

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/10/2020</b>
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NAME OF PROVIDER OR SUPPLIER  
**DEANWOOD REHABILITATION AND WELLNESS**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**5000 BURROUGHS AVE. NE  
WASHINGTON, DC 20019**

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

Initial Comments

L 000

Deanwood Rehabilitation and wellness center disclaimer:

12/4/2020

A COVID-19 Focused Infection Control Survey was conducted at Deanwood Rehabilitation and Wellness Center from November 4, 2020 through November 10, 2020. Survey activities consisted of a review of 24 sampled residents. The survey was conducted under Title 22B District of Columbia Municipal Regulations, Chapter 32 Nursing Facilities. The resident census during the survey was 248.

Facility submits this plan of correction under Procedures established by the Department Of Health in order to comply with the Department's directive to change condition which the department alleges are deficient under state regulations relating to long term care. This should not be construed as either a waiver of the facility's right to appeal and to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrong doing.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

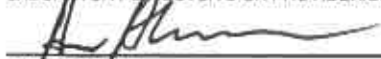
Abbreviations

- AMS - Altered Mental Status
- ARD - Assessment Reference Date
- AV- Arteriovenous
- BID - Twice- a-day
- B/P - Blood Pressure
- cm - Centimeters
- CMS - Centers for Medicare and Medicaid Services
- CNA- Certified Nurse Aide
- CRF - Community Residential Facility
- D.C. - District of Columbia
- DCMR- District of Columbia Municipal Regulations
- D/C Discontinue
- dl - deciliter
- DMH - Department of Mental Health
- EKG - 12 lead Electrocardiogram
- EMS - Emergency Medical Services (911)
- G-tube Gastrostomy tube
- HR- Hour
- HSC - Health Service Center
- HVAC - Heating ventilation/Air conditioning

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

TITLE

(X6) DATE



*LNHB*

*12-1-20*

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L 000	Continued From page 1  ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN - midnight Neuro - Neurological NP - Nurse Practitioner O2- Oxygen PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey ROM - Range of Motion Rp, R/P - Responsible party SCC - Special Care Center Sol- Solution TAR - Treatment Administration Record	L 000		12/4/20
L 051	3210.4 Nursing Facilities  A charge nurse shall be responsible for the following:  (a)Making daily resident visits to assess physical and emotional status and implementing any	L 051	<b>CORRECTIVE ACTION FOR AFFECTED RESIDENT</b> Resident # 1 was assessed on 11/27/20, resident suffered no negative outcome. Resident #2 was assessed on 11/27/20, resident suffered no negative outcome.	12/4/20

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L 051	<p>Continued From page 2</p> <p>required nursing intervention;</p> <p>(b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies;</p> <p>(c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed;</p> <p>(d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents;</p> <p>(e)Supervising and evaluating each nursing employee on the unit; and</p> <p>(f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by:</p> <p>Based on record review and staff interview for 19 of 24 sampled residents, the charge nurse failed to update the residents' care plans with person-centered goals and approaches to address their potential to be exposed to COVID-19; to address resident who were exposed to the COVID-19 virus; and failed to revise one (1) residents care plan to include dialysis services. Residents' #1, #2, #3, #4, #5, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #24.</p> <p>Findings included...</p> <p>1.The charge nurse failed to update the following residents' care plans with person-centered goals</p>	L 051	<p>Resident #3 was assessed on 11/27/20, resident suffered no negative outcome. Resident #4 was assessed on 11/27/20, resident suffered no negative outcome. Resident #5 was assessed on 11/27/20, resident suffered no negative outcome. Resident #3 was assessed on 11/27/20, resident suffered no negative outcome. Resident #4 was assessed on 11/27/20, resident suffered no negative outcome. Resident #5 was assessed on 11/27/20, resident suffered no negative outcome. Resident #6 was assessed on 11/27/20, resident suffered no negative outcome. Resident #8 was assessed on 11/27/20, resident suffered no negative outcome. Resident #9 was assessed on 11/27/20, resident suffered no negative outcome. Resident #9, #10, #11, #12, #13, #14, #15, #16 #17, #18,#19 and #24 were assessed on 11/27/20, they suffered no negative outcome.</p> <p>Care plan for resident #1 was updated 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus. Care plan for resident #2 was updated on 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus. Care plan for resident #3 was updated on 11/10/20 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p>	<p>12/4/20</p> <p>12/4/20</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION exposure to the Covid -19 virus.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <p style="text-align: center;"><b>HFD02-0017</b></p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <p style="text-align: center;"><b>11/10/2020</b></p>
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L 051	<p>Continued From page 3</p> <p>and approaches to address their potential exposure to COVID-19 virus:</p> <p>Resident #1 was admitted to the facility on August 20, 2018, with diagnoses that included Hypertension, Asthma, Human Immune Deficiency Virus, Schizoaffective Disorder, Dementia and Major Depressive Disorder.</p> <p>A review of the progress note dated October 30, 2020, at 4:51 PM showed "Report received that resident has been exposed to an individual who has tested COVID-19 positive ... RP and staff educated on infection prevention and the purpose of quarantine and maintaining the quarantine for 14 days ..."</p> <p>A review of the care plan last updated on August 5, 2020, showed that facility staff failed to update Resident # 1's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.</p> <p>Resident #2 was admitted to the facility on May 16, 2018, with diagnoses that included Hypertension, Hyperlipidemia, and Diabetes Mellitus.</p> <p>A review of the progress note dated October 30, 2020, at 6:34 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive ...Staff educated on infection prevention and maintaining the quarantine for 14 days ..."</p> <p>A review of the care plan last updated on July 21,</p>	L 051	<p>Continued from page 3:</p> <p>Care plan for resident #4 was updated 11/10/20, to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #5 was updated on 11/10/20 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #6 was updated 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #7 was updated on 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #8 was updated 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #9 was updated on 11/10/20 to reflect person centered goals and approaches to address his potential exposure to <i>the</i> Covid-19 virus.</p> <p>Care plan for resident #10 was updated on 11/10/20 to reflect person centered goals and approaches to address potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #11 was updated on 11/1020 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p>	12/4/20

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L 051	<p>Continued From page 4</p> <p>2020, showed that facility staff failed to update Resident #2's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.</p> <p>Resident #3 was admitted to the facility on April 25, 2012, with diagnoses that included Hypertension, Hyperlipidemia, Diabetes Mellitus, Heart Failure, End-stage Renal Failure (ESRD), and Major Depressive Disorder.</p> <p>A review of the progress note dated October 30, 2020, at 6:26 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive... RP and staff educated on infection prevention and maintaining the quarantine for 14 days ..."</p> <p>A review of the care plan last updated on June 19, 2020, showed that facility staff failed to update Resident #3's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.</p> <p>Resident #4 was admitted to the facility on October 12, 2016, with diagnoses that included Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Hyperlipidemia, Diabetes Mellitus, Asthma, and Dementia.</p> <p>A review of the progress note dated October 30, 2020, at 6:13 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive ... RP and staff</p>	L 051	<p>Care plan for resident #12 was updated on 11/10/20 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #13 was updated 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #14 was updated on 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #15 was updated 11/10/20 to reflect person centered goals and approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident # 16 was updated 11/10/20 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #17 was updated 11/10/20 to reflect person centered goals and approaches to address her potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #18 was updated on 11/10/20 to reflect person centered goals approaches to address his potential exposure to the Covid-19 virus.</p> <p>Care plan for resident #19 was updated on 11/10/20 to reflect person centered goals approaches to address his potential exposure to the Covid-19 virus.</p>	12/4/20

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L 051

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were educated by this writer on infection prevention and maintaining the quarantine for 14 days ..."

A review of the care plan last updated on July 21, 2020, showed that facility staff failed to update Resident #4's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.

Resident #5 was admitted to the facility on July 28, 2020, with diagnoses that included Hypertension, Asthma, Anemia, End-stage Renal Disease, Schizophrenia, Anxiety, Diabetes Mellitus, and Major Depressive Disorder.

A review of the progress note dated October 30, 2020, at 6:10 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive ...Resident RP and staff educated on infection prevention and maintaining the quarantine for 14 days ..."

A review of the care plan last updated on August 1, 2020, showed that facility staff failed to update Resident #5's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.

Resident #6 was admitted to the facility on February 2, 2015, with diagnoses that included Multiple Sclerosis, Hyperlipidemia, and Anxiety.

A review of the progress note dated October 30,

L 051

Care plan for resident #24 was updated 11/12/20 to reflect person centered goals approaches to address his diagnosis of End Stage Renal Disease.

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L 051	<p>Continued From page 6</p> <p>2020, at 5:59 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive ...RP and staff educated on infection prevention and maintaining the quarantine for 14 days ..."</p> <p>A review of the care plan last updated on August 6, 2020, showed that facility staff failed to update Resident #6's care plan to show person-centered goals and approaches to address the resident's exposure to Covid-19 infection.</p> <p>During a telephone interview conducted on November 9, 2020, at approximately 1:15 PM with Employee #7 [Unit Manager]. He acknowledged the findings.</p> <p>Resident #8 was admitted to the facility on June 28, 2020, with diagnoses that included Hyperlipidemia, Hypertension, Diabetes Mellitus, Cerebrovascular Disease, and Major Depressive Disorder.</p> <p>A review of the progress note dated October 30, 2020, at 6:58 PM showed, "Report received that resident has been exposed to an individual who has tested COVID-19 positive... Resident, RP and staff educated on infection prevention and maintaining the quarantine for 14 days ..."</p> <p>A review of the care plan last updated on July 27, 2020, showed that facility staff failed to update Resident #8's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19</p>	L 051		12/4/20

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L 051	<p>Continued From page 7</p> <p>infection.</p> <p>Resident #9 was admitted to the facility on July 28, 2008, with diagnoses that included Hypertension, Congestive Heart Failure, Hyperlipidemia, Diabetes Mellitus, and Major Depressive Disorder.</p> <p>A review of the progress note dated October 22, 2020, at 4:48 PM showed, "Call received that one of the residents staying in the same room as [Resident's name] has tested positive for COVID-19 ...They were further notified that [Resident's name] will be quarantined in his room for the following 14 days per facility policy ..."</p> <p>A review of the care plan last updated on July 22, 2020, showed that facility staff failed to update Resident #9's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19 infection.</p> <p>Resident #10 was admitted to the facility on December 6, 2019, with diagnoses that included Hyperlipidemia, Anemia, Hypertension, Kidney Disease Stage 3 and Vascular Dementia.</p> <p>A review of the progress note dated October 22, 2020, at 4:57 PM showed, "Call received that one of the residents staying in the same room as [Resident's name] has tested positive for CD-19. They were further notified that [Resident's name] will be quarantined in his room for the</p>	L 051		12/4/20



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L 051	<p>Continued From page 8</p> <p>following 14 days per facility policy ..."</p> <p>A review of the care plan last updated on September 28, 2020, showed that facility staff failed to update Resident #10's care plan to show person-centered goals and approaches to address the resident's exposure to COVID-19 infection.</p> <p>During a telephone interview conducted on November 9, 2020, at approximately 1:15 PM with Employee #7 (third and fourth floor clinical coordinator), he acknowledged the findings.</p> <p>2.The charge nurse failed to update Residents' #11, #12, #13, #14, #15, #16, #17, #18 and #19 care plans with person-centered goals and approaches after they were exposed to the COVID-19 virus:</p> <p>The following physician's orders were written for Residents' #11, #12, #13, #14, #15, #16, #17, #18 and #19 to direct the monitoring and precautions for staff to take when caring for the residents who were exposed to the COVID-19 virus:</p> <p>"Quarantine resident every shift x 14 days every shift for COVID-19 exposure for 14 Days 10/30/2020 23:00 (11:00 PM) [start date] 11/13/2020 [end date]"</p> <p>"Maintain isolation precautions (mask, gown, gloves) every shift every shift for COVID-19 exposure for 14 Days 10/30/2020 23:00 (11:00 PM) 11/13/2020"</p>	L 051		12/4/20

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L 051	<p>Continued From page 9</p> <p>"Monitor/assess resident and document in [computer system] for signs and symptoms of COVID-19 x14 days every shift for COVID-19 exposure for 14 Days [start date] 10/30/2020 23:00 (11:00 PM) [end date] 11/13/2020"</p> <p>A review of clinical records for Residents' #11, #12, #13, #14, #15, #16, #17, #18 and #19 showed the following:</p> <p>Resident #11 was admitted to the facility on 7/19/2011, with diagnoses that included Anxiety, Chronic Kidney Disease, Paranoid Schizophrenia and Essential Hypertension.</p> <p>Review of the care plan dated 9/10/2020, showed no evidence that facility staff updated Resident #11's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #12 was admitted to the facility on 9/5/2014, with diagnoses that included Hyperlipidemia, Schizophrenia, Type 2 Diabetes Mellitus and Obesity.</p> <p>Review of the care plan dated 7/10/2020, showed no evidence that facility staff updated Resident #12's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #13 was admitted to the facility on 8/4/2014, with diagnoses that included Major</p>	L 051		12/4/20

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L 051	<p>Continued From page 10</p> <p>Depressive Disorder, Anemia, Heart Failure and Peripheral Vascular Disease.</p> <p>Review of the care plan dated 6/16/2020, showed no evidence that facility staff updated Resident #13's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #14 was admitted to the facility on 9/14/2017, with diagnoses that included Dysphagia, Type 2 Diabetes Mellitus, Heart Failure, Anemia, Colostomy Status and Asthma.</p> <p>Review of the care plan dated 7/15/2020, showed no evidence that facility staff updated Resident #14's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #15 was admitted to the facility on 11/14/2015, with diagnoses that included Insomnia, Type 2 Diabetes Mellitus, and Hemiplegia.</p> <p>Review of the care plan dated 9/1/2020, showed no evidence that facility staff updated Resident #15's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #16 was admitted to the facility on 7/26/2016, with diagnoses that included Pressure Ulcer, Insomnia, Encephalopathy, Hemiplegia</p>	L 051		12/4/20

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NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>
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L 051	<p>Continued From page 11</p> <p>and Hemiparesis and Gastro Esophageal Reflux Disease (GERD).</p> <p>Review of the care plan dated 8/13/2020, showed no evidence that facility staff updated Resident #16's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #17 was admitted to the facility on 4/27/2016, with diagnoses that included Dysphagia, Chronic Respiratory Failure, Seizures and Hyperlipidemia.</p> <p>Review of the care plan dated 7/8/2020, showed no evidence that facility staff updated Resident #17's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #18 was admitted to the facility on 9/26/2012, with diagnoses that included Muscle Weakness, Dysphagia, Hyperlipidemia, Gout and Disorganized Schizophrenia.</p> <p>Review of the care plan on 10/9/2020, showed no evidence that facility staff updated Resident #18's care plan with the specific interventions directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>Resident #19 was admitted to the facility on 8/18/2020, with diagnoses that included Muscle Weakness, Heart Failure, End Stage Renal</p>	L 051		12/4/20

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L 051	<p>Continued From page 12</p> <p>Disease (ERSD) and Type 2 Diabetes Mellitus.</p> <p>Review of the care plan dated 9/14/2020, showed no evidence that facility staff updated Resident #19's care plan with the specific interventions as directed in the physician's order for COVID-19 exposure that occurred on 10/30/2020.</p> <p>During a telephone interview conducted on 11/5/2020, at approximately 12:30 PM, Employee #7 (third and fourth floor clinical coordinator) he stated, "Typically, it is myself or the unit manager who makes changes to the care plan. Care plans are updated anytime there are any significant changes in health, for example a fall or sickness." Employee #7 acknowledged the findings.</p> <p>3.The charge nurse and interdisciplinary team/staff failed to revise Resident #24's care plan to include dialysis services.</p> <p>Review of Resident #24's current clinical record on 11/07/20, at 2:00 PM showed that the resident was admitted to the facility on 07/30/20, with diagnoses that included End-Stage Renal Disease (ESRD).</p> <p>Further review of the record revealed nursing notes dated from 10/13/20, to 11/04/20, that documented the resident received hemo-dialysis services on Tuesdays, Thursdays and Saturdays.</p> <p>Resident #24's current clinical record showed a care plan initiated on 10/23/20, which lacked documented evidence of goals and approaches to address Resident #24's diagnosis of End-Stage Renal Disease.</p>	L 051		12/4/20

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L 051	<p>Continued From page 13</p> <p>During a telephone interview conducted on 11/10/20, at 11:56 AM, Employee #13 (Assistant Director of Nursing) acknowledged the findings and stated that goals and approaches to address the resident's diagnosis of End-Stage Renal Disease were accidentally deleted.</p> <p>At the time of the survey, it was noted that the facility's interdisciplinary team/staff failed to revise Resident #24's care plan to include goals and approaches to address the resident's diagnosis of End-Stage Renal Disease.</p> <p>audit on all residents to identify those</p>	L 051	<p>In service was provided by nurse educators to all unit managers on the importance to update residents care plan to reflect person centered goals and approaches to address the resident's exposure to the Covid-19 virus by 12/4/20.</p> <p>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: -All residents in the facility have the potential to be affected. -DON/ Designee will conduct house-wide</p> <p>residents that the facility did not ensure their care plans were updated to reflect their potential exposure to the Covid-19 virus by 12/4/20.</p> <p>MEASURES TO PREVENT RECURRENCE: All unit managers will complete house-wide audit to identify potential residents that their care plan was not updated to reflect their current health status by 12/4/20.</p> <p>MONITORING CORRECTIVE ACTIONS: -DON/Designee will audit all charts in the facility to ensure that care plans are updated to reflect the resident's current health status weekly x4 then monthly x3 until 12/4/20. -IDT team will review residents' chart to ensure their care plans are updated to reflect resident's present condition from all disciplines weekly x4 then monthly x3 by 12/4/20. Any findings will be reported to QAIP Director monthly until 12/4/20.</p>	12/4/20
L 052	<p>3211.1 Nursing Facilities</p> <p>Sufficient nursing time shall be given to each resident to ensure that the resident receives the following:</p> <p>(a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;</p> <p>(b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers:</p> <p>(c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair;</p> <p>(d) Protection from accident, injury, and infection;</p> <p>(e)Encouragement, assistance, and training in self-care and group activities;</p> <p>(f)Encouragement and assistance to:</p>			

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L 052	<p>Continued From page 14</p> <p>(1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;</p> <p>(2)Use the dining room if he or she is able; and</p> <p>(3)Participate in meaningful social and recreational activities; with eating;</p> <p>(g)Prompt, unhurried assistance if he or she requires or request help with eating;</p> <p>(h)Prescribed adaptive self-help devices to assist him or her in eating independently;</p> <p>(i)Assistance, if needed, with daily hygiene, including oral care; and</p> <p>j)Prompt response to an activated call bell or call for help.</p> <p>This Statute is not met as evidenced by:</p> <p>A. Based on observation, record review and staff interview for one (1) of 24 sampled residents, facility staff failed to allow for sufficient time to document in one (1) residents' medical record that he was transferred from 2 North unit [COVID -19 Positive unit]. Resident #8.</p> <p>Findings included...</p> <p>Resident #8 was admitted to the facility 6/28/2020, with diagnoses that included Hyperlipidemia, Hypertension, Diabetes Mellitus, Cerebrovascular Disease, and Major Depressive Disorder.</p>	L 052	<p><b>CORRECTIVE ACTION FOR AFFECTED RESIDENT:</b></p> <p>- Resident # 8 was assessed on 11/27/20; resident suffered no negative outcome.</p> <p>-Staff educators provided in-services on 11/27/20 to the clinical and social Services team members on the importance of proper documentation on residents who are Covid-19 positive or are exposed to the Covid-19 virus. Residents and are to be relocated to another unit by 12/4/20.</p> <p><b>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:</b></p> <p>-All residents residing in the facility have the potential to be affected.</p> <p>- DON/ Designee will conduct house-wide audits to identify potential residents that the facility staff did not ensure proper documentation was in place for relocation by 12/4/20.</p> <p><b>MEASURES TO PREVENT RECURRENCE:</b></p> <p>- Social service team will make sure proper documentation is in place once they receive a 6-108 for relocation of a resident by 12/4/20.</p> <p>- In-service will be provided by educators to clinical staff on the importance to ensure that there is proper documentation in place before a resident is relocated to another unit by 12/4/20.</p>	<p>12/4/20</p> <p>12/4/20</p>
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L 052	<p>Continued From page 15</p> <p>During a tour of unit 4South on November 4, 2020, at 11:00 AM, Resident #8 was observed in room 427 bed A.</p> <p>A review of the Progress note dated October 1, 2020, showed the following:</p> <p>10/1/2020 15:01 PM [3:01 PM] "Relocation note - [Resident's name] was relocated from 4 south to 2N[north] for testing positive for COVID-19, activity staff will proceed with the plan of care for the next 90 days."</p> <p>10/1/2020 19:40 PM [7:40 PM] Physician progress note: "Patient transferred to 2N for TOPP [temporal observation program] and observation following testing positive for COVID 19. He is otherwise asymptomatic with no fevers, cough or SOB [short of breath] Vitals are stable BP[blood pressure] 151/73 - will monitor ..."</p> <p>There was no documented information in Resident #8's medical record to show when he was transferred from unit 2 North [COVID -19 unit] to 4 south.</p> <p>During a telephone interview conducted on November 9, 2020, at approximately 1:15 PM with Employee #7 (third and fourth floor clinical coordinator), he acknowledged the findings.</p> <p>B. Based on record review and staff interview for two (2) of 24 sample residents, facility staff failed to provide sufficient nursing time to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices as</p>	L 052	<p>- IDT team will validate that proper documentation is in place for any resident who was relocated to another unit for observation by 12/4/20.</p> <p>-Unit managers will ensure that there is proper documentation for resident who are relocated from their units by 12/4/20.</p> <p><b>MONITORING CORRECTIVE ACTION:</b></p> <p>-DON/ Designee will audit charts of residents who were relocated to ensure there is proper documentation weekly x4 then monthly x3 by 12/4/20.</p>	12/4/20



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L 052	<p>Continued From page 16</p> <p>evidenced by: failure to monitor the vital signs every four hours as ordered by the physician for two (2) residents. Residents' #20 and #21.</p> <p>Findings included ...</p> <p>The facility's staff failed to monitor vital signs every four hours, as ordered by the physician for Residents' #20 and #21.</p> <p>A. Review of Resident #20's current clinical record on 11/06/20, at 10:00 AM showed that the resident was admitted to the facility on 3/25/20, with diagnoses that included Chronic Respiratory Failure, Hypertension and Obesity.</p> <p>Record revealed that the resident had a confirmed diagnosis of COVID-19 on 10/22/20.</p> <p>Review of the physician's order dated 10/22/20, that directed staff to monitor the resident's "vital signs Q (every) 4 hours every shift x 14 days (from 10/22/20 to 11/05/20)".</p> <p>Continued review of the record revealed Treatment Administration Records (TARs) and nursing notes dated from 10/22/20 to 11/05/20, that lacked documented evidence the facility's staff monitored Resident #20's vital signs every four (4) hours as directed by the physician.</p> <p>B. Review of Resident #21's current clinical record on 11/06/20, at 11:00 AM showed that the resident was admitted to the facility on 8/1/2017, with diagnoses that included Kidney Disease, Hypertension and Pneumonia.</p>	L 052		12/4/20
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L 052	<p>Continued From page 17</p> <p>Review of the record revealed that the resident had a confirmed diagnosis of COVID-19 on 10/22/20.</p> <p>Review of the physician's order dated 10/15/20 that directed staff to monitor the resident's "vital signs Q (every) 4 hours every shift x 14 days (from 10/15/20, to 10/29/20)".</p> <p>Review of the record revealed Treatment Administration Records (TARs) and nursing notes dated from 10/15/20 to 10/29/20 that lacked documented evidence the facility's staff monitored Resident #21's vital signs every four (4) hours as ordered by the physician.</p> <p>During a telephone interview conducted on 11/09/20, at approximately 2:30 PM, Employee #7 (third and fourth floor clinical coordinator), acknowledged the findings and stated that the staff did not monitor Resident #20's and 21's vital signs every four (4) hours as ordered by the physician.</p> <p>There was no evidence that facility's staff monitored Residents #20 and #21 vital signs every four hours as ordered by their physicians.</p>	L 052		12/4/20

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L 091 L 091	<p>Continued From page 18</p> <p>3217.6 Nursing Facilities</p> <p>The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter.</p> <p>This Statute is not met as evidenced by:</p> <p>Based on observations, record review and staff interview, in three (3) of three (3) observations, facility staff failed to: (I) wear required personal protective equipment (PPE) while in a resident care area and (II) maintain social distancing to help minimize the transmission of COVID-19 to residents and other staff in the facility.</p> <p>Findings included ...</p> <p>I. Facility staff failed to wear required personal protective equipment (PPE) while in the resident smoking area.</p> <p>A review of the policy entitled, "Protocol: COVID-19/CORONAVIRUS" showed, "Every employee will wear a mask and a face shield while at the residents' care area".</p> <p>During a tour of the smoking area on 11/4/2020, at approximately 11:30 AM, Employee #8 (certified nurse's aide) was observed with no face shield on while assisting a resident to light their cigarette.</p> <p>During a face-to-face interview conducted on 11/4/2020, at approximately 11:30 AM, Employee #8 stated, "I always wear my face shield. I just</p>	L 091		12/4/20
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L 091	<p>Continued From page 19</p> <p>took it off for a second." Employee #8 acknowledged the findings.</p> <p>Review of the in-service sign-in sheet dated 10/20/2020, showed Employee #8 signed-in, indicating attendance and receiving the training titled, "COVID-19 Virus".</p> <p>During a telephone interview conducted on 11/09/2020, at 11:43 AM, Employee #5 (staff development) stated, "The COVID-19 trainings include things such as hand hygiene, how to wear PPE, how the infection spreads and what precautions to take. We encourage all the employees to the follow the PPE policy and take actions when they don't."</p> <p>During a second tour of the smoking area on 11/4/2020, at approximately 4:15 PM, Employee #12 (CNA) was observed with no face shield on and face mask pulled down below her nose.</p> <p>Review of the in-service sign-in sheet dated 10/20/2020, for the training titled, "COVID-19 VIRUS", showed Employee #12 signed in, indicating attendance and receiving the aforementioned training.</p> <p>Facility staff failed to wear the required personal protective equipment (PPE) while in the resident smoking area.</p> <p>During a telephone interview conducted on 11/09/2020, at 11:43 AM, Employee #5 (staff development) stated, "The COVID-19 trainings include things such as hand hygiene, PPE, how the infection spreads and what precautions to</p>	L 091		12/4/20

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L 091	<p>Continued From page 20</p> <p>take. We encourage all the employees to the follow the PPE policy and take actions when they don't." Employee #5 acknowledged the findings.</p> <p>II. Facility staff failed to maintain social distancing guidelines to help minimize the transmission of COVID-19 to residents and other staff in the facility.</p> <p>According to the Centers for Disease Control (CDC), "To practice social or physical distancing, stay at least 6 (six) feet (about 2 arms' length) from other people who are not from your household in both indoor and outdoor spaces."</p> <p><a href="https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html#:~:text=Social%20distancing%2C%20also%20called%20%E2%80%9Cphysical,both%20indoor%20and%20outdoor%20spaces">https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html#:~:text=Social%20distancing%2C%20also%20called%20%E2%80%9Cphysical,both%20indoor%20and%20outdoor%20spaces</a></p> <p>During a tour of unit 3 south on 11/4/2020, at 3:10 PM, Employee #10 (CNA) and Employee #11 (CNA) were observed standing shoulder to shoulder [less than one (1) foot apart] while documenting.</p> <p>Review of the in-service sign-in sheet dated 10/15/2020, for the training entitled, "COVID-19 Virus/Infection", it showed Employee #11 signed in, indicating attending and receiving the aforementioned training.</p> <p>Review of the new hire orientation sign-in sheet dated 10/26/2020 that included the training titled, "Infection Control: COVID-19 (Hand Hygiene, PPE, Social Distancing)", showed Employee #10</p>	L 091	<p><b>CORRECTIVE ACTION FOR AFFECTED RESIDENTS:</b></p> <ul style="list-style-type: none"> <li>-No resident was affected</li> <li>-Targeted in- service was provided by nurse educators to employee #8 on the importance to wear face shield at all times on 11/27/20.</li> <li>-In service was also provided to employee #12 on the importance of wearing PPE's correctly at all times on 11/27/20 by staff educators.</li> <li>-Employees #10 and #11 were also re-educated on the importance of social distancing to prevent the spread of the Covid-19 virus on 11/27/20.</li> <li>-Staff educators also provided house- wide In-service on the proper use of PPE's and the importance of social of social distancing by 12/4/20.</li> </ul> <p><b>IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:</b></p> <ul style="list-style-type: none"> <li>- All employees in the facility have the potential to be affected.</li> <li>- IDT team will conduct house-wide assessment to ensure all employees are wearing their PPE's correctly at all times by 12/4/20.</li> </ul> <p><b>MEASURES TO PREVENT RECURRENCE:</b></p> <ul style="list-style-type: none"> <li>-Activities director will ensure employees working at the smoking patio are wearing their PPE's correctly and at all times and a log for validation is kept.</li> <li>-All departmental head will ensure the staff are wearing PPE's correctly and at all</li> </ul>	<p>12/4/20</p> <p>12/4/20</p> <p>12/4/20</p>
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD02-0017</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/10/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DEANWOOD REHABILITATION AND WELLNESS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5000 BURROUGHS AVE. NE WASHINGTON, DC 20019</b>
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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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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L 091	<p>Continued From page 21</p> <p>signed-in, indicating attending and receiving the aforementioned training.</p> <p>Facility staff failed to maintain social distancing guidelines to help minimize the transmission of COVID-19 to residents and other staff in the facility.</p> <p>During a face-to-face interview conducted on 11/4/2020, at 3:10 PM, both Employee #10 and Employee #11 acknowledged the findings.</p> <p>During a telephone interview conducted on 11/09/2020, at 11:43 AM, Employee #5 (staff development) stated, "The COVID-19 trainings include things such as hand hygiene, PPE, how the infection spreads and what precautions to take. We encourage all the employees to the follow the PPE policy and take actions when they don't." Employee #5 acknowledged the findings.</p>	L 091	<p>times by 12/4/20.</p> <p>-Maintenance team will reinforce tapes on the floors to ensure 6 feet apart is maintained.</p> <p>-Social distancing will be maintained especially at the Kiosk area by 12/4/20.</p> <p>-House wide in-service will be provided to all employees on the importance of wearing and keep PPE'S at all times and the importance of social distancing by 12/4/20.</p> <p><b>MONITORING CORRECTIVE ACTION:</b></p> <p>-IDT team will continue with daily rounds to ensure employees are complying with the proper use of PPE's by 12/4/20.</p> <p>- IDT team members will ensure that all tapes on the floor demarcated for social distancing is legible by 12/4/20.</p> <p>-Unit managers will monitor CNA's during documentation to ensure that they are practicing social distancing by 12/4/20.</p>	12/4/20
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