s) was provided written easons for the relocation. interview conducted on I, Employee #11 (4th Floor owledged the finding and ment. olicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to not representative that e state bed-hold policy, if a resident is permitted to sidence in the nursing eayment policy in the state of this chapter, if any; y's policies regarding	F6	623		de d	8/24/22	
	paragraph (e)(1) of the resident to return; and (iv) The information sof this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or their	pecified in paragraph (e)(1) old notice upon transfer. At			updated on the bed hold policy be 8/24/22	рy		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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F 625	resident representative specifies the duration described in paragraph. This REQUIREMENT by: Based on record revitwo (2) of 105 sample failed to provide Resiled The findings include: Review of the facility Discharge, Emergent documented, "The during hospital transforms and respons or by telephone or in hold days the resident 1. Resident #132 was from a [Local hospital included: Urinary Transled Transform and Italian transforms (Generalized A review of the Quart (MDS) for Resident #132 was a Brief Interview for North Summary Score was resident had severely A review of Resident revealed:	we written notice which of the bed-hold policy on (d)(1) of this section. Is not met as evidenced sew and staff interview, for ed residents, facility staff dent #132 and Resident intative(s) with written ified the bed-hold policy. policy entitled, "Transfer or by Care" dated 03/2022 Social Worker/Designee erwill ensure that the ible party is notified verbally writing of how many bed it has" Is readmitted on 02/11/22 if with diagnoses that be tot Infection (UTI), and, Epilepsy and Muscle and interest in the intere	F6	525	All residents residing in the facility have the potential to be affected. Licensed Social Services employees /Designee will condutionable parties are notified or provided with a copy of the bed policy when a resident is out of the facility and update them of the bhold days. Any issues found will corrected by 8/24/22	ity I. ict the or hold the ied	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 625	at 88% 911 called at 10.40 AM. After asse resident at 11.05 AM (Emergency Room). Were sent with reside and treatment list, be results, physician pro Report given to ER not representative) notified 02/02/22 at 1:24 PM placed call to [Name resident sent out to the spoke to ER staff and will be admitted and j (resident representative) (resident representative) 102/03/22 at 7:00 AM Late Entry: "[Resident Acute Care Hospital and forms attached." Review of the medicate evidence that Reside representative(s) were telephone or in writing days the resident had transferred to the ER During a face-to-face 2:45 PM, Employee at Services) acknowledge "When a resident is to the contact the family notice of transfer and	reathing and SOB with sat and arrived to the unit at assment. EMS left with and to the nearest ER The following documents nt; face sheet, medication d hold policy, recent lab gress note, code status, urse RP (resident ed" [Nurses Note]: "Follow up of Local Hospital] regarding ne ER earlier today, writer was informed that resident ust waiting for a bed. RP ve] and MD [Medical doctor] [Social Work Progress Note] t #132] was transferred tobed hold and fair hearing all record lacked documented nt #132 or their e notified verbally, by g of how many bed hold when the resident was on 02/02/22.	F6	525	MEASURES TO PREVENT RECURRENCE: Training will be provided by S Educator/ Designee to the Lic Social Services employees or importance of providing writte telephone notification to responsities when the resident is transferred to the hospital by 8/24/2022. Repeat training with provided as needed. Admission Coordinator will enthat bed hold days are accurated the 6-108 presented to him/ his the Licensed Social services employees. Also, that the responsible party has a copy bed hold policy. Any issues for will be addressed by 8/24/22. Licensed Social services employees will ensure that the documentation on the bed hold policy and that a telephone call written document was present the responsible party. Any iss found will be corrected by 8/24	ensed of the on sible of the und ere is defined to ues	8/24/22	
	days the resident had transferred to the ER During a face-to-face 2:45 PM, Employee # Services) acknowledg "When a resident is to we contact the family notice of transfer and	when the resident was on 02/02/22. interview on 04/11/22 at 10 (Director of Social ged the finding and stated, ransferred to the hospital, by phone, we complete a bed hold policy and give it			policy and that a telephone ca written document was presenthe responsible party. Any iss	all or ted to ues		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		ILTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
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F 625	It should be noted the able to provide documesident #132's reprovite copy of the bowhen the resident was 02/02/22. 2. Resident #151 was 10/22/20, with multipul Unspecified Psychos Benign Prostatic Hypura An Admission Minimus showed that facility swith a Brief Interview score of "07", indicting impairment. A progress note date [Nursing Supervisor approximately 12:00 staff to go to the Lob some demographic in The resident attempt while they were atternofficers then handous amergency psychiatriage" Review of Resident and documented evidence guardian were notified writing of how many had when the reside on 12/29/22. During a face-to-face 04/14/22 at 1:30 PM	at Employee #10 was not mented evidence that resentative(s) was provided a red hold days the resident had as transferred to the ER on sadmitted to the facility on alle diagnoses that included: sis, Epileptic Syndrome and perplasia.	F	625	MONITORING CORRECTIVE ACTION: Licensed Social Services Dire audit the charts of all residents are transferred to the hospital ensure that the responsible parotified of the bed hold policy bed hold days the resident hat that there is adequate docume to justify that information was provided. This will be ongoing The Director of Nursing will vathat the responsible party was notified or was presented with bed hold policy when the resid was transferred to the hospital audit will be conducted weekly then monthly x3. Findings will corrected immediately, and represented to QAPI committee	ctor will s who to arty is and s and entation . didate the dent l. This / x4, be port	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
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F 625 F 638 SS=D	stated that no notice of Crtly Assessment at I CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CM once every 3 months This REQUIREMENT by: Based on record rev (two) of 105 sampled failed to ensure that F Minimum Data Set (MResident #188's Qua (MDS) dated 03/03/2 after the assessment The findings include: 1. Resident #181 was 05/28/21 with multiple Chronic Obstructive F Heart Failure, and Enternational Review of the resider 03/01/22 showed Resides assessment reference made the MDS required 03/15/22. Sections G (Functional Abilities at (Assessment Adminis Employee #19 (Regic completed these sections assessment reference made the MDS required (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these sections of the resider (Assessment Adminis Employee #19 (Regic completed these secti	Review Assessment a resident using the ument specified by the State S not less frequently than is not met as evidenced few and staff interview, for 2 residents, the facility's staff Resident #181's Quarterly MDS) dated 03/01/22 and reterly Minimum Data Set 2 were completed 14 days reference date. Se admitted to the facility on a diagnoses including Pulmonary Disease, Asthma, and Stage Renal Disease. And	F 625		MD/RP be Unit MD/RP be WITH CTED: ty by house rly nin the nent as	8/24/22	

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Continued From page 116			538	MEASURES TO PREVENT RECURRENCE:		8/24/22	
/21/22 with the follost litus, Cerebrovason-Alzheimer's Denatus, Visual Halluci itation, Syncope and eview of Resident # at Set (MDS) date sessment reference the MDS assessment reference the MDS was left to be evidence showed and the modern the MDS was left to be evidence to face the MDS was left to be evidence to face the MDS was left to fa	bowing diagnoses: Diabetes cular Accident (CVA), mentia, Altered Mental inations, Restlessness and ind Collapse 2188's Quarterly Minimum di 03/03/22 revealed an ele date of 03/05/22. Based ment reference date, the date for the MDS was 500, "RN Assessment are and Date to verify blank. 21 that facility staff failed to dithin the required 14 days 22 interview on 04/11/22 at #19 (Regional MDS ledged the findings and but sign the MDS completion ents and #188. 23 inents 24 accurately reflect the electronic is not met as evidenced diew and staff interview, for ed residents, facility staff	F	641	MDS coordinator to the MDS teamembers to always ensure that the quarterly assessments are compositive within the required 14 days after ARD. Any issues found will be completed immediately. The Director of Quality Assurance Designee will validate that all quarterly assessments are compositive in a timely manner and that an R has signed to verify completion. Assues found will be corrected by 8/24/22 MONITORING CORRECTIVE ACTION: The MDS Lead staff member will ensure that quarterly assessment are completed by the MDS team correctly and that an RN signs a date the assessment to verify completion. This audit will be doweekly x4, then monthly x4. Findings will be corrected	im ihe ihe ileted the leted N Any Ints Ind		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR I Provided From page of Resident #188 was /21/22 with the following page of the following page of the following page of the MDS assessment reference the MDS assessment reference the MDS assessment reference the MDS assessment reference or formation was left to provide the MDS with the following page of the MDS with the following page of the MDS with the evidence showed mpletion was left to be evidence showed mplete the MDS with the formation was left to provide the MDS with the formation of the formati	DER OR SUPPLIER REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Pontinued From page 116 Resident #188 was admitted to the facility on /21/22 with the following diagnoses: Diabetes ellitus, Cerebrovascular Accident (CVA), on-Alzheimer's Dementia, Altered Mental atus, Visual Hallucinations, Restlessness and gitation, Syncope and Collapse eview of Resident #188's Quarterly Minimum at Set (MDS) dated 03/03/22 revealed an sessment reference date of 03/05/22. Based the MDS assessment reference date, the quired completion date for the MDS was /17/22. Section Z0500, "RN Assessment coordinator's Signature and Date to verify impletion" was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank. The evidence showed that facility staff failed to million was left blank.	DER OR SUPPLIER REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIT TAG Ontinued From page 116 Resident #188 was admitted to the facility on //21/22 with the following diagnoses: Diabetes ellitus, Cerebrovascular Accident (CVA), on-Alzheimer's Dementia, Altered Mental atus, Visual Hallucinations, Restlessness and litation, Syncope and Collapse eview of Resident #188's Quarterly Minimum as Set (MDS) dated 03/03/22 revealed an sessment reference date of 03/05/22. Based the MDS assessment reference date, the quired completion date for the MDS was /17/22. Section Z0500, "RN Assessment ordinator's Signature and Date to verify impletion" was left blank. The evidence showed that facility staff failed to miplete the MDS within the required 14 days 3/17/22). Turing a face-to-face interview on 04/11/22 at 149 PM, Employee #19 (Regional MDS pordinator) acknowledged the findings and sted that she did not sign the MDS completion tes for Residents #181 and #188. The evidence of the mode of t	DER OR SUPPLIER REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	DER OR SUPPLIER REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 116 Resident #188 was admitted to the facility on /21/22 with the following diagnoses: Diabetes allitus, Cerebrovascular Accident (CVA), or intinued From page 116 Resident #188's Quarterly Minimum that Set (MDS) dated 03/03/22 revealed an sessment reference date of 03/05/22. Based the MDS assessment reference date, the puired completed on date for the MDS was /1/7/22. Section 20500, "RN Assessment profinator's Signature and Date to verify mpletion" was left blank. The Director of Quality Assuranc Designee will validate that all quarterly assessments are completed by the MDS team correctly and that an an An signs a dated that she did not sign the MDS completion date of the verify completion. This audit will be downedly at the an RN signs a date the assessment to verify completion. This audit will be downedly and reported to QAI committee.	DER OR SUPPLIER REHABILITATION AND WELLNESS CENTER SIMMARY STATEMENT OF DEFICIENCES (EACH OPE) DEFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) DER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES (EACH OPE) DEFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO SUMMARY STATEMENT OF DEFICIENCES TEACH OPENCIANT ON THE PRECEDED BY PULL REGULATORY, STATE LIP CODE WASHINGTON, DC 20019 PRECOURTS PLAN OF CREECTION PRECEDE BY WASHINGTON, DC 20019 PRECOURTS PLAN OF CREECTION PRECEDE BY WASHINGTON, DC 20019 PRECEDE BY WASHINGTON, DC 20019 PRECEDE BY WASHINGTON, DC 20019 PRECED CACH SHIP AND IN EACH OF PRECEDED BY PREFIX TAG PRECED PRECED	

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F 641	Resident #50 was a 06/26/14 with multii Morbid Obesity, An Disorder and Major Review of Residen revealed the follow 01/30/20 (Revision #50] has an ADL (a self-care performar limited ROM (range morbid obesity the participation to represident requires to hygiene care" 11/16/20 (Creation abuse 2 CNAs (a provide ADL care at 11/17/20 [Physician ADL care at 11/17/20 [Physi	d to code Resident #50's MDS of 2 person's physical assist. admitted to the facility on ple diagnoses that included: xiety Disorder, Mood Affective Depressive Disorder. It #50's medical record ing: date) [Care Plan] "[Resident activities of daily living) are deficit r/t (related to) are of motion), limited mobility, the resident requires 2 staff position and turn in bed, the otal assistance with personal Date) [Care Plan] "Alleged Certified Nurse Aides) to	F	641	CORRECTIVE ACTION FOR THAFFECTED RESIDENTS. Resident # 50 was assessed fro head to toe by Unit Managers or 4/26/2022, resident suffered no negative outcome. MD/RP notified on 4/26/22. Codi for MDS is two persons assist fo ADL. Resident # 155 was assessed from head to toe by Unit Manager on 4/26/22, resident suffered no negative outcome. MD/RP notified on 4/26/22. MDS coding reflects his desire to go home. Resident # 183 was assessed from head to toe on 4/26/22 by Unit Manager, resident suffered no negative outcome. MD/RP notified on 4/26/22 MDS coding will refles history of multiple falls by 8/24/2 Resident #502 discharge home 6/2/22 Resident #160 was assessed from head to toe on 4/26/2022 by Unit Manager. Resident suffered no negative outcome. MD/RP notified on 4/26 on 4/26/2022 by Unit Manager. Resident suffered no negative outcome. MD/RP notified on 4/26	m ing or om ed ect 2	8/25/22	
	personal hygiene. During a face-to-fa 04/19/22 at 12:26 F	ce interview conducted on PM with Employee #19 ordinator), she acknowledged			MDS Coding will reflect rejection care by 8/24/22 Resident # 502 was discharged hon 6/2/22	of		

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F 641	Continued From page the finding and made 2. Facility staff failed #155's MDS to reflect community. Resident #155 was a 11/18/19, with multiple Dysphagia, Orophary Lack of Coordination Hemiparesis Followin Cerebrovascular Disc Side. Review of the Quarte (MDS) dated 02/18/2 coded a (Brief Intervi Summary Score "05" impairment. In Section Q (Particip Goal Setting), "Resid assessment "1" mean Q0400 (Discharge Pl planning already occ return to the community residents clinical recommunity.	e 118 In no further comment. Ito accurately code Resident this desire to return to the dmitted to the facility on e diagnoses that included: Ingeal Phase, Unspecified, Hemiplegia and Inguraged Phase Affecting Left Dominant entry Minimum Data Set 2, showed that facility staff ew for Mental Status (BIMS), indicating severe cognitive pation in Assessment and ent participated in ning yes an): Is active discharge urring for the resident to		641		/ITH TED: have ekly DS ents with rn to care, s are	8/24/22
	talk to someone about this facility and return services in the commo	mmunity), Do you want to ut the possibility of leaving hing to live and receive hunity? "No" reference to Avoid being 100B again) Does the resident					

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
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F 641	Review of Care Plan 12:13 PM showed, "held today 3/4/2020. (representative) was [social worker] reported long-term care status [Name] to locate appropriate that time he will be revealed the following 06/16/21 at 7:18 AM, Office on aging for [Resident #155]. soon to be Power of Achild was present at 07/23/21 at 2:50 PM, Representative] call of She stated that he calleave here because here social worker were lessident's sister] felt transition worker were	essments? "Yes" s a referral been made to ncy? "No" meeting note on 03/04/20 atcare plan meeting was [Resident #155] and hisRP present at the meeting. SW ed that he is a full code and The SW is working with copriate housing for him but remain in long term care." Work Progress Notes g: "Information sent to the esident #155] to be on back to the community. follow up with the family" "The care plan/IDT in meeting was held today His new RP [Representative] Attorney and mother of his at meeting" "The SW return [Resident concerning [Resident #155] liled her and was asking to e was tired of being here" " the Ombudsman called rvisory SW stated that	F 64	MEASURES TO PREVENT RECURRENCE: Training will be provided by Staff Educator/ Regional MDS coordin the MDS staff on the importance proper coding by 8/24/2022. MDS coordinators will conduct a on coding to ensure that they are correctly for residents who are tw persons assist, those on dialysis those wishing to return to the con Any issues found will be correcte 8/24/22. Unit Manager and Supervisors we ensure that CNA's are document ADL's accurately daily A resident requires two persons assist will be consistent with the MDS docume and coding. Any issues found will addressed by 8/24/22. ADON/Designee will conduct audensure that the residents who are compliant with care are document that MDS is capturing and coding aspect correctly weekly. Any issue will be corrected by 8/24/22.	ator to of check coding to and nmunity. d by ill ing who e ntation I be	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER	•	50	REET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	, , , , , ,	
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F 641	expressed a wish to community, however accurately code the During a face-to-face 04/18/22 at 1:30 PM Coordinator) she state out that section (Section 1) Section (Section 1) Section 1) Section 1) Section 2) Section 2) Section 2) Section 2) Section 2) Section 3) Section 2) Section 2) Section 3) Sec	ad that Resident #155 be discharged to the r, facility staff failed to MDS to reflect this desire. e interview conducted on , with Employee #18 (MDS ted, "The social services fills stion Q)." e interview conducted on with Employee #13 (5th r, she acknowledged that the 155 was not accurately fill out the section based on greed. This is a systemic to accurately code the MDS 160's rejection of care. admitted to the facility ble diagnoses that included: betes Mellitus, Major and Anxiety. #160's medical record g: M [Daily Behavior sident exhibits the following ons. Refuses ADL Care. Refuses Therapeutic are constant. Behavior	F	341	Unit Managers/ Designee will ensure that nurses report all f and that MDS is coding reside with falls accurately. Findings be corrected by 8/24/22 Rehab team will ensure that the notify the MDS team if the resident is two-person physic assist with ADL care as a trip check follow up exercise. Any issues found will be corrected 8/24/22.	alls ents will hey al le	8/24/22

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLE						
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	medications" 02/26/22 at 2:44 PM Documentation] "Res Refuses Treatment Activities. Behaviors a problems leads to iss A 5-day MDS dated 0 coded a BIMS summa severe cognitive impa (Behavior) that no rejoccurred. During a face-to-face 04/11/22 at 10:03 AM Coordinator) acknowl stated, "Section E (Be social services." 4. Facility staff failed of MDS was accurately resident's history of fa Review of a Facility R 10/14/21 documented van" Resident 183 was ad 03/20/14 with diagnos Mellitus Type 2, End of Acquired Absence of Review of the physici following: 10/21/21 "Y	Daily Behavior ident exhibits the following the Refuses Therapeutic are constant. Behavior uses with care." 2/26/22 showed facility staff ary score "06", indicating airment and in Section Election of care behaviors interview conducted on personal personal interview conducted on perso	F	341	F 614 MONITORING CORRECT ACTION: Rehab Director and MDS lead we conduct audits to ensure that all coding is done accurately. This will be conducted weekly x4, the monthly x3. Findings will be contimmediately, and report present QAPI committee.	vill I audit en rected	8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	with a focus area of, actual fall with no inj 4/1/2019, 6/4/2019 left knee 7/14/202 on 10/14/21 on the v Review of the Quarter revealed in section J staff coded the follow J1700 - "Fall History Reentry" was left black Review of the Quarter revealed in section J staff coded: J1700 - Did the residlast month prior to acfacility staff coded: J1700 - Did the residlast month prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit fall a months prior to admit facility staff coded "Oresident have a fall a months prior to admit fall a months	plan revised on 10/19/2021 "[Resident #183] had an ury unsteady gait on had a fall with injury to the 0 had a fall without injury, fell van without injury." perly MDS dated 11/22/21, 1 (Health Conditions) facility ving: on Admission/Entry or ank perly MDS) dated 02/22/22, 1 (Health Conditions), facility dent have a fall anytime in the dmission/entry or reentry, 1, indicating no; Did the any time in the last 2-6 ission/entry or reentry?, 1, indicating no dent had any falls since electry or the prior ever is most recent?, facility rating no. det that facility staff failed to ident #183's MDS on	F	641			8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page		F	641			8/24/22
	5. Facility staff failed the #502's MDS for dialys	to accurately code Resident sis.					
	03/17/22 with multiple End-Stage Renal Disc Pancreatitis, Chronic	ease, Anemia, Chronic					
	Review of Resident # revealed the following						
	03/17/22 [Physician's Thursday, Saturday	Order] "Dialysis: Tuesday, "					
	03/17/22 [Quarterly M staff coded the follow	IDS], showed that facility ing:					
	In Section C (Cognitiv Interview for Mental S score of "15", indicati	Status (BIMS) summary					
	and Programs), O010	, Treatments Procedures 00 under other Dialysis, indicating not on Dialysis.					
		d that facility staff failed to dent #502's MDS to reflect as on Dialysis.					
F 655 SS=D	04/19/22 at 1:40 PM, Coordinator) acknowl stated, "I will review the Baseline Care Plan	edged the finding and his (MDS assessment)."	F	655			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING			04/	20/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Planning §483.21(a) Baseline §483.21(a)(1) The faci implement a baseline that includes the instreffective and personthat meet professional The baseline care plate (i) Be developed with admission. (ii) Include the minimulation necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommily \$483.21(a)(2) The fact comprehensive care care plan if the comp (i) Is developed within admission. (iii) Meets the requirer (b) of this section (exit this section). §483.21(a)(3) The fact resident and their report the baseline care plimited to: (i) The initial goals of	Care Plans cility must develop and care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's rum healthcare information or care for a resident ted to- d on admission orders. cility may develop a plan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the cresentative with a summary colan that includes but is not of the resident.	F	655	F 655 CORRECTIVE ACTION FOR THAFFECTED RESIDENTS. Resident #3 was discharge home 3/29/2022 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: Clinical care coordinator/ Design will conduct house wide audit to ensure that residents responsible parties are provided a summary the baseline care plan. Findings be addressed by 8/24/22	e ees e of	8/24/22
	(i) The initial goals of	f the resident. resident's medications and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION		LETED
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F 655	(iii) Any services and administered by the fon behalf of the facilit (iv) Any updated info of the comprehensive This REQUIREMENT by: Based on record revistaff interview, for on residents, facility staff #3's representative vibaseline care plan. The findings include: Facility staff failed to representative with a care plan. Resident #3 was adm 12/01/21 with multiple Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status Review of the Reside lacked documented of the base-line care Resident #3's representative with a care plan. During a telephone in at 11:35 AM, the resident #3's representative with a care Resident #3's representative with a care and the base-line care resident #3's representative with a care and the base-line care resident #3's representative with a care and the base-line care resident #3's representative with a care and the base-line care resident #3's representative with a care and the base-line care resident #3's representative with a care plan or attended a care and the base-line care resident #3's representative with a care plan.	It treatments to be facility and personnel acting by. It is not met as evidenced are plan, as necessary. It is not met as evidenced are plan, as necessary. It is not met as evidenced are plan as evidence are pl	F	555	MEASURES TO PREVENT RECURRENCE: Training will be provided by Sta Development / Designee to all licensed clinical team members ensure that a summary of their s baseline care plan is provide responsible party by 8/24/2022 Licensed Social services team ensure that a copy of a summare sident's care plan and baseling plan are given to the resident's responsible party. Findings will addressed by 8/24/22. Licensed clinical team member (RN/LPN) will ensure that there documentation in place to show copy of a resident's baseline can was provided to the responsible Any issues found will be correct 8/24/22. Licensed clinical team member ask the responsible party durin IDT meeting if they need a cop baseline care plan, current melist and medical diagnosis. If ye be presented to them. Any issue found will be corrected by 8/24	will ary of a ne care is withat a are plane e party. Eted by rs will ary of the dication es, it will ues	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		095019	B. WING _			04/2	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=E	Worker) stated that F did not receive a sumplan and had not had his admission on 12/3 Develop/Implement (CFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The faimplement a compred care plan for each receident rights set for §483.10(c)(3), that in objectives and timefremedical, nursing, and needs that are identiff assessment. The cordescribe the following (i) The services that are identiff assessment. The cordescribe the following (ii) The services that are identiff assessment, and required under §483. (iii) Any services that under §483.24, §483 provided due to the runder §483.10, including treatment under §483. (iii) Any specialized services provide as a result of recommendations. If findings of the PASAI rationale in the resider (iv)In consultation wit resident's represental (A) The resident's godesired outcomes.	Resident #3's representative imary of his base-line care a care plan meeting since 21/21. Comprehensive Care Plan ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's if mental and psychosocial fied in the comprehensive inprehensive care plan must grant to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized is the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the	F6		MONITORING CORRECTIVE ACTIONS: DON/Designee will audit residents' chart to ensure that the responsible party was given a copy of the resident's baseline care plan. Findings will be corrected immediately. This audit will be conducted weekly x4, ther monthly x3, report will be presented to QAPI committee.	1	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X:	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	04/20/2022	
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F 656	whether the resident' community was asselucal contact agencie entities, for this purpo (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on record reveight (8) of 105 samp failed to develop and plans with measurab approaches to addre (Stoma Site Care, 2 assistance with denticatheter, speech defipain, behavior of urin refusal of care and contact Residents' #3, #50, # and #403. The findings include:	cilities must document is desire to return to the essed and any referrals to es and/or other appropriate ose. In the comprehensive care in accordance with the h in paragraph (c) of this If is not met as evidenced of the essed in accordance with the h in paragraph (c) of this If is not met as evidenced of the essed in the esse	F 6	CORRECTIVE AFFECTED RI Resident # 3 w 3/29/2022 Resident #50 w toe by Unit Maresident suffer MD/ RP notified implementation with ADL will be no later than 8. Resident # 126 to toe on 4/26/ resident suffer MD/RP notified address two per will be updated than 8/24/22. Resident # 132 to toe on 4/26/ resident suffer will be updated than 8/24/22.	was assessed from hanager on 4/26/2022, red no negative outcoord on 4/26/22. Care part for two persons associated immediates and the first part of the first part of two persons associated immediates and first part of two persons associated immediates and the first part of the first	ead to ome. olan sist ely but head er, ome. an to esfer later head er,	
	"Interdisciplinary Tea Meeting)" revised 03 the policy of [Facility implement person-ce resident that includes provide effective and meet professional sta 1. Facility staff failed care of Resident #3's	m Meeting (Care Plan /2022 documented, " It is Name] to develop and entered care plan for each is the instructions needed to person-centered care that andards of quality care" to include interventions to is stoma site.		catheter will be but no later that Resident # 155 Manager on 4/ no negative ou 4/26/22. Care	ve care plan for indwe e put in place immedi an 8/24/22. 5 was assessed by U /26/2022, resident sub utcome.MD/RP notified plan to address spee on place immediately b	Init ffered ed on ech	
	Residents' #3, #50, # and #403. The findings include: Review the facility's p "Interdisciplinary Tea Meeting)" revised 03 the policy of [Facility implement person-ceresident that includes provide effective and meet professional states of Resident #3's	policy entitled, m Meeting (Care Plan /2022 documented, " It is Name] to develop and entered care plan for each is the instructions needed to person-centered care that andards of quality care"		than 8/24/22. Resident # 132 to toe on 4/26/ resident suffer MD/RP notified Comprehensiv catheter will be but no later that Resident # 158 Manager on 4/ no negative ou 4/26/22. Care deficit will be in	2 was assessed from /2022,by Unit Manage ed no negative outco d on 4/26/22. We care plan for indwe e put in place immedian 8/24/22. 5 was assessed by U /26/2022, resident suffiction. MD/RP notified plan to address speem place immediately by the sufficient of the	head er, ome. elling ately Init ffered ed on ech	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	LETED
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F 656	12/01/21 with multiple Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status An Admission Minimult 12/03/21 showed that following: In Section I (Active Dimalignant neoplasm aftercare following sutracheostomy status supraglottis. In Section O (Special and Programs) - the receiving tracheostomy status supraglottis. In Section O (Special and Programs) - the receiving tracheostomy status supraglottis. Review of Resident # the following: 11/30/21 [Hospital Dimality documented, "laryngetotal laryngectomy, lated lary	e diagnoses including of Larynx, Carcinoma of tence of Larynx, and tence of Larynx (MDS) dated the diagnoses, cancer, for laynx (SP), surgical tragery of respiratory system, and malignant neoplasm of tence of the conditions of the	F	556	Resident #180 was assessed from head to toe by Unit Manager on 4/26/2022, resident suffered no negative outcome. MD/ RP notification on 4/26/22. Comprehensive care plan to address behavior of urination on the bathroom floor, smearing bathroom with feces will be updated immediately but no later than 8/24/22. Resident #81 was assessed for denture use by unit manager on 4/26/22 resident suffered no negative outcome. Care plan for assistance with denture use will be put in place immediately but no later than 8/24/22. CNA's will be educated to ensure residents with dentures have their on during meals. C N A 's are alsencouraged to assist resident wit wearing of dentures during meals needed. Resident #403 was sent to the hospital on 3/18/2022 and she did not return to the facility.	ed ting ted ted	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 656	breather." 02/07/22 [Physician's clean and remove crustoma BID (two-times and sterile (stoma share) (stoma share) (stoma share) (stoma share) (related to) laryngeal Goal-[resident's named date. Will have no s/s infection through the Interventions- lari-tub daily, assist with cough Further review of Rescare plans lacked docinterventions to addresuse of a lary-tube and 12/03/22. During a face-to-face 2:25 PM, Employee # stated that he included Resident #3's use of include interventions stoma site care. 2. Facility staff failed intervention of having Nurse Aides) for active assistance (ADL) for Review of a Facility Freceived on 11/22/21	a order] instructed, "Please usting from in and around to sa day) with moist gauze ould not be covered). The could not be covered in the covered interview on 04/13/22 at the could retain to address a lary-tube, but he did not to address the resident's of the could not to address the councile of the covered interventions to address to implement the care plan in two (2) CNAs (Certified rities of daily living	F 6	656	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED;' All residents residing in the facilit have the potential to the affected Licensed clinical team members (LPN/RN) conducted house wide audit on 4/22/2022 to ensure that residents have a person-centere comprehensive care plan, that residents with dentures have the and if need be, assistance is provided with wearing the denture and that residents with non-compliant behavior has documentation on the implementations in place. Any is found will be corrected by 8/24/2	t the d m res,	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	D WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			1 04//	20/2022	
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F 656	AM, a CNA hit her a bar of soap wrappewas interviewed; sh resident's room at 9:2 was ready to be chan yes. The CNA said sh and assist her becaus assist, but resident re provide care to her; th proceeded to provide" Resident #50 was add 06/26/14 with multiple Morbid Obesity, Anxied Disorder and Major Down Review of Resident # revealed the following A Quarterly MDS date facility staff coded the for Mental Status (BIN indicating intact cognition of Mental Status (BIN indicating intact cognition to resident requires staff participation to rethe resident requires personal hygiene care 11/16/20 (Creation Databuse 2 CNAs to participation to page 11/16/20 (Creation Databuse 2 CNAs to page 12.	6 times on her left knee with d in a towel" The CNA e said she went to OPM and asked her if she ged and Ms. Lambright said le called the nurse to come se resident is two persons fused two persons to be CNA then said she incontinent care to resident mitted to the facility on e diagnoses that included: ety Disorder, Mood Affective epressive Disorder. 50's medical record [1: et 09/24/21 showed that e following: a Brief Interview MS) summary score of "13", tion. ate) [Care Plan] "[Resident care performance deficit r/t DM (range of motion), limited ity the resident requires 2 eposition and turn in bed, total assistance with	F	556	F 656 MEASURES TO PREVE RECURRENCE: In-service will be provided to all licensed clinical staff members, Rehab staff and C N A 's by state ducator / Designee to ensure person-centered care plan for a resident is implemented as indiby 8/24/2022 Unit Managers and Supervisors audit resident clinical records to ensure that they have a revised person-centered care plan in pla a weekly basis Any issues foun be corrected by 8/24/22. ADON/Designee will audit reside clinical record to ensure that the nurses are revising and updatin resident's person-centered carplans. Any issues found will be corrected by 8/24/22.	aff that a cated s will ace on d will lents e	8/24/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
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F 656	11/16/21 at 9:40 AM 9.30 PM (11/15/2021 writer to room 229 B refusing her to finishing entering the room, the shouting, cursing the hit her on the thigh. The resident and there we was she in any pain or released the CNA and cleaning the resident. The evidence shower implement the care post two CNAs perform for on 11/15/21 during the 11:00 PM). During a face-to-face 04/12/22 at 10:00 AM Coordinator) acknown further comment. 3. Facility staff failed address Resident #81 with approximately 1:30 President was observed asked if she liked the resident reported that okay, but she wanted she eats. The writer a with her in the facility Resident #81 was addressed the she she asked the she wanted she eats. The writer a with her in the facility Resident #81 was addressed the she she she wanted she eats. The writer a with her in the facility Resident #81 was addressed the she she she she wanted she she she she wanted she she she she wanted she she wanted she she she she she wanted she	Nurses Note] "At around he couse [Resident #50] was an cleaning her. Upon the writer found [Resident #50] CNA alleging that the CNA he writer assessed the ere no signs of hitting nor or distress The writer districts and the called CNA to help finish " It is that facility staff failed to lan intervention of having and rabe according to the conducted on the conducted on the conducted on the conducted and the conducted and the conducted and the conducted according to the conducted and the conducted according to the conducted and the conducted and the conducted and the conducted according to the conducted and the conduc	Fé	356	Continuation of measures to preverecurrence: Unit managers/ Designee will ensuresidents with dentures are assess proper use of dentures on a weekl Staff will assist residents who neewith wearing dentures. Any issues will be corrected by 8/24/2022. CNA 's will ensure that residents we dentures have their dentures on a mealtime during their shift. Any iss found will be corrected immediated ongoing till 8/24/22. Unit managers will ensure a care part dentures weekly. Any issues found corrected by 8/24/22. Unit managers will ensure that reswith two persons physically assist transfer have a care plan in place implementations are followed week issues found will be corrected by 8/24/22. Charge nurses will ensure that reswith indwelling catheter have a comprehensive care plan in place the interventions are implemented indicated weekly. Any issues found corrected by 8/24/22.	ure that sed for y basis. d help found with t sues y and blan for vearing d will be idents with and kly. Any 8/24/22. sidents and that as	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	Vascular Accident (C Immuno-Deficiency \ Mellitus, and Cognitiv A review of the Quart (MDS) for Resident # that facility staff code following manner: In Section C (Cogniti Interview for Mental S Score was "03," indic severely impaired cool In Section G (Function for personal hygiene, dependent and requione staff person. For required limited assist A review of Resident revealed: 08/23/18 (Date initiat [Resident #81] at risk evidenced by weaking CVA. Interventions in hygiene, grooming, deating as needed Eself-care" "Focus: [Resident #81 as risk cavity health problem (CVA). [Resident #81 included assist with cogno2/21 [Denture Qu documented: 1) Patient is satisfied with the control of the country is satisfied with the control of the country in the country is satisfied with the control of the country in the country is satisfied with the country in the country is satisfied with the coun	VA), Human Virus (HIV), Diabetes ve Communication Deficit. erly Minimum Data Set 81 dated 03/06/22 revealed d the resident in the ve Patterns), the Brief Status (BIMS) Summary ating that the resident had gnition. enal Status), ADL assistance: the resident was totally red physical assistance from eating/meals, the resident trance from one staff person.	F	856	Supervisors will ensure weekly that plans are in place for residents with deficit and that the intervention are implemented as indicated. Any issu will be corrected by 8/24/22. Unit Managers will ensure that resid behavior of urinating on the bathroosmearing the bathroom with feces have care plan for such behavior in place resident will be assessed for toiletin program weekly. Any issues found addressed by 8/24/22.	speech es found lents with m floor, ave a . Such g	8/24/22

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F 656 Continued From page 133 Unit Nurse and Dentist." 09/02/2021 [Dentist Note]: "Patient satisfied with 10/29/21 at 8:00 AM [Physician's Order]: "ST (Speech Therapy) Strategies sit upright, alternate small bites/sips at slow rate, reduced distractions, check for pocketing, assist with cutting up meat, clear to cough/throat clear." 02/06/22 at 7:52 PM [Physician's Order]: "CHO (Consistent Carbohydrate Diet) regular texture, thin liquid consistency." During a second observation on 04/01/22 at 1:45 PM, Resident #81 was seen with her lunch tray. The resident was not wearing her dentures. When asked about the dentures, Resident #81 stated, "No one put them in for me." Review of the comprehensive care plan lacked documented evidence that facility staff included an intervention to assist Resident #81 is the resident with putting in her dentures including at mealtimes. During a face-to-face interview on 04/01/22 at 1:51 PM. Employee #2 (Director of Nursing/DON) acknowledged that Resident #81's comprehensive care plan do not include assisting the resident with putting in her dentures at mealtimes at mealtimes at mealtimes and that she would update the care plan. 4. Facility staff failed to develop a care plan to address Resident #125's needing 2 person physical assist with tranfers. Review of the FRI (Facility Reported Incident)	Un 09/ with 10/ (Sr sm che cle 02/ (Co thir Du PN The Wr sta Re door an in r Du 1:5 ack cor thee me pla 4. I add phy	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 656	dated 12/27/21 documents from wheelchair to be suddenly sway her rigagainst the 1/4 side relaceration on the upp scratched her right le rail. Writer was made assessed the wound Resident #126 was a 11/16/21 with multiple Failure, Presence of and Other Lack of Control Review of the Admiss (MDS) dated 11/17/2 staff coded the follow. In Section C (Cognitification of Mental Status (Blindicating moderately indicating moderately. In Section G (Function Extensive assistance physical assist." Review of the nursing 12/23/21 at 11:50 AM transfer from wheelch resident suddenly swascratched against the Review of Resident #1 that facility staff failed comprehensive care is need for two-person transfers.	mented "During a transfer ed by two staff, resident ght leg and the leg scratched ail; resident sustained a er lateral right leg; resident g at the edge of the 1/4 side aware of the incident; writer " admitted to the facility on e diagnoses including Heart Right Artificial Knee Joint, pordination. Sion Minimum Data Set 1, revealed that the facility ring: We Patterns): Brief Interview MS) Summary Score "11", or impaired cognition. Sional Status): Transfer er requiring "Two-person The grogress note dated of documented, "During a mair to bed by two staff, any her right leg and the leg en 1/4 side rail"	F 65	56		8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Nurse Aide) stated, "I transferred her [Resid 12/23/21). Nobody with an index and welling urinary cate of the plan to address indwelling urinary cate of the plan to approximately 3:45 Probserved with an index a urine collection bags. Resident #132 was resident #132	If, Employee #58 (Certified It was just me who dent #126] to the bed (on as there, only me." It develop a comprehensive Resident #132's use of an theter. In on 04/07/22 at 19M, Resident #132 was welling urinary catheter with 19. It deadmitted to the facility on sees that included: Urinary simer's, Dementia, Epilepsy 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized). It deadmitted to the facility on sees that included: Urinary 19 (Generalized).	F 65		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	assessment done: Si patient noted with Forstable." 04/04/22 at 2:48 PM catheter intact and did Further review of Reslacked documented edveloped a compression of the resident's use of catheter. During a face-to-face 3:48 PM with Employ Nurse/LPN), she ack #132's comprehension of include the reside catheter care, and shiplan was updated. 6. Facility staff failed person-centered care Resident #155's specific complaint of chest parameters at 1/18/19, with multiple Dysphagia, Orophary Lack of Coordination Hemiparesis Followir Cerebrovascular Disciplination in the complete states at 1/18/19, with multiple Dysphagia, Orophary Lack of Coordination Hemiparesis Followir Cerebrovascular Disciplination in the states at 1/18/19, with multiple Dysphagia, Orophary Lack of Coordination Hemiparesis Followir Cerebrovascular Disciplination in the states at 1/18/19.	ed in evening Head-to-toe kin is warm to touch, and aley catheterResident is [Nurses Note]: "Foley raining clear urine." sident #132's medical record evidence that facility staff thensive care plan to address an indwelling urinary e interview on 04/07/22 at the wee #47 (Licensed Practicing nowledged that Resident the patient-centered plan dident's indwelling urinary the would make sure the care to develop a comprehensive to develop a comprehensive to develop a comprehensive to develop a comprehensive to deficit and the resident's the plan that addressed the deficit and the resident's the plan that addressed the deficit and the resident's the plan that addressed the deficit and the resident's the plan that addressed the deficit and the resident's the plan that addressed the pl	F	656			8/24/22	
		erly Minimum Data Set 2, showed that facility staff						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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F 656	Continued From pa		F 6	56		8/24/22		
	In section B (Heari	ng, Speech, and Vision), "Unclear Speech"						
		cood "1-Usually by communicating some words as but is able if prompted or						
	Ability to understar understands"	nd others "1- Usually						
	Interview for Menta	itive Patterns) BIMS (Brief Il Status) Summary Score "05" ognitive impairment.						
	SLP Evaluation and 11/02/21 and signer revealed the follow	cument titled "Speech Therapy d Plan of Treatment" dated d by the residents' providers, ing: In the section titled itive communication deficit, aryngeal phase"						
	Language & Comm Expression =50% .	"Receptive/Expressive nunication Abilities" "Verbal making needs known= 50%, %, Functional speech on-Fluent"						
	documented evider developed a compr	ts #155's care plan lacked any nce that the facility staff rehensive person-centered essed the resident's icit.						
	04/14/22 at approx (Director of Nursing	ce interview conducted on imately 1:00 PM, Employee #2 g) stated, "He has slurred s frustrated quickly." Employee						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	#2 reviewed the care findings. B. Review of the door Background, Assessm communication too PM, "Resident is aler Resident complaint o abdomen. NP (Nurse be transferred to the evaluation. Writer cal at 3:23 PM and left w [Hospital name]." Review of a Discharg showed, "Resident w discharged on 3/31/2 being discharged her follow up with a cardinalso need an echo out Resident #155's care evidence that the faci comprehensive personaddressed the reside and the follow up card. During a face-to-face 04/18/22 at 11:43 AM of Nursing) stated, "T updated, we will have 7. Facility staff failed care plan to address frequently urinating o smearing the bathroom	ument titled "Situation, ment and Request (SBAR) of dated 03/30/22 at 6:40 t and verbally responsive f chest pain radiating to the Practitioner) ordered to hospital for further led 911 at 3:15 PM, arrived ith resident at 4:04 PM to de Summary dated 03/31/22 as admitted on 03/30/22 and 2. He [Resident #155] is nodynamically stable to ologist as outpatient. He will atpatient." plan lacked documented dity's staff developed a con-centered care plan that nt's complaint of chest pains are required. interview conducted on and the to educate everyone." to develop a comprehensive Resident #180's behavior of the bathroom floor, and with feces. dmitted to the facility on	F	56			8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	Disturbance, Parkins Disorder. According to the Quadated 03/03/22, the runder Section C (Co Score, indicating that Under Section E0200 was coded as "0" indicating that Under Section G0111 resident was coded as supervision for toilet physical assist. Under Section H (Blaresident was coded as H0200 (Urinary Toiled H0300 (Urinary Toiled H0300 (Urinary Incompass frequently incontinent H0500 (Bowel Conting frequently incontinent H0500 (Bowel Toileting an environme 03/30/22 at approximate was noted in the batter resident #64, in room Resident #180 in room the bathroom flood	arterly Minimum Data Set resident was coded "15" gnitive Patterns), a BIMS the was cognitively intact. O (Behavior), the resident dicating that no behavior bited. O Functional Status, the as "1", indicating he required use, with one-person adder and Bowel) the as such: ting Program) = No entinence) = 2, indicating he was ut	F	656			8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	ATE SURVEY OMPLETED		
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F 656	the resident moved in Resident #64 also so have even seen Resident moved in Resident #64 also so have even seen Resident moved in Resident #65 (New Marinates in the bathroom and in the bathroom, and every time he goes to gets feces on his had Resident #180's behavior behavior messes up the bathroom messes up the bathroom messes up the bathroom and gets fectives to wipe himself is documented. During a review of Records on 04/11/20. Employee #4 (Education in Employee #4 (Education	atted that staff are aware and sident #180 urinate on the sws were conducted on :15 PM and 2:00 PM with the : stered Nurse) confirmed that urinates on the floor, in his aroom. a) said that Resident #180 on the floor in his room and it his hands must be cleaned to the bathroom because he had staff are aware of avior and it is documented. b) said that Resident #180, gets feces on his hands and room. c) has worked on 5 North for 5 at Resident #180 urinates on the conduction in the same and it is aware, and it sesident #180's clinical 22 at 10:25 AM with the patch is a staff developed a plan with goals and the ses Resident #180's ly urinating on the bathroom	F 6	56		8/24/22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		(X3) DATE SURVEY COMPLETED C		
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F 656	Continued From pag	e 141	F 6	356			8/24/22
	8. Facility staff failed #403's refusal care p	to implement Resident lan.					
	dated 03/21/22, docuresident was observed sitting the commode Large amount of BM observed on floor. On o vital signs. She was CPR initiated." Resident #403 was re 02/10/22, with multip Respiratory Failure wobstructive Pulmona Tracheostomy Status	acility Reported Incident) Imented "At 10:45 AM ed in her room bathroom and was unresponsive. (Bowel Movement) was in assessment, resident has as transferred to her bed and e-admitted to the facility on le diagnoses including vith Hypercapnia, Chronic rry Disease, Unspecified, s and Right Heart Failure					
		liure. sion Minimum Data Set 2, revealed that facility staff					
		ve Patterns): a Brief Status (BIMS) Summary ı moderately impaired					
	In Section E (Behavior indicators of psychos E08000 Rejection of Frequency "0- Behavior in the section in the s	is "None of the above" Care -Presence &					
	"Limited assistance" physical assist"; "Tra requiring "Two-perso	onal Status): Bed mobility requiring "Two-person nsfer "Extensive assistance" n physical assist"; "Walk in ance" requiring "One-person					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			1	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER	,	STREET ADDRESS, CITY 5000 NANNIE HELEN E WASHINGTON, DC	BURROUGHS AVE. NE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 656	assist"; "Personal hy requiring "One-personal hy requiring "One-personal Programs) O010 "Oxygen Therapy, S care" was coded by "Review of the physic following: 02/11/22 "NPO (Noth texture NPO for Bold endoscopic gastroster "IResident #403] is retreatment/care (Refumask, g-tube feedingResident is NPO (It is feeding resident reducation" revised dicare, leave and return patient and family, Pordered" Review of the nursing the following: 03/09/22 at 11:24 PM medications"	let use "Extensive g "One-person physical giene "Limited assistance" on physical assist" al Treatments, Procedures, to Respiratory Treatments uctioning and Tracheostomy facility staff. bian's orders revealed the ning by mouth) diet NPO us via PEG (percutaneous tomy) tube" clan with a focus area of the esistive/noncompliant with tusing ADL's, Shower, Trach tusing ADL's, Shower, Trach tusing by mouth) Daughter tusing by mouth) Daughter tusing by mouth) Daughter tusing by mouth) Daughter tusing by mouth) consult as also progress notes revealed also progress notes revealed	F	556			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING				20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE /ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
	Continued From page 03/18/22 at 9:15 AM oxygen via trach (Tracesp (respiratory) dis refused trach care, so Tx (treatment)" There was no documedical record show the refusal of care piwhen care is refused the resident and fam. During a face-to-face 04/13/22 at 11:20 Al Nurse) acknowledge "When she (Resider trach care and thenSometimes I would Care Plan Timing an CFR(s): 483.21(b)(2) A combe-(i) Developed within the comprehensive at the street of the comprehensive at the street of	"sitting on the bed refused acheostomy) mask no sign of stress notedResident suction and neb (nebulizer) mented evidence in the ving that facility staff followed lan to leave and return later d and provide education to nily. e interview conducted on M, Employee #9 (Registered and the finding and stated, at #403) first came, we did she started refusing d teach." and Revision (i)(i)-(iii) mensive Care Plans aprehensive care plan must 7 days after completion of assessment. nterdisciplinary team, that mited to	F	656	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE .	8/24/22	
	(B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent pra the resident and the	d and nutrition services staff. acticable, the participation of resident's representative(s).						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMPI	
		095019	B. WING _			04/2	20/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DEANIMO	OD DELIADII ITATIONI A	AND WELLNESS CENTER		5	000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	AND WELLNESS CENTER		٧	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From pa	ge 144	F 6	357	F657		8/24/22
	medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.				CORRECTIVE ACTION FOR THE AFF RESIDENTS: Resident #27 was assessed from head	to toe	
	(F) Other appropria disciplines as deter or as requested by (iii)Reviewed and re			on 4/26/2022, resident did not suffer ar negative outcome. MD/RP notified on 4 Care plan will be revised to address de needs immediately but no later than 8/2	4/26/22 ental		
	team after each ass comprehensive and assessments. This REQUIREMEN by:			Resident #82 was assessed from head on 4/26/2022, resident did not suffer an negative outcome. MD/RP notified on 4 Care plan will be updated to address p aggressive behavior immediately but n than 8/24/2022.Resident was taken by	ny 4/26/22. hysical o later		
	eight (8) of 105 sam staff failed to revise	eview and staff interviews, for appled residents, the facility the comprehensive care a resident's dental needs;			police on 7/20/22, no longer in the facil Resident #95 was assessed from head on 4/26/22, resident suffered no negati	lity. I to toe	
	(2) two residents wi behaviors. Residen	th physically aggressive ts' #27, #82 and #151.			outcome.MD/RP notified on 4/26/22 Ca will be updated immediately but no late 8/24/22.	are plan	
	Review the facility pream Meeting (Carus) 103/2022 documents individualized care			Resident # 151 was assessed on 4/26/ resident did not suffer any negative out MD/RP updated on 4/26/2022. Care pla updated to address aggressive behavior revised immediately but no later than 8	tcome. an or will be		
	revised by the interest Review the facility p	disciplinary team"			Resident #126 was assessed from head to to on 4/26/2022. Resident suffered no negative outcome. MD/RP notified on 4/26/22. Care play will be revised to indicate resident is two		1
	revised 01/2022 dooresident is observed aggressive to havin	esident-To-Resident Altercation/Incidents" vised 01/2022 documented, " When a sident is observed or identified as being gressive to having aggressive behavior or has e potential for abusing other residents, an			persons physical assist with transfer immediately but no later than 8/24/22.		
	incidents from occu Interdisciplinary Tea actions may include	tegies to prevent such rring will be provided by the am (IDT) These immediate e monitor and adjust care to tcomes aggressor placed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			04/5	20/2022	
	OVIDER OR SUPPLIER	D WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		04/2	20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	with the interventions deescalate behaviors nurses/manager" 1. Facility staff failed to address Resident #27 Resident #27 was add 05/06/20 with the followand End-stage Renal Review of a progress showed, "Resident was during the shift and has been advised not to straw, not to drink hot avoid spicy foods" Review of Resident # plan showed a focus apotential for Dental or related carious teeth, on 05/06/20 Assist needed. Observe for oral cavity, chewing a of oral pain treatmed dentist for evaluation The evidence showed revise Resident #27's resident's tooth extraor aftercare. During a face-to-face 04/16/22, at approxim	the care plan will be updated in place to prevent and by the licensed To revise the care plans to the desired service of the facility on owing diagnoses: Diabetes Failure. The dated 03/16/22 as seen by [Dentist name] and tooth extraction Has uck on candies or through a terror carbonated drinks to the desired service of the desired servi	F 6	857	Resident # 182 was assessed from toe on 4/26/2022, resident suffered negative outcomes.MD/RP notified 4/26/22. Care plan will be updated to include dialysis perma cath site on right chest immediately, but not late 8/24/22 Resident #404 expired in the hospita 2/21/22	no on o the er than	8/24/22	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019		· · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	2. Facility failed to replans to address Resphysically aggressive (resident-to-resident 2. A. Review of a Facilidated 02/23/22, documurse observed [Resides his roommatmurse noticed blood of and mouth. The nurse #404's] left ear and mear or abrasion inclu #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he feresident #82 was ad 09/15/21with multiple Schizophrenia, End Sensorineural Hearin Review of Resident #revealed: A Quarterly MDS date facility staff coded, a indicating intact cogn (behavior), the reside exhibiting physical or others. 02/18/22 (Created da "[Resident #82] is verprofanities related to: Provide privacy/remo	vise the comprehensive care ident #82's and #151's behaviors altercations). Ity Reported Incident (FRI) mented, "The charge ident 404] sitting on the floor e's bed #420A; the charge on [Resident #404's] left ear e assessed [Resident nouth and there was no skin ding his face [Resident he said, "that man keeps ed side and when I asked side of the bed, he punched nd chest and I punched him II" mitted to the facility on ediagnoses that included: Stage Renal Disease and g Loss. #82's medical record ed 01/31/22 that showed BIMS summary score, "14", itive response. In section E	F	657	F657 IDENTIFICATION OF OTHERS THE POTENTIAL TO BE AFFECTED All residents residing in the facility wi aggressive behavior, dialysis resident residents with two persons physical awith transfer have the potential to be affected by this practic. House wide audit will be conducted by ADON, Clinical care coordinator, Unit Managers and Supervisors to ensure care plans are revised, that the comprehensive care plans are person centered, that all diagnosis are care pland that care plan interventions are implemented as indicated. Any issue found will be corrected by 8/24/22. The interdisciplinary team members sut the dietitian, clinical team ,social service will ensure that all residents have a comprehensive care plan in place that their diagnosis and that the intervention implemented as indicated. Any issues the addressed by 8/24/22. MEASURES TO PREVENT RECURRE Unit Managers /supervisors will ensure there is a care plan in place for resident dental needs monthly. Supervisors will notified at validation meeting or through shift report sheet. Any issues found will addressed by 8/24/22.	th tts, assist ce. by the t that n colaned s ch as es team, reflect ns are found will ENCE that tts with be n shift to	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		١	WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	reactions if exhibits b acceptable behavior.' 02/22/22 at 2:20 PM #82] told the charg #404) because he ca me that man keeps and when I asked hin the bed, he punched chest and I punched chin and he fell" Review of the compre 04/05/22 lacked docutacility staff revised R plan to include his ph towards another resident-to-resident and During a face-to-face 04/05/22 at 2:59 PM, the finding and made 2B. Review of the FR documented, " At 0 observed [Resident #7" Resident #151 was re 12/02/21 with multiple Unspecified Psychos Benign Prostatic Hyp Review of Resident #7 revealed:	inain calm and avoid angry ehavior. Set limits for 's' [Nurses Note] "[Resident enurse "I hit him (Resident me to my bed to bother coming over to my bed side in to go back to his side of me on my stomach and him [Resident #404] on the ehensive care plan on mented evidence that esident #82's behavior care ysically aggressive behavior lent (Resident #404) after a litercation (on 02/21/22). Interview conducted on Employee #7 acknowledged no further comment. I dated 12/09/21 730AM, the security officer the #151] assaulting another 1] at the front of the building e-admitted to the facility on ediagnoses that included: st, Epileptic Syndrome and erplasia.	F	657	In-service will be provided by staff e designee to all licensed nursing stafneed to ensure that all residents' comprehensive care plans are revisimplemented as indicated by 8/24/26 Repeat in-service will be conducted House wide audit will be carried out ADON/Clinical care coordinator, unit and supervisors to ensure that all the have comprehensive care plan in plat that the care plans are revised and implemented as indicated. Any issue will be corrected by 8/24//22 Unit managers /supervisors will conducted to ensure that a care plan is in place address dental needs for residents with deproblems will be provided to the supthrough the shift to shift report. We issues found will be corrected by 8/24 Unit managers/ supervisors will audic chart monthly to ensure that care plarevised to indicate residents' aggres behavior. Any issues found will be a by 8/24/22 Supervisors / Unit managers will ensure plans are updated to reflect accordinglysis residents weekly Any issues will be addressed by 8/24/22. Charge nurses will ensure weekly the plans are revised to indicate two persphysical assist for applicable resident C N A; s are implementing care per than Any issues found will be address/24/22.	f on the ed and 022. as neede by manage e residen ace and duct audit e to vearing ental ervisors ekly .Any 04/22. It resident ans are sive ddressed ure that ess site ues found at care sons ts and the he care	rs ts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			1	20/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022	
				į	5000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 057	0 " 15	440					8/24/22	
F 657	Continued From page		F 6	357	MONITORING CORRECTIVE ACT	IONS:		
	cognitive impairment. In Section E (Behavior):				DON/Designee will conduct house wide audit to validate that all residents have person-centered comprehensive care			
	E0100. Potential Indio Delusions (misconcep firmly held, contrary to	otions or beliefs that are			plan in place, that are being revised implemented as indicated. This aud take place weekly x4, then monthly Findings will be corrected immediate and reported to QAPI Committee.	lit will x3.		
	(e.g., hitting, kicking, grabbing, abusing oth this type occurred 1 to symptoms directed to threatening others, so at others) - "Behavior days", Impact on Res significant risk for phy impact on others pp physical injury? "yes" privacy or activity of odisrupt care or living of the distribution of the bilding. The company of the both residents [Resemble He said, 'the man jumbuilding for no reason him. I don't know whe	directed towards others pushing, scratching, ners sexually) - "Behavior of o 3 days", verbal behavioral wards others (e.g., creaming at others, cursing of this type occurred 4 to 6 ident Put the resident at visical illness or injury? "yes"; ut others at significant risk of ; significantly intrude on the others? "yes"; significantly environment? "yes" I [Nurses Note] " At y Officer's Name] and the] observed resident [#151] sident [Resident #71] at the The security officer and the e residents and separated ident #71] was interviewed. I have never spoken to ere this came from						
		ssessed and small scratch be back of his left hand" lan revealed:						
	07/27/21 (Revision da	ate) Focus area, "[Resident						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		04/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	5.475	
F 657	#151] at risk for chan related to: agitation 10/18/21 (Revision d #151] has problemat acts characterized by kicking and hitting 10/20/21 (Revision d #151] uses psychotromanagement, Parand Monitor/record occur symptoms violence staff/others) and doc 10/22/21 (Revision d #151] has behavior pagitation, hitting multibreak down doors in rolling on the floor until seen by psychotromatic problems in the plans lacked documents aff revised the care interventions to addraggressive behavior (Resident #71) after altercation (on 12/08). During a face-to-face 04/05/22 at 2:59 PM, the finding and states.	ate) Focus area, "[Resident ic manner in which resident in inappropriate behavior" ate) Focus area, "[Resident in inappropriate behavior" ate) Focus area, "[Resident in inappropriate behavior in input in input in inipput inipput in inipput	F6	657		8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN			STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A' WASHINGTON, DC 20019	DE	/20/2022	
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F 657	Continued From page	e 150	F€	557		8/24/22	
	of 105 sampled reside to update the compression and approaches that visit to the dentist for (1) resident with a riguiste post-dialysis care PermaCath; and thre behaviors and failed care plan to address person physical assis	ew and staff interview, for 11 dents, the facility staff failed chensive care plan with goals address one (1) resident's actual tooth extractions, one th upper arm fistula access e, three (3) residents with a e (3) resident exhibiting to update one (1) residents their need to have two (2) et. Residents' #27, #61, et.,#71, #67, #182, #404					
	The findings include:						
	Team Meeting (Care 03/2022 documented individualized care pl revised by the interdistribution of the facility po	licy entitled, nt Altercation/Incidents"					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		095019	B. WING _		C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, Z 5000 NANNIE HELEN BURROUG WASHINGTON, DC 20019	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	
F 657	the potential for abuse assessment of strate incidents from occurr Interdisciplinary Tear actions may include reduce negative out on 1:1 monitoring with the interventions deescalate behaviors nurses/manager" 1. Facility staff failed care plan to include of for the care for actual Resident #27 was acceptable to include of the care for actual Resident #27 was acce	aggressive behavior or has sing other residents, an gies to prevent such ing will be provided by the in (IDT) These immediate monitor and adjust care to omes aggressor placed the care plan will be updated in place to prevent and is by the licensed to revise Resident #27's visit to the dentist and plans I teeth extraction. Imitted to the facility on owing diagnoses: Sickle cell failure, Hypertension, Renal failure dependence I major depressive disorder. Interest and had tooth en advised not to suck on straw, not to drink hot or avoid spicy foods. Secondly, an medication [To prevent day (03/18/22) #27's comprehensive care area, "[Resident Name] has roral cavity health problem poor oral hygiene initiated and intervention. Goal: as evidenced by moist	F6	557	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		095019	B. WING _			04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE	
F 657	Observe for report a chewing ability, sign OT evaluation, and to the dentist for evaper PHY.[physician] During a face-to-face 04/16/22, at approxi Employee #8 (Nurse acknowledged the fi 2. Facility staff ailed include Resident #6 fistula access site por Resident #61 was an 11/06/20 with multip Diabetes Mellitus, C Disease, Chronic Vii Hypertension, Peripi Kidney failure, Systes syndrome, and Anxid Reviewed of hospital (Preliminary report) "(resident) When as dialysis he said the in (resident) showed method the right upper arm." A review of Resident plan showed a focus needs dialysis hemother than 11/09/20 with goals have no s/sx [signs accomplications from complications from complications from the complications from the complex plan showed from the complications from the complications from the complex plan showed a focus needs dialysis hemother plan showed a focus needs dialysis from the complex plan showed a focus needs dialysis from the	with oral hygiene as needed. ny changes in the oral cavity, s, and symptoms of oral pain, treatment as ordered. Refer illuation and recommendation orders." e interview conducted on mately 1:15 PM with Manager), He ndings. to revise the care plan to 1 with a right upper arm ost-dialysis care. dmitted to the facility on le diagnoses including hronic Obstructive Pulmonary ral Hepatitis C, Anemia, heral Vascular Disease, Acute emic Inflammatory response ety. I discharged information dated 03/23/22 showed ked why he did not want heedle prick hurt him. le the location of his fistula on t #61's comprehensive care s area, "[Resident Name] of renal failure on Tuesday, rdays" was initiated on and interventions. Goal: will	F	357		8/24/22	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	NE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	the right arm with go for the schedule Reviewed of the Ph followed: 03/28/22 showed "bedside at all times (End-stage renal di 03/31/22 showed "Saturdays, every d Thur [Thursday], Scontinued review representation of the continued review and review and interventions to dialysis treatment to the bedside, to remedialysis treatment the bedside, to remedialysis treatment to assess for due to resident fluid center contact information of the bedside to the bedside to the state of the bedside to the bedside to the bedside the state of the bedside to the bedside to the bedside the bed	or take B/P [blood pressure] in graft. Encouraged resident to ad dialysis appointment. Dialysis emergency kit at a sease)." Dialysis: Tuesday, Thursday, ay shift every Tue [Tuesday], at. [Saturday]" evealed that facility staff failed at this focus area with goals address Resident #61's post to include the emergency kit at a love access site dressing 2-4 at to assess daily for bruit and pain, to monitor fluid intake direstriction, and the dialysis mation. ce interview conducted on kimately 1:15 PM with the Manager), He findings. did to revise the behavior care to include physically or towards other resident teer he was involved in a	F	657		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	(.	X3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
F 657	nurse noticed blood and mouth. The nurs #404's] left ear and notear or abrasion inclu #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he fee Review of a Complaid documented, "fam after they say their fanursing home in the Name] told [news out father [Resident #40 at the [Facility Name his injuries on March Review of a Complaid documented, "Avo Patient assaulted in was assaulted 02/22 by another resident. trauma with bleeding mouth. He was trans and later died" Resident #82 was ac 09/15/21with multiple Schizophrenia, End Sensorineural Hearin Review of Resident # revealed:	re's bed #420A; the charge on [Resident #404's] left ear re assessed [Resident nouth and there was no skin ading his face [Resident d he said, "that man keeps red side and when I asked side of the bed, he punched and chest and I punched him rell" Int dated 03/26/22 religionally beaten at a District. [Representative's rether was brutally beaten at a District. [Representative's rether was attacked while living produced in the second of the bed, he punched and chest and I punched him rell" Int dated 03/26/22 religionally beaten at a District. [Representative's rether was brutally beaten at a District. [Representative's rether was attacked while living produced in a control of the second of th	F 6	557		8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		0-41 Z 01 Z 0 Z Z	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 657	a BIMS summary so cognitive response a symptoms directed to 02/18/22 (Created d #82] is verbal abusive related to: cognitive privacy/remove to privacy/remov	ore, "14", indicating intact and no physical or behavior owards others. ate) [Care Plan] "[Resident re to staff using profanities impairment Provide gatherings/recreation main calm and avoid angry behavior. Set limits for [Nurses Note] "Resident ge nurse "I hit him (Resident ame to my bed to bother me oming over to my bed side im to go back to his side of a me on my stomach and him on the chin and he fell rehensive care plan on umented evidence to show Resident #82's behavior care ically aggressive behavior dent (Resident #404). The interview conducted on the plant is include Resident the on the right chest area	F 6	57		8/24/22	
	02/11/22 with multip	dmitted to the facility on e diagnoses including sease, Anemia, Hypertension,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
095019		B. WING _			04/2	; 20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		1 0-112	.01.2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 657	Disease, Major Depril A review of Resident plan showed a focus needs hemodialysis Friday's r/t ESRD with goals and interview s/sx [signs and symptogoal dialysis, Interventing of or the scheduled (Resident receives desident review receives desident review receives this focus a interventions to addropost-dialysis care to resident's right chest from dialysis center fewelling, and tender dressing dry, no dresident receives received rece	roesophageal Reflux essive Disorder, and Anxiety. #95's comprehensive care area, "[Resident Name] on Monday, Wednesday, and "was initiated on 02/14/22 entions. Goal: will have no itoms] of complications from ons: Encouraged resident to dialysis appointment. ialysis (3 times a week)." sician's orders dated as seess dialysis PermaCath or bleeding, redness, lling every shift. (no B/P no blood draw on this arm emergency kit at the bedside ery shift." alysis: Monday, Wednesday, nift every, Check dialysis th site upon return from eeding, redness, swelling and vening shifts every mon. Inesday], fri. [Friday]," vealed that facility staff failed frea with goals and	F6	557			8/24/22

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
095019 B. WING	C 04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 Continued From page 157 all times, and is checked every shift. Dialysis center contact information. During a face-to-face interview conducted on 04/16/22, at approximately 1:15 PM with Employee #8 (Nurse Manager), He acknowledged the findings. 5. Facility staff failed to revise Resident #126's care plan after completion of the Minimum Data Set (MDS) assessment which required resident to have two (2) person physical assist when transferring between areas. Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Heart Failure Unspecified, Presence of Right Artificial Knee Joint, Chronic Kidney Disease, Stage 4 (Severe), Pressure Ulcer Sacral Region Unstageable, and Other Lack of Coordination. Review of the Admission Minimum Data Set (MDS) dated 11/17/21, revealed that the facility staff coded the following: In Section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "11" Indicating moderately impaired cognition. In Section G (Functional Status): Transfer "Extensive assistance" requiring "Two-person physical assist" Review of the nursing progress note dated 12/23/21 at 111:50 AM documented, "During a transfer from wheelchair to bed by two staff, resident suddenly sway her right leg and the leg scratched against the 'x' side rail"	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095019	B. WING _				20/2022	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, 5000 NANNIE HELEN B WASHINGTON, DC 2	URROUGHS AVE. NE	,		
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F 657	to address the reside physical assist when During a face-to-face 04/20/22 at 10:45 AN (Certified Nurse Aide transferred her [Resi Nobody was there or responding to questi Resident #126 that owhich staff was trans wheelchair to the bed During a face-to-face 04/20/22 at 1:38 PM acknowledged the fill when I put a two per (mechanaical lift)." 6. Facility staff failed interventions for Resi in two (2) resident-to (Resident's #71 and Review of the FRI da At 0730AM, the sea [Resident #151] assa [Resident #71] at the Review of the FRI daAt 2030 on 12/29/2	e plan revealed that it failed ents need for a two-person being transferred. e interview conducted on M with Employee #58 e) stated "It was just me who dent #126] to the bed. hly me." Employee #58 was ons about the incident with occurred n 12/23/2021 in eferring resident from the d. e interview conducted on with Employee #7 hding and stated, "Usually son assist its for a Hoyer to revise the care plan ident #151 who was involved resident altercations #67). ated 12/09/21 documented, "ecurity officer observed aulting another resident front of the building" ated 01/02/22 documented, "et (12/29/21), [Resident #67] ionist that [Resident #151] hit in the lobby"	F	257			8/24/22	
		s admitted to the facility on e diagnoses that included:						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP 0 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		0.1120/2022	
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F 657	Review of Resident a revealed: 12/08/2021 [Admissi a BIMS summary socognitive impairment In Section E (Behavi E0100. Potential Ind Delusions (misconce firmly held, contrary E0200. Behavioral Symptoms (e.g., hitting, kicking, grabbing, abusing of this type occurred 1 symptoms directed to threatening others, s at others) - "Behavio days", Impact on Resignificant risk for phimpact on others physical injury? "yes privacy or activity of disrupt care or living In Section G (Function Daily Living (ADL) Attransfer, walk in roor locomotion on unit, let	sis, Epileptic Syndrome and berplasia. #151's medical record on MDS], facility staff coded ore of "07", indicting severe indicators of Psychosis - sptions or beliefs that are to reality) - "yes" ymptoms: Physical stain directed towards others pushing, scratching, hers sexually) - "Behavior of to 3 days", verbal behavioral bowards others (e.g., creaming at others, cursing or of this type occurred 4 to 6 sident Put the resident at ysical illness or injury? "yes"; but others at significant risk of "; significantly intrude on the others? "yes"; significantly environment? "yes" onal Status): Activities of sesistance - bed mobility, in, walk in corridor, occomotion off unit, Resident rivision" and "one person	F	957		O/Z-4/ZZ

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, ST 5000 NANNIE HELEN BUR WASHINGTON, DC 200	RROUGHS AVE. NE	04/20/2022
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F 657	positive PASARR (Pr Resident Review) Le evaluation, it was def needs Specialized Sc Facility. Related to: s MD (medical doctor) serious health declina agreed to may need Inform the MD of any require additional eva remove services" 07/27/21 (Revision defor changes in behave agitation" 10/18/21 (Revision deproblematic manner in characterized by inapted treatment/care related (Dementia, Schizophetaking medications, really non compliant with Wade and hitting" 10/20/21 (Revision deformation of the compliant with wade and hitting"	ate) "As evidenced by a readmission Screening and vel I screen and Level II remined that the resident rervices while in the Nursing chizophreniaInform the if the Individual has a read services previously to be modified or deleted. It is significant changes may aluation to add, modify or read ate) "[Resident #151] at risk ior problems related to: ate) "[Resident #151] has n which resident acts propriate behavior; resistive red to: Cognitive Impairment renia). Non compliant with non compliant with vital signs, naving and showers. Non reguard placement kicking ate) "[Resident #151] has notion or impaired thought ate) "[Resident #151] has notion or impaired thought ate) "[Resident #151] uses tions r/t behavior	F	557		8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	·	#/ Z 0/ Z 0 Z	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	behavior problem r/t (on the entire floor, dis Non-compliant letting moving chair into and stop Combative, agmembers, trying to be Administration area a staff monitoring for sa sitter is available" B. Resident #71 was 08/20/18 with multiple Schizoaffective Disor without Behavioral Di Hypertension. Review of Resident #Quarterly MDS dated coded a BIMS summ moderate cognitive in indicators of psychos behavioral symptoms person physical assis range of motion and in C. Resident #67 was 09/29/08 with multiple Unspecified Intellectud Disorder with Hallucin Dementia without Bel Review of Resident #Quarterly MDS dated coded a BIMS summ intact cognitive responsion of psychosis, no physisymptoms, limited to	ate) "Resident #151] has (Combative, Spilling water srobing) r/t Schizophrenia. roommate into the room, other room and refusing to gitation, hitting multiple staff reak down doors in the and rolling on the floor 1:1 afety until seen by psych or admitted to the facility on a diagnoses that included der, Unspecified Dementia sturbance and at 10/23/21 where facility staff ary score of "09", indicating an and no physical or verbal is and no physical or verbal is and no physical or verbal is and no mainted assistance with one at for ADLs, no limitations in an oskin conditions. admitted to the facility on a diagnoses that included and Disabilities, Psychotic mations, and Unspecified havioral Disturbance. and the facility staff ary score of "14", indicating anse, no potential indicators sical or verbal behavioral extensive assistance with assist for ADLs and no	F 6	57		8/24/22	

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			. ,	ATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 162	F 6	57		8/24/22
	12/08/21 at 11:18 A 0730AM, the [Secu [Receptionist's Nam assaulting another of the building receptionist ran to the both residents [Refle said, 'the man jubuilding for no reashim. I don't know whasked [Resident #1 [Resident #71]. He The MPD (Metrowas called took [aggressive behavio [Hospital Name] at [Resident #71] was mark observed on the Altercation #2 involved 12/30/21 at 11:30 A (8:30 PM) on 12/29 alleged to the recephim on his chest x 2 notified the supervis [Resident #67] and (8:40 PM) [Resident gate trying to exit. Febuilding stood by grab and hit staff exit or enter the Department was ca (11:50 PM). 2 MPD	M [Nurses Note] " At rity Officer's Name] and the rite observed resident [#151] resident [Resident #71] at the resident [Resident #71] at the resident #71] was interviewed. Imped on me in front of the ron. I have never spoken to rere this came from today' following the raped my daughter roolitan Police Department) resident #151] because of his rand transported him to 2809 (AM) for evaluation. assessed and small scratch reback of his left hand" M [Nurses Note] " At 2030 (2 (12/29/21), Resident #151] hit in the lobby; the receptionist for; the supervisor assessed he denied any pain At 2040 at #151] was observed at the resident will not let be building entrance trying to siting the building will not let be building. The DC Police liled and notified at 2340 responded at 2345 (11:45 at with [Resident #151], he				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING		C 04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER		AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION DATE
F 657	into custody [Resthis AM (morning). Is lateral abdomen own No swelling, discolor during assessment. The evidence show aggressive behavior 10/08/2021, facility #151's care plan wito other residents. Suthattacked another residents. Suthattacked another residents. Suthattacked another residents access of resident #151] was put on 15 incidences of resident #151] was put on 15 incidences of resident #161 include Resident #17 right chest access of Resident #182 was 11/30/2021 with mudiabetes Mellitus, Hepatitis C, Anemia Failure. A review of Resider plan showed a focuneeds dialysis hemothers and Saturation 11/09/2020 with goal have no s/sx [signs 11/109/2020].	ident #67] was assessed He alleged being hit on the er his previous surgical site. Intation or open area observed He denied pain" He denied pain" He denied pain et a toward Resident #71 on staff failed to revise Resident the interventions to protect obsequently, Resident #151 sident (Resident #67) on He interview conducted on PM, Employee #7 inding and stated, "[Resident 1 and has had no further ent-to-resident altercations. He to update the care plan to 82's PermaCath site on the site post-dialysis care. Admitted to the facility on litiple diagnoses including hyperlipidemia, Chronic Viral and Hypertension, and Heart At #182's comprehensive care are area, "[Resident Name] but renal failure on Tuesday, and als and interventions. Goal: will	F 657		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		MPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	the right arm with g go for the schedule Review of the phys showed "Dialysis: T every day shift ever PermaCath site upofor bleeding, redness at all times, check of PermaCath site on bleeding, redness, shift. (no B/P and nevery shift." There was no evide this focus area with address Resident # include assessing/c chest PermaCath scenter for bleeding, tenderness. Keep dressing change do emergency kit at be shift. Dialysis center During a face-to-face 04/14/2022, at apping Employee # 8 (Nursacknowledged the face of the shift of the s	or take B/P [blood pressure] in raft. Encouraged resident to d dialysis appointment. dician's order dated 2/22/22 Tuesday, Thursday, Saturdays, ry, Check dialysis right chest on return from dialysis center as, swelling and tenderness. every Tuesday, Thursday, and emergency kit at the bedside every shift. Assess dialysis right chest permaCath for tenderness and swelling every to blood draw on this arm) ence that facility staff revised goals and interventions to entally size the exity of the resident's right ite upon return from dialysis redness, swelling and PermaCath dressing dry, one in dialysis, Dialysis edside at all times, check every r contact information. The interview conducted on roximately 1:15 PM with the Manager), He findings. d to review Resident #404's one for effectiveness and implement new interventions of sleeping in other resident's	F	357		8/2422

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	·	0-1/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	02/23/22, documente observed [Resident 4 besides his roommate nurse noticed blood of and mouth. The nurse #404's] left ear and metear or abrasion inclue #82] was interviewed coming over to my behim to go back to his me on my stomach at on the chin and he fellowing for a Complair documented, "family they say their father woursing home in the ENAme] in an interviewed was attacked word was attacked word was attacked word a Complair documented, "Avoid Patient assaulted in mass assaulted 02/22/facility by another reshead trauma with blee and mouth. He was the hospital and later died Resident #404 was at 12/06/16 with diagnos Unspecified Dementia Disturbances, Vascula	Reported Incident (FRI) dated d, " The charge nurse o4] sitting on the floor e's bed #420A; the charge on [Resident #404's] left ear e assessed [Resident touth and there was no skin ding his face [Resident he said, "that man keeps ed side and when I asked side of the bed, he punched on chest and I punched him II" Int dated 03/26/22 by is hoping for answers after was brutally beaten at a District. [Representative's ew that his father [Resident while living at the [Facility o4] died from his injuries on on the dated 03/31/2022 dable death. Comments: sursing home. Beneficiary 2022 in skilled nursing ident. He sustained blunt eeding noted on his left ear ransferred to an acute d" dmitted to the facility on sees that included: a without Behavioral	Fé	557		8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, 5000 NANNIE HELEN BURROU WASHINGTON, DC 20019	ZIP CODE	0-1/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 657	coded a BIMS summa severe cognitive impassive recognitive	404's medical record g: IDS] showed facility staff ary score of "03", indicating airment. or), no potential indicators of al behavioral symptoms ars (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred inal Status), walk in room between locations in his/her with one person physical nal limitation in range of ats and Alarms), arm, "Used daily" Revision date) ["Resident pement: cognitive a Observed wondering at i/28/2021. Wandering to the	F	357		8/24/22

PRINTED: 07/27/2022 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

DEANWOOD REHABILITATION AND WELLNESS CENTER DEANWOOD REHABILITATION AND WELLNESS CENTER Deanwood Rehabilitation and wellness center	20/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 Continued From page 167 F 657 Review of the Daily Behavior Documentation	8/24/22
showed the following: 02/02/22 at 2:12 PM " Elopement attempts. Wanderingsleeping in other people's bed Behaviors are constant." 02/03/22 at 1:12 PM " sleeping in other people bed. Behaviors are constant." 02/07/22 at 1:52 PM " sleeping in other people's bed. Behaviors are constant." 02/09/22 at 1:47 PM " sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 1:17 PM " sleeping in other peoples bed. Behaviors are constant." 02/10/22 at 12:17 PM " sleeping in other people bed. Behaviors are constant." 02/11/22 at 11:16 AM " sleeping in other people bed. Behaviors are constant." 02/13/22 at 12:32 PM " sleeping on other peoples bed Behaviors are constant." 02/13/22 at 2:10 PM " sleeping on other peoples bed Behaviors are constant." 02/16/22 at 1:28 PM " sleeping on other peoples bed Behaviors are constant." 02/18/22 at 2:19 PM " sleeping on other peoples bed Behaviors are constant."	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	NE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 168	F 6	57		8/24/22
	Skin Observation Too	ol:				
	Blood was coming fro	"Observations face om his mouth, we managed cold compress and ice"				
	(SBAR): 02/21/22 at a resident got hit by his Altered mental status 'No'. Non-verbal indic Functional Status und Status- (area was left (area was left blank) approximately 02:30 [Resident #404] sittin roommate's bed (420 out of his left ear, fact notify the supervisor of Columbia) police. I sitting on his walker fi writer asked [Resider resident stated 'I hit hed.' DC fire departm 3:10 am and left with stretcher accompanie attendants to [Hospita	bed A) with blood coming e. The writer immediately and called 911. DC (District saw [Resident #82] also acing [Resident #404]. The ht #82] what happened, him because he came to my hent arrived at the unit at [Resident #404] in a				
	While making routine was observed sitting 420 A. Resident was the left side of his fac made, he was assess Resident could not de	[Nursing Supervisor Charge Nurse reported that rounds, Resident [#404] on the floor beside Room noted with some blood on the, a quick assessment was seed for pain and discomfort. the escribe what happened. This ick assessment was done,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019		3 112012022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From particles Range of motion exapplied to the left simonitored T. (tempore (respirations) 18, B. Spoe (sp) (oxygens) 02/21/22 at 1:43 PM placed to [Hospital status of the residenturse [Registered Maresident (#404) is contubated and about (intensive care unit). During a tour conduction approximately 3:00 document was obset the nurses station to 08/10/2021 4 South Behavior Document #404] Common behavior Document #404] Common behavior Document #404] Common behavior modering, elopemobed" This evidence shown a. Although the faci address Resident #resident units; there care plan was updates intrusive to the supplied in	ge 169 sercise was done, ice was de of the face, vital signs was erature) 96.5, P. (pulse) 82, R. P. (blood pressure) 140/90, saturation) 97% on Room Air." If [Nurses Note] "A call was Name] to know about the nt [#404] in the ER, spoke with Nurse's Name] who stated ritically ill, he has been to be transferred to ICU p. RP made aware." Incted on 03/28/22 at PM of unit 4 south, a facility erved taped to a partition at that stated, " Updated on a List of Residents for Daily station. Room #420D [Resident that in avioral traits confusion, ent, sleeping in other peoples are was no evidence that the sted/revise to address the behavior (wandering into	F 6	DEFICIENCY)		8/24/22
	b. Facility staff faileroom numbers of re Resident #404's be how Resident #404	d to document the names, esidents who were affected by havior; and failed to assess 's behavior caused other a upset that someone is in in their bed).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 657	being monitored hou wandering into other in their beds. There monitoring the reside During a face-to-face 04/04/22 at 12:48 Pl Coordinator) stated, plan updates, creatin During care plan revat orders, nurse's noupdates as needed.' aware that Resident behaviors of going ir and sleeping in othe #7 stated, "I was nownurses on the unit. I a wanderer, I was nownurses on t	record that the resident was arry, he was still found resident rooms and sleeping is no evidence that ent was increased. e interview conducted on M, Employee #7 (Clinical "I am responsible for careing and updating interventions. iews, I do a 30-day look back of the steep that it is it is interview conducted and updating interventions. iews, I do a 30-day look back of the steep that is it is interventions. If when asked if he was a was well and documented and other resident's rooms of the resident's rooms of the steep that he was going in the steep tha	F	557		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(.	COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIAT	(X5) COMPLETION DATE	
F 657	plan showed a focus renal insufficiency r/t Hep-c, Chronic pance 03/22/22 with goals a have no s/sx [signs a complications related Monitor and report chreviews/sx that shoul team such as difficult fatigue, confusion edimportance of complifications, dieta conservation, The immedications and dialy Review of the physicis showed "Dialysis: Tuevery day shift every PermaCath site upon for bleeding, redness every evening shift every shift." Continued review review review revise this focus an interventions to addressift every shift every shift. The resident's left chereturn from dialysis care to ithe resident's left chereturn from dialysis consulting and tendered dressing dry, dressing dry, dressing dry, dressing dry, dressing dry, dressing every even even even even even even even eve	#502's comprehensive care area, "[Resident Name] has Chronic kidney disease, reatic disease was initiated and interventions. Goal: will and symptoms] of to fluid deficit. Interventions: ranges in mental status and be reported to medical by breathing, increased area, weight gain, The rance with treatment plan, ary restrictions, and energy portance of compliance with resis treatment" an's order dated 03/17/22 areaday, Thursday, Saturdays,, Check dialysis return from dialysis center, swelling and tenderness. For your Tuesday, Thursday, and hergency kit at the bedside ery shift. Assess dialysis fit chest permaCath for anderness and swelling every sealed that facility staff failed area care plan with goals and are ses Resident #502's anclude assessing/checking ast PermaCath site upon anter for bleeding, redness, and sess. Keep PermaCath gehange done in dialysis, and the bedside at all times, at the bedside at all times, and the sess and sess and sess. Keep PermaCath gehange done in dialysis, and the bedside at all times, and the sess are sessioned at all times, and the bedside at all times, and the bedside at all times, and the sessioned area and the bedside at all times, and the bedside at all times.	F6	657		8/24/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
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F 657	04/14/22, at approxim Employee #8 (Nurse the finding.	interview conducted on nately 1:15 PM with Manager), he acknowledged	F 657	F 660		8/24/22
	S483.21(c)(1) Discha The facility must devereffective discharge plon the resident's discording fresidents to be actitransition them to postereduction of factors learned missions. The factor process must be constrights set forth at 483 (i) Ensure that the distresident are identified development of a discresident. (ii) Include regular residentify changes that discharge plan. The cupdated, as needed, (iii) Involve the interdiby §483.21(b)(2)(ii), indeveloping the discharge needs. (iv) Consider caregive and the resident's or person(s) capacity and required care, as part discharge needs. (v) Involve the resider representative in the sefficient of the sef	rge Planning Process elop and implement an anning process that focuses harge goals, the preparation ve partners and effectively t-discharge care, and the ading to preventable cility's discharge planning sistent with the discharge 15(b) as applicable and- charge needs of each and result in the charge plan for each evaluation of residents to require modification of the discharge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support d capability to perform of the identification of and resident development of the form the resident and		CORECTIVE ACTION FOR THE AFF RESIDENTS: Resident #155 was assessed from he by Unit manager on 4/26/22, resident suffer any negative outcome. MD/RP on 4/26/22. Discharge planning in pla will be modified as appropriate by 8/2 Resident # 170 was assessed from he on 4/26/22, resident suffered no nega outcome.MD notified on 4/26/22. Disc planning in place and will be modified appropriate. Resident #227 was discharged home Resident #237 was assessed from he on 4/26/22, by Unit manager, resident no negative outcome.MD/RP notified 4/26/22. Discharge plan in place and modified as appropriate. Resident #406 was sent to the hospitand did not return to the facility. Resident # 412 was discharged home 5/26/21	ead to toe did not notified ce and 4/22 ead to toe tive charged as 4/1/22 ead to toe t suffered on will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
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DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
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F 660	treatment preference: (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities m (B) Facilities must up comprehensive care appropriate, in respon from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determinati (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in sel provider by using data limited to SNF, HHA, patient assessment data measures, and data of the data is available. the post-acute care s assessment data, dat data on resource use the resident's goals of preferences. (ix) Document, comple on the resident's need record, the evaluation needs and discharge evaluation must be di	resident has been asked receiving information the community. cates an interest in returning facility must document any fact agencies or other fact a resident's colan and discharge plan, as fise to information received contact agencies or other facility must document who facility must ensure that facility must ensure that facility must ensure that fandardized patient facility must ensure that fandardized facility must ensure facility	F	660	Resident who are due for dischar have the potential to be affected practice. House wide audit will be conduct social services team members to determine that there are no delay discharge process. Will ensure the documentation about the dischar process in in the residents' record ensure that discharge needs are place. Any issues found will be on by 8/24/22.	ge by this ed by s in the at ge d and in	8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 660	discharge plan to faci to avoid unnecessary discharge or transfer. This REQUIREMENT by: Based on record revi six (6) of 105 sampled failed to: (1) have a diresident; (2) record/do to the resident's dischin the clinical record; (discharge needs were the results developed Residents' #155, #170 #412. The findings include: 1. Facility staff failed to discharge plan and avoid the discharge process. Resident #155 was accordinated to the discharge plan and avoid the discharge process. Resident #155 was accordinated to the discharge plan and avoid the discharge plan and accordination, and the discharge plan are process. Resident #155 was accordinated to the discharge plan and accordination, and the discharge plan and accordination and the discharge plan and the discharge plan and accordination and the d	litate its implementation and delays in the resident's is not met as evidenced ew and staff interview, for diresidents, facility staff ischarge plan for one ocument information related large plan to the community (3) ensure the residents enaced adequately identified and into a discharge plan. (0), #227, #237, #406 and to update Resident #155's void unnecessary delays in (s). dmitted to the facility on the diagnoses including, ingeal Phase, Unspecified Hemiplegia and gunspecified and gunspecified asse Affecting Left Dominant	F 6	660	MEASURES TO PREVENT RECURE Licensed Social worker will ensure that discharge planning for resident #155 is updated to ensure that there are no during the discharge process. Findings will be corrected by 8/24/22 Licensed social worker will also ensure resident #170 discharge plan is in place avoid delays in the discharge process. Findings will be corrected by 8/24/22 Licensed social worker will ensure that needs for resident #237 are adequate identified to prevent delays in the discipancess. Findings will be corrected by In service will be provided by Staff educes and the process of the need to identify the of residents who are due for discharge ensure they are met in a timely manner avoid delays in the discharge process. Training will be provided to all license nurses by staff educator/ Designee of importance of proper documentation of date, time and place where discharge planning meeting took place. Discussive resident's behavior during the IDT (responsible party, clinical team) meeting took place. Discussively important and must be document unit manager /supervisors will audit or residents due for discharge to ensure	e that ce to . It the ly harge 8/25422 ucator/es needs e and er to . It the ly harge 10 in the on	8/24/22
		rly Minimum Data Set 2, showed that facility staff			licensed social worker has a discharg- place and that the plan id followed ad indicated. Findings will be addressed 8/2422	·	
	, ,	e Patterns) BIMS (Brief status) Summary Score "05" nitive impairment.					
	In section Q (Participa	ation in Assessment and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 660	assessment and that participated Q0400 (Discharge Piplanning already occreturn to the community of the community of the care participated) Review of the care participated about things the SW were not doing the care at [facility] at (Resident) moved to the social revealed the following the social revealed the	esident participated in the inno family or representative dan): "Is active discharge urring for the resident to nity? - No" Immunity) "Ask the resident to someone about the this facility and returning to ices in the community? - No" Ian meeting notes revealed "They (Residents family) ney felt like the facility and ngThey are not happy with not they wanted him another facility" work progress notes g: "[Resident Representative] vorker that she is trying to get iving. She stated that she ments to get him into the ocial Worker) has called and	F 6	MONITORING CORRI Licensed Social service residents' chart to ensemble delays in discharge place adequate documentating discharge plans. This aweekly x4, then month corrected, and report process.	tes Director will a ure that there are anning, that there ion about residen audit will be concity x3. Findings w	udit e no e is it's ducted rill be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SURVEY COMPLETED	
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F 660	SW (Social Worke [name] stated that SW and the trans process towards [Assisted Living F 01/06/22 at 3:18 I Living SW] [and she do to assist w [Resident #155] in 03/29/22 at 1:05 I (Aging and Disable email out to the fact. I was able to confacility] regarding completed for [Res SW] is currently let to me. In the ever assessment he is come out and recommended evid Resident #155. During a face-to-04/14/2022 at 3:4 Worker) acknowled "We started talkin man from [assisted out to do another systemic issue."	ee] the Ombudsman called the er) and the Supervisory SW t [Resident's sister] felt as if the ition worker were holding up the [Resident #155] going into facility]" PM, "The SW called [Assisted dd] She asked him what could with the process of getting into assisted living facility" PM, "supervisor with ADRC illity Resource Center) sent an amily and SW stating as follows intact at [assisted living the assessment that was esident #155]. [Assisted Living to have another nurse do the assessment." the medical record lacked ence of a discharge plan for face interview conducted on 4 PM, Employee #13 (Social edged the finding and stated, g about other placements. The ed living facility] is coming back assessment this is a led to record/document d to the resident's discharge unity in the clinical record for	F	660			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	08/16/18, with diagnoblabetes Mellitus with Disease, Cirrhosis of Pulmonary Disease, Muscle Weakness, Edialysis, and Hemipal According to the Quaded 02/14/22, Under Section E Behavior, behaviors exhibited. Under Section G (Full was coded as requiril under bed mobility, litransferring, dressing hygiene. Under Section G040 range of motion, the having no impairment extremity. Under G0600 Mobility coded as not using in Under Section Q, the participating in the diactive discharge plar resident to return to been referred to the Care Plan last updated.	vas admitted to the facility on oses which included, Type 2 th Diabetic Chronic Kidney of Liver, Chronic Obstructive Congestive Heart Failure, Dependence on Renal aresis. Varterly Minimum Data Set ler Section C0500 BIMS lent #170 was coded as "15", as cognitively intact. Under the resident was coded as no common on an off unit, or, toilet use, and personal O Functional Limitation in resident was coded as at of upper and lower	F	660			8/24/22
	Under Section Q, the participating in the diactive discharge plar resident to return to been referred to the Care Plan last updat "Goal and Expectation	e resident was coded as ischarge plan, having "An is already occurring for the the community"; and has local contact agency.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		X3) DATE SURVEY COMPLETED
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F 660	metreview progredischarge meetings. Social Work Progres 7:02 AM, read, "The [Resident #170] and application for [Namprovided to her [Namprovi	if resident's needs can be as toward discharge during " as Note dated 03/11/22 at SW (social worker) sat with assisted her in filling out the e of Assisted Living-LS], ne of Transition Worker] asage in the presence of will attempt to call her again completion of the packet so ted with the proper P (as soon as possible)." The interview with Employee on 04/11/22 at 3:20 PM she ioned from [Name of me of Organization]. We	F	660		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE S COMPL	ETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 660	the status of the application of the status of Ribs, and Ulcer of Right Lower. According to the Admidated 03/14/22, Under Score showed Reside "12", indicating that he under Section E (Bercoded as no behavior under Section G (Furwas coded as requiring one-person physical and locomotion on an limited assistance with assistance for transferand personal hygienes. Under Section G0400 range of motion, the rhaving impairment or lower extremity. Under G0600, Mobility coded as using a wall under Section Q, the "Expects to be discharge of the status	as admitted to the facility on ses which included, ation Deficit, Cerebral ostructive Pulmonary a, Hypertension, Multiple d Non-Pressure Chronic Leg with Necrosis of Muscle. ission Minimum Data Set or Section C0500 BIMS ent #227 was coded as a e was cognitively intact. Inavior), the resident was resexhibited. Inctional Status), the resident may supervision with easist under bed mobility and off unit; He required the one-person physical erring, dressing, toilet use, and the community is a one side of upper and the community is a president was coded as a one side of upper and is already occurring for the	F	660		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	_	(X3) DATE COMP	SURVEY LETED
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F 660	potential for discharge representative expresentative expresentative expresentative expresentative expresentative expresentative expresentative expresentative expresentative factories and provided the son with and information So his case manager and During a face-to-face #12 on 04/07/22 at 4 told that he had a cast through his insurance from Liberty in the want to wait to be distories be here. He wanted him to go AMA (again the case worker and provided the number about the resident be That's why I call APS He was adamant aboresident told me that came (to the facility) was going to care for comfortable about hir resident was adamant resident was adamant and can be careful to the facility) was going to care for comfortable about hir resident was adamant and can be careful to the facility and can be careful to the facility was going to care for comfortable about hir resident was adamant and can be careful to the facility and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the facility was going to care for comfortable about hir resident was adamant and the careful to the carefu	care plan "Resident shows e and resident, relative, or sees wish for discharge s: Arrange transportation Resident #227]. Assess ing to determine if resident's home." Work Progress Note dated I showed, "[Resident #227 ne. Upon discharge this adult Protective Services) to esident #227] seemed ge however this writer in his care navigator number in stated that he will contact d follow up with her" Interview with Employee 1.45 PM he stated, "We were seworker in the community eHe has an assessment system. The resident didn't charged. He was irritated to to go homeI did not want net medical advice). I called left several messages and to the family. I was worried cause he was not calm. adult protective services. But leaving. The son and the had an aid. The son with someone who said she him. I didn't feel meleaving with her. The int about leaving the facility."	F	660			8/24//22
		interview with Employee :11 PM she stated, "The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED	
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 660	04/05/22. His son di [Resident #227] was home with someone Friday and got him. and picked him up. workers door saying had a lot of anxiety." There was no evider updated Resident #2 status of the liberty at Employee #12 failed time that he left a me community case wor transitioning back into There was no docum regarding the resider related to being discommunity. Employee #12 acknowledged the find the fin	dn't come on Tuesday. He angry and wanted to go else. The son came on The son was off on Friday. He kept going to the social he wanted to go home. He determined the wanted wanted the wanted the wanted the wanted the wanted wanted the wanted the wanted wanted the wanted wanted the wanted wanted wanted the wanted w	F			8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		095019	B. WING			04/20/2022	_
	ROVIDER OR SUPPLIER DD REHABILITATION	AND WELLNESS CENTER		5000	EET ADDRESS, CITY, STATE, ZIP CODE NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019		
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F 660	Continued From pa	age 182	F	660		8/2	24/22
	In section Q (Partic Goal Setting) Resid assessment "Yes"	cipation in Assessment and dent participated in					
	Q0300 Residents overall expectation Section was not coded						
	planning already of	0400 Discharge plan: Is active discharge lanning already occurring for the resident to eturn to the community? "Yes" eview of the care plan notes revealed the ollowing:					
	Review of the care following:						
	interested in obtain returning to the cor working with him to	AM, "[Resident #237] is hing his own housing and mmunity the social worker is owards that goal. He doesn't ocuments and the SW will hing them"					
	Review of the social work progress notes revealed the following:						
	will be going to picl	AM, "The SW (Social Worker) k up birth certificates for d additional residents to begin harge"					
		ne medical record lacked nce of a discharge plan for					
	04/07/22 at 1:10 Pl Worker) acknowled "It's been difficult for	ce interview conducted on M, with Employee #13 (Social dged the finding and stated, or him, he's not disabled, and ough where he can get an					

NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLETICE DATE O4/20/2022		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
MAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)			095019	B. WING _			C 04/20/2022
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 660 Continued From page 183 apartment. The plan is for discharge." 3B. Resident #406 was admitted to the facility on 01/28/22 with multiple diagnoses including, End Stage Renal Disease, Alcohol Abuse Uncomplicated and Hemiplegia and Hemiplegia and Hemiplegia and Hemiplegia (MDS) dated 02/03/22 showed facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "15", indicating intact cognition In section G (Functional Status): Bed Mobility "Supervision" requiring "Setup" Transfer "Limited assistance" requiring "One-person physical assist" Dressing "Limited assistance" requiring "One-person physical assist" Toilet use "Extensive assistance" requiring			ND WELLNESS CENTER		5000 NANNIE HELEN BURROUG		
apartment. The plan is for discharge." 3B. Resident #406 was admitted to the facility on 01/28/22 with multiple diagnoses including, End Stage Renal Disease, Alcohol Abuse Uncomplicated and Hemiplegia and Hemiparesis Following Cerebral Infarction. Review of the Admission Minimum Data Set (MDS) dated 02/03/22 showed facility staff coded the following: In section C (Cognitive Patterns): Brief Interview for Mental Status (BIMS) Summary Score "15", indicating intact cognition In section G (Functional Status): Bed Mobility "Supervision" requiring "Setup" Transfer "Limited assistance" requiring "One-person physical assist" Dressing "Limited assistance" requiring "One-person physical assist" Toilet use "Extensive assistance" requiring	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIA	COMPLETION
Mobility Devices "Cane/Crutch" "Wheelchair" In section Q (Participation in Assessment and Goal Setting): Q0100 Resident participated in assessment "Yes" Q0300, resident's overall goal "Expects to remain in this facility" Q0400 Is active discharge planning already	F 660	apartment. The plan 3B. Resident #406 v 01/28/22 with multip Stage Renal Diseas Uncomplicated and Following Cerebral I Review of the Admis (MDS) dated 02/03/2 the following: In section C (Cogniti for Mental Status (B indicating intact cogniti "Supervision" requiri "Transfer "Limited as "One-person physicated as "One-person phy	vas admitted to the facility on le diagnoses including, End e, Alcohol Abuse Hemiplegia and Hemiparesis infarction. ssion Minimum Data Set 22 showed facility staff coded vive Patterns): Brief Interview IMS) Summary Score "15", inition onal Status): Bed Mobility ing "Setup" sistance" requiring all assist" e assistance" requiring all assist" e assistance" requiring all assist" e assistance" requiring all assist" e assistance "requiring all assist "e ane/Crutch" "Wheelchair" e pation in Assessment and 0 Resident participated in everall goal "Expects to ""	F	560		8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		095019	B. WING _			04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	•	
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F 660	Review of the social revealed the following: 02/04/22 at 4:35 PM #406] in reference in stated that he does time. Prior to his hos shelter. Housing resexplored and the apprecommendations will dentification is a isses in order to apply for for [Resident #406] at some point" Review of the nursing following: 02/08/22 at 4:16 PM the lobby with some nephew was on his met resident at the finite belonging and a home. A meeting was resident attests he needs to sign a pap Medical Advice). We #406] to stay until F have a proper dischoutside with his [Resnatched into his care.	al been made to the local or-referral not needed" I work progress notes ng: I "Spoke with [Resident has discharge plan and he not have housing now at this espitalization he lived in a sources for males will be opropriate referrals and	F6	660		8/24/22

D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPI		(X3) DATE SURVEY COMPLETED C	
095019	B. WINC	S	04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER	ER .	STREET ADDRESS, CITY, STATE, 5000 NANNIE HELEN BURROU WASHINGTON, DC 20019	ZIP CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCI PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PRE	FIX (EACH CORRECTIVE G CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE
F 660 Continued From page 185 Thursday or Friday to be discharge. Psyconsult, and elopement risk initiated for preventive measure. He refused wander of 02/10/22 at 8:13 AM "[Resident #406] was transferred to [hospital name]" Review of the care plan initiated on 02/07 a focus area of "Safe and appropriate disc Showed the following interventions "on discharge to community, encourageto discharge and concerns with impending disconsidered for an address episodes of anxious distress., The clinical team along with [Refund #406] and RP (resident representative) establish a pre-discharge plan with specifications discharge." Further review of Resident #406's medical lacked documented evidence of any update modifications or plans for the resident to sidischarge from the facility. During a face-to-face interview conducted 04/11/22 at 4:00 PM with Employee #10 (of Social Work) acknowledged the finding stated, "He was only here a short time he to leave AMA, it was not safe for him" and provided no explanation why there was not documented in the discharge plan about 1 #406 wanting to leave the facility against advice. 3C. Resident #412 was admitted to the facility unspecified Affecting Left	h. guard" s //22, with charge." liscuss charge. ety fear, esident will fic needs al record ates, safely d on Director and wanted bothing Resident medical	F 660	8/24/22

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 04/	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	(MDS) dated 03/07/2 coded the following: In section C (Cognitive for Mental Status (BI indicating intact cognitive for Mental Status (BI indicating interested in participareferral for the following for Mental Status (Mental S	sion Minimum Data Set 1, showed that facility staff We Patterns): Brief Interview MS) Summery Score "15" inition. Pation in Assessment and O Resident participated in Perall goal, "Expects to be mmunity" Intion source for Q0300A Parage planning already dent to return to the Work progress notes G: M, "This is an initial care with the IDT (Interdisciplinaryplans are to discharge "The Social [Worker] met Is] POA (Power of Attorney) Scharge process. Family is atting in [agency name] The er Program was completed In meet again to continue	F	660			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019	ODE	0412012022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 660	assessed for services [Agency name], 5/14, assigned Nurse will to his room if there are a questions sthe (sp) N Worker" 05/25/21 at 5:52 PM, further benefit from o however he has requ [Resident #412] and put in place a plan of until the HHA (Home identified and put in ple discharged from [I Review of the care plan revealed a focus area resident to have a sa home." Goal "The resident was verbal needs and requeds prior to discharge planning IDT, resident and fan Review of a physician 05/26/21 "Discharge musing (sp) PT (physicocupational therapy (prescriptions) on 5/2 Further review of Reslacked documented	"[Resident #412] will be in the community by /21 at 11:00 AM. The elephone [Resident #412] in any additional information or durse will consult this Social " [Resident #412] cou (sp) ur skilled service program ested to be discharged his Responsible party have care for the family to follow Health Agency) have been place[Resident # 412] will Facility]. Ian initiated on 03/01/21 at of "Expectation id for the fe an appropriate discharge ill be able to communicate quired services to meet rige." Interventions meeting will be held with hilly" In's orders showed on resident home with skilled sical therapy)/OT ///HHA and scripts 16/21." Sident #412's medical record evidence of any updates, is for the resident to safely	Fé	560		8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE	LETED
		095019	B. WING _		 	04/2	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE 10 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	04/11/22 at 3:51 PM, Social services) ackr stated, "When he car could safely discharg Activities Daily Living	e interview conducted on Employee #10 (Director of nowledged the finding and me there was no way he ge."	F 6	660	F 676		8/24/22
SS=D	resident's needs and provide the necessar ensure that a resider daily living do not din of the individual's clir that such diminution includes the facility e §483.24(a)(1) A residence or her ability to carry living, including those of this section §483.24(b) Activities The facility must proving the section of the section of the facility must proving the section of the sectio	a the comprehensive dent and consistent with the choices, the facility must by care and services to nat's abilities in activities of ninish unless circumstances nical condition demonstrate was unavoidable. This nsuring that: dent is given the appropriate less to maintain or improve his out the activities of daily less specified in paragraph (b) of daily living. vide care and services in agraph (a) for the following			CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS Resident # 82 was assessed from he toe by Unit manager on 4/26/22, resisuffered no negative outcome.MD/RI notified on 8/21/22 Appointment will scheduled no later than 8/21/2022 for resident to see the audiologist. Residented by DC Police for custody on 7/ Resident#81 was assessed from hea on 4/26/22, resident suffered no negoutcome.MD/RP notified resident will assisted with wearing dentures durin on 4/26/22	dent P be or dent 20/22 ad to toe ative I be	
	grooming, and oral company specific spe	y-transfer and ambulation,					

		` IDENTIFICATION NI IMBED: ` ´			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 676	snacks, §483.24(b)(5) Comm (i) Speech, (ii) Language, (iii) Other functional of This REQUIREMENT by: Based on observation and staff interview, for residents, facility staff resident with applying and 2) failed to ensur by audiology to addrescommunicating with of #82. The findings include: 1. Facility staff failed applying her dentures: During an observation approximately 1:30 President was observed asked if she liked the resident reported that okay, but she wanted she eats. The writer a with her in the facility Resident #81 was ad 08/22/18 with diagnory Vascular Accident (C) Immuno-Deficiency Wellitus, and Cognitive A review of the Quarter.	communication systems. Is not met as evidenced on, record review, resident or two (2) of 105 sampled of failed to: 1) assist a go her dentures before meals; re one (1) resident was seen ess his ability to hear when others. Residents' #81 and to assist Resident #81 with a before meals. In on 03/30/22 at M, Resident #81 the ed with her lunch tray. When food at the facility, the to the food in the facility was at to wear her dentures when asked if her dentures were and she stated, "Yes." In mitted to the facility on sees including Cerebral VA), Human	F6	376	IDENTIFICATION OF OTHERS WITTHE POTENTIAL TO BE AFFECTE Residents residing in the facility with dentures and difficulty hearing have potential to be affected by this pract DON will conduct house wide audit identify residents with hearing difficulty and ensuring that they have care place to address hearing issue. The will also ensure that residents with dentures have them on and will valid they are able to put them on without assistance, any issues found will be corrected and documented by 8/24/	the ice. to ulties an in DON	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMPI	
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	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 04/2	20/2022
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F 676	that facility staff co following manner: In Section C (Cogr Interview for Menta Score was "03," in severely impaired In Section G (Fund for personal hygiel dependent and recone staff person. Frequired limited as A review of Reside revealed: 08/23/18 (Date init [Resident #81] at revidenced by weal CVA. Interventions hygiene, grooming eating as needed self-care" "Focus: [Resident cavity health problemore (CVA). [Resident #included assist with 109/02/21 [Denture documented: 1) Paratient is satisfied the denture, 4) De 09/02/2021 [Dentis with fit and esthetic with fit and esthetic following manner: 10 mental following manner: 10 ment	ded the resident in the nitive Patterns), the Brief al Status (BIMS) Summary dicating that the resident had cognition. ctional Status), ADL assistance: ne, the resident was totally quired physical assistance from for eating/meals, the resident sistance from one staff person. Int #81's medical record iated) [Care Plan focus area]: isk for ADL Self-care deficit as kness to right side related to included: Assist with daily , dressing, oral care, andEncourage to participate in #81] at risk for dental or oral em related to health condition 81] is edentulous. Interventions in oral hygiene as needed" Quality Assurance Checklist] atient is satisfied with fit, 2) with esthetics, 3) Name is in inture kit given"	F	376	In service will be provided by Staff Ed to all licensed staff and nurse aides of importance of ensuring that residents dentures have them on and if need by them in applying their dentures before by 8/24/22. In-service will be provided by Staff Ed to all nurses and CNA's to notify charnurses if they notice that a resident chear them while care is provided by 8. Unit Managers will ensure monthly the is a care plan in place indicating that needs assistance with applying dentuissues found will be corrected by 8/24. Residents who exhibit difficulties eatimeals will be assessed by the dentist denture use. Any issues found will be corrected by 8/24/22. House wide audit will be conducted be Supervisors to ensure that there are residents with difficulty hearing. Any if found will be addressed by 8/24/22.	ducators on the swith e, assist e meals ducator rge annot 8/24/22 at there resident ures. Any 4/22. Ing their t for e by no other	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	1 0411	20,2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 676	(Speech Therapy) St small bites/sips at slot check for pocketing, clear to cough/throat 02/06/22 at 7:52 PM (Consistent Carbohy thin liquid consistence) During a second obs PM, Resident #81 was The resident was not When asked about the stated, "No one put the tated, "No one put the tated, "No one put the evidence showe offer Resident #81 as dentures at mealtime. During a face-to-face 1:51 PM, Employee and acknowledged that Recomprehensive care the resident with putting mealtimes and that splan. 2. Facility staff failed seen by audiology to when communicating. During a face-to-face 03/29/2022 at approximate app	trategies sit upright, alternate ow rate, reduce distractions, assist with cutting up meat, clear." [Physician's Order]: "CHO drate Diet) regular texture, cy." ervation on 04/01/22 at 1:45 as seen with her lunch tray. It wearing her dentures. The dentures, Resident #81 hem in for me." d that facility staff filed to esistance with putting in her ces. e interview on 04/01/22 at #2 (Director of Nursing/DON) Resident #81's plan did not include assisting ting in her dentures at the would update the care to ensure Resident #82 was address his ability to hear g with others. e interview conducted on kimately 10:00 AM, Resident ear. You have to come assistive devices were	F	676	MONITORING CORRECTIVE ACTIVE DON/Designee will conduct house we to ensure that residents with denture care plan in place, and those with dishear are scheduled to see the audio. This audit will be conducted weeklyx monthlyx3, findings will be corrected report presented to QAPI committee.	vide audit es have fficulty to logist. 4, then l, and	8/24/22

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
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	ID WELLNESS CENTER		, , ,			
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Sensorineural Hearin End Stage Renal Disconneural Hearin End Stage Renal Disconneural Review of Resident # revealed: A Quarterly MDS date facility staff coded a Eindicating intact cognic og/21/21 [Physician's Audiology consult 2/2 (patient) reports of bill impacting communicated days" 09/21/21 (Created da #82] has, impaired he consultation with ear required" Review of Resident # health record lacked the facility staff ever shis audiology consult communication and communication and communication and communication and communication acknowledged.	g Loss, Schizophrenia and ease. 82's medical record ed 01/31/22 that showed BIMS summary score, "14", itive response. Orders] "Referral for election (secondary to) to pto lateral hearing loss lation and quality of life 30 Ite) [Care Plan] "[Resident learing function Arrange care practitioner as 82's electronic and paper documented evidence that scheduled the resident for thus, impacting quality of life. Interview conducted on Employee #7 (Clinical ledged the finding and stated)	F	676		8/24/22	
audiology consult app ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily l	oointment. or Dependent Residents ent who is unable to carry living receives the necessary	F	677			
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page Sensorineural Hearin End Stage Renal Dis Review of Resident # revealed: A Quarterly MDS date facility staff coded a E indicating intact cogn 09/21/21 [Physician's Audiology consult 2/2 (patient) reports of bil impacting communicat days" 09/21/21 (Created da #82] has, impaired he consultation with ear required" Review of Resident # health record lacked the facility staff ever s his audiology consult communication and of During a face-to-face 04/05/22 at 2:59 PM, Coordinator) acknowl that Resident #82 wa audiology consult app ADL Care Provided fo CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily	ROVIDER OR SUPPLIER OD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 192 Sensorineural Hearing Loss, Schizophrenia and End Stage Renal Disease. 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ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	ROUDER OR SUPPLIER OD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 192 Sensorineural Hearing Loss, Schizophrenia and End Stage Renal Disease. 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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		ONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE 0 NANNIE HELEN BURROUGHS AVE. NE 1.SHINGTON, DC 20019		20/2022
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F 677	by: Based on record is staff interview, for residents, the facil Resident #113 shows the facil Resident #113 shows the findings included by the findings included and a certified finished providing asked, how often on Resident #113 said wash myself up in Resident #113 was 06/19/14. The resident #113 was 06/19/14. The resident Washing, and Oste Review of a Quart 02/09/22 showed to the finding for	hygiene; NT is not met as evidenced review, resident interview, and one (1) of 105 sampled ity's staff failed to provide owers. de: tion on 03/29/22 at 80 AM, Resident #113 was in Inurse aide (CNA) had just am care. The resident was does she receive showers, dt, "I don't get showers. I just my bed." as admitted to the facility on dent has a history of General, Generalized Arthritis, Difficulty opprosis. erly Minimum Date Set dated the following: aitive Pattern) - the resident had or Mental Status Summary cating the resident had intact tional Status) - Resident #113 ding supervision and set-up thing, not steady and only able aff assistance during transfers and using a mobility	F	377	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT Resident # 113 was assessed from I toe by Unit Manager on 4/26/22, res in no apparent distress. Resident waif she wanted to take shower on 6/13 Resident refuses a shower. Resident continue to be offered and encourage take a shower. Documentation will be in place. Resident R/P. Any issues found will be ad by 8/24/22. IDENTIFICATION OF OTHERS WIT POTENTIAL TO BE AFFECTED: All residents residing in the facility hapotential to be affected. Unit manage Supervisors, Clinical coordinator, wirounds to ensure that the residents a given shower on the days indicated in plan of care. Any issues found will be addressed by 8/24/22	ident is asked 8/22. t will ed to dent is dressed TH THE ave the ers, II make are in their	8/24/22

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NAME OF D	ROVIDER OR SUPPLIER	000010	1	et.	REET ADDRESS, CITY, STATE, ZIP CODE	04/2	20/2022
NAME OF F	ROVIDER OR SUFFLIER				00 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	AND WELLNESS CENTER					
	1			VV	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Difficulty in Walking Pulmonary Disease Review of a care plat 12/09/19 showed th Focus Area - [Resid of Daily Living) self-(related to) disease Vascular Accident). [Resident #113] with to promote independance supervision personal Review of the show resident's scheduled Tuesdays and Fridat Review of Skin Swerevealed the followin 04/01/22 (Friday) - the bath 04/05/22 (Tuesday) shower 04/07/22 (Friday) - the shower During a face-to-face approximately 3:00 she was recently related that a show year". When asked 04/05/22 and not know year was located. When 04/05/22 or 04/07/2 observation sheets? It that is lying bring the	ed Muscle Weakness, and Chronic Obstructive an with a revision date of e following: ent #113] has an ADL (Activity care performance deficit r/t process CVA (Cerebral Interventions: provide a basin and bathing supplies dence, [Resident #113] all hygiene and oral care. er schedule revealed the dishower days were on ys on evening shift.	F	677	In service will be provided by Staff Et to all licensed and nurse aides on the importance of giving showers to the residents on the days indicated on the of care, that if a resident refuses, the must notify the charge nurse. In-service completed by 8/24/22. Charge nurses will ensure the nurse are giving shower to the resident as indicated during their shift. Refusal of must be documented, and responsibe notified. The care plan must be updated indicate non-compliance with care. A issues found will be addressed by 8/2 Unit managers/ Designee will audit we ensure documentation is in place where it is not in place where it is not in the conducted we supervisors to ensure that the reside given showers on their due date. Any found will be corrected and responsit updated by 8/24/22	ducators e leir plan CNA rice will aides f shower le party ted to any 24/22 veekly to en issues eekly by nts are y issues	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE (ASHINGTON, DC 20019		
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F 684 SS=E	approximately 3:15 P Nursing Assistant -CN with Resident #113 or a year and she had n shower. The employer resident supplies up f own bed bath. During a face-to-face approximately 3:30 P stated that she worker months on the evenire. "She (Resident #113) employee was then a scheduled showers? hot water in a bowl!" for Quality of Care CFR(s): 483.25 § 483.25 Quality of car Quality of care is a furth a same and the residents. Bas assessment of a resident residents received accordance with profer practice, the comprehence of the comprehence	interview on 04/12/22 at M, Employee #56 (Certified NA) stated that she worked in the evening shift for about ever given the resident are said that she set the for the resident to give her interview on 04/12/22 at M, Employee #57 (CNA) doesn't take shower." The sked how does get her The employee said, "I put for her. The employee said, "I put for her. The doesn't take shower in the sked how does get her the employee said, "I put for her. The employee said, "I put for her.		677	ADON//Designee will conduct rounds ensure that residents are having show indicated in their plan of care. This au be carried out weekly x4, then monthl x3,findings will be corrected, and report presented to QAPI committee. F684 CORECTIVE ACTION FOR THE AFFECTED RESIDENTS. Resident # 3 was discharged home of 3/29/22 Resident # 50 was assessed from he toe by Unit manager resident suffered negative outcome. MD/ RP notified of 4/26/22 care plan for two persons wit is ongoing Resident # 82 was assessed by unit manager on 4/26/22, resident suffered negative outcome. Will schedule an Audiology consult no later than 8/9/22. Resident taken into custody be police on 7/20/22 Resident #181 was assessed on 4/26 resident suffered no negative outcome.MD/RP notified on 4/26/22. Resident is receiving her medication inhaler correctly monitored by Unit mand supervisor weekly.	to vers as dit will y ont ad to d no n h ADL d no by DC 6/22, via	8/24/22

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	20/2022	
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F 684	evidenced by: failed to (1) resident; failed to for an audiology consimplement the care please of daily living (ADLs) failed to administer not the physician's order (Residents' #3, #50, # The findings include: 1. The facility's staff fapractice by not provide #3 from 12/01/21 to 0 Review of an intake foby the DC Departmer Regulation and Licen 01/26/22 showed the [granddaughter] alleg Resident #3 she and responsible party) has stomano one at the cleaning." The complephotos of my grandfadried secretion and mplugging." According to Johns H mucus and the rubbir can irritate the skin ar around the stoma shot twice a day to preven	erson-centered care plan as o provide stoma site for one schedule one (1) resident ult appointment; failed to an intervention of having aides (CNAs) for activities for one (1) resident; and abulizer inhaler as ordered for one (1) resident. 482 and #181). Tailed to follow standards of ing stoma care for Resident 2/06/22. Torm for a complaint received at of Health, Health Care sing Administration on complainant ed that on every visit with ther mother (residents d to "clean my grandfather's facility does his [stoma] aint also alleged "I have ther's neck with days old, aultiple bouts of mucus Topkins, " the buildup of g of the tracheostomy tube cound the stoma. The skin buld be cleaned at least to odor, irritation and ppears red, tender or leaning should be	F6	684	F 684 IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED, Residents residing in the facility with a site, residents requiring two CNA's for A residents with hearing difficulties and the using inhaler medication have the potential affected by this practice, Supervisors/E will conduct house wide audit to ensure nurse aides are providing ADL care as in the resident plan of care, those with I problems are scheduled to see the audit and that medications are administered standard of practice. Any issues found addressed by 8/24/22	stoma ADL care, nose ntial to be Designee that indicated nearing iologist per	•	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	
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DEANWO	OD REHABILITATION AN	ND WELLNESS CENTER			5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
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F 684	Continued From page https://www.hopkinsnving/stoma.html Resident #3 was adm 12/01/21 with multiple Malignant Neoplasm Larynx, Acquired Abs Tracheostomy Status Review of Resident # the following: 12/01/22 - 02/06/22 [lacked documented exprovided stoma site of 12/01/22 - 02/06/22 [records] - lacked documented stoma 12/01/22 - 02/06/22 [record] - lacked documented stoma 12/01/22 - 02/06/22 [rec	e 197 nedicine.org/tracheostomy/li nitted to the facility on e diagnoses including of Larynx, Carcinoma of sence of Larynx, and diagnoses including of Larynx, Carcinoma of sence of Larynx, and diagnoses including of Larynx, and diagnoses including of Larynx, Carcinoma of sence of Larynx, and diagnoses including of Larynx, and dia		684	F 684 MEASURES TO PREVENT RECUE In-service will be provided to nurse a Staff Educator /Designee to ensure is provided based on the president care by 8/24/22. Staff Educator will ensure that the nunderstand how to administer inhale medication. Return demonstration a completion of medication administration check list will be in place by 8/24/22. Unit managers will ensure that reside hearing problems are schedule to se Audiologist by 8/24/22. Unit Managers will ensure that C N implementing care based on the interventions on the residents' plantespecially when it comes to ADL cate issues found will be corrected by 8/24. Unit Managers will audit weekly to esthat charge nurses are administering medications per standard of practice issues found will be corrected by 8/24. In service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be provided by staff esto all licensed nursing staff on how the staff of the service will be serviced by 8/24 and 10 the service will be serviced by 8/24 and 10 the servi	RRENCE aides by that care s plan of urses er nd tition . Tents with ee the A's are of care re. Any 24/22. nsure g inhaler e. Any 24/22 ducator o	8/24/22
	clean, and remove cr the stoma BID (two-ti and sterile Review of an Admiss 12/03/21 revealed tha Summary Score sect the resident was code Tracheostomy care a	order] instructed, please usting from in and around mes-a day) with moist gauze ion Minimum Data Set dated at the Brief Interview Mental ion was blank. Additionally, ed for receiving nd speech therapy services.			provide care to a resident with stom also how to perform CPR on a resid stoma by 8/24/2022.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 0-11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	initial date of 12/04/2 Focus Area-[resident' (related to) laryngeal Goal-[resident's name drainage around tracedate. Will have no s/s infection through the Interventions- lari-tub daily, assist with cough Further review of Recare plans lacked do interventions to addrecare distributed in the stoma site and lary-tushe said a few times radiation/chemotherare clean the stoma site and lary-tushe said a few times radiation/chemotherare clean the stoma site and in of her concerns. During a face-to-face 2:25 PM, Employee fastated that when staff lary-tube daily they process in the stoma site and in the staff lary-tube daily they process in the staff l	chensive care plan with an 1 showed the following: 's name] has lary tube r/t cancer. e] will have no abnormal hea site through the review ex (signs/symptoms) of review date. e care daily, change HME gh as needed sident #3's comprehensive cumented evidence of ess care for stoma site from . terview on 04/12/22 at 11:35 nergency contact ed that when she visited cility, she would often notice secretions. She also stated visit him at the py infusion site Resident #3 ube were dirty frequently.	F	384	MONITORING CORRECTIVE ACTION DON/Designee will conduct house with audit to ensure that residents care play ADL care are implemented as indicated their plan of care, that resident who at scheduled for Audiology appointment the appointment as scheduled and the medications are administered as indicated by the physician. That residents with state have care implementations in play. This audit will take place weekly x4 armonthly x3. Findings will be corrected report presented to QAPI committee.	de an for ed in re go for at cated stoma ce. nd then	8/2422

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019	· ·	04/20/2022
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F 684	Continued From pag	ge 199	F 6	84		8/24/22
	for the lary-tube in the stoma site care."	he care plan. I just didn't add				
		d to implement the care planing two (2) CNAs for ADLs for				
	received on 11/22/2 made by [Resident: AM, a CNA hit he a bar of soap wrappwas interviewed; s resident's room at 9 was ready to be chayes. The CNA said and assist her beca assist, but resident provide care to her;	Reported Incident (FRI) 1, documented, "allegation #50] on 11/15/21 that at 11:30 In 6 times on her left knee with Ined in a towel" The CNA Ishe said she went to Incident a sked her if she Indian and Ms. Lambright said Ishe called the nurse to come Indian are to persons Incident is two persons to the Incident is two pers				
	06/26/14 with multip Morbid Obesity, Any	dmitted to the facility on ble diagnoses that included: kiety Disorder, Mood Affective Depressive Disorder.				
	Review of Resident revealed the following	#50's medical record ng:				
	09/24/21 showed th following: a Brief Int	#50's Quarterly MDS dated at facility staff coded the erview for Mental Status ore of "13", indicating intact				
	#50] has an ADL (ad	date) [Care Plan] "[Resident ctivities if daily living) self care r/t (related to) limited ROM				

	DF DEFICIENCIES CORRECTION	` IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 684	the resident require reposition and turn in total assistance with provide ADL (Creation Date of CNAs (Certified Nursuall shift" 11/17/2020 [Physicial provide ADL care all strong of the commod of the commo	ited mobility, morbid obesity es 2 staff participation to bed, the resident requires personal hygiene care" ate) "Alleged abuse 2 e Aides) to provide ADL care n's Order] "2 CNAs to shift" ate) [Care Plan] "[Resident compliant with treatment/care in ADL routine to preferences, and [Nurses Note] "At around), the CNA called the writer se [Resident #50] was ng cleaning her. Upon e writer found [Resident #50] CNA alleging that the CNA the writer assessed the ere no signs of hitting nor or distress The writer d called CNA to help	F6	584		8/24/	/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMP	LETED
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F 684	intervention of sched audiology consult approximately Resident #82 was an 09/15/21 with multip Schizophrenia, End Sensorineural Hearing Review of Resident revealed: A Quarterly MDS data facility staff coded a indicating intact cognous on the compacting communication of the consultation with ear required"	to implement the care plan duling Resident #82 for an oppointment. dmitted to the facility on le diagnoses that included: Stage Renal Disease and ng Loss. #82's medical record ted 01/31/22 that showed BIMS summary score, "14", nitive response. s Orders] "Referral for '2 (secondary to) to ptoilateral hearing loss cation and quality of life 30 ate) [Care Plan] "[Resident hearing function Arrange or care practitioner as #82's electronic and paper I documented evidence that scheduled the resident for	F6		EFICIENCY)		8/24/22
	04/05/22 at 2:59 PM the finding and state never scheduled for appointment.	e interview conducted on I, Employee #7 acknowledged ed that Resident #82 was the audiology consult I to administer Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	, ,	OMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	•	
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F 684	Aerosol Inhaler as ordered and person as ordered and person solution 25/28/21 with multip Chronic Obstructive Heart Failure, and E. A. During a medicat on 03/29/22 starting (RN) was observed Resident #181. Who administer the reside Aerosol Inhaler. The waiting for the unit in come and show me to administer that tyle (RN-Unit Manager) instructed Employee inhaler for Resident received the presence of the unit Review of a physicial instructed, Tiotropiu Aerosol Solution 2.5 inhaler orally one tin Obstructive Pulmona Employee #45 signes she administered Resident Resident received Resident Resid	standards of practice. admitted to the facility on le diagnoses including Pulmonary Disease, Asthma, and Stage Renal Disease. Ion administration observation at 11:24 AM, Employee #45 administering medications to en asked why she did not ent's Tiotropium Bromide employee stated, "I'm nanager (Employee #43) to how to do it. I don't know how be of inhaler." Employee #43 came to the unit and e #45 how to administer the #181. It should be noted the emedication (inhaler) in the manager and surveyor. In's order dated 03/18/22 m Bromide Monohydrate mcg(microgram)/act 2 spay he a day for COPD (Chronic ary Disease).	F	584		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION		LETED
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F 684	she administered Re Bromide Monohydrat 2.5mcg(microgram)/3 9:00 AM on 03/18/22 03/26/22 - 03/28/22. Resident #181 to mis medication since it w Review of Treatment Vital Summary sheet #181's oxygen satura 96-98% on room air and respiration rate r per minute from 03/1 During a face-to-face approximately 11:45 that 03/29/22 was the Tiotropium Bromide I because she did not When ask why did shadministered prior to an error." The emplo make anyone aware administer that type of Employee #45 failed Tiotropium Bromide I as ordered from 03/1 B. During a medication 03/29/22 starting (RN) was observed a Symbicort inhaler two inhaler two spays inh	d her initials indicating that sident #181 Tiotropium te Aerosol Solution act 2 spay inhale orally at 1, 03/21/22-3/24/22, and Subsequently, causing as 8 of 12 doses of the as ordered on 03/18/22. Administration Record and documented that Resident ation rate ranged from from 03/18/22 to 03/21/22 anged from 17 to 20 breaths 8/22 to 03/24/22. Interview on 03/29/22 at AM, Employee #45 stated a first time she administered Monohydrate Aerosol inhaler know how to administer it. The initial that she 03/29/22? She said, "It was yee also said that she did not she did not know how to of inhaler. Ito administer Resident #181 Monohydrate Aerosol inhaler	F	684			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3)	(X3) DATE SURVEY COMPLETED		
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According to the mar cause serious side et infection in your mout your mouth with water using Symbicort to he getting thrush" https://www.mysymbs.html According to Medline rinse your mouth with not swallow the water effects from your medical https://medlineplus.gooo41.htm Review of a physicial following: 03/18/22 - Budesonic (Symbicort)Aerosol 1 orally two times a day Obstructive Pulmonal 03/18/22 - Tiotropium (Spiriva) Aerosol Soli 2 spay inhale orally to (Chronic Obstructive During a face-to-face approximately 11:45 that she forgot to have mouth after using eace Employee #45 failed	nufacture, "Symbicort may ffects, including Fungal th or throat (thrush). Rinse er without swallowing after elp reduce your chance of icort.com/asthma/side-effect e., " after using your inhaler, in water, gargle, and spit. Do r. This helps reduce side dicine" ov/ency/patientinstructions/0 In orders revealed the de-Formoterol Fumarate 60-4.5 mg/ACT 2 puff inhale by for COPD (Chronic ry Disorder) In Bromide Monohydrate aution 2.5mcg(microgram)/act one time a day for COPD Pulmonary Disease). In interview on 03/29/22 at AM, Employee #45 stated we the resident rinse her ch inhaler.	F	584		8/24/22		
	CORRECTION ROVIDER OR SUPPLIER OD REHABILITATION AI SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page According to the mar cause serious side et infection in your mou your mouth with wate using Symbicort to he getting thrush" https://www.mysymb s.html According to Medline rinse your mouth with not swallow the wate effects from your med https://medlineplus.g 00041.htm Review of a physicial following: 03/18/22 - Budesonic (Symbicort)Aerosol 1 orally two times a day Obstructive Pulmona 03/18/22 - Tiotropium (Spiriva) Aerosol Soli 2 spay inhale orally of (Chronic Obstructive) During a face-to-face approximately 11:45 that she forgot to have mouth after using ear Employee #45 failed practice when admin	ROVIDER OR SUPPLIER OD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 204 According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush" https://www.mysymbicort.com/asthma/side-effect s.html According to Medline, " after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine" https://medlineplus.gov/ency/patientinstructions/0 00041.htm Review of a physician orders revealed the	ROVIDER OR SUPPLIER OD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 204 According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush" https://www.mysymbicort.com/asthma/side-effect s.html According to Medline, " after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine" https://medlineplus.gov/ency/patientinstructions/0 00041.htm Review of a physician orders revealed the following: 03/18/22 - Budesonide-Formoterol Fumarate (Symbicort)Aerosol 160-4.5 mg/ACT 2 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disorder) 03/18/22 - Tiotropium Bromide Monohydrate (Spiriva) Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that she forgot to have the resident rinse her mouth after using each inhaler. Employee #45 failed to follow standards of practice when administering metered dose	ROVIDER OR SUPPLIER OD REHABILITATION AND WELLINESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 204 According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush" https://www.mysymbicort.com/asthma/side-effect s.html According to Medline, " after using your inhaler, rinse your mouth with water strength of the preduce side effects from your medicine" https://medlineplus.gov/ency/patientinstructions/0 00041.htm Review of a physician orders revealed the following: 03/18/22 - Budesonide-Formoterol Fumarate (Symbicort)Aerosol 160-4.5 mg/ACT 2 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disorder) 03/18/22 - Tiotropium Bromide Monohydrate (Spiriva) Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). During a face-to-face interview on 03/29/22 at approximately 11:45 AM, Employee #45 stated that she forgot to have the resident rinse her mouth after using each inhaler. Employee #45 failed to follow standards of practice when administering metered dose	NOUDER OR SUPPLIER DO REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICIENCY OR LSC IDENTIFYING INFORMATION) Continued From page 204 According to the manufacture, "Symbicort may cause serious side effects, including Fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Symbicort to help reduce your chance of getting thrush" According to Medline, " after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. This helps reduce side effects from your medicine" https://www.mysymbicort.com/asthma/side-effect s.html According to Medline, " after using your inhaler, rinse your mouth with water, gargle, and spit. Do not swallow the water. 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FRESTIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 685 Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) S483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing ability. S483.25(a)(1) In making appointments, and S483.25(a)(1) In making appointments, and series of vision or hearing impairment or the office of a professional specializing in the treatment of vision or hearing impairment or the office of a processional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for one (1) of 105 sampled resident, facility staff failed to ensure that Resident #82 received assistive devices to maintain hearing ability. The findings include: MEASURES TO PREVENT RECURRENCE Nurses will be encouraged to pay close attention during their shift to the residents on their units to ensure residents with difficulty hearing are scheduled for audiology consult. Any issues found will be addressed by 8/24/22. In-service will be provided to all licensed nurses, C N A 8, Unit Secretaries on the importance of schedular papointments in a timely manner by the Staff Educator no later than 8/24/22.	DEANWO	OD REHABILITATION A	AND WELLNESS CENTER		٧	VASHINGTON, DC 20019			
CPR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the residents. §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for one (1) of 105 sampled residents, facility staff failed to ensure that Resident #82 received assistive devices to maintain hearing ability. The findings include: During a face-to-face interview conducted on 03/29/22 at approximately 10.00 AM, Resident #82 stated, "I cart hear. You have to come closer." No hearing assistive devices were observed in the resident's early of the resident of t	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
Sensorineural Hearing Loss and Schizophrenia. Review of Resident #82's medical record revealed: timely manner by the Staff Educator no later than 8/24/22.	F 685	Treatment/Devices CFR(s): 483.25(a)(1) §483.25(a) Vision a To ensure that reside and assistive device hearing abilities, the assist the resident- §483.25(a)(1) In massist the resident- §483.25(a)(2) By an and from the office the treatment of visithe office of a profe provision of vision of This REQUIREMENT by: Based on observation and staff interviews residents, facility stresident #82 receives maintain hearing about the findings included During a face-to-face 03/29/22 at approximate #82 stated, "I can't closer." No hearing observed in the resident #82 was a sesident #82 was a	to Maintain Hearing/Vision 1)(2) and hearing dents receive proper treatment es to maintain vision and e facility must, if necessary, aking appointments, and tranging for transportation to of a practitioner specializing in ion or hearing impairment or sisional specializing in the or hearing assistive devices. It is not met as evidenced ion, record review, resident in, for one (1) of 105 sampled aff failed to ensure that wed assistive devices to oblity. The interview conducted on mately 10:00 AM, Resident thear. You have to come assistive devices were ident 's ear or in his room.		385	F685 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT Resident# 82 has been scheduled to audiologist for assessment and treath hearing difficulties on 6/23/22.Resider taken into custody by DC police on 7/ IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED. Resident with hearing problems have potential to be affected by this practic Managers conducted rounds on their identify residents with hearing problem to ensure they are scheduled to see the audiologist. Any issues found will be corrected by 8/24/22. MEASURES TO PREVENT RECURR Nurses will be encouraged to pay closs attention during their shift to the reside their units to ensure residents with diff hearing are scheduled for audiology of Any issues found will be addressed by 8/24/22 In-service will be provided to all licens nurses, C N A 's, Unit Secretaries on the suddivided in the service will be provided to all licens nurses, C N A 's, Unit Secretaries on the service will be provided to all licens nurses, C N A 's, Unit Secretaries on the service will be provided to all licens nurses, C N A 's, Unit Secretaries on the service will be provided to all licens nurses, C N A 's, Unit Secretaries on the service will be provided to all licens nurses.	see the nent for nt 20/22 If THE the e. Unit units to ms and he ENCE ee ents on iculty onsult.	8/24/22	
A Quarteny Minimum Data Set (MDS) gated		Sensorineural Hear Review of Resident revealed:	ing Loss and Schizophrenia. #82's medical record				o later		

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F 685	Continued From page	206	F 6	885	F 685 MONITORING CORRECTIVE ACTIO	N	8/24/22	
01/31/22 that showed Minimum Interview for		facility staff coded a Brief r Mental Status (BIMS) indicating intact cognitive			DON/Designee will conduct house wid audit to ensure that residents with hea problems see an audiologist. This aud be conducted weeklyx4 then monthly findings will be corrected, and report	ring it will		
	Audiology consult 2/2 (patient) reports of bil	nysician's Orders] "Referral for onsult 2/2 (secondary to) to pt orts of bilateral hearing loss ommunication and quality of life 30			presented to QAPI committee			
	#82] has impaired hea	te) [Care Plan] "[Resident aring function Arrange care practitioner as required						
	documented evidence scheduled the resider	82's medical record lacked e that the facility staff ever nt for his audiology consult nunication and quality of life.						
F 689 SS=H	04/05/22 at 2:59 PM, Coordinator) acknowl that Resident #82 wa audiology consult app Free of Accident Haza	ards/Supervision/Devices	Fé	889				
	. , , ,							
	supervision and assis accidents.	sident receives adequate tance devices to prevent is not met as evidenced						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 1000 NANNIE HELEN BURROUGHS AVE. NE 1/ASHINGTON, DC 20019	1 0-111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	by: Based on observation family and staff intervolve residents, the facility's residents received and evidenced by failure to #404 received adequant altercation with Reserious injury, 2. prov. Resident #56 who sure of the facility resulting Resident #409 who with adequate supervolve unknown origin (dislocated adequate supervolve) altercations with Resident #61 to preven injury, 6. provide aderesident #61 to preven injury, and 7. provide monitoring of Resident altercation with Resident #56, #409, #67, and and the facility "Resident-to-Resident revised in 01/2022 do resident is observed aggressive to having the potential for abust assessment of strategincidents from occurr Interdisciplinary Team	n, record review, resident, iews, for 11 of 105 sampled is staff failed to ensure that dequate supervision as to 1. ensure that Resident atte supervision to prevent esident #82, resulting in ride adequate supervision for stained a fall outside in front in its provide in the serious injury, 3. provide in the serious injury, 4. provide in the serious injury of cated hip), 4. provide in the fall with an adequate supervision of the entity in a fall with an adequate supervision and in the fall with an adequate supervision of the fall with an adequate supervision of the fall with an adequate supervision and in the fall with an adequate supervision of the fall with an adequate supervision and the fall with an adequate supervision and the fall with an adequate supervision and the fall with a	F	689	F 689 CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS. Resident # 404 was sent to the hospit 2/21/22, did not return to the facility. Resident # 82 was assessed from her on 4/26/22, resident suffered no negal outcome. MD/ RP notified on 4/26/22. Resident is on 1;1 monitoring and supuntil seen by psychiatry doctor. Residinto custody by DC police on 7/20/22 Resident # 56 was assessed from her on 4/7/22, resident suffered a hemator the left forehead.MD/RP notified on 4/26/22, resident suffered a hemator the left forehead.MD/RP notified on 4/26/24. Resident # 61 was assessed from her on 4/26/22, resident suffered no negal outcome. MD/RP notified on 4/26/22. will be taken to the day room A for mone every shift secondary to multiple falls. Resident # 72 was assessed from her on negative outcome. MD/RP notified 4/26/22. Resident will be taken daily the troom B for monitoring every shift. He fifth floor now. Resident # 188 was assessed from her on 4/26/22. Resident suffered no noutcome. MD/RP notified on 4/26/22, is on the fourth floor	ad to toe tive ervision ent taken ad to toe ma on (7/22. An tor The front locked elling into the total entitle	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	reduce negative out on 1:1 monitoring with the interventions deescalate behaviors nurses/manager" 1. Facility staff failed received adequate sualtercation with Residinjury. Review of a Facility F 02/23/22, documented observed [Resident 4 besides his roommat nurse noticed blood and mouth. The nurs #404's] left ear and nurse noticed blood and mouth. The nurs #404's] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he fer Review of a Complaid documented, "familithey say their father on ursing home in the I Name] in an interviewed was attacked whame]. [Resident #40 Name]. [Resi	comes aggressor placed the care plan will be updated in place to prevent and by the licensed to ensure Resident #404 upervision to prevent and dent #82, resulting in serious Reported Incident (FRI) dated ed, "The charge nurse 104] sitting on the floor e's bed #420A; the charge on [Resident #404's] left ear e assessed [Resident nouth and there was no skinding his face [Resident he said, "that man keeps ed side and when I asked side of the bed, he punched and chest and I punched him II" Int dated 03/26/22 by is hoping for answers after was brutally beaten at a District. [Representative's ew that his father [Resident while living at the [Facility 04] died from his injuries on	F	689	Resident # 151 was assessed from toe on 4/26/22. Resident suffered in negative outcomes MD/RP notified on 4/26/22. Resident 1;1 monitoring and supervision until reassessed by psych doctor/or until notice. Resident # 183 was assessed from toe on 4/26/22, resident suffered not negative outcomes. MD/ RP notifier 4/26/22. Bus driver has been trained importance to keep resident safe in while transporting them. IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED All residents residing in the facility head potential to be affected by this deficit practice. DON/Designees will conduct rounds to ensure that residents are monitor always supervised. Any issues foun corrected by 8/24/22	nt is on I I I I I I I I I I I I I I I I I I	8/24/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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DEANWO	OD REHABILITATION	AND WELLNESS CENTER			000 NANNIE HELEN BURROUGHS AVE. NE			
				V	VASHINGTON, DC 20019			
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							8/24/22	
F 689	Continued From pa	age 209	F 6	688	MEASURES TO PREVENT RECURRI	ENCE		
	head trauma with bleeding noted on his left ear and mouth. He was transferred to an acute hospital and later died" Resident Background Information: A. Resident #82 was admitted to the facility on 09/15/21 with multiple diagnoses that included: Schizophrenia, End Stage Renal Disease and Sensorineural Hearing Loss. Resident #82's Quarterly Minimum Data Set (MDS) dated 01/31/22 showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of "14", indicating intact cognitive response, no physical or behavior symptoms directed towards others, required supervision with one person physical assist for activities of daily living (ADLs), used a walker for mobility and received antipsychotic medications. B. Resident #404 was admitted to the facility on 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia without Behavioral Ischemic Attack.				In- service will be provided by Staff Ed to all nursing staff to ensure that reside monitored and supervised by 8/24/22.			
					Unit Mangers/Designee will ensure that residents on their units are accounted during their shifts. Any issues found with addressed by 8/24/22.	for		
					Supervisory lobby employee will ensur	e that		
					residents sitting outside are supervised Findings will be reported to the front de will call the unit for the nurse to come a address the issue immediately. Hourly rounds will be made by staff meduring their shift to ensure that resider not left alone in a situation that can lea fall. Any issues found will be addressed 8/24/22. The facility van driver was provided travan safety on 6/7/22. The driver will enthat the residents are safe in the van ditransportation. C.N.A /escort riding with the resident and encouraged to ensure that the resident safe in the van. Any issues found will be addressed by 8/24/22.	d. esk who and embers are d to a d by ining on asure uring re ts are		
	revealed the follow 12/16/21 [Quarterly	/ MDS] showed facility staff mary score of "03", indicating			Charge nurse will place aggressive and uncontrolled resident on 1:1 until assess Psychiatrist doctor for treatment modal	ssed by		
	psychosis, no phys directed towards of	vior), no potential indicators of sical behavioral symptoms thers (e.g., hitting, kicking, g, grabbing, abusing others						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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DEANWO	OD REHABILITATION	AND WELLNESS CENTER		W	ASHINGTON, DC 20019		
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F 689	towards others (e.g. screaming at other "1 to 3 days", wand daily" In Section G (Funce (how resident walk room), "Supervision assist" and no function In Section P (Restream wander/elopement Care Plan: 07/27/2 #404 is at risk for Eimpairment, demer the adjacent unit on adjacent unit on adjacent unit on adjacent unit on Algument wandering to the attended or unol time. Hourly eloper location." Review of the Daily showed the following to the plant of the pl	chavioral symptoms directed g., threatening others, s., cursing at others) occurred dering behaviors "occurred dering behaviors in his/her in with one person physical dering at a dering derin	F	689	Charge nurses will also ensure that residents who wander are supervised redirected during their shift and put documentation in place to justify supervision. Findings will be corrected 8/24/22. Charge nurse/ Rehab staff will assess resident who fell secondary to trying to pick something from the floor for need a Reacher and will be provided by 8/24/22 if applicable. In service will be provided to all CNA's/escorts by staff educators on the importance of ensuring that the residence are safe while riding the van by 8/24/2. In service will be provided by staff educators on the importance of ensuring that the residence are safe while riding the van by 8/24/2. In service will be provided by staff educators on it is staff on how to use the wheelchair breaks while the resident is sitting on it.	of ne ents 22.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	V=	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 689	bed. Behaviors are of 02/10/22 at 1:47 PM bed. Behaviors are of 02/11/22 at 12:17 PM peoples bedBehaviors are of 02/11/22 at 11:16 AM bed. Behaviors are of 02/13/22 at 12:32 PM peoples bedBehaviors are of 02/14/22 at 2:10 PM bedBehaviors are of 02/16/22 at 1:28 PM bedBehaviors are of 02/18/22 at 2:19 PM bedBehaviors are of 02/19/22 at 1:18 PM bedBehaviors are of 02/20/22 at 12:23 PM peoples bedBehaviors are of 0	"sleeping in other peoples constant." "sleeping in other iors are constant." "sleeping in other people constant." "sleeping on other peoples constant." d "sleeping on other peoples constant." d Assessment Request d Asses	F	689	MEASURES TO PREVENT RECURR CONT Resident # 56 will be assessed for sm by charge nurse and her care plan will updated to reflect her smoking needs 8/24/22. Education will be provided by Staff edit to all licensed nurses on the importan assessing all residents who smoke meand update their care plans to reflect tourrent situation. Unit manager will ensure that resident will be supervised while resident is on wheelchair during their shift by C N A findings will be addressed by 8/24/22. Charge nurses must ensure that resid who fall during their shift are assessed pain and medicated as ordered by the physician. Also, complete an incident for fall. Findings will be corrected by 8. Unit Manager will ensure that resident aggressive behaviors are supervised of their shift and that residents are not plecose to each other to help prevent altercations. Resident # 72 will not be close to resident #188., likewise reside 71 and # 67. Residents are on differe units. Resident #72 is on the fifth floor resident #188 is on the fourth floor Resident #151 is in a private room with one-on-one continuous monitoring for aggressive behavior	oking I be by ucator ice of onthly heir #61 the 'S, ents I for report /24/22 s with during aced placed ent # nt ,	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		LETED
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DEANWO	OD REHABILITATION	I AND WELLNESS CENTER			ASHINGTON, DC 20019		
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F 689	unchanged Skin blank) Assessr Additional comme am The writer of on the floor near right blood coming writer immediately 911. DC (District of [Resident #82] als [Resident #404]. It what happened, rehe came to my be at the unit at 3:10 #404] in a stretche ambulance attend [Physician Name] made aware." 02/21/22 at 4:16 A Progress Note] "T While making rout was observed sittle 420 A. Resident with left side of his made, he was ass Resident could not is his base line. A Range of motion of applied to the left monitored T. (tem (respirations) 18, 18 Spoe (sp) (oxyger 02/21/22 at 1:43 F placed to [Hospita status of the resid nurse [Registered	evident? 'No'. Functional Status /Wound Status- (area was left ment (area was left blank) nts At approximately 02:30 observed [Resident #404] sitting commate's bed (420 bed A) out of his left ear, face. The rotify the supervisor and called of Columbia) police. I saw to sitting on his walker facing The writer asked [Resident #82] esident stated 'I hit him because d.' DC fire department arrived am and left with [Resident er accompanied by two ants to [Hospital Name]. and RP (representative) was AM [Nursing Supervisor he Charge Nurse reported that time rounds, Resident [#404] ing on the floor beside Room was noted with some blood on face, a quick assessment was sessed for pain and discomfort. It describe what happened. This quick assessment was done, exercise was done, ice was side of the face, vital signs was perature) 96.5, P. (pulse) 82, R. B.P. (blood pressure) 140/90, in saturation) 97% on Room Air." PM [Nurses Note] "A call was I Name] to know about the ent [#404] in the ER, spoke with Nurse's Name] who stated critically ill, he has been	F	689	MONITORING CORRECTIVE A DON /Designee will conduct free rounds during their shifts to ense residents are adequately supervisafety reasons. This audit will be weekly x4 then monthly x3. Find corrected and reported to QAPI	quent ure that the rised for e conducted lings will be	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
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F 689	(intensive care unit). During a tour conduct approximately 3:00 of document was obset the nurses station the 08/10/2021 4 South Behavior Document #404] Common behavior document wondering, elopement bed" This evidence show knowledge of and do intrusive behavior of rooms and sleeping a. Although the facil address Resident #4 resident units; there care plan was updat residents intrusive behavior of rooms and b. Facility staff failed resident rooms and b. Facility staff failed room numbers of resident #404's behow Resident #404's behow Resident #404's behow Resident #404's behow Resident such as put for physical injury, in activity, upset that he in their bed. c. Although the staff was being monitored wandering into other in their beds. There	to be transferred to ICU RP made aware." cted on 03/28/22 at PM of unit 4 south, a facility rved taped to a partition at last stated, " Updated on List of Residents for Daily ation. Room #420D [Resident avioral traits confusion, ent, sleeping in other peoples are determined to the transfer of	F	589		8/24/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	ATE SURVEY DMPLETED
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F 689	04/04/22 at 12:48 PN Coordinator) stated, plan updates, creatin During care plan rev at orders, nurse's no updates as needed." aware that Resident behaviors of going in and sleeping in other and sleeping in other transport of the property of the facility of the property	e interview conducted on M, Employee #7 (Clinical "I am responsible for care ing and updating interventions. iews, I do a 30-day look back ites, psych notes and make When asked if he was #404 had documented into other resident's rooms in resident's beds, Employee wer made aware by the knew him [Resident #404] as it aware that he was going is [Resident #404] care plant idated to reflect that behavior erventions. When asked List of Residents for Daily ation" that stated Resident ployee #7 stated, "I didn't	F	689		8/24/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 689	out of her wheelchair not have any compla assisted back into the her room for further in assessments. Neuro everything was within (Certified Registered made aware of the fato transfer the reside evaluation. 911 was a to take the resident was transferred to [Nupdated for resident retrieving items from wheelchair and she wimportance of not be for safety" Resident #56 was ad 11/20/19 with diagnostage Renal Disease Diabetes Mellitus, Ch. Disease (COPD), He Absence of Right and The Quarterly MDS of C0500 BIMS Score scoded as a "15" indic cognitively intact. Unresident was coded a Under Section G Fur was coded as requirione-person physical locomotion on and of hygiene. Under Sectil Limitation in range of coded as having importants.	nething off the floor and slid T. She was assessed and did ints of pain. She was then wheelchair and taken up to interventions and check was conducted, and in normal limits CRNP Nurse Practitioner) was all and an order was obtained int to the hospital for further calledarrived at the facility it to the hospital. Resident lame of Hospital] Care plan to seek assistance with the floor while in the was educated on the inding over while in the chair Imitted to the facility on ses which included End e, Hypertension, Type 2 inronic Obstructive Pulmonary wart Failure, Acquired d Left Leg Below the Knee.	F	689		8/24/22		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		04/20/2022		
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F 689	the resident was code Review of the nursing follows: 04/06/22 at 12:19 PM (Activities Aide)] was she observed resider rolling into the parking after the wheelchair a into a car and fell. Re 'My wheelchair sudde building into the parking and into a car and hit assessment done; A the left forehead. No discoloration observe Practitioner)was not to transfer to the near to transfer to the near 04/07/22 at 11:04 AM Progress Note] "see fall and f/u (follow up) she had a negative hiknee X-R (Xray), and facility this morning to care." 04/07/22 at 11:40 AM [Hospital Name] at 10 S/P (status post) fall. remains on left forehead Nose bleeding observes ponsive. Denied per hospital transfer (computed tomograph demonstrated no evice the state of the per hospital transfer (computed tomograph demonstrated no evice the state of the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated no evice the per hospital transfer (computed tomograph demonstrated n	ed as using a wheelchair. I progress notes read as I " [Employee #22 coming from the patio when It's wheelchair suddenly g lot. The Security chased and resident, but resident ran sident said during interview, enly started rolling from the ing lot, I was unable to stop it my head." Head to toe hematoma was observed on skin tear, no bleeding, no id. Denied pain NP (Nurse official and she gave an order rest ER" [Nurse Practitioner en today for assessment s/p in ER visit While in the ER, ised scan and negative right she was sent back to the in continue rehab and acute "Resident returned from in the interview of the condition on assessment, swelling is ad with discoloration noted. In the interview of the condition on assessment, swelling is ad with discoloration noted. In the interview of the condition on assessment, swelling is ad with discoloration noted. In the interview of the condition on assessment, swelling is ad with discoloration noted. In the interview of the condition on assessment, swelling is ad with discoloration noted. In the interview of the condition on assessment, swelling is additional to the condition on assessment, swelling is additional to the condition of th	Fé	689			8/24/22	

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F 689	AM. She stated that Department was help wheelchair). The state brakes on the wheelch down and she hit her the wheelchair hit a comparison of the state of the facility, and he state of the facility of the front door of the facility of th	22, at approximately 10:30 someone from Activities bing her outside (pushing her if member did not put the chair. The wheelchair rolled is head on the concrete after car and she fell over. Interview with Employee bin 04/08/22, at interview with her 2022 (date of the incident). (writer) proceeded outside lowed me where he left eday of the incident by expected and it turned left at incident was and identified it as the spot ident. He said that the had it from there. He left within minutes, he turned bident #56's] wheelchair ing lot. He ran to try to catch fair, but it was too late. elchair hit a car that was to corner (third row of the fell out of the chair onto the	F6	689			8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 689	wheelchair, and he to wheelchair. He did nof the wheelchair. I was happened." During an interview of 04/13/22 at 11:40 AM the wheelchair aroun left." During an interview of Employee #22 said the wheelchair before he lock [Resident #56's] because she was heat they had not gotten to him "I got it from head to where her friend [Resident #56] turned he left her to head to where her friend [Resident #56 and the front of the building Subsequently, Resides at a way from the sleentrance of the building wheelchair and sustained of her head. Additionally, there was assessed the seating wheelchair was assessed the seating states. It was a season wheelchair and sustained the seating wheelchair and sustained the seating wheelchair was assessed th	ook his hands off the ot push me when he let go snow how to put the locks on a outside when the incident with Resident #56 on I, she stated, "I did not turn d after the staff member on 04/13/22 at 12:20 PM, nat he normally locks the leaves a resident but did not wheelchair on 04/06/22, ading to the smoking area, to that area when she told ere". He said that he thinks I her wheelchair around after the other side of the building sident #80] was. dent, there was no evidence ded adequate supervision other residents who were in the ing in the non-smoking area. The end of the said that he ed car (approximately 40 oped sidewalk at the ed car (approximately 40 oped sidewalk at the ing), fell out of her ined a hematoma to the left as no evidence that facility in device (wheelchair) used by rmine if it was personal fit	F	589			8/24/22	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/20/2022	
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F 689	Continued From page	e 219	F 6	889			8/24/22
	Resident #56 is a sm as a smoker and their assessment or care president smoking. During a face-to-face #30 (Director of Reha 04/13/22, at 2:20 PM assessment was not	interview with Employee abilitation Department) on , she confirmed a wheelchair completed for Resident #56					
	During a face-to-face on 04/20/22 at 10:28 incident, Resident #5 wheelchair. Prior to to didn't know she was	entation to show that a as initiated on 04/10/22. interview with Employee #7 AM, he stated, "Prior to this 6 was not assessed for a his there was no escort. I going outside and the facility know she was going outside.					
	The resident is free to	o go outside. So we put so this doesn't happen					
	(Director of Nursing) she stated, "She [Re- herself to smoke. He to wheel her to go sn around to go back sh	oloyee #22] saw her two					
	plan resulting in the r	ied in Resident #61's care esident having multiple falls.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 04/20/2022	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				5000	ET ADDRESS, CITY, STATE, ZIP CODE NANNIE HELEN BURROUGHS AVE. N SHINGTON, DC 20019	·	14/20/2022
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F 689	entrance of the fact writer that 'I hit the against a surface at hit my head on theright side of his for abrasion with no bit this time transfer 911 for further associated #61 was multiple diagnoses Chronic Obstructiv Hypertension, Acur Inflammatory Respiration of Resident revealed the follow A Quarterly Minimulance Assessment Referred documented the for In Section C (Cogr Interview for Mental score of "09", indictimpairment. In Section E (Behat psychosis, rejection the assistance of of the unit (how the relocations in his/her on the same floor. self-sufficiency on off the unit (how the returns from off unit returns from off unit	d lying face down at the ility Resident reported to wheel of my wheelchair and fell off my wheelchair and ground and my head hurts". Drehead noted with an eeding/swelling observed at resident to the nearest ER via essment" admitted on 11/06/20 with including Diabetes Mellitus, at Ekidney failure, Systemic conse Syndrome and Anxiety. It #61's medical record ing: Im Data Set (MDS), with an ence dated 09/09/21 that llowing: Intitive Patterns), a Brief al Status (BIMS) summary ating moderate cognitive Vior), no indicators of an of care, or wandering. Itional Status), supervision with the person for locomotion on esident moves, between room and an adjacent corridor	F	689			8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER D REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019		•		
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	injury (skin tears, abr. Superficial bruises, hany fall-related injury complain of pain) sind (11/06/2020). A care plan with a sta "At risk for fall" due to gait, cognitive impairrendition, pain, poor processand impairwill remain free of injunext review date. Interisk on admission quain low position." 10/17/21 at 7:11 PM notified at 1405 (2:05 the front desk that redown at the entrance outside and observe Resident is alert and Resident reported to my wheelchair agains wheelchair and hit my my head hurts". Residistress at this time his head on a scale oright side of his forehwith no bleeding/swe (medical doctor) mad to the nearest ER (enfurther assessment 11/26/21 at 11:36 PM 10:10 pm staff heard	Conditions), one (1) fall with asions, lacerations. ematomas, and sprains; or that causes the resident to be admission/entry/reentry art date of 11/07/20 showed, or history of falls, unsteady ment, unstable health coordination, Diseased ed balance. Goal: Resident arry from falls through the erventions: Assess for fall arterly and as needed. Bed [Progress Note] "Writer was PM) by the receptionist at sident is observed lying face of the facility. Writer rushed resident lying face down. verbally responsive. writer that 'I hit the wheel of it a surface and fell off my or head on the ground and dent denies any other aresident verbalized pain on f (1-10) 9/10 resident's ead noted with an abrasion ling observed MD e aware transfer resident nergency room) via 911 for	F6	689			8/24/22	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 Observed resident on the floor in laying position on his left side in front of his wheelchair Resident c/o (complained of) of having severe	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE	(X5) COMPLETION
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 222 observed resident on the floor in laying position on his left side in front of his wheelchair Resident c/o (complained of) of having severe	COMPLETION
observed resident on the floor in laying position on his left side in front of his wheelchair Resident c/o (complained of) of having severe	
pain to the left [side of] forehead, no discoloration or swelling noted to the site DC (District of Columbia) EMS (emergency medical services) called non-emergency ambulance to transport resident" 11/27/21(Revision date) [Care Plan with focus area] "Actual fall on 10/17/21 with a right forehead abrasion, 11/24/21 fall with no injury, 11/27/21 fall with no injury at the front lobby." Goal: Resident will not speed when moving around in his wheelchair through the next review date. Interventions: Staff will make frequent rounds to resident's room to constantly remind resident to use the call button to call staff for assistance. Increased staff supervision with intensity based on residents' needs. Bed alarm in place. PT (physical therapy) consult for strength and mobility. Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bed-bound" 11/27/21 at 1:55 PM [Nurses Note] "Resident alert and verbally responsive. He returned from ER at 1:35pm (1:35PM) in stable condition Resident denied pain. CT (computed tomography) scan of the head and face indicated no acute fracture" Review of Resident #61's the medical record from 10/17/21, through 11/25/21, showed there was an "increase in staff supervision with intensity" based on residents' needs as directed in the care plan	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			5000 NANNIE HELEN BURROUGHS AVE. NE			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	04/19/21 at 9:30 AM, Floor Unit Manager) a and stated, "He [Resi or monitored. He [Res	interview conducted on with Employee #8 (2nd acknowledged the finding dent #61] is not supervised sident #61] goes off the unit is returned with no problem."	F	689			8/24/22	
	location, resulting in a altercation with Resid Review of a facility re 03/30/22 documented	toring of Resident #72's a resident-to-resident ent #188. ported incident dated I, "according to the						
	the two of the residen other,[Resident #72] his face with his right	unit and the CNA,When ts got close to each ounched [Resident #188] in hand, Subsequently o the floor no injuries were						
	Resident Background	Information						
	10/25/18 with the follo Non-Alzheimer's Dem Tachycardia, Chronic	nentia, Ventricular						
		erly Minimum Data Set 72 dated 01/29/22 revealed d the following:						
		Status (BIMS) Summary ating that the resident had						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019	ODE	HIZUIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	and Frequency. For the resident wandered. So this type occurred 4 to daily." B. Resident #188 was 01/21/22 with the follow Non-Alzheimer's Dem Status, Visual Halluci Agitation. A review of the Quart (MDS) for Resident # revealed that facility for Mental Status (BIN "99," indicating that the impaired cognition and daily. During a tour conduct approximately 9:52 Adocument was observate nurses station that 08/10/2021 4 South Lesen Behavior Documentat #72] Common behave elopement, med., test Resident-to-resident and 22/24/22 [Physician's seen because of alter Patient not injured. Heseparated from the office of the seen because of of the seen becaus	or), Wandering - Presence the question, "Has the taff answered, "Behavior of to 6 days, but less than admitted to the facility on the bound of the facility on the facility of t	F	589		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		TION SHOULD BE THE APPROPRIA			
F 689	Assessment and Rec Communication Tool] punched Resident #1 symptom started: 03/ and initiate behavior Comments. [Residen and [Resident #188] well. When the two o #72] then punched R his right hand, to the Subsequently, [Reside a result of the punch incident and then we immediately. [Reside 1 on 1 monitoring at 1 center was updated a the residentMD aw has been updated tomade aware of the 03/03/22 to 03/31/22 Documentation] show documented, "Reside Going through other Wandering Behavior problems led to issue Resident #72's medic 03/30/22 [Physician's consult secondary to altercation."	[Situational, Background, puest (SBAR):" Resident #72 then 88. 2. Date problem or 30/2022 Psych consult monitoring Additional t #72] was walking in the hall was walking in the hall was walking in the hall as f them were close, [Resident esident #188 in his face with left side of face. Ident #188] fell to the floor as The charge nurse saw the ent to separate the residents in t #72] has been placed on this time. The mobile crisis and will be out to evaluate vare Resident's care plan reflect the incident. RP incident as well." [Daily Behavior wed that facility staff ent exhibits the following: people. Elopement attempts. Ors are constant. Behavior is with care" 16 times in cal record. [COrder]: "Psych (Psychiatric) resident-to-resident	F6	589		8/24/22		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 0 1120/2022		
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F 689	Continued From pa	_	F 689		8/24/22		
	active care plan to a physically aggressive	address Resident #72's ve behavior.					
	to revise Resident # his aggressive beha	ed that the facility's staff failed \$72's plan of care to address aviors resulting in another ident #188 resulting in minor					
	approximately 3:30 acknowledged the f	te interview 04/14/22 at PM, Employee #7 inding and stated that to longer a wanderer.					
	supervision of Resiprevent two residen	d to provide adequate dent #151 to protect and ts (Residents' #71 and #67) aggressive behavior t altercations).					
	" At 0730AM, the [Resident #151] ass	lated 12/09/21 documented, security officer observed saulting another resident e front of the building"					
	At 2030 on 12/29/	lated 01/02/22 documented, " '2 (12/29/21), [Resident #67] stionist that [Resident #151] hit in the lobby"					
	Resident Backgroui	nd Information					
	10/22/20 with multip	as admitted to the facility on ole diagnoses that included: osis, Epileptic Syndrome and operplasia.					
	Review of Resident revealed:	#151's medical record					

STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION IDENTIFICA	/SUPPLIER/CLIA TION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS	CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		1 0-1/20/2022		
(X4) ID SUMMARY STATEMENT OF DEI PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
12/08/21 [Admission MDS], facility BIMS summary score of "07", indic cognitive impairment. In Section E (Behavior): E0100. Potential Indicators of Psyd Delusions (misconceptions or belia firmly held, contrary to reality) - "yes E0200. Behavioral Symptoms: Phy behavioral symptoms directed tow. (e.g., hitting, kicking, pushing, scra grabbing, abusing others sexually) this type occurred 1 to 3 days", ver symptoms directed towards others threatening others, screaming at of at others) - "Behavior of this type of days", Impact on Resident Put is significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical illness of impact on others put others at significant risk for physical injury? "yes"; significantly privacy or activity of others? "yes"; disrupt care or living environment? In Section G (Functional Status): A Daily Living (ADL) Assistance - bettransfer, walk in room, walk in corr locomotion on unit, locomotion off #151 required "supervision" and "or physical assist" Review of the Care Plan revealed: 07/27/21 (Revision date) "As evide positive PASARR (Preadmission S Resident Review) Level I screen a	chosis - efs that are es" visical ards others tching, - "Behavior of tbal behavioral (e.g., thers, cursing eccurred 4 to 6 the resident at or injury? "yes"; ignificant risk of intrude on the significantly "yes" activities of d mobility, idor, unit, Resident one person	F 68	39	8/24/22		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	NE	04/20/2022
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F 689	Facility. Related to: MD (medical docto serious health decl agreed to may nee Inform the MD of ar require additional er remove services 07/27/21 (Revision for changes in beha agitation" 10/18/21 (Revision problematic manne characterized by in to treatment/care re (Dementia, Schizor taking medications non compliant with compliant with Wa and hitting" 10/20/21 (Revision impaired cognitive processes r/t (related 10/20/21 (Revision psychotropic medic management, Para Monitor/record occus ymptoms violen staff/others) and do 10/22/21 (Revision behavior problem re on the entire floor, Non-compliant lettire	Services while in the Nursing schizophreniaInform the r) if the Individual has a sine and services previously d to be modified or deleted. In the significant changes may evaluation to add, modify or " I date) "[Resident #151] at risk avior problems related to: I date) "[Resident #151] has are in which resident acts appropriate behavior; resistive elated to: Cognitive Impairment obrenia). Non compliant with a non compliant with vital signs, shaving and showers. Non der guard placement kicking I date) "[Resident #151] has function or impaired thought ed to) Dementia" I date) "[Resident #151] uses	F	589		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 689	members, trying to be Administration area a staff monitoring for sa sitter is available" B. Resident #71 was 08/20/18 with multiple Schizoaffective Disorwithout Behavioral Dispersion. Review of Resident #Quarterly MDS dated coded a BIMS summ moderate cognitive ir indicators of psychos behavioral symptoms person physical assis range of motion and C. Resident #67 was 09/29/08 with multiple Unspecified Intellectude Disorder with Hallucin Dementia without Be Review of Resident #Quarterly MDS dated coded a BIMS summ intact cognitive responsion physical assis in the code of psychosis, no physical assistance.	gitation, hitting multiple staff reak down doors in the and rolling on the floor 1:1 afety until seen by psych or admitted to the facility on a diagnoses that included der, Unspecified Dementia sturbance and 171's medical revealed, a 10/23/21 where facility staff ary score of "09", indicating apairment, no potential is and no physical or verbal is, limited assistance with one at for ADLs, no limitations in the staff conditions. admitted to the facility on a diagnoses that included and Disabilities, Psychotic anations, and Unspecified thavioral Disturbance. 167's medical revealed, a 11/06/21 where facility staff ary score of "14", indicating anse, no potential indicators sical or verbal behavioral extensive assistance with assist for ADLs and no for motion.	F6	889			8/24/22

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	[Receptionist's Namassaulting another of the building. receptionist ran to the both residents [Refle said, 'the man jubuilding for no reason him. I don't know whasked [Resident #15]. He sum the MPD (Metrop was called took [Flaggressive behavior [Hospital Name] at Carrell [Resident #71] was mark observed on the Resident-to-Resident #71] was mark observed on the Resident-to-Resident #67] and (8:30 PM) on 12/29/alleged to the recephim on his chest x 2 notified the supervis [Resident #67] and (8:40 PM) [Resident gate trying to exit. Houlding stood by grab and hit staff ex staff exit or enter the Department was call (11:50 PM). 2 MPD PM). During interview was not cooperating of the Police Officer into custody [Resthis AM (morning). Hours in the police of the Police	ity Officer's Name] and the e] observed resident [#151] esident [Resident #71] at the The security officer and the residents and separated esident #71] was interviewed. I was interviewed. I was encounted to the encounter of the	F	589		8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ID WELLNESS CENTER		, -	CITY, STATE, ZIP CODE N BURROUGHS AVE. NE C 20019	1 04/20/2022
(X4) ID PREFIX TAG			ID PREFI) TAG	(EACH C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689	No swelling, discolora during assessment. Here was no documented resident-to-resident at There was no documented resident revised Resident protect other resident Resident #151 attack facility. During a face-to-face 04/14/22, Employee acknowledged the fin Resident #151 has be admitted back to the finot had any resident-6. Facility staff failed #183's wheelchair duresulting in the resider Review of the FRI dat "At 6:33PM on 10/1escort reported to the was on the van going slipped under his [seatchair when the driver Resident #183 was at 03/20/14 with multiple Acquired Absence of	ation or open area observed de denied pain" 151's medical record aggressive behaviors and a altercation on 12/08/21. ented evidence that facility it #151's plan of care to s and then on 12/29/21, ed another resident at the interview conducted on #7 (Clinical Coordinator) dings and stated that een on 1:1 since he was facility in 01/2022 and has to-resident altercations. to properly secure Resident ring a van transport, int falling. ted 10/19/21 documented, 9/21, [Resident #183] in enurse that when resident to this appointment resident to this appointment resident all belt slit out of his wheel held the brake" dmitted to the facility on ediagnoses including, Left Leg Below Knee, e 2 and End Stage Renal	F	89		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED	
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	ROVIDER OR SUPPLIER DD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	showed that facility so In Section C (Cognitic summary score of "1 cognition. In Section G (Function assistance requiring with ADLs, uses a wind and had no limitation 10/14/21 at 2:26 PM on LOA (leave of absolute with a solution and the slipped out of well as not hurting. It is sitting position and the appointment. [Reside facility after the apported to his unit. It done with range of mequal strength. He re-	e MDS dated 10/01/21, taff coded the following: ve Patterns), a BIMS 5", that indicated intact onal Status), extensive one-person physical assist neelchair for mobility device	F	DEFICIENCY)		8/24/22	
	shortness of breath revidence of rednessResident is wheeld [below knee amputat Representative) and 10/14/21 at 3:42 PM "Resident's wheeld the bus at all times where the bus at	noted at this time no nor bruising noted hair bound with a left BKA ion]. RP (Resident MD made aware."					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY IPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NI WASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	is properly strapped of Alter/remove any pote Educate resident/fam (interdisciplinary team 10/21/21 [Physician's program" During a face-to-face 04/07/22 at 3:05 PM, remember the time I is bumped my head a limy wheelchair." During a face-to-face 04/08/22 at approxim #34 (Van Driver), he property when it happen on each side, there a fell backward, all the (Employee #34 and # #183] wasn't injured a scheduled appointment During a face-to-face 04/08/22 at 3:15 PM, Nurse Aide) stated, "I back, still in the wheel hard." The evidence showed properly secure Residuled with adequate supervision of the second stated with a second stated wit	on the van before driving off. ential causes if possible. iily/caregivers/IDT n) as to cause." Order] "Yellow star fall interview conducted on Resident #183 stated, "Oh I fell backward on the bus and ttle. I didn't have the tilts on interview conducted on ately 2:00 PM, Employee stated, "We were still on the bed I secured the straps re 4 straps. The wheelchair straps weren't secured. We estated took him to [his ent]." interview conducted on Employee #35 (Certified He [Resident #183] flipped elchair. He fell on his back d that facility staff failed to dent #183's wheelchair to to transport. to provide Resident #409 vision, assistance and hip an avoidable accident after	F 6	89		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	_	LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 689	by the State agencyafter having hip su observed two days la positioned like the le sent to the hospital fisurgery. Resident #409 was a 07/08/21 with diagnor for Orthopedic Afterd Artificial Hip Joint, Al (Unspecified), Repeated (Generalized), and Mobility. Review of Resident are revealed the following and Mobility. Review of Resident are revealed the following and Mobility. In Section C (Cognit Interview for Mental Score was "99," indicated in the section of	form for a complaint received on 12/06/21 documented " rgery on 07/08/21, was ater on 07/10/21 with "leg tter 'K'" Resident #409 was or a dislocated hip and hip admitted to the facility on uses that included: Encounter are, Presence of Left zheimer's Disease ated Falls, Muscle Weakness Other Abnormalities of Gait #409's medical record g: In Data Set (MDS) for 107/11/21 revealed that	F	889		8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	l ^{(X}	3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019		04/20/2022
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F 689	incontinent" for bladd In Section J (Health (resident have a fall aprior to admission /er fracture related to a fato admission /entry of major surgery during admission; resident haprocedure during the that requires active countries. In Section O (Special and Programs), start Physical Therapy "07 07/08/21 at 12:10 PM Summary] "Hospital with left hip fracture; replacement). With necomplicationsDischWeight Bearing as LeftRestrictions as precautions" 07/08/21 at 8:29 PM "Resident was adm Hospital] for rehabilita ArthroplastyResident local with close monitoring used items within close 07/08/21 (3:00 PM-12 Documentation], facil Resident #409 was g	Conditions), "Yes" to: ny time in the last month atry or reentry; resident have all in the last 6 months prior reentry; resident have the 100 days prior to ave a major surgical prior inpatient hospital stay are during the SNF stay. Treatments, Procedures, date for Occupational and /09/2021." I [Hospital Discharge I Course Patient presented status post Arthroplasty (hip to postoperative harge Procedure Orders Tolerated (WBAT); Laterally; follows: Posterior hip [Admission Note] itted from [Name of Local ation post left hip tent has hip abduction with II and safety precautions ation close to nurses' station of call light and commonly se reach"	F6	89		8/25/22

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F 689	hip for inflammation, 07/09/21 at 2:18 PM and Plan of Treatmer therapy after having a hemiarthroplasty that Precautions (no fle abduction past midlin WBAT" 07/09/21 (7:00 AM-3. Documentation], facil Resident #409 receiv assistance with dress mobility, and provide and bladder. 07/09/21 (3:00 PM - Documentation], facil Resident #409 receiv mobility, and provide and bladder. 07/09/21 (11:00 PM- Documentation], facil Resident #409 receiv mobility, and provide and bladder. 07/09/21 (11:00 PM- Documentation], facil Resident #409 receiv mobility, and provide and bladder.	is Order] "Left hip: monitor left pain, and drainage." [Physical Therapy Evaluation at Note] "referred to skilled a L (left)) hip resulted from a fall exion past 90 degrees, i.e., or internal rotation, [OO PM) [CNA lity staff documented that red a bath/shower and sing, assistance with bed d incontinent care for bowel [OO PM) [CNA lity staff documented that red a saistance with bed d incontinent care for bowel	F	689	DEFICIENCY)		8/25/22
	reposition when resident of the control of the cont	lent is in bed." Order] "Wedge resident ire, turn and reposition when					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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F 689	staff documented that between Resident #4 care, and wedged re and repositioning who or 10/21 (7:00-3:00 facility staff documen received a bath/show dressing and bed mo or 10/10/21 at 3:29 PM "Patient seen at the and the family. Patien pain at the site of suadded oxycodone (as needed) for 14 documentation of 14 documentation of 14 documentation of 15 care from the family of 15 care from the family. Patien pain at the site of suadded oxycodone (as needed) for 14 documentation of 15 care from the family. Patien pain at the site of suadded oxycodone (as needed) for 14 documentation of 16 care from the family. Patien pain at the site of suadded oxycodone (as needed) for 14 documentation of 16 care from the family of 16 care from the	:00 PM) [Treatment rd (TAR)], showed that facility at they placed a pillow 409's lower extremities after sident appropriately turning ten the resident was in bed. PM) [CNA Documentation], and that Resident #409 wer and assistance with obility. [Physician's Progress Note] request of Nurse Manager nt reportedly has increasing agery, worse with movement (narcotic pain reliever) print ays for breakthrough pain" [SBAR] "Resident transfer of Date problem or symptom of Date problem or symptom of Saturday and the Saturday of Saturday and the Saturday of Saturday	F	689		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	there was any concel have order[ed] an X-r want[ed] her mom to immediately because done and read right [i X-ray can be gotten f take b/n (between) 2-done[Physician's N doctor said an X-ray be done so the reside the hospital via non-efurther evaluation perwas taken out from the [Hospital Name]." 07/12/21 at 6:34 PM Summary] "The patie Facility], where she hew days Her daug visit her looked unthat her left leg was some they were concerned with the surgery at the requested transportar (Emergency Departm 2:30 AM: The patie what this means] to Narratives: 02:27 Pto [Name of Facility]. discharge. Request kedischarge" A review of the Reside 07/10/21, provided here	(sp) just a few hours ago. If an note[d] the doctor would ay. She insisted that she be sent to the hospital a she need[ed] an X-ray to be away]. Writer told her that an rom the doctor, but it will a hours for the X-ray to be dame] was notified and the will take about 4-6 hours to ent should be transfer[red] to emergency transport for a family requestResident the facility at 5:50 [PM] to as been staying for the past and the recovers, and found significantly inwardly rotated. It is something is going wrong the left hip, and they tion to the hospital ED then to Course/Critical Care and something is going wrong the left hip was reduced [explain blerated the procedure well ble] Dan to discharge back 03:51 PM cleared for the mobilizer for the side of the course with the facility staff and they from 07/08/21 to the with adequate supervision, recautions to ensure that	F	889	8/24/22

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 689	04/14/22, at approxi #409's daughter/rep 07/10/21, I noticed to and flinched when I what was wrong. I don her leg. Her leg v'K'. I spoke with the wanted to see the dothe doctor, who said primary doctor, and pain. I insisted that rher hip. I was told the time (4-6 hours), so She told me she did and I can call 911, said it wasn't a medicalled a non-emerge was transported to [During a face-to-face approximately 3:30 stated, "I told the da (x-ray). She insisted [Resident #409's hip the hospital. Per the doctor's permission, ambulance was called transferred out to [Hof the incident." During a face-to-face approximately 4:00 I Unit Manager) state with hip precautions therapy or by the un resident is admitted.	nterview conducted on mately 12:30 PM, Resident resentative stated, "On hat my mother looked out of it pulled back the cover to see idn't see the knee immobilizer was positioned like the letter unit manager and told her loctor. They finally brought in he wasn't my mother's he ordered oxycodone for my mother get an X-ray for e X-ray would take a long I asked the nurse to call 911. not have a doctor's order, o I did. 911 showed up and ical emergency, so they [911] ency vehicle, and my mother Hospital Name]." The interview on 04/19/22, at PM, Employee #4 (Educator) ughter how long it would take we call 911 to have a X-rayed and evaluated at daughter's request, with the a non-emergency ed. The resident [was ospital Name]. I did an SBAR The interview on 04/19/22 at PM, Employee #8 (2nd Floor did that training for residents usually occurs with physical it managers when the	F	589		8/24/22

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F 695 SS=H	and two (2) nurses we evening shifts on this the pillow/wedge betw to put the hip immobil how to roll the resider from crossing midline the bed in the lowest light near the resident able to provide a copysign in sheet or the hip provided to the staff. Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheal succare, consistent with practice, the comprescare plan, the resider and 483.65 of this sull This REQUIREMENT by: Based on observation and family interviews sampled residents with facility's staff failed to airway (stoma) was not device Heat Moisture subsequently, the resident graphy of respirator facility that was neces Resident #3's larynge	I trained the 2-3 CNAs no worked the day and unit. I reviewed how to put ween the resident's legs, how izer on the resident, and not on her side to prevent her. I reminded staff to keep position and keep the call to the "impromptu training" and outs that he said were stomy Care and Suctioning and tracheal suctioning. The that a resident who be including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning, is provided such professional standards of the including tracheostomy etioning.	F 6		n the facility om head to ger. ative /26/22.	

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F 695	replacement 3. obtain HMEs, 4. change and equipment in accordate orders for Resident # for the use of a "buttowith a Tracheostomy." These failures resulted Resident #3, exampled The findings include: 1. The facility's staff for #3's airway (stoma) would device HME resident to be transfered (ER) for dislodgment. According to Johns Hold (https://www.hopkinstesources/glossary.htm) HME is a humidifying the trach tube and cosizes. It is also known including Thermal Humose, Artificial nose, It is also known including Thermal Humose, Artificial	a/provide Resident #3 with I clean respiratory ince with the physician's 304, and 4. obtain an order in" (HME) for Resident #304 and in actual harm for a #1. alled to ensure Resident was not occluded by a subsequently, causing the rred to the emergency room opkins Medicine medicine.org/tracheostomy/r ml#Tracheotomy) a filter that fits onto the end of mes in several shapes and in by several other terms midifying Filters, Swedish Filter, Thermovent T. alted to the facility on ple diagnoses including of Larynx, Carcinoma of ence of Larynx, and on Minimum Data Set ated 12/03/21 revealed that	F	695	IDENTIFICATION OF OTHERS WITHE POTENTIAL TO BE AFFECTION Residents with respiratory problems are using respiratory equipment to respiration, have the potential to be affected. Respiratory therapist /Designee will assess all the residents who are us respiratory equipment to aide in respiration during their shift to ensure residents are in no respiratory distance in no respiratory distance found will be corrected 8/24/22	ED: s that aid in c l l sing ure the tress.	8/24//22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	speech therapy servi showed that Residen receiving respiratory Review of the resident the following: -12/01/21 at 19:54 [a note]- Resident under with direct laryngosod upon assessment, person and place with cap [HME] in plates and place in the following in plates and states are tracheostomy and do (blood pressure), 86 (temperature), 95% fon room air) -12/02/21 [physician day shift. -12/02/21 at 13:15 [reassessment]- Type- i was alert and orienter place with an HME. I holder changed. HMI assessment respirator room air, lung sounds assessment respirator capillary oxygen satured lung sounds clear -12/03/21 [physician capillary oxygen satured lung sounds clear	ces. A continued review at #3 was not coded for therapy services. Int's medical record revealed dission nursing progress rewent awake tracheostomy opy and biopsy on 10/27/27 resident alert and oriented to Resident has a lary tube are In thysician assistant physician patient) seen at bedside ablePt. also has sing wellvitals: 126/81 (pulse, 18 (respiration), 97.6 RA (oxygen saturation rate and holder in lary tube and holder in lary tube cleaned, tube changed. Pre-treatment orly rate 18, SPO2 98% [on] is clear Post-treatment orly rate 18, SPO2 (peripheral progress) on room air, order] - transfer resident to regency room) for further	F	695	MEASURES TO PREVENT RECUITS. In- service will be provided by Staft to all licensed nursing staff to ensidents on respiratory equipment assessed by the licensed nurse exhift, make sure the stoma is not that the respiratory equipment is of that respiratory supplies are alway bed side and in central supply stor In addition, respiratory medical eqwill be cleaned by Respiratory therapist /Designee on a weekly bwill be completed by 8/24/22. Repin-service provided as needed. Education will be provided to licen nursing staff by staff educator on hearry out CRP on a resident with Heary tube completed by 8/24/2022 Charge nurses and Supervisors weekly that residents with respirat are assessed, that residents are in respiratory distress, that care plan in place to reflect their diagnosis a interventions are implemented as Any issues found will be addresse 8/24/22	ff Educate sure that it are very occluded, lean, and vs at the rage room uipment asis. This eat sed now to HME, or it. ill ensure ory issues n no goals are and that indicated	or n.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 695	respiratory therapist in has an HME stuck in Resident has a lari-turand no respiratory disidenied pain. No bleed (saturation) checked RA (room air). [Docto instruction to transfer (emergency room) for Resident's granddaugk know what happened explained when she changed HME on yes (airway) was clear but there was an HME st therapist explained to maybe the HME initial (airway) and the resident's daughter Respiratory Therapis resident was alive, in how she determine non-verbal 911 cal at 1400 v/s (vital si pressure), 63 (pulse) (temperature), O2 Sa air). -12/04/21 [hospital di Diagnosis-tracheosto radiology XR (x-ray) in PA (posterior-anterior Call for follow-up app within 2 to 4 days [pressure of the content of the co	ursing progress note] - The notified writer that resident the stoma (airway). be. Resident was assessed stress noted. Resident ding noted. O2 (oxygen) Sat immediately and was 99% r's name] notified. He gave resident to nearest ER r further evaluation. In the respiratory therapist edid care for lari-tube and sterday 12/2/21, the stoma at today she observed that suck in the stoma. The the granddaughter that ally stuck down in stoma then coughed it up rcalled and spoke with twanted to find out if distress or pain and asked that since resident is led at 1345 and they arrived gns): 121/80 (blood 18 (respirations), 97.8 at (saturation) 99% RA (room	F	695	Respiratory therapist will assess residerespiratory diagnosis during their shift ensure that they have adequate respir supply. Will also ensure daily that the respiratory equipment is clean. Also edocumented evidence of assessment. issues found will be corrected by 8/24/ Unit Mangers will ensure that all residerespiratory diagnosis are in no form of respiratory distress while conducting reduring their shifts. Any issues found wireported and corrected by 8/24/22 Charge Nurses will check on residents respiratory diagnosis on their units durshift to ensure they are in no respirator distress. Any issues found will be address. Any issues found will be addressed by 8/24/22 Unit Managers/ supervisors will ensure that the nurses take orders for HME at implement them as indicated. Superviswill be notified through supervisor reported and validation meeting. Any issues for will be corrected by 8/24/22 Coaching and counselling will be proved by Staff Educator / designee to charge nurses who are not implementing physician orders as indicated by 8/24/24. Respiratory therapist/ central supply coordinator will ensure respiratory equipment are available through week audits. Any issues found will be corrected by 8/24/22.	to ratory nsure Any 22 ents with counds ill be swith ring their ry ressed end sors ort und ided exercises and services and sort and sort and services and sort and services and sort and sort and services and sort and services and sort and services and s	8/24/22

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F 695	Resident came back 129/89 (blood pressu 98% (oxygen saturati -12/04/21 [physician stoma in neck. The [phreather12/06/21 at 16:13 [phreather12/06/21 a	from the hospitalon arrival re), 18 (respiratory rate) on rate) on room air. order] - Do not occlude patient] is an obligate neck on spiration. Pt. spears alert and stable dispeasure), 71 (pulse), 17 A (oxygen saturation rate on obration): lung CTA (Clear to erally). ew of progress notes lacked at that Employee #31 st) assessed or provided from 12/03/21 to 12/06/21 are emergency room). sher 2021 Treatment dishowed the following: any shift (start date 12/03/21). Itialed on 12/03/21 indicating sident #3's HME on dayshift ehensive care plan with an 1 showed the following: as showed the following: as shift (start date 12/03/21) and showed the following: as shift (start date 12/03/21). Itialed on 12/03/21 indicating sident #3's HME on dayshift ehensive care plan with an 1 showed the following: as shift (start date 12/03/21) are given by the review as (signs/symptoms) of review date. are care daily, change HME	F	695	F 695 MEASURES TO PREVENT RECURRENCE CONT. Respiratory therapist will also ensure there is documented evidence of intervention to address residents wirespiratory needs weekly. Findings corrected by 8/24/22. Respiratory therapist must provide to all licensed nurses on what an H and how to care for residents with a HME .Documented evidence on ed provided must be kept handy. Unit managers will ensure that nurse following the physicians order as the provide care to residents with respin needs. Findings will be corrected by 8/24/22 Education will be provided to licens on the importance of signing the tree record only when care is provided. Training will also be conducted by respiratory therapist to all licensed on how to use other respiratory equisuch as CPAP	th will be training ME is an ucation less are ey ratory / ed staff atment	8/24/22	

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F 695	Further review of Rescare plans lacked dod interventions to addreuse of a lary-tube and 12/03/22. Review of a complain Department of Health that Resident #3 was 12/03/21, because the (Resident #3) neck store Resident #3 was unatime of the survey bethe hospital on 03/29. During a telephone in AM, the resident's resident's resident's resident's resident's resident's resident's resident's resident's stomatinformed her what has grandfather's stomatinformed her what has neither one of them occlinical coordinator] sthings that happened During a face-to-face approximately 5:00 P stated, I cleaned som a shift. Respiratory settime. I had training from the remember when." The don't remember the real HME."	dident#3's comprehensive cumented evidence of ess care for Resident #3's HME from 12/01/22 to treceived by the DC on 01/26/22 from alleged rushed to the ER on ere was an HME put into his oma (airway)." ble to be interviewed at the cause he was discharged to 1/2022. Iterview on 04/12/22 at 11:35 eponsible party ed that the clinical espiratory therapist called in the HME was stuck in her	F6	95	MEASURES TO PREVENT RECURRENCONTINUE Unit manager will ensure that resident # 3 all supplies needed to take care of his reserved's weekly. Also, to ensure that the lie nurse get a physician order for HME for tracheostomy status for the resident. Find the addressed by 8/24/22 Unit managers will ensure that a person-approach is created to care for residents laryngectomy or other respiratory needs a Findings will be corrected by 8/24/22. In service will be provided by Respiratory to all licensed nurses on how to provide or residents with respiratory diagnosis. Respiratory therapist must ensure weekly know the size of respiratory equipment at the facility supplies it to the resident. Finds be corrected by 8/24/22. Unit managers/ supervisors will validate the resident's respiratory equipment is cleaned charge nurses/ respiratory therapist during shift. Findings will be addressed by 8/24/24. Unit managers will ensure that the charge are putting in correct documentation in the treatment records for care provided to the residents. Findings will be corrected imm. MDS coordinator must ensure that reside respiratory diagnosis are coded accurate. Unit managers will ensure residents on tracheostomy are suctioned by the respir therapist and licensed nurses during their Findings will be corrected by 8/24/22. Respiratory therapist are in house daily.	304 has spiratory censed dings will centered with weekly. If therapisticare to that the end ensured dings will hat the end by the end their centered end their cente	;	

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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE /ASHINGTON, DC 20019	1 04/1	
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F 695	reported that when the informed him that an resident's stoma (airway) transferred to the em. The employee then so not in any distress whis stoma (airway). Winvestigation was conthe incident of the HM. #3's stoma (airway) is stated, "No." The emprespiratory therapist with the resident's HME. During a telephone in PM, Employee #31 (If that she informed the HME was "stuck in his sure how the HME go (Resident #3) did not stoma it would have the employee stated that days a week, and on facility nursing staff was a week, and on facility nursing staff was a week, and on facility nursing staff education. Resident #3's lary-tuted documented the train office. The employee nursing staff to do a rensure competency. During a face-to-face approximately 3:00 P stated that respiratory training on tracheostoprovide education on	HME was stuck in the way), he had Resident #3 ergency room for evaluation. hared that Resident #3 was nen the HME was lodged in When asked if an aducted to determine how ME being lodged in Resident appened, Employee #7 ployee also said the was responsible for changing was responsible for changing that Resident #3's sestoma (airway). I'm not stuck in his stoma. If he get the HME out of his peen detrimental." The she worked three to four the days, she was not in the was responsible for cleaning the and changing the HME. said that she provided on on how to care for	F	695	DON/Designee will conduct house wide to ensure that residents with respiratory problems are in no respiratory problems all needed supplies, that the respiratory equipment and clean and that there is documentation in place that care was provided. This audit will be carried out w x 4 then monthly x3. Findings will be corand reported to QAPI COMMITTEE.	that have veekly	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AVI WASHINGTON, DC 20019	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	resided, she could rhim. A review of in-service documented evidence ducation on the lare ducation stated that the respiresponsible for provelary tube and HME. respiratory therapist written documentatic staff. However, she records of education therapist." There was no evided developed a person for and provide necessary who had a larying Resident #3's airway medical device HMB transferred to the Edevice. 2. The facility failed respiratory medical was necessary to calaryingectomy (lary-face).	the floor where Resident #3 not remember working with the training documents lacked ce that staff was provided by tubes or HMEs. The interview on 04/14/22 at PM, Employee #4 (Educator) ratory therapist was iding staff education on the The employee said that the twas to provide her with on of education provided to said, "I don't have any in provided by the respiratory ince that facility staff recentered approach to care essary services to Resident gectomy. Subsequently, by (stoma) was occluded by a E, causing him to be R for dislodgment of the to keep a supply of equipment in the facility that are for and treat Resident #3's tube) and stoma (airway). Esident had to be transferred	F6	95		8/24/22
	Medical Science, a	iversity of Arkansas for lary tube is a flexible silicone aintain the stoma right after				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		5000	EET ADDRESS, CITY, STATE, ZIP CODE NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019	, <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	maintain the airway laryngectomy. (https://patientslearn.ds/sites/95/2018/03/Review of Employee Therapist) signed and description, showed providing necessary resident (sp) to perform Review of an Admiss 12/03/21 revealed the Summary Score secresident was not asserident was coded care and speech the Review of the resident Review of the resident was not assert the Review of the resident Review of the resident Review of the resident was not assert the Review of the resident Review of the Review o	rgery. A lary tube is used to and can be following auams.edu/wp-content/uploa Lary_Tube_Care.pdf) ##31's (Respiratory and dated 06/03/19 job that she was responsible for material and equipment for orm required therapy. ##36 sion MDS assessment dated that the Brief Interview Mental attion was blank, indicating the sessed. Additionally, the for receiving Tracheostomy trapy services.	F	395			8/24/22
	revealed the following revealed the following resident Laryn [lary] by the respiratory the send resident out to replacement. 911 and -01/07/22 at 6:10 PM [Name of Hospital] in laryngectomy tube. It said size was gather -01/08/22 at 6:32 AM	A: "It was observed today that tube is out. He was assessed erapist and recommended to the ER for laryn [lary] tube rivedleft at 4:40 PM. " A: "[MD's Name] called from leed to know the size RT (respiratory therapy) note red at admission." A: "Resident returned from the 2:30 AM in stable condition					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COMPLETED		
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		
F 695	O2 SAT (oxygen sair)."; and -01/08/22 at 4:02 PM orientedResident obreathing with the ne hospital 1/7/22. Resid [Name of Hospital] for change of lary tube saturation) 98." Review of the comproinitial date of 12/04/2 showed the following Focus Area- [residen (related to) laryngeal for laryn (sp) tube plataryn (sp) tube replace Goal- [resident's namedrainage around trace date. Will have no s/s infection through the Interventions- lari-tube daily, assist with cough Review of a respirator assessment/infection lacked documented of the trapist assessed of #3 from 01/05/22 to 0. Review of complaint complainant alleged the ER on 01/07/22 for due to facility throwing had. During a telephone in	enturation) 95% RA (room : "Resident alert and beserved with difficult we lary tube placed from dent's family took him to resident O2 sat (oxygen entersident entersid	F 6	695		8/24/22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C)4/20/2022	
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NI WASHINGTON, DC 20019	•	PH/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	She stated, "I told the tube was missing work I asked them why it lary-tube replaced." During a telephone PM, Employee #31 that when the resided (01/07/22) she had for replacement. The while Resident #3 work the emergency room about the size of the could not give the product that was respiratory supplies but she could not or because she "did not asked if she made to medical director away I don't talk the docton name] and [Clinical several times. Through interview was no evidence that face Resident #3's Lary therefore, none were use. Subsequently, emergency room for the state of the	rare of the lary-tube missing. Them that my grandfather's lary Then I visited him 5 days prior. Took them so long to get his Interview on 04/14/22 at 2:35 (Respiratory Therapist) stated There is lary tube was misplaced The resident sent out the ER The employee then reported that The employee then reported that The is a single the employee the inquire The resident's lary-tube, but she The resident's lary-tube, but she The resident's lary-tube The resident said, "Yes" The responsibility to order The resident size because she The resident siz	F 6	95		8/24/22	

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	NG	COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIF 5000 NANNIE HELEN BURROUGH WASHINGTON, DC 20019		V .: 20: 20 22 2
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
F 695	important to keep you easy to cough up [mu wear a stoma protect Moisture Exchange (I cassette). These are and will moisten much https://www.ouh.nhs./11587Pstoma.pdf Review of complaint allegations that the fa and HMEs for Resident # the following Physician's Day shift." 12/02/21 [Physician's Day shift." The medical record a nursing notes: 01/07/22 at 4:51 PM was observed today tout. He was assessed and recommended to for larynx tube replace 4:40 PM. However, review of reassessment / infectio lacked documented experience.	University Hospital, it is ar mucus thin so that it is acous]. You should always or such as aHeat HME: baseplate and available on prescription ous uk/patient-guide/leaflets/files #DC00010525 revealed acility did not have lary-tubes ent #3. Bays medical record showed an's orders: Order] "Change HME daily Order] "Change Lari-Tube Iso contained the following [nursing progress note]- It that resident larynx tube is do by the respiratory therapist is send resident out to the ER ement. 911 arrivedleft at espiratory therapy in screener progress notes evidence the respiratory reprovided care for Resident	F	695		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	NE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 695	[MD's Name] called University Hospital) laryngectomy tube. said size was gathe -01/08/22 at 6:32 A Resident returned ficonditionvs (vital pressure), 18 (respi (temperature), O2 SRA (room air)01/08/22 at 4:02 PR Resident alert and offeeding and all mewith difficult breathing placed from hospitatook him to [Name offeeding and all mewith difficult breathing placed from hospitatook him to [Name offeeding and all mewith difficult breathing placed from hospitatook him to [Name offeeding and all mewith difficult breathing placed from hospitatook him to [Name offeeding and all mewith difficult breathing placed from 01/08/22 to 03 facility's nurses initiation of 1/08/22 to 03 facility's nurses initiation of 1/08/22 to 03 not have HMEs con Resident #3's lary-terminated for laryn (sp) tube plaryn (sp) tube replated to) larynger for laryn (sp) tube replated for laryn (sp) tube s	M [nursing progress note] - from HUH (Howard need to know the size RT (respiratory therapy) note ared at admission. M [nursing progress note] - from HUH at 2:30 AM in stable signs): 144/75 (blood ration), 70 (pulse), 96.8 SAT (oxygen saturation) 95% M [nursing progress note] - foriented. Resident tolerated dications. Resident observed any with the new lary tube all 1/7/21. Resident's family for Hospital] for follow-up and lary [laryngectomy] tube (oxygen saturation) 98. At Administration Records (02/22 showed that the alled they changed Resident dayshift. However, it should be respiratory therapist the HME could not be changed (02/22 because the facility did apatible to connect with ube. The showed the following: and the showed the showed the following: and the showed the	F 6	95		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		ONSTRUCTION	LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		5000	EET ADDRESS, CITY, STATE, ZIP CODE D NANNIE HELEN BURROUGHS AVE. NE SHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 695	date. Will have no skinfection through the Interventions- lari-tub daily, assist with course of Recare plans lacked do interventions to addruse of a lary-tube an 12/03/22. Review of the of an inshowed the facility of cassette HMEs and Further review of the entry "received [on] (Interventions to addruse of a lary-tube and Further review of the entry "received [on] (Interventions of the entry "received [on] (Interventions of the entry "received [on] (Interventions of the following: 02/22/22 at 9:30 AM February 8th, I email respiratory therapist] name lary-tubes and prior conversation shifted that she needed to keep the she (Employee #31) supplies. I gave her to (02/07/22). Checked Monday 02/14/22) arbelonging (Lary-tube (Employee #31) has items (lary-tubes and ASAP."	hea site through the review sx (signs/symptoms) of review date. be care daily, change HME gh as needed sident#3's comprehensive cumented evidence of ess care for Resident #3's d HME from 12/01/22 to nvoice dated 03/02/22 redered one box of 30 d laryngectomy (Lary) tube. invoice showed handwritten 03/03/22". The Resident #3's responsible 11 (Social Worker) showed -"On February 7th and ed [Employee #31's name-in reference to Resident #3's HME's being ordered. In the (Employee #31) stated throw the size of tube so that could order his (Resident #3) the information on the 7th back with her the following and she stated she order the	F	595		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		095019	B. WING _			C 04/20	/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER	'	STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		0 1120	<i></i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	ordered. I gave the n still hasn't received th #31's name- respirate February 7th of 2022 get back with me and are important necess in." 03/25/22 at 12:47 PM HME's and lary-tubes #3's name] back in Frequesting the invoice send me any and all to these invoices? During a telephone in AM, the resident's en (granddaughter) state lari-tube several time be replaced by the trecenter) center. She fit [Employee #31; respirand 02/08/22 size for and straps) but she n (Employee #31) a we said [Employee #31) a we said [Employee #7-C the supplies and she them." During a face-to-face 2:25 PM, Employee # stated, "We had a protime, and I told the re (Employee #31) and During a face-to-face approximately 2:00 PWorker) stated that Fermi	deeded information, and he hose supplies that [Employee ory therapist] ordered on an analysis of the supplies it is supplies it is to his current state he is it is supplies it is to his current state he is it is supplies on the sup	F6	595			8/24/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ ' '	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	Lary-tubes). During a telephone in PM, Employee #31 (F that Resident # 3 did to his lary-tube from "ordered and received When asked why it to to get the HME, Empl know the size of the r HMEs we had in hous the lary-tube his famil The employee then signanddaughter on 01/name of the lary-tube HME, but the granddatold me (granddaught important", and she did he lary-tube until 02/that she did call the reget the size of his lary call her back. Howeve (Administrator) and E Coordinator) aware m #3 did not have HMEs. It should be noted that in Treatment Administrator.	derview on 04/14/22 at 2:35 Respiratory Therapist) stated not a have HME to connect 1/01/08/22 to until they were 1/15 by the facility [03/03/22]". Took so long for Resident #3 loyee #31 said "I did not resident's lary-tube. And the se was not compatible with ly provided on 01/08/22." aid she reached out to the 1/12/22 or 01/13/22 to get the e so she could order an aughter said, "The doctor ter) that the HME is not 1/16 id not send me the size of 07/22." Employee #31 said resident's physician once to 1/2 tube once, but he did not er, she made Employee #1 mployee #7 (Clinical nultiple times that Resident s. at nursing staff documented tration Records that they is HME on the following	F 6	95		8/24/22
	However, it should be	e noted the invoiced provide				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	by the facility with ar showed the facility d 03/03/22, at which till During a face-to-face approximately 2:00 f (Admission Director) residents' medical sufacility before the resasked if Resident #3 ordered and in the facility admitted. It should b invoice the facility pr date of 03/02/22, which was not in the facility admitted.	n order date of 03/02/22 id not receive HMEs until me they received 30. e interview on 04/20/22 at	F	595		8/24/22
	respiratory equipment physician's orders and for the use of a "butto Status and failed to orgoals and approached HME for Resident #304 was a 10/17/2019 with diagonal Tracheostomy Statu Malignant Neoplasm Vascular Disease, M (Generalized), and Cand Mobility.	admitted to the facility on gnoses that included: s, Personal History of of Larynx, Peripheral				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019		V 20. 20. 20. 20. 20. 20. 20. 20. 20.
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE
F 695	for Mental Status (BI "15," indicating that to intact. Section G (Functional Daily Living (ADL) Attransfers, and person required extensive postaff member; and folimited physical assist member. Section O (Special Tour Programs): O0100 Sour Respiratory Treatmentherapy, suctioning, anumber of days this at least 15 minutes as was "0." A review of Resident revealed: 10/17/2019 [HospitalPMH (past medical with laryngectomy wow (15 years ago) Larung (status post) larynge Does not need O2 (continuity for the status post) and the status post of the status	Patterns), the Brief Interview MS) Summary Score was he resident was cognitively al Status) G0110 Activities of esistance: for bed mobility, hal hygiene, the resident hysical assistance from one reating the resident required etance from one staff	Fé	695		8/24/22
	valve. 11/30/2019 [Physicia	a replacement speaking n Orders]: omy kit is at resident bedside				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5000 NANNIE HELEN BURROUGHS WASHINGTON, DC 20019		0.120,2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT	DATE
F 695	3L/min continuously 11/30/2020 [Physicia set-up weekly every Change O2 tubing a PRN one time a day 02/18/2022 [Respira Resident alert and trach collar. Humidif dated. Voice prosthe secretion expectora 02/14/2022 [Physicia concentrator and air and PRN as needed 04/04/2022 [Physicia every shift to mainta (medical doctor/RP below (2% every shift According to the Ma Administration Reco in the designated sp	ian's Order]: "Oxygen at via trach mask every shift." an's Order]: Change trach Monday & PRN and humidifier bottle weekly & every [Monday] atory Therapy Assessment]: "d oriented in no distress on ication set-up changed and esis cleaned. Small tan ted." an's Order]:"Clean compressor filters weekly !.' an's Order]: "Check Spo2 in above 92%. Notify MD (representative) if noted ift."	F6	695	.vt)	8/24/22
	on 3/7/2022, 3/14/20 3/28/2022.; and they concentrator and air and PRN as needed 3/21/2022 and 3/28/ According to the App Administration Reco	022, 3/21/2022 and / cleaned [oxygen] compressor filters weekly I on 3/07/2022, 3/14/2022, 2022.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER DD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		0 1120/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA	
F 695	weekly and PRN one on 04/04/2022 and 04 [oxygen] concentrato weekly 04/04/2022 and 04 [oxygen] concentrato weekly 04/04/2022 and During a second-flood 12:31 AM, Resident from lying on his bed was receiving humiditubing connected to hand connected to a hwater that had oxyge end. The corrugated indicate when facility sterile water bottle had on 04/04/2022 at 3:3 interview with Employ (DON), she stated that the respiratory therap providing care to the currently had no respreported that the facil respiratory therapist (up after the last shift to 4:30 PM. When as trained to order trach equipment, adjust se positive airway press was done by the resp. She reported that she contacting an agency confirmed by the end that she would check	ing and humidifier bottle time a day every [Monday] 4/11/2022; and they cleaned or and air compressor filters and 04/11/2022. Tour on 04/04/2022 at 4304 was observed in his and watching television. He fied oxygen via corrugated his trach collar on one end himidifier bottle of sterile on filtered into it on the other tubing had no label to staff last changed it, and the hid a label dated 03/06/2022. O PM, during a face-to-face hie 42, Director of Nursing hat usually, the nurses and hist are responsible for hist and the hist	F	595		8/24/22

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OPLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. WASHINGTON, DC 20019	NE	
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F 695	at 4:18 PM, Resider his bed. The resider and was receiving he tubing and the humilabels dated 04/05/2 responsible for suct care, the resident storage of the resident storage of the resident storage out everything a few weeks." There was no evided the resident's bedsider and no evidence of uses to breathe outs to breathe outs the outs of the resident was to breathe outs of the resident was the oxygen tubing a labels from 04/05/20 concentrator was beconcentrator and the were dirty. On 04/18/2022 at 9 interview with Empleshe stated that Restracheostomy and described the stated that she with stoma care (clerespiratory therapist (trach collar, tubing, t	and interview on 04/07/2022 Int #304 was observed lying in a twas wearing a trach collar umidified oxygen. The oxygen dified oxygen bottle had 2022. When asked who is ioning and providing his trach ated, " I do not get suctioned. myself. I do not have a trach; I by with a valve. I use to keep my stoma moist and the respiratory therapist used the respiratory therapist used the per the physician's orders the resident's "button" that he	F 6	95		8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019		V :: 20:2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE 8/24/22
F 695	Manager/Registered of the observation, we responsible for clear resident's bedside, he were responsible. He resident's dirty oxygand said he would clear and said he would he said he orientation to the fact residents requiring rewould have to sched to determine what say explained that the clear and said he would not find his HM up. Through observation medical record, revier resident and staff into documented that the tubing and humidifier the concentrator and weekly, however the interview it was note. Also, through review record did not show HME for the resident.	AM, Employee #8 (Unit Nurse), present at the time when asked who was aling the concentrator at the responded the nurses a acknowledged the en concentrator and air filters ean them. The interview on 04/18/2022 at expect #42 (Newly hired est), he stated he was contract and he had just started he was not provided an illity and had just met the espiratory care. He said he had just met the espiratory care.	F	695		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLE	ETED
		095019	B. WING		04/2	0/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	D WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695 F 697 SS=D	provided to residents consistent with profes the comprehensive part and the residents' goard the resident of the facilities	agement. Ire that pain management is who require such services, sional standards of practice, erson-centered care plan, als and preferences. Is not met as evidenced ew and staff interview, for d residents, facility staff ain medication to Resident rith the physician's order; Resident #236's pain before (pain reliever). Is policy titled "Pain I March 2022, showed: In resident becomes a duty to monitor and assess as of pain, advocate for d meet our goal of keeping le as possibleMeeting a management; nursing staff is: symptoms of pain which nverbal gestures.	F 695		ain. 2 for ain.	8/24/22
	throbbing etc.)					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	I		S1 50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	U4 73	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	-Rating of Pin numeriuse of facial expressiseverityProvide non pharma or as requested by re-Medicate for pain -Monitor the effective through reassessment -Document nursing a intervention, behavior assessment; and resinterventions." 1. Facility staff failed medication to Reside the physician's order. Resident #118 was a 01/28/22 with diagnoral Alcohol Dependence Intertorchanteric Fract Use and History of Factor According to the Quanted 04/11/22, Under Score showed Reside "15" indicating that shunder Section E Behavior Under Section J Heal was coded for Pain a medication; Under Sepain intensity was 05 According to the physical should be precived over the physical of the physical should be precived on the physical should be precived by th	cally on a scale od 0-10 or on chart to determine pain cologic approach as needed esident. ness of pain medication of the seesment, nursing or of resident during pain ident response to to administer pain of the seesment of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility on sees that included, Insomnia, Hypertension, Displaced of the facility of the faci	F	697	IDENTIFICATION OF OTHERS WITH TO POTENTIAL TO BE AFFECTED: All residents residing in the facility have to potential to be affected by this practice. ADON. Clinical Care Coordinator, Chargenurses, Supervisors and Unit Managers conduct house wide audit to ensure that nurses are administering pain medication according to the physician's order and the residents are assessed for pain prior to a administering pain medications. Any issufound will be corrected by 8/21/22	the will the at	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY PLETED	
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DEANWO	OD REHABILITATION AN	D WELLNESS CENTER		WASHINGTON, DC 20019	•	
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F 697	pain level when he was medication on the following medicat	ry 2022 Medication d showed Resident #118's as administered the owing dates: ain Level = 1; ain Level =2; ain Level=3; ain Level =3; ain Level =0; ain Level =0; 2022 Medication d showed Resident #118's as administered the owing dates: ain Level = 2; ain Level =2; ain Level =2; ain Level =3; ain Level =0; 222 Medication d showed Resident #118's as administered the owing dates: ain Level = 0; 222 Medication d showed Resident #118's as administered the owing dates: ain Level = 0; 224 Medication d showed Resident #118's as administered the owing dates: ain Level = 0; 255 According to the side of the side o	F 69	In- service will be provided by Staff team / Designee to all licensed nursensure that they assess residents fand after administration of pain me that the medication is administered physician's order and outcome of indocumented by 8/24/2022. Unit Mangers will conduct rounds of during their shift to ensure that the assessing residents for pain, pre are administration of pain medication amedications are administered accomplysician order. Any issues found addressed by 8/24/22. Supervisors will audit weekly to ensure the area assessing residents befadministering pain medication and medication is administered per phy Any issues found will be corrected.	Development sing staff to or pain before dication and according to nedication In their units nurses are not post not that pain rding to the will be sure that ore that the sician's order.	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 697	on 04/11/22 at approstated, " I believe the the effectiveness of forgot to document the 2. Facility staff failed pain before administ Resident #236 was a 10/01/21, with the fo Unspecified Cirrhosic Cervical Region, Oth Displaced Fracture of and Sequela. Review of the Quarte (MDS) dated 03/16/2 In section C (Cogniti for Mental Status Sucoded by facility staff cognition. In section J (Health of Management "At any the resident?" "Recemedication regimen?" "Received PRN pain and declined?" Facility J0200 "Should a pain conducted?" Facility	e interview with Employee #7 eximately 1:30 PM, He enurses were documenting the pain medication and he initial pain level." to assess Resident # 236's tering Tylenol. admitted to the facility on llowing diagnoses: s of Liver, Fusion of Spine, her Chronic Pain, and Other of Sixth Cervical Vertebra, erly Minimum Data Set 22 revealed: ve Patterns) Brief Interview mmary Score of "15" was f and indicates intact Conditions): J0100 Pain of time in the last 5 days has ived scheduled pain of Facility staff coded "0" No" medication or was offered ity staff coded "0" No." n assessment interview be	F	697	MONITORING CORRECTIVE ACTION DON/ Designee will conduct house with audit to ensure that nurses are assess residents before and after administer medication and that the medications administered according to the physicial order. This audit will be conducted weekly with a conducted weekly with a conducted weekly with a conducted weekly and reported to QAPI Committee.	ide sing ng pain are an's	8/24/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING			C 04/20/2022	
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F 697	potential for alteratio immobility, neck and revised on 10/05/21, pain medication as p orders and note the of pain on patient sursymptoms, sleep, ap relationships with oth concentrate etc. Eva signs/symptoms i.e. severity, contributing characteristics intens/relieving factor. Give breakthrough pain as effectiveness." Review of the physic following: 03/14/22- "Tylenol Taby mouth every 6 ho (1-3)" 03/14/22- "Pain relied 4% Lidocaine Apply morning for pain for thours." During an observation at approximately 12:: (Registered Nurse) with medications to Reside Employee for someth administered the Accassess the resident's moderate, severe). To	lan with a focus area of: " in in comfort/pain related to bilateral shoulder pain" " interventions: "Administer er MD (medical doctor) effectiveness. Assess effects ch as accompanying petite, physical activity, hers, emotion's ability to luate for and report pain exact location, character, factors Evaluate pain sity, location, precipitating e PRN medications for s per MD orders and note the ablet 325 mg Give 2 tablets urs as needed for mild pain If maximum strength patch to left deltoid topically in the 15 days and remove after 12 In and interview on 03/29/22 20 PM, Employee #37 vas administering lent #236 when he asked the hing for pain. Employee #37 vas administering lent #236 when he asked the hing for pain. Employee #37 vas and lotevel (such as mild, The surveyor asked he did not assess the	F	697			8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	D WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 698 SS=E	#236's pain level and Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensurequire dialysis received with professional star comprehensive personal star communication form collaboration between contained pertinent in resident care) was compedical record as paran emergency kit (presonal star comprehensive personal star contained pertinent in resident care) was compedical record as paran emergency kit (presonal star contained pertinent in resident who had dialysis access site. Figure 1. Facility staff failed communication form collaboration between staff was included as medical record. Resident #61 was ad 11/06/20 with multiple Diabetes Mellitus, Ch	e did nto assess Resident stated, "No, I didn't ask." are that residents who re such services, consistent adards of practice, the in-centered care plan, and not preferences. is not met as evidenced in, record review and staff of 105 sampled residents, (1) ensure the dialysis (used to reflect ongoing in the facility and dialysis staff formation that reflected the impleted and included in the it of the record and (2) have essure bandage) at bedside an arteriovenous graft Residents' #61, #95, #181, to ensure the dialysis used to reflect ongoing in the facility staff and dialysis part of Resident #61's	F 6		CORRECTIVE ACTIONS FOR THE AFFECTED RESIDENTS: Resident #61 was assessed from hear on 4/26/22 by Unit Manager. Resident suffered no negative outcomes. MD/R notified on 4/26/22.Dialysis communics slip will reflect ongoing collaboration be nursing and dialysis staff by 8/24/22 Resident #95 was assessed from hear by Unit Manager on 4/26/2022. Resident suffered no negative outcom MD/RP notified on 4/26/22. Dialysis Communication slip will be placed in residents' chart immediately but no late 8/24/22. Resident #181 was assessed from hear toe by Unit Manager on 4/26/2022. Resident suffered no negative outcom RP notified on 4/26/22 Dialysis kit will placed at resident's bedside immediated no later than 8/24/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/22. Resident # 182 was assessed from hear toe by Unit Manager ON 4/26/20 was assessed from hear toe by Unit Manager ON 4/26/20 was discharged	t P P P P P P P P P P P P P P P P P P P	8/24/22

		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
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F 698	Hypertension, Periph Kidney failure, Syster syndrome, and Anxie Physician orders date "Dialysis days remain Thursday, and Sature Dialysis appointment A review of Resident January 1, 2022, to Nothe resident dialysis not included as part or record. Observation made or dialysis communication record for the second-floor uplaced in the same birecords [medical and were being maintained in the resident's medical in a separate binder a resident that goes to During a face-to-face 04/14/22, at approxin Employee # 8 (Nurse acknowledged the fin	eral Vascular Disease, Acute mic Inflammatory response ty. ed 03/28/22 directed, at the same Tuesday, day everyday shift for ESRD" #61's medical records from March 23, 2022, showed that record for communication center and the facility was of the resident medical 10 04/14/22, at 9:10 AM of the con record is that it was in a all the residents that go to con records. All dispose residents in the way of the communication mentioned and separately [not contained and separately [not contained and separately [not contained and separately included in all record but was maintained along with all the other dialysis information. Interview conducted on mately 1:15 PM with Manager), He	F	698	F 698 IDENTIFICATION OF OTHER WITH THE POTENTIAL TO BE AFFECTED: Dialysis residents residing in the fact have the potential to be affected, Charge Nurses, Supervisor / Design conduct house wide audit to ensure dialysis communication slips are completed correctly, that there is a ciplan indicating that resident has diag for ESRD on HD, and that there is a dialysis emergency kit at bed side. A ensure that dialysis communication are placed in the resident's medical records. Any issues found will be corrected by 8/24/22.	ee will that are gnosis	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	20/2022
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
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F 698	collaboration between was completed with president's care and pleased medical record as a president #95 was ad 02/11/22 with multiple End-stage Renal Dise Hyperlipidemia, Gasti Disease, Major Depresident March 1, 2022, to Appresident dialysis record to the technique of the technique of the technique of the technique of the second-floor uplaced in the same birecords [medical and were being maintaine in the resident's medical showed that the follow	used to reflect ongoing in the facility and dialysis staff itertinent information for the aced in Resident #95's part of the record. mitted to the facility on diagnoses including ease, Anemia, Hypertension, roesophageal Reflux essive Disorder, and Anxiety. an order dated 02/14/22 anday, Wednesday, Fridays," #95's medical records from fil 5, 2022, showed that the red for communication center and the facility was fif the resident medical 104/14/22, at 9:15 AM of the on record is that it was in a fall the residents that go to on records. All dis for all dialysis residents nits were observed to be nder indicating that both communication] mentioned disparately [not contained cal record]. communication records wing documentation of for the resident care was left intioned in the	F	698	MEASURES TO PREVENT RECURING In -service will be provided by Staff Educator / Designee to all licensed in staff, on the importance to ensure the dialysis communication slips are compaccurately, and that the communication are placed in the resident's medical medical medical in the resident's medical medical in the resident's clinical recordent of the month. Any issues found waddressed by 8/24/22 Licensed staff nursing will ensure we there is a dialysis emergency kit at befor the dialysis residents assigned to Any issues found will be addressed by 8/24/22 Charge Nurses will ensure that they form the dialysis treatment on reside dialysis day. Any issues found will be corrected by 8/24/22. Unit Managers will audit dialysis communication booklet weekly to ensure the nurses are completing the form of Any issues found will be corrected by In service will be provided by staff ed to C N A, Licensed nurses, on the importance of always keeping dialysis emergency kit at bedside.	ursing to the pleted on slips ecord by lat s are I at the vill be lekly that edside them. Yully slip prent's sure that orrectly. 8/24/22 ucator	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C				
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019					
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F 698	"Date on communical assessment time, and before dialysis" "03/02/22, 03/04/22, assessment time, and before dialysis" "03/09/22, time the residence dialysis" "03/11/22, 03/14/22, assessment time, and before dialysis" "03/21/22, Predialysis and time the resident day of dialysis" "03/23/22, code statuday of dialysis, Predialysis aresident eats before of "03/28/22 Postdialysis aresident eats before of "03/28/22 Postdialysis assessment vital sign" "03/30/22, time the resident dialysis, post-dialysis assessment vital sign" "04/01/22 was medicidialysis, post-dialysis assessment eats before of the evidence showed the ev	tion record and Predialysis detime the resident eats 03/07/22 Predialysis detime the resident eats esident eats before dialysis detime the resident eats 03/16/22 Predialysis detime the resident eats and Post assessment time, eats before dialysis so, was medication given the day of essessment time, time dialysis so time and completion is so time and c	F6	698	Unit manager will ensure that resident emergency dialysis kit is at bedside. Fi will be addressed by 8/24/22 Unit manager will ensure that resident dialysis communication slip is filled out correctly to indicate medication adminisprior to dialysis, assessment of the active and time the resident left the unit. Findings will be corrected by 8/24/22 Charge nurse will ensure that resident dialysis communication slip is complete is part of the resident's clinical record. Findings will be corrected by 8/24/22 Charge nurses will also ensure that the indicated on the communication slip if the resident at the before leaving for dialysis their shift. Findings will be corrected by 8/24/22.	#182 stered cesses #61.s ed and ey he during	8/24/22		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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F 698	Continued From page	e 271	F 6	598	MONITORING CORRECTIVE ACTI	ONS:	8/24/22	
were being complete resident's medical re		d and placed in the cord as part of the record.			DON/ Designee will conduct an audi all dialysis communication booklets ensure that the dialysis communicat slips are completed accurately, that	o on		
	During a face-to-face interview conducted on 04/14/22, at approximately 1:15 PM with Employee # 8 (Nurse Manager), He acknowledged the findings 3. Facility staff failed to have an emergency kit at the bedside of Resident #181 who has an arteriovenous (AV) graft used for hemodialysis graft site.			is an emergency kit at resident's becand that the communication slips are placed in the resident's medical recording exercise will be conducted wee then monthly x3. Findings will be	lside e rd. kly x4			
				corrected immediately and reported QAPI committee.	10			
		ent #181's nightstand, and dresser revealed that ave an emergency kit						
		dmitted to the facility on e diagnoses including End						
		n order dated 12/27/21 ialysis AV graft site for bruit						
	Minimum Data Set da following: Section C (Brief Inter Score)- the resident indicating the resider interview. Section I (Active Diagcoded for Renal Insurend-Stage Renal Dis Section O (Special Tri	tion of Medicare 5-Day ated 03/22/22 showed the view Mental Summary had a summary score of "99" It was unable to finish the gnoses) The resident was fficiency, Renal Failure or ease reatment, Procedures, and ent was coded for receiving						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		095019	B. WING			C 4/20/2022		
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019		-1/20/2022		
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F 698	Review of care plan 05/31/21 showed the Focus Area-[residen (hemodialysis) r/t (rerenal disease) 3 time Thursdays, and Satu During a face-to-face approximately 4:05 fistated that the reside room and the kit migroom. It should be not Employee #32 obseroom and no kit was 4. Facility staff failed communication form collaboration between was completed with resident's care and predical record as a Resident #182 was a 11/30/21 with multipl Diabetes Mellitus, Hyllepatitis C, Anemia Failure. Reviewed physician directed, "Dialysis: T Saturdays, every day resident dialysis records."	with a revision date of e following: It's name] need dialysis stated to) ESRD (end-stage es/week on Tuesdays, ardays. It interview on 03/29/22 at PM, Employee #32 (LPN) ent recently moved to the ht have been left in the old otted the surveyor and reved the resident's previous found. It o ensure that the dialysis used to reflect ongoing en the facility and dialysis staff pertinent information for the olaced in Resident #182 part of the record. Indicated to the facility on the diagnoses including experipidemia, Chronic Viral and Hypertension, and Heart Indicated to diagnoses including experipidemia, Chronic Viral and Hypertension, and Heart Indicated to the diagnoses including experipidemia, Chronic Viral and Hypertension, and Heart	F 69	98		8/24/22		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				(X3) DATE SURVEY COMPLETED	
	095019	B. WING _			04/2	0/2022	
	ND WELLNESS CENTER						
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not included as part record. Observation made of dialysis communication folder that contained dialysis communication records for the second-floor of placed in the same be records [medical and were being maintained in the resident's medical and were being maintained in the resident's medical and were being maintained in the resident's medical showed that the follopertinent information blank on the date medical communication record "Date on communication record "Date on communication record dialysis, Predialysis at time, access location time" "03/05/22 was medical dialysis, Predialysis at time, access location time" "03/05/22 was medical dialysis, Predialysis at time, access location time" "03/07/22 "access location" "03/07/22 "access location"	of the resident medical n 04/14/22, at 9:25 AM of the on record is that it was in a all the residents that go to on records. All reds for all dialysis residents units were observed to be sinder indicating that both I communication] mentioned ed separately [not contained dical record]. communication records wing documentation of for the resident care was left entioned in the red. attion record and Predialysis d time the resident eats cation given the day of assessment vital sign and an post-dialysis assessment cation given the day of assessment time" cation"	F	698			8/24/22	
	cation given the day of						
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR RE	CORRECTION Dentification number: 095019 ROVIDER OR SUPPLIER DD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 273 not included as part of the resident medical record. Observation made on 04/14/22, at 9:25 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record]. Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the communication record. "Date on communication record and Predialysis assessment time, and time the resident eats before dialysis" "03/03/22 was medication given the day of dialysis, Predialysis assessment vital sign and time, access location, post-dialysis assessment time" "03/05/22 was medication given the day of dialysis, Predialysis assessment time, and time the resident eats before dialysis assessment time, time the resident eats before dialysis assessment time, time the resident eats before dialysis, post-dialysis	CORRECTION O95019 B. WING_ ROVIDER OR SUPPLIER DD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 273 not included as part of the resident medical record. Observation made on 04/14/22, at 9:25 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. 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"Date on communication record and Predialysis assessment time, and time the resident eats before dialysis" "03/03/22 was medication given the day of dialysis, Predialysis assessment vital sign and time, access location, post-dialysis assessment time" "03/05/22 was medication given the day of dialysis, Predialysis assessment time" "03/07/22 "access location" "03/11/22 Predialysis assessment time, time the resident eats before dialysis, post-dialysis assessment time"	ROVIDER OR SUPPLIER DO REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 273 not included as part of the resident medical record. Observation made on 04/14/22, at 9:25 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication record is that it was in a for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident's medical record]. Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the communication record and Predialysis assessment time, and time the resident eats before dialysis, Predialysis assessment vital sign and time, access location, post-dialysis assessment time" "03/03/02/22 was medication given the day of dialysis, Predialysis assessment time" "03/07/22 "access location" "03/07/22 "access location" "03/11/22 Predialysis assessment time, time the resident eats before dialysis, post-dialysis assessment time"	CONTINUED TO THE PROPERTY OF DEPTICENCIES SUMMANY STATEMENT OF DEPTICENCIES SOON NAMINE HELEN BURROUGHS AVE. NE WASHINGTON, DC 2019 SUMMANY STATEMENT OF DEPTICENCIES SOON NAMINE HELEN BURROUGHS AVE. NE WASHINGTON, DC 2019 SUMMANY STATEMENT OF DEPTICENCIES SOON NAMINE HELEN BURROUGHS AVE. NE WASHINGTON, DC 2019 CONTINUED FROM THE PROPERTY OF DEPTICENCIES SOON NAMINE HELEN BURROUGHS AVE. NE WASHINGTON, DC 2019 PROVIDERS PLAN DF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA	COMPLICATION NUMBER: 095019 B WING STREET ADDRESS, CITY, STATE, ZIP CODE SUMMANY STATEMENT OF DEPICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY MUST DE PROVIDERS BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 273 not included as part of the resident medical record. Observation made on 04/14/22, at 9:25 AM of the dialysis communication record is that it was in a folder that contained all the residents that go to dialysis communication records. All communication records for all dialysis residents for the second-floor units were observed to be placed in the same binder indicating that both records [medical and communication] mentioned were being maintained separately [not contained in the resident record]. Further review of the communication records showed that the following documentation of pertinent information for the resident care was left blank on the date mentioned in the communication record and Predialysis assessment time, and time the resident eats before dialysis. Predialysis assessment time, and time the resident teats before dialysis, post-dialysis assessment time. "03/07/22" was medication given the day of dialysis, Predialysis assessment time." "03/07/22" access location given the day of dialysis, Predialysis assessment time." "03/07/22" access location given the day of dialysis, Predialysis assessment time." "03/07/22" access location given the day of dialysis, Predialysis assessment time."	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		DATE SURVEY COMPLETED	
		095019	B. WING			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		0412012022
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F 698	dialysis, Predialysis noted or resident co "03/15/22 was med dialysis, Predialysis time, access location before dialysis, curr Problem noted or resident eats before esident eats befor esident eats befor resident complaint time, nurse signature "03/22/22 was med dialysis, Predialysis time, time resident edialysis assessmen "03/23/22 was med dialysis, Predialysis time, time resident edialysis assessmen "03/23/22 was med dialysis, Predialysis time, time resident edialysis assessmen "03/26/22, time the Problem noted or repost-dialysis assessmen "03/26/22, time the Problem noted or repost-dialysis assessmen "03/26/22, time the Problem noted or resident's medical resident's m	assessment time, Problem omplaint" ication given the day of assessment vital signs and in, time the resident eats ent diet and supplements, esident complaint" ication given the day of assessment and time, time affore dialysis, Problem noted int, post-dialysis assessment eats before dialysis, Post and time, nurse signature" ication given the day of Vital signs and assessment eats before dialysis, Post and time, nurse signature" ication given the day of Vital signs and assessment eats before dialysis, Post and time, nurse signature" ication given the day of Vital signs and assessment eats before dialysis, Post and time, nurse signature" ication given the day of Vital signs and assessment eats before dialysis, Post and time, nurse signature" ication given the day of Vital signs and assessment eats before dialysis, esident complaint and sment vital signs time" eet that the facility staff failed dialysis communication forms ed and placed in the ecord as part of the record. ice interview conducted on imately 1:15 PM with se Manager), he	F 6	98		8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	. ,	COMPLETED		
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019		V 1/23/2322	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 698	communication for collaboration betwee was completed and medical record as a Resident #502 was 03/17/22 with multi End-stage Renal D Pancreatitis, Chron Peripheral Vascula Cirrhosis of the Live Review of the Physic directed, "Dialysis: every day shift eve A review of Reside March 1, 2022, to A resident dialysis rebetween the dialysis	d to ensure that the dialysis in used to reflect ongoing sen the facility and dialysis staff diplaced in Resident #502's a part of the record. Admitted to the facility on ple diagnoses including isease, Anemia, Chronic ic Viral Hep-C, Hypertension, in Disease, Hyperlipidemia, and er. Sician order dated 03/17/22 Tuesday, Thursday, Saturday,	F6	98		8/24/22	
	of the dialysis comin a folder that confit to dialysis communication recommunication recommunication recommunication the second-floor placed in the same records [medical arwere being maintai in the resident's medical that the following placed in the same records [medical arwere being maintai in the resident's medical that the following placed in the same records [medical arwere being maintai in the resident's medical arwere being maintai in the resident's medical arwere placed in the same records [medical arwere placed in the same records are records a	ords for all dialysis residents r units were observed to be binder indicating that both and communication] mentioned ned separately [not contained edical record]. The communication records lowing documentation of on for the resident care was left					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION ING		(X3) DATE S		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	I	(X5) COMPLETION DATE
F 698	location, and time the dialysis" "03/24/22 was medic dialysis, Predialysis a dialysis assessment, "03/26/22 was medic dialysis, Predialysis assessment and resident status" "03/29/22 Postdialysis and resident status" "03/31/22 was medic dialysis, Predialysis a dialysis assessment in	assessment time, access resident eats before ation given the day of assessment time and Post nurses signature" ation given the day of assessment time returned ation given the day of assessment time returned	F	698			8/24/22
F 726 SS=D	to ensure that the dia were being complete resident's medical reconstruction of the diagram of t	interview conducted on nately 1:15 PM with Manager), He dings.	F	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			1	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NI WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 726	well-being of each re resident assessments and considering the rediagnoses of the faciliaccordance with the at §483.70(e). §483.35(a)(3) The facilicensed nurses have and skill sets necessineeds, as identified the assessments, and defect with the facility must ensite to demonstrate complete to resident's needs. §483.35(c) Proficience The facility must ensite to demonstrate complete chniques necessarineeds, as identified the assessments, and defect the facility must ensite to demonstrate complete chniques necessarineeds, as identified the assessments, and defect the facility nursing staff with the and skills sets to provide the facility nursing staff with the and skills sets to provide the facility nursing staff with the and skills sets to provide the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility how to administer Tick Inhaler for Resident #404's intruresident-to resident assessments and the facility has the facility how to a facilit	sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required cility must ensure that the specific competencies ary to care for residents' arough resident escribed in the plan of care. In g care includes but is not evaluating, planning and at care plans and responding are that nurse aides are able etency in skills and at to care for residents' arough resident escribed in the plan of care. In the plan of care are that nurse aides are able etency in skills and are to care for residents' arough resident escribed in the plan of care. It is not met as evidenced ans, record reviews and staff a staff failed to have sufficient appropriate competencies aride nursing and related sident safety as evidence by	F7	726	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 56 was assessed from he toe by Unit Manager on 4/26/2022. Resident suffered a hematoma on the side of her forehead. X ray ordered a resident medicated for pain. MD/RP notified on 4/26/22. Changes will be non residents' active clinical record by 8/24/22 Resident #181 was assessed from he toe on 4/26 4/26/22. Resident is receiving her informedication correctly. Resident # 404 was sent to the hosp 2/21/22 and expired.	ne left and made y nead to	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING				20/2022	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022	
	OD REHABILITATION AN	D WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019					
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F 726	the first day of survey The findings include: Policy Title: "Correctic Records" revised 03/2 "Procedure and Imp Whenever there is an observed in resident(chart. The facility will The medical staff or of in the resident electro strike the error in doc document the reason being strike and sign After striking the error record of the resident staff will right an adde documentation if it is If the error in docume resident(s) paper med or clinical staff who m across the error, the st the correction and ad crossed out. After the paper error above, the medical st an addendum for corn needed or appropriate 1. Facility staff failed make changes in the clinical record. During a review of the approximately 5:35 P notes dated 04/06/22 was observed outside	on in Resident Medical 2022 documented, olementation-error or multiple errors of medical records or clinical proceed as follows: dinical staff that made error onic medical record must umentation, and then why the documentation in and save. In the electronic medical, the medical staff or clinical endum for correct needed or appropriate. Intation occurred in dical chart, the medical staff ade error will draw a line staff will add his/her initial to define the date the error is the saff or clinical staff will write erect documentation if it is e"	F7	726	IDENTIFICATION OF OTHERS WITHE POTENTIAL TO BE AFFECTE All residents in the facility have the potential to be affected by this pract Clinical Care Coordinator, DON and Managers will conduct house wide a ensure that the nurses are administ inhalers correctly to the residents. A issues found will be addressed by 8 Also, they will ensure that licensed rare competent in administering medications via inhaler and underst how to address resident with intrusive behavior. Any issues found will be addressed by 8/24/22. The clinical team will also ensure the changes to a resident's active clinical records are updated as indicated. Any issues found will be addressed 8/24/22.	ice. I Unit audit to ering any /24/22. nurses and we	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		4/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 726	was observed with her forehead. Wher informed the staff th something off the flusheelchair" However, upon revinotes on 04/08/22 a information related recorded, "On 4/6/2 Security [Employee patio when she obsuddenly rolling into chased after the whresident ran into a couring interview, 'M rolling from the built unable to stop it and the county of	a hematoma to the left side of a sked what occurred, she hat she was attempting to get for and slid out of her ew of the nursing progress at 9:56 AM the following to the resident's incident was 2022 at 18:37 read, "The #46] was coming from the erved resident's wheelchair to the parking lot. The Security heelchair and resident, but car and fell. Resident said by wheelchair suddenly started ding into the parking lot, I was do into a car and hit my head." The interview with Employee #7 as AM, he stated, with the was trying to document what I was trying to document the ence that when facility staff as documentation in Resident record that it was done in	F 7	In-service will be provide Educator/ Designee on ensure that proper train nurses and a competer completed and signed Training will be provide nurses on how to admininalers. Return demorequired to validate und #45 on 3/29/22 on how medication via inhaler to demonstration indicate effective. Unit Managers /superv licensed nurses on the ensure that they are acmedication correctly. A corrected by 8/24/22. Unit manager will obse he/she administer med resident #181. Findings 8/24/22	ded by DON to Staff in the importance to ning is provided to all ncy check list is by 8/24/22 and to all Licensed inister medication via instration will be derstanding by 8/24/22 as provided to employed to administer to the residents. Returned that training was risors will monitor in units weekly to dministering inhaler any issues will be arve employee as lication via inhaler to	2 ee

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, D.C. 2019	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019 PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OBFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION CONNELTON DATE DEFICIENCY			005040	B WING				-	
DEANWOOD REHABILITATION AND WELLNESS CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 726 Continued From page 280 During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. It should be noted the resident resident resident resident #181. It should be noted the resident resident resident resident resident resident resident resident or Resident res			095019	B. WING _			04/	20/2022	
CAJID SUMMARY STATEMENT OF DEFICIENCIES DEFICE PROFILE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. F 726 Continued From page 280 F 726 Supervisors will conduct rounds weekly observing nurses as they administer on on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor. Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). Review of the Medication Administration Record for March 2022 revealed that the following: Tiotropium Bromide Administration Record for March 2022 revealed that the following: Tiotropium Bromide Administration Record for March 2022 revealed that the following: Tiotropium Bromide Administration Record for March 2022 revealed that the following: Tiotropium Bromide Administration Record for March 2022 revealed that the following: Tiotropium Bromide Administration Record for March 2022 revealed that the following: Tiotropium Bromide Monohydrate Aerosol Sultino 2.5mcg/microgram/jact 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease).	NAME OF P	ROVIDER OR SUPPLIER				, , ,			
Summary Statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG	DEANWO	OD REHABILITATION	AND WELLNESS CENTER						
F 726 Continued From page 280 During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the resident received the medication (inhaler) in the presence of the unit manager and surveyor. Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). PREFIX TAG Supervisors will conduct rounds weekly observing nurses as they administer medication via inhaler to ensure the process is done correctly. Any issues found will be corrected by 8/24/22. In-service will be provided to all Licensed nurses by staff educator/ Designee on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all licensed nurses, C N A, Rehab staff, housekeeping staff by staff educator on the importance of monitoring residents with intrusive behavior on the units every shift. DON/Designee will audit charts of residents with intrusive behavior weekly and ensure that interventions are implemented by the nurses and CAN'S to ensure safety to resident and others. Will also ensure that the care plans for residents					W	VASHINGTON, DC 20019			
F 726 Continued From page 280 During a medication administration observation on 03/29/22 starting at 11:24 AM, Employee #45 (RN) was observed administering medications to Resident #181. When asked why she did not administer the resident's Tiotropium Bromide Aerosol Inhaler. The employee stated, "I'm waiting for the unit manager (Employee #43) to come and show me how to do it. I don't know how to administer that type of inhaler." Employee #43 (RN-Unit Manager) came to the unit and instructed Employee #45 how to administer the inhaler for Resident #181. It should be noted the resident received the medication (inhaler) in the presence of the unit manager and surveyor. Review of a physician order dated 03/18/22 instructed, Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day for COPD (Chronic Obstructive Pulmonary Disease). Review of the Medication Administration Record for March 2022 revealed that the following: Tietropium Bromide Monohydrate Aerosol. Review of the Medication Administration Record for March 2022 revealed that the following: Tietropium Bromide Monohydrate Aerosol. F 726 F 726 F 726 F 726 In-service will be provided to all Licensed nurses by staff educator/ Designee on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all Licensed nurses by staff educator on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all Licensed nurses by staff educator on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all Licensed nurses by staff educator on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all Licensed nurses by staff educator on the importance of updating a resident's active clinical records by 8/24/22. In service will be provided to all Licensed nurses by staff educator on the importance of updating a resident's	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION DATE	
Solution 2.5mcg(microgram)/act 2 spay inhale orally one time a day (9:00 AM) for COPD (Chronic Obstructive Pulmonary Disease) start date 03/18/2022. Employee #45 signed her initials indicating that she administered Resident #181 Tiotropium Bromide Monohydrate Aerosol Solution 2.5mcg(microgram)/act 2 spay inhale orally at 9:00 AM on 03/18/22, 03/21/22-3/24/22, and 03/26/22 - 03/28/22. Review of Treatment Administration Record and Vital Summary sheet documented that Resident	F 726	During a medication on 03/29/22 starting (RN) was observed Resident #181. Wh administer the resic Aerosol Inhaler. The waiting for the unit come and show me to administer that ty (RN-Unit Manager) instructed Employe inhaler for Resident resident received the presence of the unit Review of a physici instructed, Tiotropiu Aerosol Solution 2.1 inhale orally one tin Obstructive Pulmor Review of the Medi for March 2022 reventiotropium Bromide Solution 2.5mcg(mi orally one time a data (Chronic Obstructive date 03/18/2022. Employee #45 sign she administered Reromide Monohydrom 2.5mcg(microgram) 9:00 AM on 03/18/203/26/22 - 03/28/22	n administration observation g at 11:24 AM, Employee #45 administering medications to en asked why she did not dent's Tiotropium Bromide e employee stated, "I'm manager (Employee #43) to e how to do it. I don't know how ype of inhaler." Employee #43 came to the unit and e #45 how to administer the it #181. It should be noted the ne medication (inhaler) in the it manager and surveyor. an order dated 03/18/22 am Bromide Monohydrate 5mcg(microgram)/act 2 spay ne a day for COPD (Chronic nary Disease). cation Administration Record ealed that the following: e Monohydrate Aerosol crogram)/act 2 spay inhale ay (9:00 AM) for COPD e Pulmonary Disease) start ed her initials indicating that tesident #181 Tiotropium ate Aerosol Solution b/act 2 spay inhale orally at 22, 03/21/22-3/24/22, and c. ont Administration Record and	F 7	726	observing nurses as they administer medication via inhaler to ensure the prodone correctly. Any issues found will be corrected by 8/24/22. In-service will be provided to all Licens nurses by staff educator/ Designee on importance of updating a resident's act clinical records by 8/24/22. In service will be provided to all license nurses, C N A, Rehab staff, housekeep staff by staff educator on the importance monitoring residents with intrusive behathe units every shift. DON/Designee will audit charts of residintrusive behavior weekly and ensure the interventions are implemented by the nuclear CAN'S to ensure safety to resident and Will also ensure that the care plans for two have intrusive behavior (wandering) revised/ updated. Findings will be correctly also behavior weekly that remployees have completed their nursing competency skill check list and are abled demonstrate what they have studied. Facarry out return demonstration of medicadministration will result to reeducation	ents with at urses and others. esidents are cted by	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE		04/20/2022	
				5000 NANNIE HELEN BURROUGHS AVE. N	E		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 726	and respiration rate rabreaths per minute from During a face-to-face approximately 11:45 at that 03/29/22 was the	tion rate ranged from rom 03/18/22 to 03/21/22 anged from 17 to 20 om 03/18/22 to 03/24/22. interview on 03/29/22 at AM, Employee #45 stated of first time she administered	F 7	Staff educator will ensure that new nurses are well trained on how to ac residents with intrusive behavior, who resident is exhibiting intrusive behavior what documentation need to be in particles. Findings will be addressed by 8/24/2 DON/ Designee will monitor licensed assist in validating the completion of medication administration check list	ddress hat to do it vior and blace. 22. d nurse ar f the during		
	because she did not lead to the When ask why did she administered prior to an error." The employ not make anyone away administer that type of	03/29/22? She said, "It was ree also stated that she did are she did not know how to f inhaler.		orientation Paying close attention to administering medication vis inhaler will be corrected by 8/24/22. Unit manager will ensure that corrected the care plan id updated to reflect the made.by 8/24/22. Unit manager/designee will ensure the care plan id updated to reflect the made.by 8/24/22.	: Findings ctions on ted and the ne change	nat es	
	3. Facility staff failed to demonstrate competent nursing skills sets to assure resident safety as evidenced by failure to address Resident #404's intrusive behavior which led to an altercation that resulted in serious injury to Resident #404.			are completing incident reports for in residents correctly and that they mu where and when the incident took p those involved in the incident. Findir corrected by 8/2422	ntrusive st indicate lace and	e	
	02/23/22, documente observed [Resident 4 besides his roommate nurse noticed blood of and mouth. The nurse #404's] left ear and metear or abrasion inclue #82] was interviewed coming over to my behim to go back to his me on my stomach at on the chin and he fel	outh and there was no skin ding his face [Resident he said, "that man keeps d side and when I asked side of the bed, he punched nd chest and I punched him I"		In service will be provided to all licer on how to correct a documented err Coaching and counselling will be prourses who are not in compliance with medication administration by staff error of the compliance with the control of the	or by 8/9/2 ovided to rith		
		nt dated 03/26/22 y is hoping for answers after was brutally beaten at a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019		V 11-0/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 726	Name] in an interver #404] was attacked with Name]. [Resident #4 March 20 (2022)" Review of a Complait documented, "Avo Patient assaulted in was assaulted 02/22 facility by another resident trauma with ble and mouth. He was thospital and later die die Resident #404 was a 12/06/16 with diagnount Unspecified Dement Disturbances, Vascu Behavioral Disturbances, V	District. [Representative's riew that his father [Resident while living at the [Facility 04] died from his injuries on int dated 03/31/22 idable death. Comments: nursing home. Beneficiary 7/2022 in skilled nursing sident. He sustained blunt reding noted on his left ear transferred to an acute ad" Admitted to the facility on reses that included: it without Behavioral lar Dementia without rices and Transient Cerebral red to a partition at reat stated, " Updated on List of Residents for Daily red to Residents for Daily red traits confusion, and, sleeping in other peoples without stated as the property of the	F7	MONITORING CORRECTIVE A DON/Designee will conduct rance ensure that nurses are administration and signed by the nurses. This a conducted weekly x4, then mont will be corrected immediately an QAPI committee	dom rounds t ering medica mpetency ch- is complete audit will be thly x3. Findii	ntion eck d ngs	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 726	In Section E (Behavior psychosis, no physical directed towards other pushing, scratching, sexually), verbal behavior towards others (e.g., screaming at others, "1 to 3 days", wander daily" In Section G (Function (how resident walks be room), "Supervision vassist" and no function motion In Section P (Restrain wander/elopement all wander/elopement all wander/elopement all wander/elopement all wander unit on 5 adjacent unit on 5 adjacent unit on 7/3/2 Wandering to the adjacent unit on 7/3/2 Wandering to the adjacent unit on 5 adjacent unit on 6 adjacent unit on 6 adjacent unit on 7/3/2 Wandering to the adjacent unit on 6 adjacent unit on 8 adjacent unit on 8 adjacent unit on 9 adjacent unit on 8 adjacent unit on 9 adjacent uni	or), no potential indicators of all behavioral symptoms ars (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred ing behaviors "occurred ing behaviors "occurred ing behaviors "occurred ing behaviors "occurred in all Status), walk in room between locations in his/her with one person physical anal limitation in range of ints and Alarms), arm, "Used daily" (Revision date) ["Resident pement: cognitive a Observed wondering at 6/28/2021. Wandering to the 21. Redirected easily. accent unit on 6/8/2021. Indering on 7/11/2021. In the adjacent unit irected Avoid leaving erved for long periods of ant/wandering monitoring and sehavior Documentation : " Elopement attempts. g in other people's bed " Elopement attempts.	F 7	726		8/24/22		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		095019	B. WING			C 04/20/2022	
	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	1 04/	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	bed. Behaviors are of 02/07/22 at 1:52 PM bed. Behaviors are of 02/09/22 at 1:47 PM bed. Behaviors are of 02/10/22 at 12:17 PM peoples bedBehaviors are of 02/11/22 at 11:16 AM bed. Behaviors are of 02/13/22 at 12:32 PM peoples bedBehaviors are of 02/14/22 at 2:10 PM bedBehaviors are of 02/16/22 at 1:28 PM bedBehaviors are of 02/18/22 at 2:19 PM bedBehaviors are of 02/19/22 at 1:18 PM bedBehaviors are of 02/19/22 at 1:18 PM bedBehaviors are of 02/19/22 at 1:23 PM peoples bedBehaviors are of 02/20/22 at 12:23 P	" sleeping in other people onstant." " sleeping in other people's onstant." "sleeping in other peoples onstant." I "sleeping in other ors are constant." I " sleeping in other people onstant." I " sleeping on other ors are constant." "sleeping on other peoples constant." I "sleeping on other peoples constant."	F	726			8/24/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		095019	B. WING			C 04/20/2022	
	ROVIDER OR SUPPLIER	AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	•		
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F 726	[Resident #82] what hit him because he department arrived with [Resident #404 by two ambulance [Physician Name] a made aware." This evidence show a. Although the fact address Resident # resident units; there care plan was updatesidents intrusive resident rooms and b. Facility staff faile room numbers of refered resident #404 residents such as properly for physical injury, activity, upset that in their bed. c. Although the staff was being monitore wandering into othe in their beds. There monitoring the resident plan updates, creat During a face-to-face output of the plan regident replan regident regident regident.	at happened, resident stated 'I came to my bed.' DC fire at the unit at 3:10 am and left 4] in a stretcher accompanied attendants to [Hospital Name]. and RP (representative) was wed: illity had a care plan in place to #404's wandering on to other e was no evidence that the ated/revised to address the behavior (wandering into other I sleeping in their beds). Indicate the document the names, esidents who were affected by ehavior; and failed to assess the behavior impacted other butting himself or others at risk intrusion on their privacy or the in their room and sleeping at its no evidence that den was readjusted to	F 72	26		8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED		
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NAME OF D		095019	B. WING		DEET ADDRESS SITY STATE 71D SODE	04/	20/2022
	ROVIDER OR SUPPLIER DD REHABILITATION AN	ID WELLNESS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019		00 NANNIE HELEN BURROUGHS AVE. NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	aware that Resident abehaviors of going in and sleeping in other #7 stated, "I was nev nurses on the unit. I had a wanderer, I was no into rooms or else his would have been upon and have specific into about the, "4 South L Behavior Documental	When asked if he was #404 had documented to other resident's rooms resident's beds, Employee er made aware by the knew him [Resident #404] as a taware that he was going as [Resident #404] care plan lated to reflect that behavior erventions. When asked ist of Residents for Daily tion" that stated Resident bloyee #7 stated, "I didn't	F	726			8/24/22
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1) §483.35(g) Nurse Staffang Staff	affing Information. equirements. The facility and the actual hours worked gories of licensed and aff directly responsible for t: s. I nurses or licensed defined under State law). des. g requirements. ost the nurse staffing data h (g)(1) of this section on a inning of each shift.	F.	732	F732; CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this practic IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED: None		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING			04/	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		04//	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	(A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public staffing data. The fact written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fact posted daily nurse states are the second posted daily nurse states are the facility to the second posted daily nurse states are the facility to the second posted daily nurse states are the facility to the second posted daily nurse states are the facility to the second posted daily nurse states are the facility to the second posted daily nurse states are the second posted daily nurse s	le format. acce readily accessible to access to posted nurse cility must, upon oral or e nurse staffing data c for review at a cost not to ty standard. data retention acility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced n, record review and staff or staff failed to record the worked and the hours per ay on the "Report of Nursing sible for Resident Care" aintain 18 months of the affing data. The resident was 245. It of Nursing Staff Directly dent Care" form dated following: stered Nurses) for 7 AM - PM -11:30 PM - 4	F	732	MEASURES TO PREVENT RECURRENT In-service will be provided by Staff Educator /Designee to the Staffing coord always ensure that the total number of he worked per day by the nursing staff who a providing direct patient care is recorded. That all staffing records must be maintained facility's policy by 8/24/22. Human Resources Manager's assistant was taffing records weekly to ensure the staff coordinator is recording the actual number of nursing staff directly responsible for recare. Any issues found will be corrected by 8/24. Human Resources Director will conduct a ensure that the staffing coordinator is posterior of nursing staff directly responsible residents care correctly. Any issues found corrected by 8/24/22. Human Resource Manager will ensure the staffing records are preserved monthly. A issues found will be corrected by 8/24/22. The Administrator will ensure staffing recordationed every three months.	inator to purs are Also, ed. per will audit iffing er sident's 4/22. audit to sting a e for d will be at at any .	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , LDENTIEICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095019	B. WING _	B. WING		C 04/20/2022	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022
DEANIMO	OD DELIADII ITATIONI AN	ID WELL NESS CENTED		5	000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWOOD REHABILITATION AND WELLNESS CENTER			٧	VASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	7 AM - 3:30 PM - 6 Number of LPNs for 3 Number of LPNs for 3 Number of CNA (Cert 3:30 PM - 22 Number of CNAs for 3 Number of CNAs for 3 Number of CNAs for 3 Actual Hours (the total were numbers entered (PPD). The facility's "Nursing for Resident Care" rethe RNs, LPNs and Corecord the total number actual hours and record the total number actual hours and record the core and the c	ensed Practical Nurses) for B PM -11:30 PM - 5 I1 PM -7:30 AM - 4 iffied Nurse Aides) for 7 AM - B PM -11:30 PM - 24 I1 PM -7:30 AM - 20 II) was left blank; and there III of for hours per patient day III Staff Directly Responsible III staff	F7	732	MONITORING CORRECTIVE ACTION Human Resources Director / Designee conduct audits to ensure that the staffin coordinator is recording the actual num staff directly responsible for patient care correctly and that records are maintaine per policy. This audit will be done week 4, then monthly x3. Findings will be corrected immediately and reported to committee.	will og ber of e ed ly x	8/24/22
F 741 SS=D	04/14/22 at approxim #20 stated that she reacknowledged the fin see proof that the fact the posted nurse staff stated the facility was they maintained the four Sufficient/Competent CFR(s): 483.40(a)(1) §483.40(a) The facility who provide direct seappropriate competer provide nursing and resident safety and at practicable physical, in	ately 3:43 PM, Employee eviewed the form and dings. The Writer asked to ility maintained 18 months of fing data. Employee #20 unable to showed proof that forms. Staff-Behav Health Needs	F 7	741			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING	B. WING		C 04/20/2022	
	PROVIDER OR SUPPLIER	ND WELLNESS CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 741	resident assessment and considering the rediagnoses of the faci accordance with §48 competencies and skimited to, knowledge and supervision for: §483.40(a)(1) Caring and psychosocial diswith a history of traur stress disorder, that if facility assessment of §483.70(e), and [as linked to history opost-traumatic stress implemented beginni (Phase 3)]. §483.40(a)(2) Implementer interventions. This REQUIREMENT by: Based on observation interview, for one (1) facility staff failed to: assessment of the effor a resident with a resident safety. Resident safety. Resident safety. Resident safety. Resident safety. Resident safety of the findings include:	is and individual plans of care number, acuity and lity's resident population in 3.70(e). These cills sets include, but are not e of and appropriate training. If or residents with mental orders, as well as residents ma and/or post-traumatic have been identified in the onducted pursuant to of trauma and/or edisorder, will be ng November 28, 2019 In is not met as evidenced on, record review and staff of 105 sampled residents, monitor and provide ongoing fectiveness of interventions mental or psychosocial strate reasonable attempts nent approaches to help health needs to assure dent #404.	F	741	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 404 was sent to the hospita 2/21/22 and later expired. IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected by this practice. DON/ Designee will conduct house wich to ensure that the nurses are monitoring providing ongoing assessments and interventions for residents with behavior issues. Any issues found will be correctly 8/24/22.	THE e the . de audit ng and	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095019	B. WING			C 04/20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 741	observed [Resident 4 besides his roommate nurse noticed blood of and mouth. The nurse #404's] left ear and metear or abrasion inclue #82] was interviewed coming over to my behim to go back to his me on my stomach a on the chin and he feed to the	04] sitting on the floor e's bed #420A; the charge on [Resident #404's] left ear e assessed [Resident nouth and there was no skin ding his face [Resident he said, "that man keeps ed side and when I asked side of the bed, he punched and chest and I punched him II" Int dated 03/26/22 by is hoping for answers after was brutally beaten at a District. [Representative's ew that his father [Resident while living at the [Facility 04] died from his injuries on Int dated 03/31/2022 dable death. Comments: hursing home. Beneficiary 2022 in skilled nursing ident. He sustained blunt eding noted on his left ear ransferred to an acute d" Idmitted to the facility on ses that included: a without Behavioral ar Dementia without ces and Transient Cerebral	F7	741	In-service will be provided by Staff Education Designee to Licensed Nurses on the importance to ensure that residents with behavior are monitored and supervised of their shift by 8/24/22 Competency check list will be completed Licensed nurses to indicate that they understand how to provide care to reside with aggressive behavior by 8/24/22. ADON/Designee will ensure that nurses monitoring and supervising residents with aggressive behavior during their shift. An issues found will be corrected by 8/24/22 Unit Mangers will validate that resident when behavior problems are monitored and supervised every shift, and that there is documentation to justify supervision. Any issues found will be addressed by 8/24/22 Charge nurses will conduct rounds to enthat residents with aggressive behavior abeing supervised every shift. Any issues will be addressed by 8/24/22	ator/ during by ents are h by cith city city	8/24/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
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F 741	the nurses station that 08/10/2021 4 South 18 Behavior Documents #404] Common behavior Documents wondering, elopement bed" Review of Resident # revealed the followin 12/16/21 [Quarterly Nocoded a BIMS summ severe cognitive impound in Section E (Behavior psychosis, no physicial directed towards other pushing, scratching, sexually), verbal behavior towards others (e.g., screaming at others, "1 to 3 days", wandedaily" In Section G (Function (how resident walks room), "Supervision assist" and no function 19 Section P (Restrain wander/elopement and Care Plan: 07/27/21 #404 is at risk for Eloimpairment, demention the adjacent unit on the section of the source of the source of the source of the section of the source of the section o	ved taped to a partition at at stated, " Updated on List of Residents for Daily ation. Room #420D [Resident avioral traits confusion, at, sleeping in other peoples at 404's medical record g: MDS] showed facility staff arry score of "03", indicating airment. or), no potential indicators of all behavioral symptoms ares (e.g., hitting, kicking, grabbing, abusing others avioral symptoms directed threatening others, cursing at others) occurred and Status), walk in room between locations in his/her with one person physical onal limitation in range of the sand Alarms), farm, "Used daily" (Revision date) ["Resident"	F	741	Unit Managers will assess residents are determine if they qualify for one-on-one supervision secondary to aggressive behavior. If a resident is qualified, that one-on-one services will provided until seen by the psych doctor. Unit Managers will ensure that every intervention in the care plan for intrusive behavior is being implemented. Any issequence of 12 and above to report resident who is intrusive to the charge nurses or CNA's. Hourly rounds will be conducted by Licensed nurses and CN during their shift to monitor residents were non-verbal or unable to identify an intruder. Any identified intruder will be redirected out of the room and supervically and intruder will be corrected by 8. Family members will be updated if their loved one is exhibiting intrusive behavior will be interdisciplinary meetings. Documentation of intrusive behavior will place, plan of care updated, and implementations carried out as indicated Any issues found will be corrected by 8.	be or. ve sues s with a any e JA who sed. 8/24/22 ir ior person iill be ed.	8/21/22	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022	
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
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F 741	Wandering to the adjateasily redirected. Wo Redirected. Wondering 7/27/2021, Easily redunattended or unobsetime. Hourly elopemelocation." Review of the Daily Behaviors are constanted at 1:12 PM Wanderingsleeping Behaviors are constanted. Behavior	accent unit on 6/8/2021. Indering on 7/11/2021. Ing to the adjacent unit irected Avoid leaving erved for long periods of ent/wandering monitoring and sehavior Documentation: " Elopement attempts. Ing in other people's bed Int." " sleeping in other people onstant." " sleeping in other people's bed In " sleeping in other peoples onstant." " sleeping in other peoples onstant." In " sleeping in other people onstant." In " sleeping in other people onstant." In " sleeping on other peoples onstant."	F	741	MEASURES TO PREVENT RECURRENCONTINUE Charge nurses will ensure that residents risk for elopement are monitored and supduring their shifts. Findings will be addres 8/24/22. Unit managers will also ensure that reside elopement monitoring and must have the wander guard band always. Findings will corrected by 8/24/22. Charge nurses and CN A 's will ensure the redirect residents who are wandering durshifts. Findings will be corrected by 8/24/2. Unit managers will ensure that residents wander are assessed by psych doctor for evaluation and treatment and their care prevised/ updated. Findings will be correct 8/24/22. Clinical care coordinator will audit charts residents with behavior to ensure that placare is being implemented weekly. Finding be corrected by 8/24/22.	with at pervised ssed by ents on eir be nat they ing their 22. who further plans ed by for an of	8/24/22	

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F 741	bedBehaviors are conceptions of the decision of the decisio	"sleeping on other people's onstant." "sleeping on other peoples onstant." Assessment Request 1:00 AM "Situation The roommateThe writer 40:4] sitting on the floor near bed A) with blood coming eThe writer asked pappened, resident stated 'I ame to my bed.' DC fire the unit at 3:10 am and left in a stretcher accompanied pendants to [Hospital Name]. If RP (representative) was described to address the phavior (wandering on to other was no evidence that the d/revised to address the phavior (wandering into other people in their beds). Becord that Resident #404 phourly, he was still found resident rooms and sleeping in the was readjusted to	F	741	MONITORING CORRECTIVE ACTION DON/Designee will conduct audits to et that residents are accounted for, monits and supervised every shift. This audit we conducted weekly x4, then monthly x3. Findings will be addressed immediately reported to QAPI committee.	nsure ored, vill be	8/24/22	

	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP 5000 NANNIE HELEN BURROUGH: WASHINGTON, DC 20019	CODE	
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F 741 Continued From page 294 During a face-to-face interview conducted on 04/04/22 at 12:48 PM. Employee #7 (Clinical Coordinator) stated, "I am responsible for care plan updates, creating and updating interventions. During care plan reviews, I do a 30-day look back at orders, nurse's notes, psych notes and make updates as needed." When asked if he was aware that Resident #404 had documented behaviors of going into other resident's rooms and sleeping in the nurses on the unit. I knew him [Resident #404] as a wanderer, I was not aware that he was going into rooms or else his [Resident #404] care plan would have been updated to reflect that behavior and have specific interventions. When asked about the, "4 South List of Residents for Daily Behavior Documentation" "that stated Resident #404's behavior, Employee #7 stated, "I didn't see it." F 755 F Pharmacy Servs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unilicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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.	y this practice. IERS WITH THE CTED:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 04/20/2022	
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F 755 Continued From pa		e 295	F 7	755	5		8/24/22
	§483.45(b) Service C must employ or obtai pharmacist who-			MEASURES TO PREVENT RECURRENCE:			
	§483.45(b)(1) Provide aspects of the provisithe facility.			The Director of Nursing will create control substance form that will el accurate reconciliation and accou all controlled substances by 8/24/ In service will be provided by Stat	nable nting of 22.		
:	receipt and disposition	(b)(2) Establishes a system of records of nd disposition of all controlled drugs in t detail to enable an accurate ation; and			Educator/ Designee to all licensed staff on how to use the new Control substance form and education on Diazepam will be counted, one of two of two vials by 8/24/22.	d clinical ol how	
	§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced				Unit Managers will ensure that nu using the newly created control for accurately and that there are no hat the form during their shift. Any issues will be corrected by 8/	rm oles on	
	facility staff failed to e for the reconciliation was followed; and fai	iew and staff interviews, ensure that the system used of controlled medications led to accurately reconcile as for three (3) of 16 records			Nurse Supervisors will conduct at weekly to ensure that the nurses utilizing the control substance for accurately. Any issues will be cor 8/24/22	are n	
	The findings include:				ADON and Clinical Coordinator w random rounds to ensure that the are completing the narcotic count correctly. Any issues found will be	nurses sheets	
	storage of controlled 08/2020 stated: Policy: "Medications Enforcement Adminis substances are subjestorage, disposal, and facility in accordance other applicable lawsProcedures:Unlefollowing will be performant of the procedure of the pr	nd procedures for the substances revised on classified by the Drug stration (DEA) as controlled ect to special handling, d recordkeeping in the with federal, state, and and regulations ess otherwise indicatedthe ormed" At each shift is are transferred, a physical			addressed by 8/24/22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
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F 755	inventory of all control refrigerated items, is personnel and is doc substance inventory in Medication Administration and accommendation of the Medication records the reconciliation and accommedication records the reconciliation and accommedication are sidents (Reside ordered "Diazepam (accommedication accommedication accommedic	onducted by two licensed umented Controlled is regularly reconciled to the ation Record (MAR) and introl Count Sheet (or similar re with facility policy" It have a system of the enables accurate counting for all controlled in on 03/31/22 at 11:02 AM of unit 4 South, there was two ints' #151 and #188) with antianxiety) 10 MG. The package was indoses (20 MG in total) is book showed, "amount is book showed, "amount in arcotic box) revealed two (2) for amount in the staff reconciled in enables are counted as one (1) is destroyed if not used.	F 7	55	MONITORING CORRECTIVE ACTION DON/Designee will conduct audits on units to ensure that the nurses are us controlled medication sheet accuratel all control substances are always acc for. This audit will be conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week then monthly x3. Findings will be additionable and reported to QAPI control with the conducted week	all the ing the y and tha ounted cly x4, ressed	8/24/22 t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 5000 NANNIE HELEN BURROUGHS A WASHINGTON, DC 20019	DDE		
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F 755	MD (medical doctor) During a face-to-face 03/31/22 at 12:02 PN she stated, "I spoke about the Diazepam, just the kit as 1 not the asked how the facility once one dose is additionate one dose is additionated that she wasn. During a telephone in contracted pharmacistated that the two share counted as one buildenotes the kit as one of the medications was followed by the medications was followed by the narcotic card of the narcotic card of the narcotic card of the card of the narcotic card of the narcotic card of the narcotic card country of the narcotic card cou	in 4 hrs. (hours) once call if ineffective." e interview conducted on M with Employee #2 (DON), to the pharmacist and asked she stated they are counting ne number of doses." When y accounts for the other dose ministered, Employee #2 't sure. htterview, the facility's st on 03/31/22 at 3:18 PM yringes in the Diazepam kit because the manufacturer ne (1)." illed to ensure that the reconciliation of controlled owed on three (3) the 2 South unit of the facility eximately 12:00 PM, a review count sheets for Medication	F 7	755	8/24/22		

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F 755	left blank. During a face-to-fac (DON) on 03/29/22 when the nurses we nurse signed as Nunarcotic card count form (narcotic card count form (narcotic card I am going to be made 2B. During a tour of at approximately 10 controlled drugs should be made approximately 10 controlled drug	ce interview with Employee #2 at 12:30 AM, she stated that orked a double shift, the same arse #1 and Nurse #2 on the a sheets. "I can see how the count document) is confusing. aking changes to that." In the 5 North unit on 03/31/22 0:00 AM, a review of the iff-to-shift count record for 1 and #2 revealed the COn 03/05/22, 03/06/22, 9/22, one licensed nurse and drugs shift-to-shift count a 7:00 AM-3:30 PM and 3:00 COn 03/06/22, and 03/27/22, one and the controlled drugs record for two shifts 7:00	F 755		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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F 755	2C. The facility staff system used for the medications was fol *A review of the Sh Unit 2 North was co approximately 10:00 that on April 1 - 12, sheet had one nurse the spaces allotted and one nurse comi Narcotics together fishift, and 3 PM - 11. *A review of the Shi Unit 2 South was coapproximately 10:10 on April 1, 2022, 3p and on April 4, 2022, Narcotic sheet had spaces allotted to the coming on duty to retogether. A review of the Shift Controlled Drug Rec Count [Reconciliation Form] di Narcotics balance in coming on duty and change of shift." The evidence show was found signing of the shift of the shif	if a stated in the facility's policy. If failed to ensure that the reconciliation of controlled lowed. If the count Narcotic records on impleted on 04/12/22, at 0 AM. The review showed 2022, the Shift count Narcotic e's signature was placed in for one nurse going off dutying on duty to reconcile the or the 7:30 AM to 3:30 PM	F 7	55		8/24/22	

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F 756 SS=E	Employee #8 on 04/1 AM. After a review of acknowledged the fin Drug Regimen Review CFR(s): 483.45(c)(1) (1) §483.45(c)(1) The drug the reviewed at I licensed pharmacist. §483.45(c)(2) This result of the resident's medical direct and these reports must (i) Irregularities to the attacility's medical direct and these reports must (ii) Irregularities including that meets the condition of the condition of the resident's medical direct and the irregularities in during this review must be parate, written report attending physician and the irregularity the (iii) The attending phyresident's medical rectiregularity has been in the irregularity of the irregularity has been in the irregularity has been in the irregularity has been in the irregularity of the irregularity has been in the irregularity of the irregularity has been in the irregularity of the irregularity has been in the irregularity has been in the irregularity of the irregularity has been in the irregularity of the irregu	or the receipt, usage, inciliation of controlled of followed. Sew was conducted with 2/22, at approximately 11:10 the documentation, he dings. W, Report Irregular, Act On (2)(4)(5) Simen Review. Sug regimen of each resident east once a month by a series of the east		755			8/24/22
	(ii) Any irregularities r during this review mu separate, written repo attending physician a director and director of minimum, the resident and the irregularity th (iii) The attending phy resident's medical red irregularity has been action has been taken	noted by the pharmacist st be documented on a port that is sent to the nd the facility's medical of nursing and lists, at a nt's name, the relevant drug, e pharmacist identified. vsician must document in the cord that the identified					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
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F 756	physician should doc the resident's medical §483.45(c)(5) The fact maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action. This REQUIREMENT by: Based on record revisix (6) of 105 sample failed to: (1) show do attending physician of monthly medication reacted upon the pharm. Residents' #16, #22, The findings include: Review of the facility Regimen Review", da" Recommendation documented by the father prescriber accep recommendation for disagn. Nursing or designated and document recommendation in blood pressure" 1. Facility staff failed recommendation to "I	ument his or her rationale in I record. cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take if its an irregularity that in to protect the resident. To is not met as evidenced its and staff interview, for its dresidents, facility staff cumented evidence that the irregimen review and that they hacists' recommendations. #61, #167, #190, #238 policy entitled, "Medication ated 08/2020 documented, is are acted upon and acility staff and/or prescriber. Its and acts upon	F	756	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #22 was assessed from he by Unit Manger on 4/26/22. Residen no negative outcome. MD/RP notifie 4/26/22. Monthly reviews will be imp immediately but no later than 8/24/22. Resident # 61 was assessed from he by Unit manager on 4/26/22, residen no negative outcome. MD/RP notifie 4/26/22. Monthly reviews will be imp immediately but no later than 8/24/22. Resident #167 was assessed from he on 4/18/22, resident suffered no negoutcome. MD/RP notified on 4/26/22 reviews will be implemented immedino later than 8/24/22. Resident # 190 was assessed from toe on 4/26/22, resident suffered no outcome. MD/RP notified on 4/26/22 reviews will be implemented immedino later than 8/24/22. Resident # 238 was assessed from toe on 4/26/22, resident suffered no outcome MD/RP notified on 4/26/22 reviews will be implemented immedino later than 8/24/22. Resident # 16 was assessed from he by Unit Manager on 4/26/22, residen no negative outcome/RP notified on Monthly reviews will be implemented immediately but no later than 8/24/22.	t suffered d on lemented 2. ead to toe t suffered d on lemented 2. ead to toe ative 2. Monthly ately but lead to negative 1. Monthly ately but lead to toe at suffered 2. Monthly ately but lead to toe t suffered 4/26/22.	8/24/22	

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				W	ASHINGTON, DC 20019		
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F 756	Resident #16 was ad 03/14/08, with multipl Type 2 Diabetes Mell Heart Failure, Major I Recurrent Severe Wit and Dementia in Othe Elsewhere Without Be Review of the Quarte (MDS) dated 03/24/22 (Cognitive Patterns) Conterview for Mental Service Facility staff coded "On In Section N (Medical No410 "Indicate the received the following pharmacological class during the last 7 days reentry if less than 7 resident #16 as received the following pharmacological class during the last 7 days reentry if less than 7 resident #16 as received the following pharmacological class during the last 7 days. N0450 "Did the resident medications since ad the prior OBRA assess recent? Facility staff of "Has a gradual dose attempted?" Facility staff of "Has a gr	mitted to the facility on e diagnoses that included: itus with Hyperglycemia, Depressive Disorder thout Psychotic Features, er Diseases Classified ehavioral Disturbance. rly Minimum Data Set 2, revealed: In Section C C0100 "Should Brief Status be Conducted?" " No. tions): number of days the resident medications by sification, not how it is used, or since admission/entry or days." Facility staff coded iving Antipsychotic, oagulant and Diuretic during ent receive antipsychotic mission/entry or reentry or sement whichever is more coded "1" No reduction (GDR) been staff coded "0" No.	F	756	IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED. All residents residing in the facility have potential to be affected. DON/ Designee will conduct house with audit to ensure that all pharmacy recommendations are addressed in a manner. Any issues found will be correctly 8/24/22 ADON will conduct an audit to ensure attending physicians / Designee are reviewing pharmacy recommendations are signing off on it in a timely manner avoid delays in treatment. Any issues will be corrected by 8/24/22	de timely ected that s and r to	0/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019	B. WING			04/	20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	OULD BE COMP		
F 756	05/21/20, Escitalopra give 1 tablet orally on 06/23/21, "Risperdal give 1 tablet by mouth psychotic disorder." Review of Resident #Record revealed a phreview was conducted 02/14/22, 03/15/22. Oval was marked that given to the IDT (Inte The pharmacy drug re 12/19/21, recommend Risperdal for a GDR dx." There is no documedical record of the recommendation. During a telephone in 04/19/22 at 10:49 AW (Consultant Pharmaca a report, we give a parespond." During a face-to-face 04/19/22 at 1:11 PM, of Nursing) stated, "I Employee #2 acknow documented evidence or responded to the purchase the attending physicial discounter that the statending physicial states are possible to the purchase the states of the process of the pro	m Oxalate Tablet 20 MG e time a day for depression" tablet 1 MG (risperidone) n two times a day for 16's Electronic Health narmacy drug regimen d on 12/19/21, 01/18/22, on these assessments an e stated "Recommendations r-disciplinary team). regimen review dated dations are "Please eval respecially with a psychotic mented evidence in the physician responding to this terview conducted on the physician responding to this rege to each doctor to interview conducted on with Employee #2 interview conducted on with Employee #2 (Director didn't see a note."	F	756	In -service will be provided by Staff Ed to all licensed nursing staff to ensure of follow up with pharmacy recommendation promptly by 8/24/22. Supervisors will audit residents' chart to ensure that nurses are calling phys Designee with recommendations from Pharmacist. Any issues found will be oby 8/24/22. DON's secretary will ensure that all phrecommendations are printed out and to the Unit Managers for follow up on basis. Any issues found will be addres 8/24/22. Unit Managers will ensure weekly that physicians sign the pharmacy recommendation to review. Any issues found will be corre 8/24/22. ADON will ensure on a weekly basis to pharmacy recommendations have been out and that the Licensed nurses are fully with the physicians to address the recommendations. Any issues found we corrected by 8/24/22.	ducators that they tions monthly icians/ the corrected harmacy handed a weekly seed by the hendation o validate cted by hat all en printed following	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			04/	20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	D WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	the recommendations #167, #190 and #238 2A. Resident #22 was 11/09/15 with multiple Hypertension, Anemia Review of Resident # revealed: An Annual Minimum I 03/23/22 showed that Interview for Mental S score of "10", indicati impairment. 02/04/20 (Revision da #22] is, at risk for adv polypharmacy Rev recommendations an 02/04/20 (Revision da #22] receives 9 or mois at risk for adverse of pharmacist medication Inform physician of received. MRR form for Decem (3) months labs over that the physician or of medication review for reviewed. MRR form for Januar month) Keppra (antis no evidence that the	s for Residents' #22, #61, s admitted to the facility on a diagnoses that included a and Hyperlipidemia. 22's medical record Data Set (MDS) dated a facility staff coded a Brief status (BIMS) summary and moderate cognitive ate) [Care Plan] "[Resident arese reaction r/t (related to) are indicated. Ate) [Care Plan] "[Resident are different medications and drug interactions Clinical an review monthly and prn. accommendations" ber 2021 read, "Every three due". There was no evidence designee signed the m to indicate that it was y 2022 read, "month (every eizure) overdue". There was	F7	756	Unit manager will ensure that month for resident #22 is reviewed by the physician and off on it. Findings will be corrected by Unit manager will ensure that month recommendation on the GDR for res 16 is addressed by the physician and documentation in place by 8/24/22 Charge nurse will ensure that month pharmacy recommendation for resident 167 is addressed by the physician to by 8/24/22 Unit manager will ensure that month pharmacy recommendation for resident will be addressed by the physician by Unit manager will ensure that the physician service will be addressed by 8/24/22 Don/Designee Will ensure that all month pharmacy reviews are printed out, addressed by the physician in a time manner. Findings will be addressed 18/24/22	d signed y 8/24/22 by ident # d by ent # p signed by 8/24/22 by sician bonthly	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
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NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-112	LUILULL	
				50	000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		W	VASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I SHOULD BE		
F 756	Continued From page	e 305	F 7	756			8/24/22	
		s admitted to the facility on			MONITORING CORRECTIVE ACTION:	:		
	11/06/20 with multiple diagnoses including Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Viral Hepatitis C, Anemia, Hypertension, Peripheral Vascular Disease, Acute Kidney failure, Systemic Inflammatory response syndrome, and Anxiety. A review of Resident #61's medical record showed that from July 2021 to February 2022, the monthly MRR's lacked documented evidence that the attending physician or designee reviewed the monthly medication regimen review and acted on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's signature and the date and response area, were left blank, indicating it was not reviewed.				DON / Designee will conduct house wid ensure that pharmacy recommendations reviewed by the attending physician and there is adequate documentation validat review. This audit will take place weekly monthly x3. Findings will be corrected a reported to QAPI Committee.	e audit to s are d that ting x4, then		
	10/25/19 with multiple end-stage Renal Dise Hyperlipidemia, Hyper Obstructive Pulmona Depressive Disorder, A review of Resident showed that from Jurthe monthly MRR's lathat the attending phythe monthly medication the recommendati Physician/Prescriber [agree/disagree/other signature and the dat left blank, indicating in	ease, Anemia, ertension, Chronic ry Disease, Major and anxiety. #167's medical record ne 2021 to February 2022, recked documented evidence visician or designee reviewed on regimen review and acted ons. The response box regional response area, were						
		as admitted to the facility on hat included: End Stage						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			1	C / 20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	Continued From pag Renal Disease, Hype Pressure Induced De Sacral Region, Diabe Review of Resident ; revealed: MRR form for Decen 80mg (milligram) Atc reducer) be reduced that the physician or medication review for reviewed. MRR form for Februa Darbopoetin (antipla (hemodialysis) clinic that the physician or medication review for reviewed. MRR form for March (evaluate) Buspar (a effects" There wa physician or designe review form to indicat 2E. Resident #238 w 10/28/20 with the fol Mellitus, Hypertensic Hyperlipidemia, Gas Disease, Chronic He	e 306 ertensive Emergency, eep Tissue Damage of the etes Mellitus and Anxiety. #190's medical record her 2021, read " could ervastatin (cholesterol ?" There was no evidence designee signed the rm to indicate that it was ery 2022, read " suggest telet) state 'give at HD ." There was no evidence designee signed the rm to indicate that it was 2022 read, "Please eval eritanxiety) for serotonin es no evidence that the e signed the medication ete that it was reviewed. eras admitted to the facility on lowing diagnoses: Diabetes eras on, Cirrhosis of the Liver, tro-esophageal Reflux erastitis, Cerebral Infarction		756			8/24/22
	A review of Resident showed that from Oo the monthly MRR's li that the attending ph	nentia with behavioral. #238's medical record stober 2021 to March 2022, acked documented evidence ysician or designee reviewed ion regimen review and acted					

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER STREET ADDRESS, CITY, STATE, ZIP CODE				B. WING _					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 756 Continued From page 307 on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's			ND WELLNESS CENTER		5000	NANNIE HELEN BURROUGHS AVE. NE	1 04/	20/2022	
F 756 Continued From page 307 F 756 on the recommendations. The Physician/Prescriber response box [agree/disagree/other], allotted for the physician's	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
left blank, indicating it was not reviewed. During a telephone interview conducted on 04/19/22 at 10:55 AM, Employee #23 (Consultant Pharmacist) was asked about the MRRs for each of the aforementioned residents, to which she stated, "The MRR report forms are submitted to the Administrator, Director of Nursing (DON) and the Unit Managers. They are distributed to the appropriate physician or Nurse Practitioner (NP). Once a response is provided (agree, disagree, other) it goes into the patients chart as part of their permanent record." During a face-to-face interview conducted on 04/19/22 at 1:11 PM, Employee #2 (DON) acknowledged the findings that Resident #22's, #167's, #190's and #238's MRR were not reviewed. Employee #2 further stated, "At this time, I review the MRRs. They are printed out and given to the assigned Unit Manager who notify the MD (medical doctor) or NP (Nurse Practitioner). Sometimes the recommendations don't require any action. Once they (MD/NP) review and sign the MRR form, it is filed." When asked why facility staff failed to document agree, disagree, or other and why there was no physician or designee signature on the medication review form to indicated that it was reviewed. Employee #2 stated, "There is no specific time frame for the reviews to be done, but we try to get them done as soon as possible." F 761 Label/Store Drugs and Biologicals F 761 SS=D CFR(s): 483.45(g)(h)(1)(2)	on Phy [ag sig left Dun 04/Phi of t sta the app On oth the Dun 04/ack #16 rev tim give the Prador rev ask disaphy me rev spe but F 761 Lat	the recommendation by sician/Prescriber gree/disagree/other gree/other gr	response box r], allotted for the physician's te and response area, were t was not reviewed. Interview conducted on M, Employee #23 (Consultant ed about the MRRs for each d residents, to which she port forms are submitted to rector of Nursing (DON) and they are distributed to the n or Nurse Practitioner (NP). Provided (agree, disagree, e patients chart as part of rd." Interview conducted on Employee #2 (DON) adings that Resident #22's, 238's MRR were not #2 further stated, "At this RRs. They are printed out and M Unit Manager who notify tor) or NP (Nurse mes the recommendations on. Once they (MD/NP) MRR form, it is filed." When off failed to document agree, d why there was no e signature on the rm to indicated that it was #2 stated, "There is no or the reviews to be done, in done as soon as possible." ind Biologicals					8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-4/	20/2022
				5000 NANNIE HELEN BURROUGHS AVE. NE			
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F 761	Continued From page 308		F	761	CORRECTIVE ACTION FOR THE		8/24/22
	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted				AFFECTED RESIDENTS:		
	professional principle appropriate accessor			No Resident was affected by this pract	ce.		
	instructions, and the applicable.	expiration date when			IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED.:	THE	
	§483.45(h) Storage o			All residents residing in the facility have potential to be affected.)		
	Federal laws, the faci	ordance with State and illity must store all drugs and compartments under proper and permit only authorized cess to the keys.			DON/ Designee will conduct audit on a carts to ensure that all medications are correctly labeled and stored properly. A issues found will be corrected by 8/24/2	ıny	
	locked, permanently storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distributed quantity stored is minded to be stored in the state of the stored in the facility staff failed to be biologicals were properties (3) of 16 medical the facility's policy at medications revised of the Control of the stored in the stored	nd procedures for storage of on 08/2020 stated,					
	"Medications and b	iologicals are stored safely, y following manufacturer's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/		
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Procedures: III. Expir Dating) When the comanufacturer's contained the container or vial with a container or vial with a container or vial with a container or vial or container will be unless the manufacture date If a vial or constated date opened, the automatically default the expiration date with accordingly All expir removed from the act accordance with facility amount remaining " 1. Facility staff failed safely store medication A. During a tour and counit on 03/29/22 at application Cart #1, the container of	ation Dating (Beyond-Use priginal seal of a iner or vial is initially broken, will be dated The nurse pened" sticker on the did the date opened, and the interior and another of the date opened without a she date opened will to the date dispensed, and libe calculated and medications will be ive supply and destroyed in ity policy, regardless of the opened will to accurately label and ons. Observation on the 2 South opening with no date of when it was red for use; og Insulin pen was observed and Glargine (Lantus) 100 Insulin with no date sopened. Interview with Employee see) on 03/29/22 at PM, she acknowledged that insulin vial were not stored	F7	761	MEASURES TO PREVENT RECURRENCE: In service will be provided by Staff Development team/ Designee to a licensed nursing staff to ensure the medications are labeled and store correctly by 8/24/22. MDS team has been assigned to a that medications are labeled and scorrectly for safety purposes. This be done during ground rounds dai issues found will be corrected by 8 Charge nurses will ensure that the their carts on a weekly basis to enemedications are labeled and store appropriately. Any issues found we corrected by 8/24/22 ADON/Designee will conduct rand rounds on a weekly basis to ensure medications are labeled and store correctly. Any issues found will be by 8/24/22 Supervisors will ensure that medicatrs are clean and that the medicatored correctly on a weekly basis issues found will be corrected by 8 Licensed Nurses who are found to non-compliant will be provided coand counseling and will be sent to developers for re in-service. This is completed by 8/24/22. Repeat coand counseling provided as needs	all hat d ensure stored audit will ly. Any 8/24/22. ey audit sure that d ill be lome that d corrected cation rations are . Any 8/24/22 o be aching staff s aching	i	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022
	ROVIDER OR SUPPLIER	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	on Unit 4 South, Med was noted: three (3) of that had expiration day and 3/25/22", three (3) no date opened or extwo (2) blister packets 1 MG for a resident wo 03/15/22. During a face-to-face time of the observation acknowledged the find my usual floor. I work 1 work	tion on 03/30/22 at 11:11 AM ication Cart #1, the following vials of Insulin stored for use ates of "2/22/22, 2/27/2022 B) open vials of Insulin with piration date, one (1) and sof Lorazepam (antianxiety) who was discharged on interview conducted at the on, Employee #47 (LPN) dings and stated, "This isn't upstairs." interview conducted on I, Employee #23 (Consultant Narcotic medications that ed or if the patient is be returned to the pharmacy licensed staff. They are not edication cart or medication tion on 03/31/22 at 10:18 Medication Cart 1, the three (3) vials of Insulin d expiration dates of and 2/22/22", three (3) (1) vial no date opened or interview at the time of the see #48 (LPN) acknowledged at that licensed staff are in putting dates when they	F		DON/ Designee will conduct audit all medication carts to ensure that medications are labeled and store correctly. This audit will be done w x4, then monthly x3. Findings will corrected immediately and reporte QAPI Committee	the d reekly be	8/24/22
SS=E		-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		095019	B. WING			04/2	0/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	ıΕ		
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DLANVO	OD REHABILHATION A	WEELNESS CENTER		WASHINGTON, DC 20019			
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			1				8/24/22
F 812	Continued From page	ge 311	F 81	2 F812			
	CFR(s): 483.60(i)(1	_		CORRECTIVE ACTION FOR T RESIDENTS:	HE AFFECT	TED	
	§483.60(i) Food saf The facility must -	ety requirements.		No resident was affected by this practice.	s deficient		
	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to serve and distribute foods in accordance with professional standards of practice for food services safety as evidenced by hot food temperatures that tested at less than 135° Fahrenheit (F) during a food tray assessment on April 12, 2022.			POTENTIAL TO BE AFFECTED All the residents in the facility has to be affected by this practice. Food services director will conceivery two hours in the kitchen to food is distributed in accordance.	residents in the facility have the potential ffected by this practice. ervices director will conduct rounds wo hours in the kitchen to ensure that		
				residents get their food within the temperature. Any issues found corrected by 8/24/22.	he standard		
	The findings include	: :					
	Hot foods temperatures were inconsistent during a test tray assessment on April 12, 2022. Hot foods from the regular diet, such as fried fish (pollock), green beans, and rice, tested under 135° Fahrenheit (F), while mechanical and pureed foods were above required temperature.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING _			1	20/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	20,2022
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			0000 NANNIE HELEN BURROUGHS AVE. NE		
				٧	WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 812	Continued From page	e 312	F 8	312			8/24/22
F 835	Fried Fish (regular die White Rice (regular die Green Beans (regular die Green Beans (regular die Fried Fish (mechanica White rice (mechanica Fried Fish (puree) = 1 Mixed Vegetables (pure Mashed Potatoes = 1 These findings were a #15, during a face-to-2022, at 3:45 PM. Administration CFR(s): 483.70 §483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, a well-being of each restricted physical, and provided to observation interview, Administratives and psychosocial well evidenced by failure to implemented measure resident-to-resident a six (6) residents; adequivoided to one (1) redislocated hip of unkr	et) = 132° F iet) = 132° F r (diet)) = 129° F echanical) = 138° F al) = 147° F al) = 142° F 150° F acknowledged by Employee face interview on April 12, on. ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced on, record review and staff ion failed to use its and efficiently to attain or oracticable physical, mental, I-being of each resident as o ensure that: staff es to prevent buse and altercations for quate supervision was esident who sustain a nown origin; to adequately		335	F 812 MEASURES TO PREVENT RECURR In-service will be provided by Staff Ed Designee to the dietary staff on the im to ensure that food is served and distr accordance with professional standard 8/24/22. Food Services Director will ensure that members serve and distribute food in accordance with professional standard practice for food services. Any issues will be corrected by 8/24/22. Dietician and Nutritionist will ensure th food served to the residents are in acc	ucator/ portance ibuted in ds by It his staff ds of found eat the cordance e for food by Its le the vill be od m that 140 eny /22 N: and uted in audit will is.	
	dislocated hip of unkr supervise one (1) res						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING_			1	20/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	20/2022
				5	000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION A	ND WELLNESS CENTER		٧	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	-		F 8	335			8/24/22
	treatment, and to en	re on hand for care and sure staff were trained on			CORRECTIVE ACTION FOR THE AFF RESIDENTS:	ECTED	
	survey was 255.	e census on the first day of			Resident #82 was placed on 1:1 monitor aggressive behavior. Resident was take custody by DC police on 7/20/22 Resident #151 is on 1:1continous monitor.	en into	
Resident #409 is discharge 1. In the area of 42 CFR§ 483.12, Freedom from Abuse Neglect and Exploitation Administration Abuse Neglect and Exploitation Administration		aggressive behavior. Resident #409 is discharge to another f 9/28/2021. Resident #56 obtained hematoma on the	-				
	Abuse, Neglect, and Exploitation, Administration failed to ensure residents were free from abuse (willful infliction of injury) and neglect as evidenced by: failure to prevent the willful infliction of serious injury of Resident #404 by				side of the forehead on 4/7/2022. RP ar were notified. X-ray was done without a Resident #183 was assessed from head No bruises, redness or swelling found. I MD notified.	nd MD fracture. d to toe.	
	Resident #82; failure care measures for R	e to implement person center esident #151 who had esive behavior towards one			Resident #3 is no longer in the facility a sent to the hospital 3/29/2022 and did n to the facility. Resident #304 was assessed for respira	ot return	
	(1) resident and willf resident; and failed t training to provide po (1) resident post hip			distress secondary to lack of equipment on 4/26/22, resident suffered no negative outcon All respiratory equipment will be handy and cleaned by 8/24/22.			
	the resident sustaine	ed a dislocated hip.			Administration will be provided coaching training on: (1) Proper implementation a compliance of facility processes including	and	
During the face-to-face inter approximately at 6:01 PM, E #2 were made aware of the	1 PM, Employees' #63 and			conducting daily clinical grand rounds to that the immediate clinical and physical of the residents are being met. (2) Prop obtaining clinical validation reports fron	needs erly		
ļ	Cross reference 42 (Freedom from Abuse	CFR§ 483.12, F600, e, Neglect, and Exploitation			clinical and non clinical team to address in a timely manner, (3) How to properly and review all allegations of abuse, inc	s issues conduct idents	
	Free of Accident Haz the Administration fa resident receives ad	a of 42 CFR 483.25(d)(1)(2), F689 dent Hazards/Supervision/Devices, ration failed to ensure that each eives adequate supervision and			and accidents by the Rytes Compliance Consulting Group to ensure that the factor administered in a manner that enables its resources effectively and efficiently to maintain the highest practicable physics.	cility is it to use o attain sical,	
	evidenced by: reside resulting in serious in resident-to-resident	o prevent accidents as ent-to-resident altercation njury to one (1) resident; altercation resulting in harm			mental, and psychosocial well-being of resident. Training and coaching will be completed by 8/242022.	eacn	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		095019	B. WING				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 100 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	resident while seated front of the facility and fall resulting in harm; resident-centered into devices) for one (1) replacement, who suld dislocated hip of unknone (1) residents who transport; failed to iminterventions to help a history of falls. During the face-to-face approximately at 6:01 #2 were made aware Cross Reference 42 Con Free of Accident Haze 3. In the area of 42 Con Respiratory Care, the ensure Resident #3's occluded by a medical exchanger (HME) suresident to be transfered Room (ER) for dislod respiratory medical ewas necessary to car laryngectomy (lary-tusubsequently, the resident #3 with HMI clean respiratory equithe physician's orders for the use of a "butto"	in a wheelchair outside in d subsequently sustained a failed to implement erventions (assistive esident status post left hip posequently sustained a nown origin; failed to secure eelchair during a van plement care plan prevent one (1) resident with eight in the facility of the findings. CFR 483.25(d)(1)(2), F689 ands/Supervision/Devices FR 483.25(i), F695 and Administration failed to airway (stoma) was not all device (Heat Moisture besquently, causing the rred to the Emergency gment; (2) keep a supply of quipment in the facility that the for and treat Resident #3's be) and stoma (airway) sident had to be transferred tement; (3) Obtain/provide Es; (4) failed to change and ipment in accordance with significant residents and important residents and reside	F	835	IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED: All residents residing in the facility have potential to be affected by this practice. Administration will conduct house wide to ensure that facility is using its resource effectively and efficiently to attain and maintain the highest practicable physical mental, and psychosocial well-being of residents, to ensure that no resident is exposed to abuse and neglect, that resi are provided help with assistive devices residents are supervised at the front of building and that the employees are adequately supervising the residents to prevent altercations, that residents with respiratory diagnosis have their supplie always and the van has all safety components. This audit will be reviewed the Regional Director of Operations/Reg Corporate Compliance. Any issues fou be corrected by 8/24/22.	e the audit ces al, the idents s, that the s d by gional	8/24/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	LETED
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	ROVIDER OR SUPPLIER	ND WELLNESS CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE O NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	04/2	20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835 F 837 SS=E	approximately at 6:0 #2 were made award Governing Body CFR(s): 483.70(d)(1) \$483.70(d) Governing \$483.70(d)(1) The fabody, or designated governing body, that establishing and imp the management and \$483.70(d)(2) The grade administrator who is (i) Licensed by the Strequired; (ii) Responsible for rand (iii) Reports to and is governing body. This REQUIREMEN by: Based on observati interview, Governing established and imp the management and were followed and a and implemented to abuse and altercatic ensure adequate su	ace interview on 04/20/22 at PM, Employees' #63 and e of the findings. (2) Ing body. Ing body. Ing body. Ing begin active a governing persons functioning as a total segally responsible for oblementing policies regarding doperation of the facility; and overning body appoints the control of the facility; and overning body appoints the control of the facility; and overning body appoints the control of the facility; and overning body appoints the control of the facility; and overning body appoints the control of the facility; and overning body appoints the control of the facility; and the facility and operation of the facility action plans were developed at prevent resident-to-resident one for six (6) residents; pervision was provided to one	F 83		MEASURES TO PREVENT RECURRENCE: Administration will ensure that Clinical Grand Fare conducted daily by the IDT (clinical and non-clinical). Participation of the Clinical Grand Rounds will be tracked and trended through th validation report and the Clinical Grand Round obtained during the stand down meeting at end This corrected practice will be in place no later 8/24/2022. Administration will ensure that abuse investiga and documentations are reviewed and audited administrator/DON daily. This corrected practice in place no later than 8/21/2022. Administration will ensure that end of day stand meetings are conducted, and clinical validation are submitted daily by the IDT to administration corrected practice will be in place no later than 8/24/2022. In-service will be provided by Rytes Compliant Consulting Group to the administration on the importance of providing a person-centered car for the residents efficiently to attain or maintain highest practicable physical, mental, and psychwell-being of each resident. Administration will up weekly to ensure compliance. Findings will corrected by 8/24/22 In-service will be provided by the Rytes Compl Consulting Group to the administration, depart heads and licensed nursing staff to ensure tha implement written measures put in place to enspatient safety and to attain or maintain the high practicable physical, mental, and psychosocial well-being of each resident by 8/24/22. Rytes Compliance Consulting Group will provice in-service to administration, department heads licensed nursing staff, C N A, on what to do we resident becomes aggressive, Administration	d e clinical findings d of day. than tions by the ce will be d down a reports a. This ce e plan the hosocial I follow be iance ment t they sure nest de , hen a	8/24/22
	unknown origin; ade resident who sustai the appropriate resp	tain a dislocated hip of quately supervise one (1) ned a fall with injury; ensure iratory medical supplies were d treatment; ensure staff were			weekly to ensure compliance. Findings will be corrected by 8/24/22 The Regional Director of Operations and the R Compliance officer will ensure that the adminis making sure that that morning rounds and valid are taking place daily. Findings will be correcte 8/24/22	legional strator is dation	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	LETED
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	ROVIDER OR SUPPLIER DD REHABILITATION AI	ND WELLNESS CENTER		50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 837	laryngectomies; and staff maintained the incident/Accident Re one (1) resident. The survey was 255. The findings include: 1. In the area of 42 Condent Abuse, Neglect, and failed to ensure reside (willful infliction of injectidenced by: failure infliction of serious in Resident #82; failure care measures for Resident and willfur resident; and failed to training to provide per (1) resident sustained During the face-to-failure and the sustained During the face-to-failure one (1) resident sustained During the face-to-failure one (te for two (2) residents with a to ensure the administrative integrity of an port (investigative report) for exploitation, administration tents were free from abuse and to prevent the willful jury of Resident #404 by to implement person center esident #151 who had sive behavior towards one all infliction of injury to one (1) to ensure staff received erson centered care to one replacement. Subsequently, did a dislocated hip.	F	3337	Administration will ensure that staff educator provide in service to licensed nurses, C N A restorative staff on how to take care of reside with hip dislocation to attain or maintain the hip practicable physical, mental, and psychosocia well-being of each resident Administration will conduct rounds daily to enthat the residents are monitored every shift for safety. Any issues found will be corrected by 8/24/22. Administration will ensure that the residents respiratory diagnosis have supply are at beds and in central supply for their respiratory nee attain or maintain the highest practicable phymental, and psychosocial well-being of each resident In-service will be provided by Rytes Compliance Consulting Group to administration, departmen licensed nurses and C N A 's on the importance ensuring supervision for residents with assistive to attain or maintain the highest practicable phymental, and psychosocial well-being of each residents and psychosocial well-being of each residents with assistive to attain or maintain the highest practicable phymental, and psychosocial well-being of each residents with assistive to attain or maintain the highest practicable phymental, and psychosocial well-being of each resident will ensure compliance weekly. Administration will ensure that Charge nurses a ensuring that residents with aggressive behavior placed on -on- one until evaluated by psychiatris Findings will be addressed by 8/24/22 Administration will ensure that Unit manager are ensure that resident exhibiting aggressive behavior that the resident exhibiting aggressive behavior placed on and Admin/DON/Designee will ensure compliance we Findings will be addressed by 8/24/22.	sure or with side ds to sical, et heads, ee of devices sical, sident.	8/24/22
	Cross reference 42 C Freedom from Abuse	CFR§ 483.12, F600, , Neglect, and Exploitation			Administration will ensure compliance weekly by inventory sheets for supplies. Respiratory theral ensure that respiratory supplies are available. It will be corrected by 8/24/22	oist will	
	Free of Accident Haz the Administration fairesident receives addressistance devices to evidenced by: reside resulting in serious in	CFR 483.25(d)(1)(2), F689 cards/Supervision/Devices, filed to ensure that each equate supervision and prevent accidents as int-to-resident altercation one (1) resident; altercation resulting in harm			Administration will ensure weekly that respirator therapist and charge nurses are cleaning respiration medical equipment, that the nurses are taking or provide care for residents with respiratory diagnithat the orders are implemented per the physicial orders, Administration will ensure weekly that licensed implementing care plan interventions to help pre residents with multiple falls. Findings will be add 8/24/22.	atory rders to osis and ans' nurses are	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	I ' '	E SURVEY IPLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION A	ND WELLNESS CENTER		500	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019		
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F 837	resident while seate front of the facility ar fall resulting in harm resident-centered in devices) for one (1) replacement, who su dislocated hip of unlone (1) residents witransport; failed to in interventions to help a history of falls. During the face-to-fa approximately at 6:0 #2 were made award. Cross Reference 42 Free of Accident Haid and the face of 42 (Respiratory Care, the ensure Resident #3' occluded by a medic Exchanger (HME) si resident to be transf Room (ER) for dislocation (ER) for dislocation (ER) for dislocation (ER) for dislocation (ER) for a replation	ailure to supervise one (1) d in a wheelchair outside in nd subsequently sustained a ; failed to implement terventions (assistive resident status post left hip ubsequently sustained a known origin; failed to secure neelchair during a van nplement care plan prevent one (1) resident with ace interview on 04/20/22 1 PM, Employees' #63 and e of the findings. CFR 483.25(d)(1)(2), F689 zards/Supervision/Devices	F	837	MONITORING CORRECTIVE ACT Administration will conduct house was to ensure that residents with behave problems are supervised and monitevery shift. This audit will be conducted weekly x3 and monthly x4. Finding corrected and reported to QAPI Co	wide audit vior tored ucted gs will be	8/24/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE (X4) PLAN OF CORRECTION (X5) PROVIDER/SUPPLIER/CLIA (X6) MULTIPLE CONSTRUCTION (X6) DATE SU COMPLE						
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NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				50	000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			ASHINGTON, DC 20019		
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F 837	Continued From page Cross Reference 42 (Respiratory Care During the face-to-face approximately at 6:01 #2 were made aware 4. In the areas of 42 (records and 483.70(i) accepted professional the facility must main each resident the gensure a resident's reinformation as evident record information on record for one (1) resof an "Incident/Accideresident-to-resident a serious injury to the resident's medical record documented for three #3, #126, #164, #404 Cross Reference 42 (Cross Reference 42)	ce interview on 04/20/2022 PM, Employees' #63 and of the findings. CFR 483.70(i) Medical (1) In accordance with a standards and practices, tain medical records on overning body failed to ecord contained accurate (1) a Treatment administration ident; maintain the integrity ent Report" related to a ltercation resulting in esident; and ensure cord were accurately (3) residents. Residents'	F 8	337	F837 starts here: CORRECTIVE ACTION FOR THE AFFEC' RESIDENTS: Resident #82 was placed on 1:1 monitoring aggressive behavior. Resident was taken in custody by DC police on 7/20/22 Resident #151 is on 1:1continous monitoring aggressive behavior. Resident #409 is discharge to another facil 9/28/2021. Resident #56 obtained hematoma on the let the forehead on 4/7/2022. RP and MD werk X-ray was done without a fracture. Addition was hired to supervise residents outside. Resident #183 was assessed from head to bruises, redness or swelling found. RP and notified. Resident #3 is no longer in the facility and to the hospital 3/29/2022 and did not return facility. Resident #304 was assessed for respirator secondary to lack of equipment on 4/26/22 suffered no negative outcome. All respirato equipment will be at bedside and in central 8/24/22. Education to be provided by the Rytes Con Consulting Group to the Governing Body of duties and responsibilities and how to funct properly as members of the Governing Body of duties and responsibilities and how to funct properly as members of the Governing Body	fed for a fo	8/21/22
F 838 SS=C	accepted professional the facility must main each resident F842 During the face-to-face approximately at 6:01 #2 were made aware Facility Assessment CFR(s): 483.70(e)(1) §483.70(e) Facility as The facility must cond	Il standards and practices, tain medical records on 2 ce interview on 04/20/22 PM, Employees' #63 and of the findings(3)	F 8	338	ensure that established and implemented pregarding the management and operation of facility were followed and action plans were developed and implemented. Members of the Governing Body include but are not limited Regional Director of Operations, Regional I Compliance, DON, ADON, QA, Compliance and Staff Educator. This will be completed than 8/24/2022. Rytes Compliance Consulting Group to proveducation to the Governing Body on proper implementation of established policies and procedures pertaining to (1) prevention of rabuse, (2) physical safety and fall preventic ensuring staff clinical competencies, (4) maintegrity of medical records and incident reland (5) maintaining adequate medical suppressions.	of the end	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COMPLETED		
		095019	B. WING _			04/2	20/2022	
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 838	competently during be and emergencies. The update that assessmeleast annually. The facupdate this assessment facility plans for, any substantial modification assessment. The facincluding, but not limit (i) Both the number of resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fact that population; (iii) The staff competer provide the level and resident population; (iv) The physical enviservices, and other pertinent fact are necessary to (v) Any ethnic, cultural may potentially affect facility, including, but food and nutrition ser §483.70(e)(2) The fact but not limited to, (i) All buildings and/of and vehicles; (ii) Equipment (medicini) Services provided	sary to care for its residents of hot day-to-day operations e facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a fon to any part of this lity assessment must solitity's resident population, and the facility's by the resident population of diseases, conditions, and disabilities, overall acuity, acts that are present within encies that are necessary to types of care needed for the ronment, equipment, hysical plant considerations care for this population; and al, or religious factors that the care provided by the not limited to, activities and	F 8	338	MEASURES TO PREVENT RECURRENCE: The governing body will ensure that established implemented policies regarding the manageme operation of the facility are followed and plans a developed and implemented for the smooth rur the facility. Any issues found will be corrected by the facility. Any issues found will be corrected by the facility of the residents. Any issue will be corrected by 8/24/22. The governing body will ensure that the administed partment heads and nursing staff are implementating policies and procedures and are keeping residents safe. Any issues found will be correct 8/24/22. In-service provided by Rytes Compliance Consequence of the facility of t	nt and are ning of by 8/24/22. Inistration policies es found stration, nenting ng the red by ulting tency and 2 quality that the re put in ny issues ance ON, unit dress ne team residents ndings Quality ents are reveekly.	8/24/22	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE : COMPI		
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	20/2022	
	101.52.1.01.100.1.2.2.1				000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			VASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
F 838	employees and those contract), and volunte education and/or train related to resident ca (v) Contracts, memor or other agreements services or equipmen normal operations an (vi) Health information such as systems for epatient records and einformation with other systems for epatient records approach This REQUIREMENT by: Based on record revifacility staff failed to under the state of survey was 255. The findings included The resident alpha consurvey, 03/26/22, reviewere in the facility. The capacity of 296 reside Review of the "Facility last updated 02/24/22 and the systems of the resident alpha consurvey, 03/26/22, reviewere in the facility. The capacity of 296 reside Review of the "Facility last updated 02/24/22 and the systems of the resident alpha consurvey, 03/26/22, reviewere in the facility. The capacity of 296 reside Review of the "Facility last updated 02/24/22 and the systems of the resident alpha consurvey.	luding managers, staff (both who provide services under eers, as well as their ning and any competencies re; andums of understanding, with third parties to provide at to the facility during both demergencies; and nethonology resources, electronically managing lectronically sharing reganizations. Ty-based and assessment, utilizing an is not met as evidenced ew and staff interview, apdate the Facility at the facility's current dent census on the first day of ealed that 255 residents ne facility has a licensed bed	F	338	The governing body must ensure that thas adequate supplies to meet that resi need. Inventory of supplies must be rev a weekly basis. Any issues found will be corrected by 8/24/22. The governing body designee will follow the DON to ensure that respiratory equi cleaned at all times by the respiratory the designee. The Administration will valida findings on a weekly basis. Any issues the corrected by 8/9/22. The governing body will ensure that resare supervised for safety, especially the frequent falls and residents with hip replacement weekly. Findings will be coby 8/24/22 The governing body will follow up with administration to ensure that residents unwheelchair are assessed for wheelchair managements weekly. Findings will be addressed, documented and their plan on will be updated by 8/24/22 The governing body will ensure that the Administration is following up to ensure the licensed nurses and C N A's know how to provide care for residents with hip replace and that injury of unknown origin are accomposed investigated. Findings will be addressed 8/24/22 Rytes Compliance Consulting Group will in service to the Administration on the importance of maintaining the integrity of reports and facility records are maintaine. The governing body will ensure the license nursing staff are adequately trained on the take care of patients with laryngectomies respiratory therapist will be responsible for training and will ensure compliance by 8/24/2022.	dents iewed on y up with pment is herapist/ te found will idents isse with herected he sing of care hat be ements urately by provide incident d. sed bw to The	8/24/22	
		of Medical Conditions			5.2 <u>5.2</u>			

NAME OF PROVIDER OR SUPPLIER		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
DEANWOOD REHABILITATION AND WELLNESS CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG PROVIDER OR LEACH DEFICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE DEFICIENCY MUST BE PRECEDED BY PULL TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE DEFICIENCY			095019	B. WING _				
DEANWOOD REHABILITATION AND WELLNESS CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 838 Continued From page 321 stipulated, "The DON (Director of Nursing) with the Admissions department reviews all admission referrals to ensure that resources are needed in the case of complex referrals, in-service are conducted for nursing staff to meet the particular needs of the referral prior to admission." However, through observation3, record review staff and family interviews, it was determined that facility staff failed to maintain or have in the facility Resident #3's medical equipment, a Lary Tube (used to maintain the opening of the tracheostoma) subsequently, the resident had to be transferred to the ER for a replacement. Under, "Other special care needs" - the facility lists "ventilator care" as a service offered. During a face-to-face interview with Employee #2 and Employee #5 on 04/20/22 at approximately 11:15 AM (during the Quality Assurance Interview) they stated the facility does not accept resident on ventilators. F 842 SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG PROFIDED PROFIDES PLAN OF CORRECTIVE ACTION (CAS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DUE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DUE (EACH CORRECTIVE ACTION of UNIVERS) (DAY 14/222 F 838 Governing body will ensure the facility has a van that contains safety components, and that the driver is educated on resident safety while riding the van. MONITORING CORRECTIVE ACTION The governing body will conduct rounds to ensure that the clinical team are investigating injury of unknown origin correctly and that licensed nursed are providing correct care to residents with Lary tube, that residents are supervised and monitored, that the clinical team are investigating injury of unknown origin correctly and that licensed nursed are providing correct care to r	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	20/2022
(A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) F 838 Continued From page 321 F 838 Continued From page 321 stipulated, "The DON (Director of Nursing) with the Admissions department reviews all admission referrals to ensure that resources are available to accommodate all cases. If additional resources are needed in the case of complex referrals, in-service are conducted for nursing staff to meet the particular needs of the referral prior to admission." However, through observation3, record review staff and family interviews, it was determined that facility staff failed to maintain or have in the facility Resident #3's medical equipment, a Lary Tube (used to maintain the opening of the tracheostoma) subsequently, the resident had to be transferred to the ER for a replacement. Under, "Other special care needs" - the facility lists "ventilator care" as a service offered. During a face-to-face interview with Employee #2 and Employee #5 on 04/20/22 at approximately 11:15 AM (during the Quality Assurance Interview) they stated the facility does not accept resident on ventilators. F 842 F 842 F 838 Governing body will ensure Training is provided by staff educator/ Designee to administration, department heads, licensed nurses and C N A on how to care for residents with high previous and C N A on how to supervise esidents with high previous provided by staff educator/ Designee to administration, department heads, licensed nurses and C N A on how to cupervise residents with high previous provided by staff educator/ Designee Training is provided by staff educator/ Designee to administration, department heads, licensed nurses and C N A on how to cupervise residents with high previous provided by staff educator/ Designee Training is provided by staff educator/					50	000 NANNIE HEI EN BURROUGHS AVE. NE		
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SS=E CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842	stipulated, "The DON the Admissions depair referrals to ensure the accommodate all cas are needed in the cas in-service are conduct the particular needs of admission." However, through obstaff and family intervice and family intervice and family staff failed to make the facility staff failed to make the facility Resident #3's. Tube (used to maintat tracheostoma) subsebe transferred to the Under, "Other special lists "ventilator care" a face-to-face intervice Employee #5 on 04/2 AM (during the Qualit stated the facility doe ventilators. Resident Records - Ic CFR(s): 483.20(f)(5), \$483.20(f)(5) Resider (i) A facility may not resident-identifiable to accordance with a coagrees not to use or except to the extent to do so.	(Director of Nursing) with rtment reviews all admission at resources are available to es. If additional resources se of complex referrals, sted for nursing staff to meet of the referral prior to servation3, record review riews, it was determined that naintain or have in the medical equipment, a Lary in the opening of the quently, the resident had to ER for a replacement. I care needs" - the facility as a service offered. During aw with Employee #2 and 10/22 at approximately 11:15 by Assurance Interview) they is not accept resident on dentifiable Information 483.70(i)(1)-(5) Int-identifiable information. The elease information that is the public. The elease information that is the an agent only in intract under which the agent disclose the information the facility itself is permitted			Training is provided by staff educator/ Do to administration, department heads, lice nurses and C N A on how to care for reswith hip replacements, how to investigate of unknown origin, how to supervise resiwith aggressive behavior, patient safety the building. Governing body will conduct rounds to e that the respiratory therapist is following residents with stoma to ensure there are occlusions. Findings will be corrected by 8/24/22. Governing body will ensure that the facilia van that contains safety components, the driver is educated on resident safety riding the van. MONITORING CORRECTIVE ACTION The governing body will conduct rounds ensure that residents are supervised and monitored, that the clinical team are investigating injury of unknown origin co and that licensed nursed are providing care to residents with Lary tube, that resare safe in and out of the building, that fareports maintain its integrity, that the fac adequate supply to take care of the residenceds. This audit will take place weekly monthly x3. Findings will be corrected and the correc	ensed idents e injury dents out of nsure up with no ity has and that while to define the idents accility illity has dents x4, then	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		095019	B. WING _			04/	20/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DEANWO	OD PEHARII ITATION AI	ND WELLNESS CENTER		5	000 NANNIE HELEN BURROUGHS AVE. NE		
DLANVO	OD REHABILHATION AI	ND WELLNESS CENTER		٧	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	§483.70(i)(1) In according professional standard must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The facall information contain regardless of the formation records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, particularly poperations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research professional examiners, for a serious threat to he by and in compliance §483.70(i)(3) The factor for- (i) The period of time (ii) Five years from the there is no requirement in the serious for requirement in the serious for the requirement in the serious for the requirement in the serious for the period of time (iii) Five years from the there is no requirement in the serious for the requirement in the serious for the period of time (iii) Five years from the there is no requirement in the serious for the period of time (iii) Five years from the there is no requirement in the serious for the period of time (iii) Five years from the there is no requirement in the period of time (iii) Five years from the period of time (iiii) Five years from the period of time (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ardance with accepted ds and practices, the facility al records on each resident department of the facility must keep confidential med in the resident's records, and or storage method of the facility must be permitted by applicable law; and supposes, or health care ted by and in compliance department of the facility must keep confidential med in the resident of the facility must be permitted by applicable law; and to avert department of the facility must safeguard medical gainst loss, destruction, or and the required by State law; or the date of discharge when	F8	342	F838 STARTS HERE	ypes ity of : fety will	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY PLETED	
		095019	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	033013		STREET ADDRESS, CITY, STATE, ZIP C	•	/20/2022
NAIVIE OF F	KOVIDER OR SUFFLIER			, - , , -		
DEANWO	OD REHABILITATION A	ND WELLNESS CENTER		5000 NANNIE HELEN BURROUGHS . WASHINGTON, DC 20019	AVE. NE	
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F 842	(ii) Sufficient informat (iii) A record of the re (iii) The comprehens provided; (iv) The results of an and resident review of determinations condi (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMEN' by: Based on record rev five (5) of 105 sampl staff failed to ensure contained accurate in failure to: accurately Treatment administra resident; maintain the "Incident/Accident Re resident-to-resident as serious injury to the re resident's medical re documented for three #3, #126, #164, #404 The findings include: Review of the facility Documentation/Reco "It is the policy of [Fa accurate documenta contributing tote high Clinical documents	e law. edical record must contain- ion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and elogy and other diagnostic equired under §483.50. T is not met as evidenced view and staff interview, for ed residents, the facility's a resident's record information as evidenced by record information on a ation record for one (1) e integrity of an eport" related to a altercation resulting in resident; and ensure cord were accurately e (3) residents. Residents' 4, and #408.	F 8-	CORRECTIVE ACTIONS FOR AFFECTED RESIDENT: Resident #3 was sent to the and did not return to the factor Resident #126 was assessed on 4/26/22, resident suffered outcome. MD/RP notified or manager will ensure resident transferred from wheelchair persons assist with hoyer life.	OR THE thospital 3/29/22 ility. d from head to toe d no negative 14/26/22.Unit ht is properly to bed, two	8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		095019	B. WING			04/	20/2022
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NAME OF T	NOVIDER OR SOLT LIER				000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			ASHINGTON, DC 20019		
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F 842	resident's health" 1. The facility staff fai	led to ensure Resident #3's tion Record for 01/08/22 to	F	342	Resident #164 was assessed by unit ron 4/26/22 to ensure that blood pressitaken on the correct arm. Resident surnegative outcome. Resident # 404 went to the hospital arreturn Resident #404 sent to ER and did not the facility.	ure was ifered no nd did not	8/24/22
	Larynx, Acquired Abs Tracheostomy Status Review of a physiciar	e diagnoses including of Larynx, Carcinoma of ence of Larynx, and . n's order dated 12/02/21			IDENTIFICATION OTHERS WITH TH POTENTIAL TO BE AFFECTED All residents in the facility have the po		
		order] instructed stated staff to, ME (Heat Moisture Exchanger) daily House wide audit will be co		be affected by this practice. House wide audit will be conduct by D Designee to ensure that all residents t	ON/		
	from 01/08/22 to 02/0 facility's nurses initialed Resident #3's HME diduring a telephone in PM, Employee #31 (Finat Resident #3 did ris lary-tube from 01/0 asked why it took so I HMEs, Employee #31	7/22 showed that the ed that they changed aily on dayshift. However, terview on 04/14/22 at 2:35 Respiratory Therapist) stated not have HMEs to connect to 08/22 to 02/07/22. When ong for Resident #3 to get I said, "I did not know the lary-tube. And the HMEs we compatible with the			record contain accurate information, the is sufficient documentation on all incide reports, that the nurses are taking blood pressure for residents on dialysis on the arm and that documentation is done for residents who are in the facility. Any issues found will be corrected BY	nat there ent od ne correct or	
	-	to accurately document the £126's incident investigation					
	dated 12/27/21 docur from wheelchair to be	acility Reported Incident) nented "During a transfer d by two staff, resident onto leg and the leg scratched					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		095019	B. WING _			04/	20/2022
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-7/2	20/2022
				5	000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			VASHINGTON, DC 20019		
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F 842	Continued From page	e 325	F 8	342	MEASURES TO PREVENT RECURREN	ICE.	8/24/22
	laceration on the upp scratched her right le rail. Writer was made assessed the wound. Resident #126 was a 11/16/21 with multiple Failure Unspecified, I	dmitted to the facility on diagnoses including Heart Presence of Right Artificial (idney Disease, Stage 4			In service will be provided to all licensed staff by Staff Educator/ Designee on the importance of ensuring that information i resident's record is accurate, that docum on incident report is completed accuratel that blood pressure is taken on the arm v dialysis access site is not present by 8/2. In -service will be provided to C N A's to blood pressure on the non-dialysis arm by the Staff Developme designee by 8/24/22.	n the entations y and where the 4/22. take	
	(MDS) dated 11/17/2 staff coded the follow				ADON/ Designee will conduct audit to en nurses are documenting accurately on the which blood pressure was taken for dialy residents. Any issues found will be correctly 8/24/22	ccurately on the arm on taken for dialysis	
	for Mental Status (BII indicating moderately In section G (Function		Supervisors / Designee will ensure that licen nurses are completing incident reports in a timanner. Any issues found will be corrected 8/21422. Unit managers will ensure that the nurses do document on a resident who is out of the fac		a timely sed by s do not facility.		
	submitted to the Depa 12/23/21 at 6:47 PM stransfer from wheelch residents suddenly swagainst the ½ side rai of incident; writer ass Review of the nursing 12/23/2021 at 11:50 A transfer from wheelch	showed, "During a pair to bed by two staff vay her leg scratched Iwriter was made aware essed the wound" I progress note dated AM documented, "During a pair to bed by two staff, ay her right leg and the leg			Any issues found will be corrected by 8/2		
	Review of the facility's	s investigation of the incident					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER	1	50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	revealed a handwritte nurse aide who was in 12/22/2021 at 5:15 P floated to 3N to work [Resident #126] asked took her to her room the leg was bleeding called the nurse to control to the leg was bleeding called the nurse to control to the leg was bleeding called the nurse to control to the leg was bleeding called the nurse to control to the leg was bleeding called the nurse to control to the leg was bleeding. The handwritten nurse signed and dated 12/1 lacked any mention of interviewed regarding. During a face-to-face 04/20/2022 at 10:45 and which staff was trans wheelchair to the bed which staff was trans wheelchair to the bed 04/20/2022 at 1:38 P Coordinator) Employs findings. 3. Facility staff failed site where they obtain pressure. Resident #164 was an 07/26/2016 with multiple site where they obtain pressure.	en statement by the certified involved in the incident dated M showed, "On 12/22/21, I at approximately 5:15 PM d me to put her in bed. I in transferring her I notice. When I got her on the bed, I ime and have a look at it." e's statement which was 22/21 was reviewed and it if any additional staff being in the incident. interview conducted on AM with Employee #58 is stated "It was just me who dent #126] to the bed. If yme." Employee # 58 was ons about the incident with occumented on 12/23/2021 inferring resident from the I. interview conducted on M with Employee #7 (Clinical ee #7 acknowledged the to accurately document the ned Resident #164's blood dmitted to the facility on the incidents.	F	842	MEASURES TO PREVENT RECURRENCE CONT. Unit managers/ supervisors wensure weekly that the charge nurses are documenting accurate in residents' medical records. Findings will be corrected by 8/24//22 Administrator/ DON/ADON will ensure weekly that the integrit resident's incident report is maintained. Findings will be corrected by 8/24/22. Unit manager will ensure that resident # 126's record contain accurate information., and that investigations on incidents are completed Findings will be corrected by 8/24/22 Unit manager will ensure weet that charge nurses are documented to the correct arm on which blood pressure is taken. For resident #164. Findings will be corrected 8/24/22 ADON/Designee will ensure with that no one is documenting or resident who is out of the facil Findings will be corrected by 8/24/25.	erately Il cy of ekly enting d t ed by weekly a a ity.	8/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
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	ROVIDER OR SUPPLIER OD REHABILITATION AN	I ID WELLNESS CENTER		50	REET ADDRESS, CITY, STATE, ZIP CODE 00 NANNIE HELEN BURROUGHS AVE. NE ASHINGTON, DC 20019	1 04/	ZUIZUZZ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	revealed the following 03/04/2022 [Quarterly BIMS summary score cognitive response at O (Special Treatment Programs). 04/07/2022 [Physicia AV (arteriovenous) grobleeding, redness, te every shift, (No B/P (blood draws on this at 03/18/2022 (Revision "[Resident #164] has dialysisDo not take specimens from left at Review of the vital sig 03/18/22 to 04/10/22 documented: 03/18/22 at 8:05 PM of mercury) Lying I/ar 03/22/22 at 9:39 PM 03/25/22 at 11:11 PM 03/26/22 at 8:40 PM 03/27/22 at 11:29 AM 03/27/22 at 11:38 PM 03/27/22 at 11:55 PM 04/09/22 at 7:35 PM 04/09/22 at 11:50 AM The evidence shower	y MDS], facility staff coded a e of "15", indicating intact and "yes" to dialysis in Section is, Procedures, and "s Order] "Assess dialysis raft site on left upper arm for inderness, and swelling blood pressure) and no arm) every shift" I date) [Care Plan] Left arm site used for blood pressure or blood irm" I gns documentation from showed that facility 136/87 mmHg (millimeters im (left arm) 130/74 mmHg Lying I/arm 128/72 mmHg Lying I/arm 128/72 mmHg Lying I/arm 139/74 mmHg Lying I/arm 130/74 mmHg Lying I/arm 130/74 mmHg Lying I/arm 138/76 mmHg Lying I/arm 138/76 mmHg Lying I/arm 128/72 mmHg Lying I/arm 138/76 mmHg Lying I/arm 138/76 mmHg Lying I/arm 148/72 mmHg Lying I/arm 148/72 mmHg Lying I/arm 158/74 mmHg Lying I/arm 158/75 mmHg Lying I/arm 158/76 mmHg Lying I/arm 168 that facility staff failed to the site where they were	F	342	MONITORING CORRECTIVE ACTIONS DON/Designee will conduct he wide audit to ensure that reside treatment record (TAR) contains accurate information, that incidents/accidents are investing that blood pressure is taken on nondialysis arm for dialysis residents and that nurses are documenting on residents who not in the facility. This audit with carried out weekly x4, then max immediately and reported to committee.	gated, not or are ll be onthly	8/24/22

AND PLAN OF CORRECTION IDENTIFICATION	I NI IMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
095	5019 E	B. WING		C 04/20/2022
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CEI	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	04/20/2022
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
During a face-to-face interview conduct 04/20/22 at 10:36 AM, Employee #2 (I Nursing) acknowledged the finding ad "This is an identified issue and a PIP (performance improvement plan) is in address the issues of documentation." 4.Facility staff documented completing Resident #404 while he was out of the (hospitalized) and recreated an "Incide Report" related to a resident-to-reside altercation resulting in serious injury to resident. A. Review of a Facility Reported Incide dated 02/23/22, documented, "The conurse observed [Resident 404] sitting to besides his roommate's bed #420A; nurse noticed blood on [Resident #404 and mouth. The nurse assessed [Resil #404's] left ear and mouth and there we tear or abrasion including his face [File #82] was interviewed he said, "that macoming over to my bed side and when him to go back to his side of the bed, him e on my stomach and chest and I pure on the chin and he fell" Resident #404 was admitted to the fact 12/06/16 with diagnoses that included: Unspecified Dementia without Behavioral Disturbances, Vascular Dementia with Behavioral Disturbances and Transien Ischemic Attack. Review of Resident #404's medical recipied showed the following:	Director of stated, place to I tasks on e facility ent/Accident ent (FRI) charge on the floor the charge the charge the charge dent eas no skin Resident en keeps I asked en punched enched him elility on enched e	F 842		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		095019	B. WING		04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION	AND WELLNESS CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE VASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 842	every hour" 02/21/22 [Treatmen revealed a check m for the evening shift sections, "Nurse to evaluation on show "Check wonder gua on left ankle every sointment to entire b and behind ear and "Monitor for sign of the task was completed to the task was completed." The TAR further reveault for the task was completed to the task was completed. The TAR further reveault for the task was completed to the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the task was completed. The TAR further reveault for the TAR further reveault	It Administration Record] ark and licensed staff initials at (3:00 PM- 11:00 PM) in the complete full body skin er dayson Monday"; ard functioning and placement shift, hours"; "Apply ody"; "Assess skin around ear lobe for irritation"; COVID- 19", indicating that eted. realed that facility staff perature of "97.7" (degrees et/22 for the evening shift. showed that from 02/21/22 at 2 at 3:00 AM, facility staff es that Resident #404 was "In section, "Hourly ng monitoring and location. If [Nursing Supervisor The Ambulance left with the It to [Hospital Name]. They the Resident's face sheet, de status, Recent Physical,	F 842		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUC	TION		LETED
		095019	B. WING _				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AI	ND WELLNESS CENTER	1	5000 NANNIE	RESS, CITY, STATE, ZIP CODE E HELEN BURROUGHS AVE. NE ON, DC 20019	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD E COSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	unit). RP (represental unit). RP (represental unit). RP (represental unit). RP (represental unit). Representation of the unit). Repr	ed to ICU (intensive care titve) made aware" e interview conducted on nately 1:00 PM, Employee #7) acknowledged the findings comments. If to maintain the integrity of the Report" related to a aftercation resulting in resident. It interview conducted on M, Employee #1 Ided the survey team with a novestigation documents of ent altercation. The an "Incident/Accident at #404's name dated dothe following: An with no markings to reflect ad no injuries, for "type of as checked and the words at to it, "no" in the section in to the hospital, name and the #7 (Clinical Coordinator) ring report", name and the #6 (Administrator in the promote of Nursing", the of Employee #1 in the promote of Employee #1 in the promote of Employee's #25 #26 (CNA), #27 (CNA), #28 and #29 (CNA).	F	142			8/24/22
	survey team from En	ence was received by the nployee #1 on 03/30/22 at spondence revealed a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		095019	B. WING _			C 04/20 /2	2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5000 NANNIE HELEN BURROUGHS AV WASHINGTON, DC 20019		J. 1. 20.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	-	(X5) OMPLETION DATE
F 842	second copy of the fadocuments of the res This document was a with Resident #404's that revealed the foll depiction with markin on the right side of th "Other (specify)" had and left ear" written in asking if person takes [Hospital's Name] nes signature of Employe as the "person prepa signature of "Directo name and signature of section "Administrator revealed written states (Registered Nurse), # #29 (CNA) and a type and signature of Resi and time. During a face-to-face 03/31/22 at 3:30 PM, why there are two ve investigation report. S (the original) on Satu report and had the er statements." Employe completed the incided dated 02/22/22, wrote #7's name and signat he was out of the cou #1 continued to say, in Training) found the 2/21/22) in the shred documents that were	acility's investigation ident-to-resident altercation. In "Incident/Accident Report" name on it dated "2/21/22" owing: An anatomical gs to showed areas of injury e face, for "type of injury", "bleeding from the mouth ext to it, "yes" in the section in to the hospital and at to it, the name and e #7 (Clinical Coordinator) ring report", name and of Nursing" was blank, the of Employee #1 in the r". The documents also ements from Employee's #25 fe28 (Nursing Supervisor), ed statement with the name ident #82, absent of date	F	342		8	3/24/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(XX	3) DATE SURVEY COMPLETED
		095019	B. WING _			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZI 5000 NANNIE HELEN BURROUGI WASHINGTON, DC 20019		V .: 20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 842	04/04/22 at 12:48 PM Coordinator) Employed incident/accident reposurvey team on 03/30 investigation docume he completed the incisubmitted it to Emplo 02/21/22. When show "Incident/Accident Ref 02/22/22 with his nanification and the control of the color	I, Employee #7 (Clinical ee #7 was asked about the ort that was provided to the 0/22 as part of the facility's ints. Employee #7 stated that dent/accident form and yee #1 (Administrator) on wed a copy of the eport" document dated ine and signature, Employee to my writing. This is not the illed out and provided to the interview conducted on with Employee #6, she it of the original incident in the part of the process at uldn't find it (original incident in the incident/accident de writing in Employee #7]. When we out the incident/accident de writing in Employee #7's ee line]. That's my iployee #1] just signed it [the ator signature line]." interview conducted on Employee #6 (Administrator dged and admitted to int/Accident Report" related to altercation resulting in dent #404.	F	342		8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		095019	B. WING			C 04/20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019	NE	04/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	"Resident complain yesterday 2/16/22 an (Nurse Practitioner) morning with impress left distal femur, Acut right lateral femoral oworked with resident shifts will be interview had a fall or if resider had reported fallen to Resident #408 was a 05/25/21 with multiple Hemiplegia and Hem Muscle Weakness an Review of Resident # revealed the following: a BIMS sur severe cognitive imparts of the property of the	ded of right knee pain d she was assessed by NP X-ray report received this sion of Acute fracture of the e hairline fracture of the ondyle All staff who from 2/9/22 to 2/16/22 all wed to determine if resident anyone" dmitted to the facility on e diagnoses that included: iparesis, Hypocalcemia, ad Lack of Coordination. 408's medical record g: MDS], facility staff coded the mary score "04", indicating airment.	F 84	12		8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		095019	B. WING				20/2022
	ROVIDER OR SUPPLIER OD REHABILITATION AN	ID WELLNESS CENTER	•	50	TREET ADDRESS, CITY, STATE, ZIP CODE 1000 NANNIE HELEN BURROUGHS AVE. NE 1/ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	6-108 was completed Ombudsman" Review of Resident # record revealed that a hospitalized, facility of the following resident 02/27/2022 at 9:14 A 02/27/2022 at 10:20 02/28/2022 at 12:18 02/28/2022 at 12:19 ID During a face-to-face 04/18/22 at approxim (Clinical Coordinator) and stated, "The assaup if they are still in the resident maybe out of QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct iden This REQUIREMENT by: Based on staff intervial maybe of all system of the state of the comprehensive quality performance improves inclusive of all system	sent to the hospital. The land forwarded to and forwarded to an accompleting assessments: M Safe Smoker AM Dental/Oral PM Elopement Risk PM Use of Side Rail(s) Bladder and Bowel. Interview conducted on ately 1:00 PM, Employee #7 acknowledged the findings assessments automatically popine system even though the fine facility." The ent Activities (ii) Seessment and assurance. The acknowledged the findings are system even though the fine facility." The acknowledged the findings acknowledge		842			8/24/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	s	TREET ADDRESS. CITY. STATE. ZIP CODE	1 04/	20/2022
					000 NANNIE HELEN BURROUGHS AVE. NE		
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 335	, F8	367	F 867		8/24/22
	identify quality deficiencies. The resident census during the survey was 255. The findings include:				QAPI / QAA will ensure that the facility staff maintain and implement an effective comprehensive quality assurance and performance program that will show that area of deficiencies are adequately addressed. Any		
	appropriate plans of a quality deficiencies as Under §483.12, F600 Neglect, and Exploita Under §483.25(d)(2),	Freedom from Abuse,			issues found will be corrected by 8/24. QA committee will ensure that the staf implementing plans that are put in place address deficiencies. Any issues found corrected by 8/24/22. DON will ensure that the interdisciplinal discuss residents who are at risk for a	22. ff are ce to d will be ary team decline	
	Under § 483.25(i), F69 Under §483.25(k) F69 During a face-to-face with Employee #2 and at approximately 12:0	195 Respiratory care 197 Pain Management 198 Interview was conducted 199 Interview was conducted 299 Interview was conducted 290 Interview was			are discussed during the standup meetissues found will be corrected by 8/24. DON / Designee will ensure that all induction accidents are discussed during the meetings and to validate that the incide been fully investigated. Any issues for be corrected by 8/24/22.	/22. cidents/ crning lent had und will	
	interview. They were resident-to-resident a resident behaviors, re of daily living (ADL) or Respiratory/Tracheos management, in their each area addressed [Resident-to-resident behaviors]- In QA we We review them in the escalated to QA when whe was the root carresident-to-resident a the "At risk meeting",	stomy Care and Pain review and if so how was ? The stated: abuse and resident don't address behaviors. e "At Risk Meeting", its only n it's a systemic problem. mmittee meeting, we look at n, the interventions, and			Charge nurses will monitor and supervesidents who wanders to ensure they safe. Any issues found will be corrected 8/24/22. Quality Assurance Director/ Designee ensure that the facility is implementing and procedures to address residents wintrusive behavior during At Risk meet Any issues found will be corrected by The safety committee(department head clinical team, MDS, Activities staff and secretaries) will ensure that they addressed issues at length during the meet ensure that the residents are provide everything that the residents need to resafe. Any issues found will be addressed 8/24/22	will g policies with tings. 8/24/22. ads, d unit ess etings to ed with remain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	095019 B. WING		1	C 04/20/2022			
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			0000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 867	further stated, "We do QA we are supposed will be bringing behave			S and to wed issues	8/24/22		
	meeting, we discuss performance (Shower	e do a weekly quality of life residents' functional rs, feeders) and issues with the "At Risk Meeting".			Residents who wander will be monit and supervised every shift for safety purposes. Any issues found will be corrected by 8/24//22.		
		stomy Care and Pain iscussed at QA. Following s reviewed at the morning					
	was determined that committed/facility statimplement action plan	me of the QAA review, it Quality Assurance If failed to develop and as to correct identified elated to resident-to-resident viors, ADL care,					
F 880 SS=F	Infection Prevention & CFR(s): 483.80(a)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	(2)(4)(e)(f) ntrol	F 8	380			
	infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection p	n safe, sanitary and nent and to help prevent the nsmission of communicable					
	program.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				5	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019	<u>, </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 880	The facility must esta and control program (a minimum, the follow §483.80(a)(1) A systereporting, investigatin and communicable distaff, volunteers, visit providing services un arrangement based us conducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable disease infections before they persons in the facility (ii) When and to whore communicable disease reported; (iii) Standard and trant to be followed to preve (iv)When and how iscresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possilicircumstances. (v) The circumstance must prohibit employed disease or infected she involved she infected she	blish an infection prevention (IPCP) that must include, at ving elements: Immorphisms for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; I standards, policies, and orgam, which must include, allance designed to identify ble diseases or a can spread to other in possible incidents of the or infections should be insmission-based precautions tent spread of infections; the policies and the incidents of the isolation, infectious agent or organism at the isolation should be the ole for the resident under the se under which the facility the es with a communicable kin lesions from direct to or their food, if direct	F	880	F 800 CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #132 was assessed from he to toe on 4/26/22, resident suffered in negative out come.MD/RP notified of 4/26/22. Resident urine collection base in a privacy bag, snugly and appropristrapped to his bed. IDENTIFICATION OF OTHERS WITTHE POTENTIAL TO BE AFFECTE Residents with Foley residing in the facility have the potential to be affect by this practice. House wide audit will be conducted Licensed nursing staff to ensure that residents with urine collection bags a privacy bag and that the bag is not the floor. Also, to ensure that all employees are using their PPE'S correctly while in patient care area. Any issues found will be corrected be 8/24/22.	no on ag is riately TH D. ted by t have t on	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
	095019 B. WING			04/2	20/2022			
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
DEANNA	OD DELLA DIL ITATIONI AN	ID WELLNESS SENTED		5	000 NANNIE HELEN BURROUGHS AVE. NE			
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER		١	WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880 Continued From page 338			F		F 880 MEASURES TO PREVENT RECURF	RENCE:	8/24/22	
F 880	(vi)The hand hygiene by staff involved in directions. §483.80(a)(4) A syster identified under the factorrective actions take. §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev. The facility will conduct IPCP and update their This REQUIREMENT by: Based on observation staff failed to: (1) ensicollection bag was not maintain infection corpractices to help prevent transmission of comminfections. The censur was 255. The findings include:	procedures to be followed rect resident contact. Immorrace for recording incidents acility's IPCP and the en by the facility. Ite, store, process, and to prevent the spread of view. In an annual review of its reprogram, as necessary. In is not met as evidenced en and staff interview, facility ure Resident #132's urine at resting on the floor and (2)	F 8	880	Training will be provided to all staff in facility by Staff Educators / Designee ensure that staff put on the correct PF in patient care area by 8/24/22 In- service will be provided by Staff Ed Designee on the importance to ensure urine collection bag is not on the floor 8/24/22. Unit Managers will conduct rounds on units during their shift to ensure staff a using PPEs correctly. Any issues four corrected by 8/24/22. Charge nurses will conduct rounds dutheir shift to ensure urine collection be on the floor. Any issues found will be corrected by 8/24//22. QA nurse/Designee will conduct rander rounds weekly to ensure that employe wearing their PPE's correctly and follow infection control practices. Any issues will be corrected by 8/24/22. Supervisors / Designee will conduct roweekly to ensure infection control practice implemented as indicated. Any issued implemented is not on the floor that it is in a privacy bag at all times.	the to PE while ducator/ e that by their are and will be uring ag is not om ees are owing found ounds ctices sues t # 132's		
	(CDC) guidelines for associated urinary traincludes: " Keep the	ter for Disease Control prevention of catheter act infections (CAUTI) e collecting bag below the all times. Do not rest the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	095019 B. WING			04/	20/2022		
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	(https://www.cdc.gov/deline2009final.pdf) On 04/07/22 at appro#132 was observed reurine collection bag reurine collection. Alzhe and Muscle Weaknes A review of the Quarte (MDS) for dated 02/1 staff coded the follow. In Section C (Cognitival Interview for Mental Secore of "99," indication cognition. During a face-to-face 3:48 PM, Employee #Nurse/LPN), acknowled was on the floor and signification in its lowest position morning. I will explain Nurse's Aide) that the floor." 2. Facility staff failed while in a resident call (3) occurrences. A. During tour of unit AM, Employee #29 (0)	chicpac/pdf/CAUTI/CAUTIgui eximately 3: 45 PM, Resident resident lying in bed with his resting lying on the floor. readmitted to the facility on rese that included: Urinary rimer's, Dementia, Epilepsy rimer's, Dementia, Epil	F	380	F 880 MONITORING CORRECTIVE AC DON/ Designee will conduct hous audit to ensure that employees are wearing their PPE's correctly and that the bag for urine collection is the floor. This audit will take place x3, then monthly x4. Findings will be addressed immed and report presented to QAPI com	e wide e ensure not on weekly	8/24/22

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		095019	B. WING _			C 04/20/2022	
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. N WASHINGTON, DC 20019	E	04/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	During a face-to-face time of the observation acknowledged the firm was aware of the fact shields at all times in 32. Facility staff failed resident care area. B. During a tour of ur 6:21 AM, Employee acoming out of a residemask but did not have to be a residemask but did not have to be a residemation of the observation acknowledged that should policy and stated, "I juittle air." C. Facility staff failed providing for Residem On 04/06/22 at 6:10 And Nursing Assistant) was care (bed bath) for Residem aface shield. During a face-to-face 6:20 AM, Employee approtocol is to always forgot to put it (face shifluenza and Pneum CFR(s): 483.80(d) Influenza immunizations	interview conducted at the on, Employee #29 ading and stated that she ility's policy to wear face the facility. It to wear PPE while in a hit 4 north on 04/06/22 at #49 (CNA) was observed ent's room wearing a face e on a face shield. Interview conducted at the on, Employee #49 he knew the facility's PPE ust took it off, and I needed a how to wear a face shield when at #55. AM, Employee #26 (Certified as observed providing am esident #55 without wearing hinterview on 04/06/22 at #26 stated that the facility's wear a face shield. She just shield) on. Indecoccal Immunizations (2) and pneumococcal	F 8			8/24//22	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED		
	095019 B. WING		04/2	20/2022			
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	(i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is or immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided educati and potential side efferimmunization; and (B) That the resident immunization or did not immunization or did not immunization or did not immunization. §483.80(d)(2) Pneummust develop policies that— (i) Before offering the immunization; (ii) Each resident is or immunization; (iii) Each resident or the immunization of the immunizatio	influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza r 1 through March 31 mmunization is medically resident has already been a time period; e resident's representative refuse immunization; and dical record includes dicates, at a minimum, the for resident's representative on regarding the benefits ects of influenza received the influenza receive the influenza received the influenza redical contraindications or receive the received the influenza redical contraindications or received the received the influenza redical contraindications or received the influenza redical contraindications or received the influenza redical contraindications or received the influenza redical contraindication or resident or the resident's resident's resident's regarding the side effects of the resident has red; refuse immunization; and	F	8883	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 182 was assessed from h toe on 4/26/22 by unit manager, resident apparent distress. MD/RP notified 4/26/22. Resident suffered no negative outcome. Resident refused to take the pneumococcal vaccine. Risk versus be explained. Resident #603 was assessed from he toe by unit manager on 4/26/22, residently accepted that pneumococcal vacthis was administered on 6/15/22. House wide audit in progress for pneumococcal vaccine administration issues will be corrected by 8/9/22 IDENTIFICATION OF OTHERS WITH POTENTIAL TO BE AFFECTED. All resident eligible for to receive pneumococcal vaccine have the pote be affected by this practice House wide audit is ongoing to identification that the facility staff did not entered they have taken or at least offered to administer the pneumococcal vaccine issues will be addressed by 8/24/22.	lent in on //e e e e e e e e e e e e e e e e e e	8/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019 B. WING		04/2	20/2022			
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				50	TREET ADDRESS, CITY, STATE, ZIP CODE 000 NANNIE HELEN BURROUGHS AVE. NE /ASHINGTON, DC 20019	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 883	following: (A) That the resident was provided educat and potential side effinmunization; and (B) That the resident pneumococcal immute pneumococ	or resident's representative ion regarding the benefits fects of pneumococcal either received the inization or did not receive inmunization due to medical efusal. To is not met as evidenced riew and staff interview, for ed residents, facility staff there was documentation in al record of the inprovided regarding the immunization, the refusal of or medical he vaccine(s). Residents' entitled, "Pneumococcal et" (not dated) documented, cility Name] to offer to all cocal upon admission and ance with the the Centers of Disease ine facility Medical Director"	F	883	MEASURES TO PREVENT RECURRENCE. In- service will be provided to all Lice nursing staff to ensure that they offer administer pneumococcal vaccine at cost to the resident upon admission a ongoing by 8/24/2022. Licensed clinical staff will ensure that re-offer to administer pneumococcal vaccine to residents who refused and ensure proper documentation is in pl Any issues found will be addressed to 8/24/22. Review will be conducted by supervisensure that the consent for pneumocovaccine is signed upon admission and the contents of the consent is implemented. Any issues found will to addressed by 8/24/22. The pneumococcal consent form has added to the admission package so a responsible party to determine if they their loved ones to take the vaccine of Any issues found will be corrected by 8/2142022. Resident #182 will be offered pneumococcal vaccine by 8/9/22 Resident #603 will be offered pneumococcal vaccine by 8/24/22	t to no and t they d ace. by sors to cocal ad that be assist / want or not.	8/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L LIDENTIFICATION NITIMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		095019	B. WING _				20/2022	
NAME OF PI	ROVIDER OR SUPPLIER		 	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	20/2022	
DEANWO	OD REHABILITATION AN	ID WELLNESS CENTER			5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019			
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F 883	Status (BIMS) score cognitive response. Review of Resident # health record lacked facility staff provided resident or their representation of their r	Brief Interview for Mental of "14", indicating intact and paper documented evidence that information/education to the esentative regarding the the influenza and nization or the refusal of the admitted to the facility on ses that included: of Left Patella and Upper s, Seizures and Anemia. Sion MDS dated 03/20/2022, we Status), facility staff as "resident is rarely/never documented evidence that information/education to the esentative(s) regarding the	F	883	,	udit ssed	8/24/22	
	It should be noted that	at Employee #5 was not able						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED C 04/20/2022	
095019			B. WING _				
NAME OF PROVIDER OR SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5000 NANNIE HELEN BURROUGHS AVE. I WASHINGTON, DC 20019		4/20/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 883	provide the survey te	e 344 am with any documentation or #603 vaccine(s) education,	F8	83		8/24/22	